

# The Ebb and Flow of Child Health Policy Development in South Africa:

Three case studies reflecting the role of the Children's Institute at the  
University of Cape Town in shaping child health policy in South Africa



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# **The Ebb and Flow of Child Health Policy Development in South Africa:**

**Three case studies reflecting the role of  
the Children's Institute at the University of Cape Town  
in shaping child health policy in South Africa**

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## Contents

<b>1. Introduction</b>	<b>1</b>
1.1 About the Children's Institute	2
<b>2. Overview of child health services in South Africa</b>	<b>3</b>
2.1 What are child health services?	4
2.2 The organisation and delivery of child health services	4
<b>3. The policy development process</b>	<b>8</b>
3.1 Models of policy development	8
<b>4. The policy development process within the national Department of Health</b>	<b>11</b>
<b>5. The CI's approach to and role in child health policy development</b>	<b>12</b>
<b>6. The case studies</b>	<b>15</b>
6.1 Overview of process across the three cases	15
6.2 The Policy on Screening for Developmental Disabilities	19
6.3 The National School Health Policy	25
6.4 The Policy Framework for Non-communicable Chronic Conditions in Children	31
<b>7. Overall conclusions</b>	<b>35</b>
<b>8. Recommendations for child health policy development in South Africa</b>	<b>37</b>
<b><i>Bibliography</i></b>	<b>38</b>

## Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBOs	Community-based Organisations
CHPI	Child Health Policy Institute
CHU	Child Health Unit
CI	Children's Institute
DOH	Department of Health
HIV	Human Immunodeficiency Virus
HPSI	Health Promoting Schools Initiative
MCWH	Maternal Child and Woman's Health
NGOs	Non-governmental Organisations
ORC	Office on the Rights of the Child
PAWC	Provincial Administration of the Western Cape
PHRC	Provincial Health Restructuring Committee
RDP	Reconstruction and Development Plan
UCT	University of Cape Town

## Diagrams and tables

Diagram 1:	The multiple streams model	10
Diagram 2:	The stages in the Developmental Screening Policy development process that the CI was involved in	20
Table 1:	The role of the CI in three child health policies	16

# 1. Introduction

The complex tapestry of policy development with its interplay of multiple processes, role players and relationships makes for fascinating analysis and reflection. Very often in the life of policy research organisations the emphasis is on the research and related outputs and not much time is given to reflection on the experience of engaging with the policy process. Ongoing reflection on the processes, outputs and potential impact of policy-related projects will enhance the understanding of those engaged in policy processes. It will enable methodologies, dissemination of information, and due processes to be improved, which will in turn improve the nature and manner of academic organisations' input into policy processes. In addition, reflecting on the policy process from an 'external' organisation's point of view might help government policy-makers to find more efficient and effective ways of formulating, monitoring, evaluating and implementing policy.

The Children's Institute (CI) at the University of Cape Town was set up for the purpose of bringing evidence to bear on policies, laws and programmes for children. Since its inception, the CI has been engaged in several policy processes involving all phases of the policy cycle. Some entailed evaluating previously implemented policy, for example the Primary School Nutrition Programme (Mc Coy, 1996) and the delivery of 'free health care' to children under six and pregnant women (Mc Coy, 1997). Both evaluations were done one year post-implementation. In the three policy development processes that form the subject matter of this publication, we were involved from the point of identifying the need for the policy to the point of completing the policy. In one of the policy processes, CI involvement extended to the implementation and a one-year post-implementation evaluation.

The three case studies in this publication reflect on the role and contribution of the CI to three government child health policies over a seven-year period. The three child health policies are:

- The National School Health Policy and Implementation Guidelines (Department of Health, 2003);
- The Policy Framework for Non-communicable Chronic Conditions in Children (Department of Health, 2002); and
- The Western Cape Provincial Policy on Screening for Developmental Disabilities in Pre-school Children (Department of Health, 1999).

The case studies reflect the role of the CI in the different phases of policy development, including the implementation and evaluation phases of the Developmental Screening Policy. The case studies describe the CI's role, methodologies used, experiences (both explicit and behind the scenes), the strengths and challenges of the CI's involvement, and attempts to draw out lessons and suggestions on how to improve and strengthen child health policy development processes in general.

The publication contains:

- A brief description of the Children's Institute.
- A general description of the organisation and the delivery of child health services as background for readers unfamiliar with the South African environment.
- An attempt to describe policy development processes within the Department of Health. Understanding this context is very important as the constraints and challenges are integrally related to policy development at a national level. This in

turn is linked to the setting up of child health programmes at a national level, and also links to the previous description.

- An overview of each of the three policies.
- An analysis of the role and experiences of the CI across the three policy processes.
- Suggestions/recommendations for improving future interactions of the CI and similar organisations in local child health policy processes.
- Suggestions/recommendations for improving policy development for child health at a national and provincial level.

### **1.1 About the Children's Institute**

The Children's Institute (CI) is a multi-disciplinary child policy research institute based at the University of Cape Town. Its mission is to bring research to bear on policy and law development, programming and service delivery for children.

The CI was established in 2001, building on the foundations of its predecessor, the Child Health Policy Institute (CHPI). The Institute builds on the strength of its academic base, its multi-disciplinary staff complement and its wide network of collaborators and allies in the children's sector.

The CHPI was established in 1996 as a component of the Child Health Unit (CHU), with the mission of bringing research to bear on the development of health policies, programmes and services for children. The CHU was at the time the public health division of the Department of Paediatrics and Child Health at the University of Cape Town. The CHPI projects and activities were purposely selected to meet its agenda of shaping health policy for children. Projects and activities with the potential to inform and shape policies, programmes or services were prioritised. In 2001, the mandate of the CHPI was broadened to include a wide range of areas of child policy, not just health – hence the launch of the Children's Institute in July 2001.

Aside from its primary role of generating and collating evidence, the CI actively engages in evidence-based advocacy as a strategy for achieving its mission. This means bringing research-based evidence to the 'table' when engaging with policy-makers, government officials and civil society duty-bearers and contributing a sound evidence-base upon which decisions regarding policies, laws and practices can be based. Advocacy was a key strategy that the CHPI developed and used, as the traditional dissemination of research results in academic journals and large research reports were often not accessible by, and seldom gained entry to, the policy environment.

Over the six years of its existence the CHPI became an important contributor to the child health policy arena and was involved in initiating, developing and evaluating several national and provincial child health policies. Its first assignment, for the Office on the Rights of the Child (ORC), was to develop the framework for the National Plan of Action for Children – the ORC being the structure established to monitor and co-ordinate the implementation of the Convention on the Rights of the Child in South Africa. Following this, the CHPI conducted the first evaluations of two presidential-led Reconstruction and Development Plan (RDP) projects: the provision of free health care for pregnant and lactating women, and children under six years; and the Primary School Nutrition Programme.

The three case studies examined in this paper originated and were executed during the existence of the CHPI, though finalisation of the policies occurred after the establishment of the CI.

The level of detail in each case study differs. The Policy on Screening for Developmental Disabilities in Pre-school Children and its implementation was formally evaluated; therefore this study includes greater detail on the role of the CHPI, as well as the perception of the CHPI's role from the point of view of people who participated in the process. The other two case studies did not include formal evaluations and thus the perceptions of participants involved in the policy processes are more superficial.

The case studies reflect the experiences of both the CHPI and the CI. For simplicity we refer throughout to the CI as the primary organisation, but mention the CHPI specifically when relevant.

## **2. Overview of child health services in South Africa**

It is important to have a picture of the overall child health service context in South Africa, as the nuances that emerge in the case studies will be better understood with this background in place. Since the election of the first democratic government in 1994, several important changes have taken place within the health system of South Africa. A number of these changes were debated for several years prior to 1994 and many were effected with the onset of the new political order and resultant political will.

One such change is the government's explicit commitment to making children a priority, thus heeding the 'First Call' for children. The health sector adopted the spirit of the nation's commitment to children and implemented the major child health service mandate of the RDP viz. free health care for pregnant women and children under six years.

Until 1994, child health services were organised and structured as part of the overall health system. No specific emphasis was placed on children and there were very few policies and programmes that specifically targeted children. Since 1994 however, the number of health policies and programmes specifically geared towards children have increased substantially.

However, changes to the health system are still in evolution. The vision is now to move from a centralised, curative-biased, hospital-centred health system to one that adheres to the principles of the primary health care approach and is managed and organised within a district health system.

Through a process of restructuring at both national and provincial levels, directorates for Maternal, Child and Women's Health (MCWH) have been established. The purpose of these directorates is to oversee the overall delivery of health services to children; to develop and implement child health policies, programmes and services; and to monitor child health status and health service delivery.

## **2.1 What are child health services?**

Health services for children can be categorised in many different ways. The most common categorisation divides child health services into Promotive, Preventative, Curative (which is further divided into acute and chronic) and Rehabilitative.

*Promotive health services* are intended to increase knowledge and understanding and to bring about change in the behaviour of the parents, caregivers and the public regarding keeping children healthy.

*Preventative health services* are aimed at implementing known interventions such as immunising children against childhood infections or giving vitamin supplementation to improve their ability to fight serious infections.

*Curative health services* refer to treating children when an illness has already occurred. This service is further divided into acute and chronic. Acute refers to illnesses of short duration, whilst chronic refers to illnesses expected to last at least one year or longer, such as asthma, diabetes, HIV, childhood cancers and various disabilities. Curative care requires special attention, as most health care resources are still expended on curative care. There are three different levels of curative care, i.e. primary, secondary and tertiary:

- **Level one or primary level care** is the provision of basic curative care that does not require hospitalisation or complex investigations. Primary level care is generally rendered at community or district level.
- **Level two or secondary level care** refers to care that can only be rendered in a hospital with general specialists. Secondary level care is rendered in a hospital that is located at regional or provincial level.
- **Level three or tertiary level care** refers to care that can only be rendered in designated hospitals where super-specialists are available to the patient. Tertiary level care is rendered in designated hospitals such as the Red Cross Children's Hospital. Tertiary level health activities are funded at national level, as well from the budget of the province in which they are located.

*Rehabilitative health services* aim to rehabilitate children after an illness, accident or disability so that they can function as optimally as possible.

## **2.2 The organisation and delivery of child health services**

In South Africa, three spheres of governance exist, namely national, provincial and local. Each sphere has specific responsibilities in the provision of child health care. The Constitution (Act No 108 of 1996), specifically in schedules 4 and 5, sets out the broad principles for the division of responsibility for health care services between the three spheres of government. The details regarding the division of responsibilities has been fleshed out in various policies and practices over the past 10 years and has recently been legislated in the new National Health Act No 61 of 2003 (Republic of South Africa, 2003).

Within these three spheres, child health services are rendered by a number of different agencies including governmental, non-governmental, private-for-profit and private not-for-profit providers.

The remainder of this case study deals mainly with governmental policies relating to public sector service provision, given that the majority of South African children rely on public



sector health care facilities. Governmental level health responsibilities are executed through the national and provincial Departments of Health, as well as through local authority health departments such as the City of Johannesburg, Cape Town or Etwekweni Municipality health departments.

**a) Role and responsibilities of the national Department of Health**

The national Department of Health is responsible for setting overall policies, laws and programmes for children and has several programmes that are organised into clusters. The main clusters dealing with child health are the MCWH and the Nutrition clusters.

The Department of Health collaborates with other units in drawing up norms and standards for service delivery, monitoring and evaluation. The main focus is the prevention of morbidity and mortality and the promotion of health through, among other interventions, human resource development, the Expanded Programme on Immunisation and the Integrated Management of Childhood Illnesses.

This national MCWH cluster (or chief directorate) also has jurisdiction over the nine provincial MCWH programmes, each of the provincial programmes having a specific person responsible for child health. This is meant to be replicated at district level but, while present in many districts, is not yet in place in all districts.

The cluster has a number of directorates, child health being one of them. The child health director is thus the person responsible for overseeing all activities relating to child health and ensuring appropriate co-ordination and collaboration with other clusters within the Department of Health. The child health directorate is mainly responsible for acute curative health services for children, preventative programmes such as the Expanded Programme for Immunisation, School Health, Youth and Adolescent Health, and Nutrition.

There are several other components of child health that are managed by other programmes at a national level. The main additional programmes are:

- The Directorate for Health Promotion, responsible for policies and programmes relating to health promotion activities for children. This includes, for example, the Health Promoting Schools Initiative.
- The Directorate for Chronic Care, Disabilities and Geriatrics. They develop policies and programmes that govern disabilities, non-communicable (non-infectious) health conditions and mental health issues in adults and children.
- The Directorate for HIV/AIDS determines HIV/AIDS policies and programmes for adults and children.

In addition, clusters that deal with the general health systems issues such as human resources and district development have a significant impact on the structure and development of child health services.

The planning and development of policies and programmes that affect child health therefore requires close collaboration and joint planning between all the divisions mentioned above, with co-ordination being the primary responsibility of the child health director in the MCWH cluster, supported by the overall chief director for the cluster.

When it comes to legislation, even where children would be significantly affected, the process is led by the legal services division in the Department of Health with input from all

directorates involved. This is potentially an area where, if the input of the MCWH cluster is not adequately sought or given, child health issues could be overlooked in legislation involving the health system as a whole – the recently passed National Health Act being an example where children are only marginally referred to but profoundly affected by the clauses in the Act.

No direct service provision occurs at a national level, although selected highly specialised hospital services are co-ordinated at a national level.

#### ***b) Responsibilities of provincial Departments of Health***

The provincial structures mirror those at a national level. Each province has a dedicated programme manager for MCWH. Each programme, however, has varying combinations of child health activities for which they are responsible. In some provinces, for instance, nutrition is a stand-alone programme, whereas in others it is combined with MCWH. Provinces are responsible for executing national laws, policies and programmes; although they are given latitude to adapt the ultimate shape and delivery of these for their specific provincial context, they are not at liberty to ignore a national policy or programme directive. In general, all national policy and programmes are developed in consultation with provincial child health managers.

Currently there are three types of public sector health facilities through which primary (or first) level care is provided, namely clinics, community health centres (known as day hospitals in some areas) and district hospitals. Community health centres and district hospitals fall under the management of the provincial health departments, whilst clinics are managed by local government health authorities. The size and nature of such local government health authorities vary greatly between districts and provinces. It should be noted that negotiations to transfer the responsibilities for the running of clinics to the provincial health departments are underway.

Provinces are also responsible for rendering referral hospital care through secondary and tertiary hospitals.

##### *i) Primary level health care facilities*

Community health centres and district hospitals focus primarily on first level curative care, meaning curative care that does not require complex or specialist interventions.

Community health centres, which render only outpatient services, are staffed by general practitioners, nurses and allied staff. Care to children at these centres is primarily rendered by medical officers, some of whom have additional training in child health. Some of these centres operate only on weekdays during normal working hours. Others are designated to render 24-hour services, seven days a week. The availability of such centres differs from province to province. For example, in the Western Cape metropolitan region, there are approximately 42 such centres, nine of which function on a 24-hour basis. In some provinces there are more district level hospitals than in the Western Cape, whilst in others there are mostly clinics with hardly any community health centres. The first level of referral from a community health centre is to the district hospital, or else a secondary hospital if there is no district hospital in the area.

District hospitals are the first level of hospital care where in-patient facilities, and facilities for surgical procedures that do not require a specialist, exist. District hospitals are staffed by nurses and general practitioners, supported by allied health professionals such as physiotherapists and radiographers. The staffing mix varies between hospitals. Children are

also attended to at the outpatient departments of district hospitals. The number and availability of district hospitals varies between provinces. For example, provinces such as Limpopo have a fairly extensive network of district hospitals (pers. comm. Dr. A. Robertson, February 2005) whereas the Western Cape metropolitan area has only two district hospitals with a larger network of regional (second level) hospitals instead. Prior to 1994, both community health centres and district hospitals charged user fees for children according to a sliding scale based on family income.

The third type of facility is the local government clinic that renders preventative as well as curative care. These clinics fall directly under the management of local health authorities, such as municipalities or regional councils. The difference between the clinics and community health centres is that clinics are mainly staffed by nurses. Curative care in clinics is rendered by clinical nurse practitioners, who have additional training in primary health care. A clinical nurse practitioner is allowed to diagnose and prescribe for primary level conditions. Any cases that they are unable to handle are referred to the community health centre or district hospital where a doctor is available.

Clinics are the backbone of primary level service provision in the public sector. They exist in various configurations and proportions across provinces, from one-nurse outfits in sparsely populated areas of the Northern Cape to large operations with many staff in the more densely populated and better-resourced metropolitan areas. Prior to 1994, clinics, which were either fixed or mobile, rendered mainly preventative and health promotion services and fell under the jurisdiction of various local authorities across the country. Preventative activities for children including immunisation, growth monitoring and developmental screening were rendered free of charge. Post-1994, clinics were given increasing responsibility for handling curative cases as well, and now render a full spectrum of health promotion, preventative and curative care for children and adults. Only serious illnesses requiring attention from doctors, trauma cases, and chronic conditions for children are not managed at clinic level.

#### *ii) Hospital facilities*

More serious or complex conditions requiring specialist care and/or further investigation are referred to secondary level facilities (the next level up from the primary level and which handle slightly more complicated cases requiring in-hospital care or further investigation) or tertiary level facilities (hospitals that offer highly specialised care and investigations, such as the Red Cross Children's Hospital). Secondary and tertiary level hospitals are integral parts of the delivery of health services to children and form a referral continuum together with primary level facilities.

Access to and quality of secondary and tertiary level hospitals varies, depending on where children live. For example, children living far from city-based hospitals with Intensive Care Units do not have ready access to intensive care. Furthermore, treatment for certain chronic conditions is almost non-existent in the more rural provinces of South Africa (pers. comm. Dr. A. Robertson, February 2005).

Prior to 1994, secondary and tertiary hospitals charged user fees to children based on a family income-dependent sliding scale. In addition, referral letters from primary level facilities were required to gain access to hospitals. In the absence of primary level facilities in a particular area – or sometimes based on client preference – the outpatient departments of hospitals performed primary level functions as patients accessed these departments for fairly minor ailments. This resulted in expensive resources being used to treat minor ailments, which in itself warranted change (Shung-King, 1998).

The structure and organisation of child health services creates many challenges for effective and co-ordinated policy planning and implementation. We will now look at how the policy development process works. Understanding the current process for policy-making is very important as background to this publication, and the issues that emerge from the case studies later on need to be understood within the context described in these earlier sections.

### **3. The policy development process**

Policy is a purposeful course of action that is followed in dealing with a problem and provides a framework for decisions and actions. Policy-making is a complex process.

A number of models/frameworks have been developed to understand the process of policy formation. Each model approaches policy development quite differently and helps one appreciate how diverse policy development is in the real world. The steps outlined for each model provide a brief summary of the process as played out through each model. Each step involves a number of additional processes and actions. Some of these processes and actions are expanded on in greater detail when describing the actual case studies.

#### **3.1 Models of policy development**

Three of the most common models (the Stages, Incremental and Multiple Streams models) are briefly described below. Bear in mind that, whilst several theoretical policy development models are proposed, in reality a combination of the different theoretical models is often employed during the actual policy development process.

##### **3.1.1 Stages model**

As the name suggests, the policy process in this model unfolds in distinct stages.

###### ***a) Identification of policy problem***

This stage involves unpacking the issue/problem at hand using a combination of literature review, evidence and talking to key role players. It involves understanding the nature, size, extent and potentially remediable factors related to the problem/issue.

###### ***b) Agenda setting***

This step involves focusing the attention of public officials on the problem.

###### ***c) Formulation of policy proposals***

This involves the identification and analysis of potential solutions to the policy question/problem and then putting forward the pros and cons of each potential solution. It could involve a very complex analysis of cost-effectiveness and cost-efficiency, or a slightly less technical feasibility study.

###### ***d) Adoption of policy***

This involves selecting the most appropriate policy option, developing the policy around the preferred option and getting the policy passed and accepted through the official decision-making structures.

### **e) Implementation**

This step is self-explanatory and ideally any policy should have a clear set of implementation guidelines.

### **f) Evaluation**

This is a critical part of the policy process, but is seldom thought through at the outset and not always conducted. This model is derived from the early work of Harold Lasswell (1951). There have been various modifications of this model since then.

The strengths of this model are that it moves away from the earlier focus on institutions and introduces a process approach. It reduces the intricacies of policy-making into manageable analytic units.

The main criticism is that, although it does parallel cognitive steps, it is not a reflection of what happens in the real world. Policy-making often does not follow these steps in order and more often than not, several steps happen at once. A further criticism is that it fails to reflect the political nature of the policy development process and makes it appear like a very neat linear process.

### **3.1.2 Incremental model**

This model is generally used where policy already exists and changes to the policy are required. The key features of this model are that the new policy option generally differs only marginally from existing policy and that it focuses on small changes.

The strengths of the model are that it is convenient as there may be heavy investment in existing programmes which preclude any real radical change.

The main criticism is that it is conservative and may allow ineffective policies to continue. It also limits original or innovative new inputs and does not allow for the full participation of other role players and stakeholders.

An example of the incremental model in South Africa is the 'free health care' policy. It started off being only for children under six, and pregnant and lactating women, and then got incrementally extended to other groups, without adequate evaluation of how the initial policy was working.

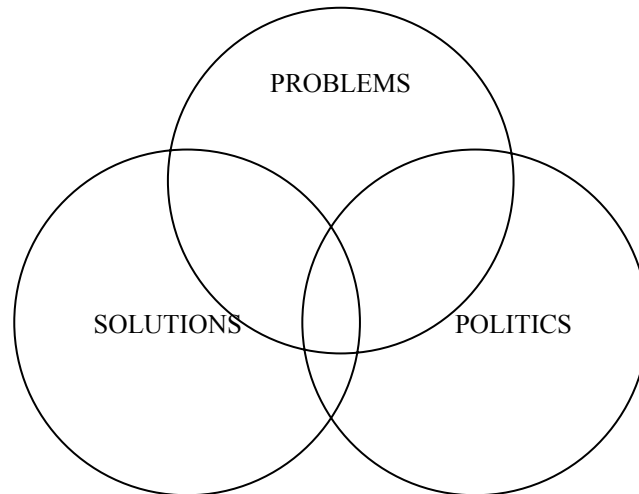
### **3.1.3 Multiple streams model**

This model was developed by Kingdon (1984). In this model, policy-making can be conceptualised as three separate 'streams':

- **Problem stream.** In this stream social conditions become defined as problems and are brought to the attention of government and public officials.
- **Policy/solutions stream.** A community composed of researchers, advocates and other specialists who analyse problems and formulate possible solutions.
- **Politics stream.** A stream consisting of elections, leadership contests, change of ministers etc.

Organisations and agencies may find themselves in different streams at different points in time. For example an academic research institution may be part of the ‘problem’ stream by bringing evidence of a policy problem to the table or might also be in the solutions stream where they help to formulate options and solutions to address the problem. Similarly government might be in the solutions stream as they are also policy experts/specialists, whilst at the same time being part of the political stream.

**Diagram 1: The multiple streams model**



**Source:** Kingdon JW (1984). *Agendas, Alternatives and Public Policies*. Little, Brown; Boston.

This model assumes that each stream has a life of its own and that at points there might be partial couplings. Major policy reform results when a ‘window of opportunity’ joins the three streams. For example: in response to a problem the policy community develops a solution that is financially and technically feasible and politicians find it advantageous to approve the policy. ‘Policy entrepreneurs’ play a key role in connecting the three streams. This approach incorporates an enlarged view of policy communities. It recognises the role of substantive information in responding to real world problems. The conditions creating a ‘window of opportunity’ do need further analysis.

The main criticism of the model is the ‘leaving things to chance’ approach rather than making concerted efforts to get the three ‘streams’ to interact in a planned and controlled fashion. In instances where there is a strong co-ordinator or driver who takes the initiative to create windows of opportunity and who channels these towards a particular policy goal, it can work very well.

#### **4. The policy development process within the national Department of Health**

The policy-making process for child health is complex and how it is executed varies between the different clusters within the national Department of Health, between national and provincial departments of health, and between provinces.

There are no uniform processes or guidelines as to what constitutes a policy document, how policy should be developed and approved, or what format and content policy documents should contain. In a rapid survey done in 1997 by the CI, wherein selected senior health officials and organisations involved in policy development were interviewed regarding their experience and understanding of policy development processes in the country, the then director of systems development and policy co-ordination at the national Department of Health stated that "there were many policy frameworks in place and that he was trying to get staff in the DOH to use a particular framework" (Wigton and Abrahams, 1998). Based on the experiences of the CI over the past 10 years, our assessment is that the situation of not having a standardised format or process for policy development and approval has not changed.

The current process that is followed at a national level is as follows:

- A draft policy is developed by a particular programme/directorate within the national Department of Health. Some programmes develop the draft policy after a very wide consultative process, whilst others restrict consultation to a few experts or a reference group.
- The policy is then circulated for comments to other directorates, national departments, other stakeholders from non-health sectors in government where appropriate, and to external stakeholders. The policy is thereafter meant to be circulated to all provinces which in turn circulate it to district managers and to staff within health facilities for further comment. The application of this step varies between policy processes and seems to depend on the extent to which the leader/driver of the policy process wishes to consult. The consultation process at a national level is non-negotiable, where the policy has to be circulated to all relevant clusters for comment and thus all senior managers will see and comment on the policy. However, the extent of stakeholder consultation at provincial and district levels varies widely. It is also not monitored and therefore much depends on the commitment of the provincial representative.
- Comments are considered and a final policy document is compiled and presented to the Provincial Health Restructuring Committee (PHRC). This committee consists of heads of health from all nine provinces, chief directors of all national clusters and the director general of health and his/her deputies at national level.
- Upon acceptance by the PHRC the document is forwarded to MINMEC for final approval and official acceptance as a Department of Health policy. MINMEC is a committee made up of the national minister of health, together with the nine provincial ministers of health, as well as the nine provincial heads of health. In recent years, the final acceptance of a new policy is dependent on a costing of the policy having been done.

The process for provincial approval of policies seems to vary between provinces. This publication did not determine the process within each province. In the Western Cape, where one of the case studies discussed here was done, the process, according to the MCWH programme manager, varies. The policy, having been prepared by a programme manager, has to be commented on and approved at a meeting of the most senior managers, meaning

the chief directors of the various divisions. It also has to include an implementation or operational plan and, in recent years, a budget.

The 'classification' of the actual policy documents differs. In some instances it is called a policy, whilst at other times it is called policy guidelines or simply guidelines. The contents of policy documents also differ in terms of actual sections as well as the level of detail. No uniform blueprint or framework exists that stipulates the minimum required content to which all policies must conform. Very few policies have implementation guidelines and even fewer have a budget or proper costing of the policy.

However, in some provinces (such as the Western Cape) this situation has changed. Since 2004 there is a committee called the Western Cape Clinical Guideline Accreditation Committee which accredits all provincial guidelines using a standardised tool.

## **5. The CI's approach to and role in child health policy development**

The CI has, since its inception, addressed all phases of the policy cycle including problem identification, policy development from start to finish (which includes formal adoption of the policy), implementation and evaluation. The exact phase of the policy cycle that the CI worked on varied from project to project. This involvement straddled direct engagement in the development of the policy through evaluating the policy to conducting policy analyses on completed policies.

The majority of government commissions involved evaluating policies that had already been implemented. In addition, the CI has analysed many policies that were already developed and which required critical analysis and feedback for the policy writers. In three policies (the subjects of the case studies in this paper) the CI was involved from the problem identification stage through to the policy development.

For each type of involvement an internal template or process was developed so that input could be consistent and standardised. For policy analyses, a series of checklists were developed to guide or analyse. Some of these checklists were later incorporated as part of the course material for a three-day short course on child health policy that was subsequently delivered to a number of national and provincial programme managers involved in policy development.

For policies where involvement commenced at the policy initiation stage, an internal process evolved that was consistently applied to each new policy area.

### **5.1 The CI's role in child health policy development**

This section describes the generic approach taken by the CI starting at the very beginning of the policy cycle.

One of the key objectives of the CI is to characterise and analyse children's health needs, assess if existing policy responses are adequate to address those needs, identify policy gaps/opportunities and contribute to the development of appropriate policy responses to children's health needs.



Identifying policy gaps/opportunities requires ongoing consultation with key groups in the country that are responsible for, or involved with, child health. Ongoing dialogue and networking with groups such as clinical health care providers to children, national and provincial child health programme managers, and civil society organisations involved with activities that impact on child health, form an integral part of CI activities.

In the first few years of the CHPI, staff carried out regular site visits to all provincial MCWH managers where discussions on the key needs of programme managers were held. Once a year, the CHPI invited all national and provincial MCWH programme managers to a meeting where common challenges with respect to child health services were discussed. In turn, the CHPI staff attended some of the quarterly meetings of national and provincial MCWH managers to hear what their main concerns were, especially regarding policy challenges.

In addition to these conversations with government officials, policy needs and gaps were brought to the CHPI's attention by health service providers including clinicians from the Red Cross Children's Hospital, fellow child health researchers and civil society groups.

As part of developing a clear and consistent approach to addressing the policy gaps brought to its attention, the CHPI developed a set of steps that became the predominant 'methodology' for addressing and taking policy concerns forward.

#### **a) *Characterising the policy issue***

This is done by conducting a review of local and international literature. The literature base includes peer-reviewed articles, grey and fugitive literature, research reports and other relevant documents. This characterisation entails a description of the size and extent of the issue, the current situation in South Africa and elsewhere, the underlying determining and influencing factors, the interventions/responses that exist locally and internationally, lessons and challenges that need to be considered and the potential options that must be weighed in developing a coherent policy response. The product of the review is a discussion document which becomes the basis for the next step – the convening of a national policy roundtable discussion.

#### **b) *Convening a policy roundtable***

The policy roundtable is conducted nationally and generally involves bringing together between 30 and 40 representatives from a range of stakeholder groups that include the government, service providers, civil society organisations, academia and relevant international agencies. Prior to convening the roundtable, discussions are held with role players as to what the nature and content of the roundtable should be.

The aim of these roundtables is to unpack the issue/problem, identify clear steps for taking it forward and to identify whether there is a need for a policy response. If so, specific persons/organisations are identified to take the process forward.

Aside from the discussion paper that helps to frame the discussion questions/issues, additional speakers are invited to give input on relevant topics. Speakers usually include, amongst others, research experts from the area under discussion, clinical service providers who understand the hands-on service implications, and government officials who are involved in policy formulation or in managing a particular programme that relates to the area of concern.

The output from the roundtable discussions usually includes a list of issues requiring attention, coupled with proposed strategies on how to address the issues that were identified. The issue list generally includes a set of gaps/challenges in the area of child health under discussion, a set of recommendations on how to take it forward, a set of research questions that needed to be addressed and a suggested way forward for filling any identified policy gaps.

Specific individuals or organisations are selected or nominated through a consensual decision-making process by the roundtable attendants and are tasked with taking the lead on selected issues. A lead organisation usually takes the responsibility for further follow-up and co-ordination of the issues emanating from the roundtable discussion. The lead organisation differs depending on the issue. Specific policy responses are usually taken on by provincial or national governmental health departments, and other issues by the CI itself and/or various partner organisations or collaborators.

A workshop report that serves as a record of the roundtable process is produced and distributed to all participants.

### **c) Developing an action plan beyond the roundtable**

This step is generally the most challenging, as developing a research and action agenda that will contribute constructively to policy and law formulation is critical.

This step takes many weeks and months of discussions, caucusing and planning and, depending on the relationship to the persons driving the policy process, varies from being very smooth to very trying. This step involves significant advocacy efforts involving campaigning/negotiating for transformation to begin. In reference to the ‘multiple streams model’, this may be the phase in which the policy entrepreneur actively seeks to create the essential ‘window of opportunity’ needed to get the policy development process initiated. The policy entrepreneurs often need to take an active role in creating the ‘window of opportunity’ and this is often done through a focused campaign/dialogue strategy aimed purposefully at getting buy-in from the decision-makers to initiate and manage the process.

Sometimes, as illustrated later in the three case studies, national or provincial managers might not initially agree that a policy is needed despite evidence to the contrary, and might prefer the *status quo* to remain unchanged for various reasons such as staying in a comfort zone, being resistant to change, having other priorities, agendas or budgetary issues. Therefore appropriately campaigning the policy-makers, implementers and users for their buy-in and commitment is extremely important as they will ultimately be responsible for the co-ordination and implementation of the process.

This has been a significant role played by the CI and has often taken up the most time and energy in the policy processes in which it has been involved.

The steps outlined above reflect the first two steps of the ‘stages model’ described in section 3.1.1 fairly accurately.

### **d) Engaging in development of the policy**

Further involvement in the policy development process is dependent on the nature of the policy process and varies from policy to policy.

The Children's Institute's specific role in each of the three policy case studies are described in detail in the next section.

## **6. The case studies**

This section describes an overview to the approach used in all three case studies, the role and experience of the CI with each policy, the lessons learnt in each instance, and ends with a synthesis of overall lessons and challenges across all three cases.

Each of the case studies outlines the following:

- The background regarding how the issue came onto the policy agenda
- The process of policy development
- Current status of the policy
- Strengths and challenges of the process
- Lessons learnt

The section ends with a set of recommendations for future policy development – both for the CI and similar organisations, as well as for government policy-makers.

### **6.1 Overview of process across the three cases**

The case studies involve the development of three important policies for child health. Two of the case studies, the National School Health Policy and Implementation Guidelines (referred to as the School Health Policy in short) and the Western Cape Provincial Policy on Screening for Developmental Disabilities in Pre-school Children (Developmental Screening Policy in short), relate to the development of policies for preventative components of the child health services that would primarily be implemented at district level, in and through community health facilities. The last policy, namely the Policy Framework for Non-communicable Chronic Conditions in Children (referred to as the Chronic Conditions Policy in short) relates to chronic care for children and cuts across all levels of service provision (from the district through to specialist hospitals) and includes preventative, curative and rehabilitation aspects.

Each of the three policy processes followed the same set of steps in the sequence outlined in column one of the diagram below. The CI followed slightly different routes at the point of policy development, where each policy process followed a slightly different approach.

The School Health and Chronic Conditions Policies were national policies, whilst the Developmental Screening Policy started out as a national process, but ended up with only one province taking the initiative of developing it into a policy.

The process of the CI involvement, as mentioned before, followed the 'stages model' of policy development very closely and will be described within this framework.

The role of the CI in the various steps across the three policies is outlined in Table 1 on the next pages.

**Table 1: The role of the CI in three child health policies**

Stage	School Health Policy		Developmental Screening Policy		Chronic Conditions Policy	
	Government	CI	Government	CI	Government	CI
<b><i>Problem identification</i></b>	MCWH programme managers identified the policy gap.	Initiated dialogue with MCWH programme managers.	Identified a need for a national policy, but did not act upon it.	Colleagues involved in the Developmental Screening Policy approached the CI and asked it to facilitate a dialogue on developmental screening countrywide given the lack of standard practice with no national policy to guide health workers.	Identified by child health service providers at Red Cross Children's Hospital.	Dialogued with service providers at Red Cross Children's Hospital to ascertain which areas of child health they perceived to have a policy gap/need.
<b><i>Characterisation of the problem</i></b>		The CI characterised the problem by conducting a review of literature on school health locally and internationally, and by speaking to key persons in the area.		The CI characterised the problem through conducting a review of literature on developmental screening locally and internationally, as well as speaking to key persons in the area.		A series of papers were compiled on various aspects of long-term (chronic) health conditions and were made available as background discussions papers.

<b>Stage</b>	<b>School Health Policy</b>		<b>Developmental Screening Policy</b>		<b>Chronic Conditions Policy</b>	
<b><i>Development of policy</i></b>	<p>This policy process was led by the MCWH programme at the national level. They constituted a reference team including two members of the CI. The reference group consisted of representatives from the national MCWH and health promotion programme, as well as a representative from the national Departments of Education and Social Development. The CI was commissioned to conduct nine consultative provincial workshops as well as a final national workshop, and to write the policy document. This included writing implementation guidelines and conducting a costing of the policy.</p>		<p>This policy process was led by a provincial MCWH programme manager and took place in only one of the nine provinces (Western Cape). A similar format to a reference group was adopted. The reference group gave guidance on the policy development, training programme development and the implementation process for the policy. The CI was a relative outsider to this process and participated minimally in the policy development phase. The more active participation involved members of the CHU, the organisation that the CI was most closely associated with at the time. This relative non-involvement by the CI allowed the province to commission the CI at a later stage to evaluate the first year of implementation.</p>		<p>This process was led by the national director for chronic diseases, disabilities and geriatrics. A member of the CI together with a number of paediatricians from across the country and representatives from other national health programmes formed part of a task team that assisted in the conceptualisation and drafting of the policy. The process of implementation was then handed over to the national director of child health. The implementation guidelines, developed by two paediatricians, are in the process of being finalised.</p>	
	<b><i>Government</i></b>	<b><i>CI</i></b>	<b><i>Government</i></b>	<b><i>CI</i></b>	<b><i>Government</i></b>	<b><i>CI</i></b>
<b><i>Adoption of policy</i></b>	<p>This is a process that is government-driven and the School Health Policy took about two years to traverse the adoption process. It was formally approved by MINMEC in 2003 and launched by the Minister of Health in 2004, six years after the process first began.</p>	<p>Throughout the two-year process the CI constantly liaised with Department of Health officials to ascertain what progress had been made and to suggest ways of speeding the</p>	<p>This policy adoption is a government function. It was adopted by the provincial government of the Western Cape two years after the process first began.</p>	<p>The CI played a minimal role in this part of the process as the MCWH deputy director was a very active driver of the process.</p>	<p>This policy took two years to traverse the national policy approval process. It is still awaiting official adoption and launching seven years</p>	<p>Throughout the two-year process the CI constantly liaised with Department of Health officials to ascertain what progress had been made and to suggest ways of speeding up</p>

		process up. This had little effect on the eventual time that the process took.			from the time the process began.	the process. This had little effect on the eventual time that the process took.
<b>Stage</b>	<b>School Health Policy</b>		<b>Developmental Screening Policy</b>		<b>Chronic Conditions Policy</b>	
	<b>Government</b>	<b>CI</b>	<b>Government</b>	<b>CI</b>	<b>Government</b>	<b>CI</b>
<b>Implementation</b>	Implementation commenced in 2004/2005 in all provinces except the Western Cape where it only began in 2006. Top management processes delayed the implementation of the national policy. The development of a provincial policy was requested, which took place from 2004/2005 in line with the provincial health care restructuring plan.	The CI played no role in the implementation process and due to other priorities declined the request from the Department of Health to run nine provincial workshops on how to implement the policy.	Implementation commenced officially in 1999 and was driven by the provincial MCWH programme manager.	The CI did not have any role in the implementation of the policy.	Implementation will only commence after the policy and the implementation guidelines are formally launched.	
<b>Evaluation</b>	No evaluation had yet been done.		The MCWH deputy director initiated an evaluation of the policy one year post-implementation.	The CI conducted the first evaluation, one year post-implementation, at the request of the provincial MCWH manager.	The evaluation can only be considered after the policy is implemented.	

## 6.2 THE POLICY ON SCREENING FOR DEVELOPMENTAL DISABILITIES

*“I think this is a wonderful example of research and how closely it links with policy formulation and also influences service delivery.”*

(Deputy director, Maternal Child and Woman's Health (MCWH),  
Western Cape provincial Department of Health)

The quotation illustrates the symbiotic relationship that research institutions, policy-makers and service providers can enjoy when evidence is brought to bear upon a policy development process in a participative and systematic fashion. This case study describes the role of CI in the initiation, development, implementation and evaluation of a provincial child health policy, in partnership with health programme managers, service providers and other child health researchers and academics.\*

This case study outlines:

- The background to and description of the Developmental Screening Policy for the Western Cape Province of South Africa
- The policy development process
- The implementation and evaluation of the programme
- Current status of the policy
- Strengths and challenges of the process
- Lessons learnt

### 6.2.1 Background to the policy

Developing countries are home to 85% of the world's disabled. In South Africa, it is estimated that approximately 6% of the childhood population within rural communities of the country are disabled (Corenljie, 1991; Couper, 2000). The prevalence of developmental disability is thus comparable to other priority child health problems, including low birth weight (11.2%), malnutrition (4.3%), preventable childhood infections such as diarrhoeal disease (10.2%), lower respiratory tract infections (5.8%) and the escalating problem of violence and trauma against children (3.2%). Only the HIV/AIDS pandemic is disproportionately higher, accounting for 40.3% of all child deaths under five years (Shung-King et al 2000; Bradshaw et al 2003).

Despite its prevalence and significant impact on the lives of children, their caregivers and families, childhood disability receives low priority within South African health care services. Curative services tend to take precedence over preventative and health promotion activities, and rehabilitation services in particular are severely neglected. Although the benefits of early identification and intervention of the disabled child are well known, such services are frequently unavailable or inaccessible to the majority of South African children.

Within the developed world, for example in the United States, United Kingdom and Australia, children's development is monitored on a regular basis from birth. The preferred method for developmental monitoring in the developing context is developmental screening, although this is not routinely carried out. From as early as the 1970s in South Africa, health workers were observed practising their own, non-standardised methods of screening children for developmental disability. Different parts of the country conducted

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\*All the initial phases of this policy occurred during the days of the Child Health Policy Institute (CHPI). The CHPI became the Children's Institute (CI) during the initial phases of negotiating the commission for the evaluation. For simplicity's sake the case study will refer to the CI throughout.

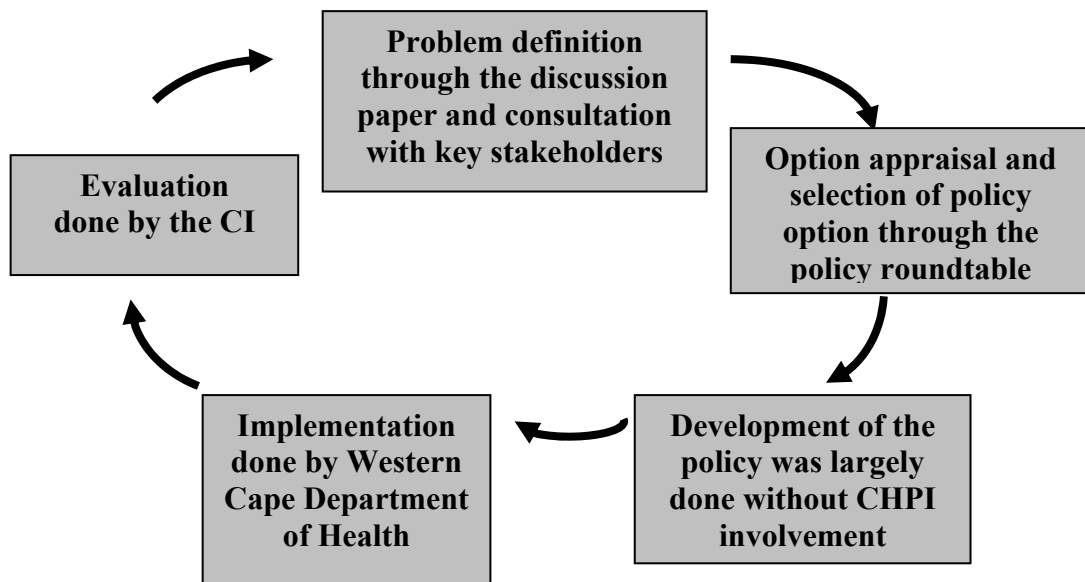
developmental screenings to various extents, with some areas doing it regularly whilst others did not do it at all. In addition, different instruments were used across the country.

### **6.2.2 The policy development process**

In 1996, the need for a uniform developmental screening policy and programme was brought to the attention of staff at the CHPI by service providers who worked in the developmental programme of the CHU at the University of Cape Town. Conflicting opinions as to how this should be addressed existed between the national directorate of Chronic Diseases, Disabilities and Geriatrics, provincial MCWH managers and service specialists in the field.

The CHPI took up the challenge to initiate dialogue on this important aspect of child health services. The exact roles of the CI in the overall policy process are outlined in Diagram 2

**Diagram 2: The stages in the Developmental Screening Policy development process that the CI was involved in**



*“The role of CI was to facilitate, both financially and in an umbrella role, that initial discussion that we had around “should we be screening?””*

(Provincial reference group member, service provider)

#### **a) Problem definition and option appraisal**

The CI initiated consultation on the issue of developmental screening by hosting a national policy roundtable.

Planning for the roundtable was done in collaboration with the CHU developmental screening division at the University of Cape Town and the Western Cape provincial MCWH programme. This provincial department was particularly keen to be involved as they had also identified this as a programme priority and intended to investigate how they could further the process in their province.



The roundtable involved 29 participants from service providers as well as from research and academic institutions across the country. In preparation, the CI produced a discussion paper based mainly on international experiences with developmental screening. The national roundtable participants unpacked developmental disability and debated a number of issues, including the feasibility of developmental screening in South Africa, basic requirements for screening tools/instruments, and research, service and policy gaps and challenges.

Different policy options were appraised and consensus was reached that developmental screening for moderate and severe disability should take place in line with comprehensive primary health care delivery. It was agreed that screening should coincide with health facility visits for immunisation, that caregivers should be fully involved, and that screening should be linked to appropriate interventions.

A workshop report was distributed to all participants, including those who could not attend (Child Health Policy Institute, 1996).

*"It was interesting to go through that process (at national workshop). Should you go the policy route, should you develop guidelines? And it was done in a rather scientific way."*

*"The CHPI was in the mode of looking at questions and translating them into policy issues. They provided a service which was a support service"*

(Deputy director, MCWH, Western Cape provincial Department of Health)

#### **b) Policy development and implementation**

Following the workshop only one province, i.e. the Western Cape, took up the challenge to develop a policy for developmental screening that would facilitate a standardised approach. According to the previous MCWH programme manager for the Western Cape, the policy of free health care for children under six years of age (announced by the national minister of health in 1994 and which required nurses engaged in prevention and promotion work to take on curative care for children without being adequately staffed and equipped), was a strong consideration for some provinces not to take on the developmental screening initiative. It also affected the implementation in the Western Cape, this province having decided to screen for moderate to severe disabilities only.

The policy development process, training and review of the screening tools was not funded by the Western Cape Department of Health, but was partially sponsored by Johnson & Johnson. Without this funding the project would not have been possible. Throughout the process there was very strong support and participation from the Department of Education in the Western Cape. Representatives from this department were active members of the provincial reference group.

The MCWH programme took the lead in the co-ordination of the policy development and in its implementation. This was done in conjunction with a reference group that consisted of representatives from the various service delivery regions in the province, the human resource development office of the provincial Department of Health and members of the Child Health Unit. Through their links with the CHU, the CI was involved marginally in the drafting of the developmental screening programme. Referring to the involvement of the CHU and the CI, the deputy director of MCWH stated, *"It was good to have that more scientific, expert type of input. Having scientific and professional reports available through the process gave it more clout"*.

The Western Cape Screening Programme for Developmental Disabilities in Pre-school Children, as it was formally known, is a standardised screening system to identify undiagnosed or unsuspected developmental problems in pre-school children. The programme, the only one of its kind in the country, was introduced as formal policy in the Western Cape in December 1999 (Provincial Directive, Superintendent General, Department of Health and Social Services, December 1999). Whilst the most desirable outcome was that this should happen at a national level, the other eight provinces felt that they did not have the capacity at the time to address such a policy process and would wait for the outcome of the Western Cape provincial process.

Since 1999, health workers at primary health care facilities in the Western Cape have been delivering this programme as part of a basic package of primary health care services to children. It involves the use of standardised screening tools to screen children for moderate and severe disability when they visit the health facility for their immunisations at six weeks, nine months and eighteen months.

A formal developmental screening policy document came out in the form of a circular in December 1999 that was released together with the developmental screening tools and guidelines. Implementation, particularly the inclusion of a pilot phase, was guided more by the CHU than the CI. Every effort was made to include as many role players as possible from primary level health and education in the development and revision of the screening tools. Extensive training in implementation was also done by a core group from the reference group, this group having held 27 training workshops over a three-year period.

### **c) Evaluation of the programme**

A year into the implementation of the Western Cape developmental screening programme, the MCWH sub-directorate of the Provincial Administration of the Western Cape (PAWC) Department of Health commissioned the CI to conduct an evaluation of the programme. The evaluation was supported by external funding from a non-governmental trust, called the Health Systems Trust. The evaluation came at a critical point in the implementation, as pressure was mounting from the services to expand the programme to include children aged two to five. The deputy director of the Western Cape MCWH programme was however concerned that the health system was not supporting the existing programme and needed "*scientific and academic proof*" from an external source to say "*ok, this is where we are at, these are the shortfalls and these are the recommendations*".

### **d) Brief overview of evaluation methodology**

The objectives of the evaluation were:

1. To document the background to as well as the development and implementation of the developmental screening programme.
2. To describe the current delivery of the programme.
3. To determine barriers and success factors within the implementation process.
4. To make recommendations to the Western Cape Department of Health regarding the developmental screening programme.

In order to achieve these objectives, a combination of quantitative and qualitative data was gathered in stages from all levels of the health system (provincial, regional and district) using a number of methods. In addition to documentary and literature reviews, information was gathered via structured interviews with health managers at a provincial and regional level, a rapid facility survey, and facility-based assessments. Data collection at health

facilities included structured interviews with nurse managers to obtain a profile of the facility, clinical observations of developmental screening, focus group discussions with health workers, exit interviews with caregivers, and record reviews. Information gathered from interviews and focus groups was analysed thematically, while rapid facility survey results were analysed quantitatively using EpiInfo.

#### **e) Key findings**

Despite numerous successes in development and the overall level of awareness regarding the programme, developmental screening was not conducted uniformly across the province. Almost a quarter of primary health care facilities did not deliver any aspect of the programme and only one of nine facilities delivered according to protocol. This study concluded that despite the developmental screening programme being a well-conceptualised and highly valued programme, its delivery had failed as a result of constraints within the broader health system. As previous evaluations of child health programmes have demonstrated, the overall transformation of the health system, organisation of service delivery at a PHC level and gaps in human resource development and information systems have impacted significantly on the delivery of preventative services for children.

The CI thus recommended that the expansion of the programme be delayed until the first phase has been properly implemented. In addition, a number of aspects of the screening tool and screening process had to be altered. The overriding recommendation was that unless systemic problems in the overall health system were addressed, it would not be possible to successfully implement child-specific programmes and interventions. The last recommendation emphasised the need for high level political and financial commitment to ensure that a good primary health care infrastructure be in place for the delivery of all components of the health service- but that child specific issues required prioritisation.

#### **f) Dissemination of the evaluation results**

Direct feedback was provided in the form of written and oral presentations to the PAWC Department of Health including the MCWH sub-directorate, the provincial reference group for developmental screening, the MCWH advisory committee, regional directors of health and the PAWC top management team. Written outputs included a full technical evaluation report (Michelson et al, 2003) and a summary report (Michelson et al, 2003), which were widely distributed to relevant role players locally, provincially and nationally. Other non-peer reviewed publications mostly targeting health workers (Adnams et al, 2003) and conference presentations were made. In addition, the evaluation and its results were published in the CI newsletter that goes out to almost 2000 members of its target audience, including politicians, service providers, academics, researchers, civil society organisations and individuals (Michelson, 2003).

### **6.2.3 Current status**

The current situation is that developmental screening is still taking place in the Western Cape, albeit not quite according to the new policy. Inconsistencies still exist where staff are using some tools from the old screening programme and some from the new one. Not all evaluation recommendations were followed through. The MCWH deputy director who drove this process has since moved on and at the time of writing, her successor had not yet been appointed. Colleagues in the same division are continuing the process.

The CI has not participated further in the process post-evaluation.

## **6.2.4 Strengths, challenges and lessons**

The CHPI made a significant contribution to the development of the disability screening programme in the Western Cape. It gave the process a kick start by facilitating initial discussions around developmental disability and the feasibility of developing a policy to this end. They were able to translate research/evidence into policy issues as well as inform practice during the drafting and piloting of the programme and its various components. Through the evaluation of the programme, the CHPI was able to further inform significant decision-making regarding developmental screening policy and practice, and highlight strengths and weaknesses in the policy development processes and the health system as a whole.

It was the first time that the CHPI was involved in the entire policy cycle, from the initiation of a policy, through making input into the development and implementation of the policy, and then evaluating the policy and its implementation.

The CI's functioning outside of government (although remaining involved with decision-makers in the policy development process) was an advantage to the development of the developmental screening programme/policy. From the outside, CI was able to objectively fulfil what was described as an enabling/facilitatory role. Furthermore, as the CI is held in high esteem, their input and in particular the scientific evidence generated, was accepted as reliable and valid, and contributed to important policy decisions being taken. As the Department of Health manager pointed out, *"If you have more objective, scientific, expert type of input, it enables you to see objectively the total picture which is very difficult for the various (government) stakeholders to see."*

Retrospectively, it was realised that it was particularly important that the CI was not directly involved in the actual policy development and implementation, as it allowed them to return to the process as external evaluators. Close involvement with the policy development and implementation would have affected the objectivity and possibly the credibility of the evaluation.

One of the key challenges during this process was the length of time that the process took, being almost six years from the initiation of the process to the completion of the evaluation. In many respects the CI's agenda had progressed and new and more urgent issues had entered the policy arena. But due to the CI's commitment to the process, it was imperative to see it through. The CI was able to engage a Masters student for the evaluation, which she did as part of her dissertation and for which she obtained a distinction.

Having to stand back and watch the implementation and follow-up processes from the sidelines was made easier due to the fact that the provincial MCWH manager was a very competent person. In the absence of someone with so much interest and passion for the issue, it might have become a very frustrating process.

Perhaps the most difficult decision is when to exit from the process. Given that the programme is not working optimally and that it is integrally linked to broader health systems issues does make it much more difficult to exit, as ideally one would like to keep close involvement with the process knowing that all is well. Not being an implementer or health decision-maker heightens one's frustration at times, but the academic objectivity is best maintained and in fact very necessary.

## 6. 3 THE NATIONAL SCHOOL HEALTH POLICY

The development of the School Health Policy followed very similar steps to that of the Developmental Screening Policy. The exception with the School Health Policy was that the CI was asked to develop the entire policy on behalf of the national Department of Health. Thus the role of initiator and supporter was extended to also being the policy writer. The CI had nothing to do with the implementation process, except to write the implementation guidelines for the policy and so far no evaluation of implementation has been done. An independent policy critique of the actual policy (not the process or the implementation) was done by an external consultant who did a broader review of all child health policies for the CI. Her opinions are reflected in this case study.

This case study will follow the same format as the previous one:

- The background regarding how the issue came onto the policy agenda
- The process of policy development and adoption
- Current status of the process
- Strengths and challenges in the process
- Lessons learnt

### 6.3.1 Background to the development of the School Health Policy

The specific health interventions and programmes delivered to school-going children in pre- and post-democracy South Africa differed markedly across the country. In some provinces school health did not really exist, whilst in others it was delivered as a vertical service<sup>†</sup> with dedicated school health personnel, mainly nurses. This programme reported directly to school health-specific provincial and national Department of Health structures.

School health services were also delivered very differently within different communities. Having just emerged from a highly fragmented health care system, with 14 different health departments each functioning in differing capacities, inequities across areas were significant. For example, in white areas school health services were delivered effectively to all schools in the area several times each year. In the most disadvantaged areas, school health services were provided once every two or three years, or not at all. In addition, the protocols, tools, assessment procedures and monitoring systems used by school health teams varied considerably across the areas.

At the same time a comprehensive health promotion initiative called the Health Promoting Schools Initiative (HPSI) was launched and executed through the health promotion directorates within the national and provincial departments of health. The HPSI advocated a comprehensive approach to creating healthy school communities, which included children, educators and the communities they related to. This initiative had four key pillars, health care in schools being one of them. It was envisaged that the health care aspects in schools would be delivered by the school health service; therefore from the outset the school health policy and service should have been a sub-component of the HPSI. But at this stage the School Health Policy process was being driven through the MCWH cluster, therefore the HPSI and school health were in different divisions and driven by different people. A strong

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<sup>†</sup> A vertical programme is one where the programme is solely dedicated to a single activity or programme. It has its own staff, budget and reporting lines and does not necessarily have a connection with any other aspects of the health service. This is opposite to the comprehensive health care approach where a range of different services, programmes and activities are integrated with one another and delivered by the same staff.

link needed to be forged between the two directorates to ensure that the processes did not duplicate but rather complemented one another.

The need for a School Health Policy that would deliver equitable services to school-going children across the country and that articulated with the HPSI was identified by national and provincial programme managers for the MCWH. However, programme managers differed on what this meant in practice. As a result, the relationship between the HPSI and the school health services varied between provinces. In the Western Cape for example, the HPSI took off very successfully and worked in an integrated fashion with the school health service. But in other provinces, the two areas functioned quite separately and in some instances had competing staff and priorities.

In 1996, the CI conducted an informal needs analysis with provincial MCWH managers by visiting each of the nine provinces and meeting with the provincial managers and their staff. The purpose of these visits was to ensure that the CI's agenda was responsive to the needs of the child health managers and persons responsible for the execution of child health services in the provinces. One of the key needs expressed by all MCWH provincial managers was the need for assistance in developing a clear strategy for school health services delivery. Most of them felt that a national School Health Policy and a clear standardised approach were needed across the country.

The same need for a national policy was also expressed by the national MCWH programme.

The nature of the relationship between the HPSI and such a School Health Policy was an issue of some concern, but the clear need to have a separate policy on school health was uniformly expressed, irrespective of what the eventual relationship would be.

### **6.3.2 The policy development process**

#### **a) The process**

Much of the initial work on the School Health Policy was done while the CHPI was still in existence. The policy development phase took place after the CHPI became the CI.

In December 1997, the CI convened a national roundtable discussion on school health in Cape Town (Child Health Policy Institute, 1997). The workshop was arranged in collaboration with members of the Child Health Unit (CHU) and the School of Public Health at the University of the Western Cape. The workshop was attended by 24 participants from national and provincial health and education departments, and academic institutions with an interest in the area of school health.

The workshop yielded a number of identified health needs and challenges for children in schools, research gaps, and recommendations for policy and service delivery. One of the key service needs identified was a set of guidelines for service providers that would ensure standardisation of the service across provinces and districts. The need for the development of a School Health Policy that could be integrally linked with initiatives in the education sector as well as with the HPSI was identified. The national MCWH programme accepted the responsibility for developing a national School Health Policy that would contain the guidelines required by service providers.

Three years elapsed between the 1996 workshop and the first steps towards a School Health Policy. In 1999 the CI, after consistently approaching the Department of Health over the three-year period to find out what progress had been made on the School Health Policy, was

finally commissioned by the Department of Health to lead the process towards the development of a national School Health Policy and to write the policy based on the input received during the consultation process.

A national reference team was put together to guide the process. The team consisted of members from the national MCWH chief directorate, the person responsible for the HPSI, a nominated person from the national Departments of Social Development and Education, and two researchers from the CI as external consultants. The participation of the CI researchers was funded by an external agency.

The process of developing the policy followed a specified format that emerged from deliberations within the national reference team.

The CI had the responsibility for providing the evidence, which was done by bringing reviews of national and international school health services, along with proposed models of service delivery, to the table. This process was funded by the United Nations Children's Fund as they were particularly interested in looking at issues related to the pubertal girl-child in connection with having access to water and sanitation at schools.

The material developed by the CI was used to develop the agenda and background readings for provincial consultative workshops to be held across the country.

Nine consultative workshops, one in each province, were held over a three-month period with a cross-section of individuals from health, education, social development and relevant NGOs. The policy was to be developed based on the outputs from these workshops. The final draft was discussed at a large national consultative workshop attended by representatives from all nine provinces, the national departments of health, education and social development and selected NGOs. Members of both the school health division and the national and provincial divisions of the HPSI also attended.

In addition to developing the policy following the provincial workshops, the CI also undertook to develop a set of implementation guidelines and to do a costing exercise of what the projected costs of implementing the policy would be. The costing was done by an economist who worked in the Western Cape provincial Department of Health at the time.

#### ***b) Developing the policy***

As part of the preparatory work to inform the policy, the CI reviewed school health services where these existed in selected developed and developing countries. In addition, a rapid literature review of available information regarding the health needs of school-aged children was done.

One of the key steps in the 'stages model' is the option appraisal step, where possible options are identified, and the pros and cons of each option appraised. In preparation for the provincial workshops, and in consultation with the reference group, the CI developed three options. The three options were based on what already existed and what the possibilities for a new form of school health service were. The options were presented to the workshop participants with a view to obtaining their critical analysis of the three options and then identifying the preferred option, based on the analyses.

The key issues discussed at each workshop included the perceived health needs of school-aged children; what the different components of a school health service should contain; who was best able to deliver it and how that could be done; how a standardised service across the

country might be obtained; and how best the service would be delivered, considering the options put forward in the option appraisal exercise. The three options considered were:

- not having a school health service at all and allowing needs of school children to be met through normal routine health services;
- retaining the vertical service model which was the prevailing model before significant health transformation took place and which was still being applied in many parts of the country;
- integrating the service into the comprehensive primary health care service delivery model so that school health would be delivered as one of many activities delivered by clinic staff.

A fourth model proposed by the CI that advocated an integrally shared responsibility at policy and service delivery level between the Departments of Health and Education was thrown out as the ministers of these departments had not met and health officials felt that they could not make suggestions on behalf of the Department of Education, not even at the stage of policy-option appraisal. This later proved to be the major constraint to the process.

Two key components of the debate were how a school health service would relate to the HPSI and how it would relate to the Department of Education and its initiatives.

The format of the workshops was participatory with many opportunities for debate, small group discussion and plenary deliberations around the key issues. The facilitators strove to get consensus at the end of each workshop and to analyse what the preferred options were for each issue. The most commonly preferred option was intended to prevail.

A separate report for each of the nine workshops was written (Abrahams, 2001). At the end of the nine workshops, the consensus recommendations, as well as the differences, were collated into a draft report that was presented and discussed at a national workshop where representatives from all the provinces and the relevant national departments had a final opportunity to input into the policy process.

CI researchers then wrote the policy together with a set of implementation guidelines. This was circulated to all nine provinces for further comment. Very few provinces responded with comments at this stage. The policy costing was done and, together with the policy and the implementation guidelines, were submitted for approval to the various bodies in the Department of Health.

### ***c) The policy approval process***

The approval process lasted nearly two years as it took several months for the policy to go from one committee to the next. The committees' agendas were often packed and on more than one occasion all children's issues were simply deferred to the next meeting. Meetings took place at six-week to two-month intervals and the School Health Policy was struck off the agenda several times in a row. The approval process received an energy injection when, ironically, one of the most senior officials in the Department of Health had a child refused school enrollment because of not being immunised with the required vaccines at age five—a responsibility that she felt rested with the school health service. A phone call to the MCWH cluster manager, demanding to know why the school health policy was not yet official, then got the process with MINMEC kick-started again.



After waiting two years for the final approval, the policy and implementation guidelines were approved in 2003 without a single change by the MINMEC committee and launched as official Department of Health policy in 2004. The actual launching was dependent on the availability of the national minister of health and due to her pressing schedule was also postponed several times.

### **6.3.3 The implementation**

Following the launch of the policy, the national Department of Health held workshops in each of the nine provinces to go through the final policy with them. The CI was approached to facilitate the workshops, but declined the offer as one of the two staff members who had been involved in the policy process had already moved on and new work pressures prevented the other staff member from being able to commit to the process.

Following the workshops facilitated by the national Department of Health, implementation was left to the provinces.

In 2006, the CI member who was originally involved in the process conducted a quick telephonic survey with persons directly responsible for school health in four of the nine provinces.

Implementation again varied across provinces, but it was encouraging to hear that all provinces had made significant efforts to implement the policy. All of the respondents indicated that consistent pressure from the national minister of health on the provincial heads of health assisted in getting the policy taken seriously within provinces. In October 2005 National Eye Care week was used by the minister as a platform to once again stress the importance of school health to the provinces and to call for its full implementation. Ironically in the Western Cape metropolitan region, where school health services and the HPSI worked extremely well at the time of the policy development phase, school health has fallen by the wayside. The reason for this seemed to be that the most senior Department of Health official, under whose jurisdiction regional and district health services in the province fell, did not support the notion of school health and the service has systematically disintegrated<sup>‡</sup>, first in the rural and then in the metropolitan regions. The province is now in the process of trying to revive the school health service in line with the national policy.

Practically the proposed model of integrating school health service into existing primary health care services was applied differently across provinces. In addition, the proposed national indicators for monitoring implementation were found to be less workable than had been originally thought and this is also being done differently across provinces. But despite this, the national Department of Health still expects the provinces to use the original indicators to monitor and evaluate the implementation of the school health services and to provide MINMEC with six-monthly reports via the provincial heads of health.

The main challenge cited by all the provinces is that very little subsequent support came from the national office, and in most instances, their senior provincial managers did not allocate additional resources to run the school health service, even though they supported the policy in principle. It was clear from all the respondents that, without a specific driver in each province for school health, the policy implementation would not happen as other curative priorities take precedent.

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<sup>‡</sup> Personal communication. Ms. L. Olivier, previously deputy director for Maternal, Child and Woman's Health, Western Cape Department of Health. October 2006.

### **6.3.4 The policy critique**

This policy has been lauded as one of the better-written policies. A particular strength of the policy was that it had a set of clearly written implementation guidelines, as well as a costing that gave provinces an indication of what they had to budget for. It was affirming to the staff of the CI to get this feedback and suggests that policy research organisations, given the resources at their disposal, have an important role to play in assisting with the development of coherent and well-written policies.

Further more, the consultation process in developing the policy extended across all nine provinces and attempted, as far as possible, to include all the important role players.

The reference group, which included CI members, enjoyed good relationships throughout which made the process easier – but there were significant challenges in constructing the policy content.

A glaring weakness of the process was the absence of a structured relationship between the national Departments of Health and Education. This severely affected the potential to integrate the policy into Department of Education processes. It also impacted on eventual policy content as CI researchers were asked to remove any reference to the potential roles and input of the Department of Education staff in the delivery of the school health service. This became a serious and unresolved point of contention and resulted in a missed opportunity to have the school health service integrated with education department staff and initiatives.

A further difficulty was that the HPSI process, which was meant to yield a national policy in which school health would play an integral part, did not happen at that time. The disjoint between the two processes was disconcerting and did not make sense. Whilst MWCH staff members responsible for the two policies were fully committed to collaboration, the lack of relationship between their respective senior managers prevented the collaboration from working.

It was very difficult for CI staff to stand back from these relationship issues. Being external to the official departments has definite benefits in enabling objectivity, but being dependent on the department officials to forge crucial relationships and links, which did not happen for more than three years, was hugely frustrating.

The one lesson that CI staff learnt was that being so integrally involved in the policy process did not make it easy to be completely objective. At certain critical points during the process, CI staff criticised certain content and process decisions and relations became strained, which almost resulted in the CI pulling out of the process. CI staff ended up compromising on what they believed the best policy options to be, which included a significant role for the Department of Education, and this presented quite a dilemma. In retrospect, if a reasonable compromise cannot be reached and the integrity of academic organisations is at stake, it might require complete withdrawal from the process. However, given the CI's contractual and overall commitment to seeing the process through, the promise of sorting out the relationship between the Departments of Health and Education at a later stage resulted in CI staff accepting the ruling of the Department of Health officials in the interest of completing the policy document.

This policy process was a huge learning curve for the CI, as it was one of the first complete policy processes that it was involved in, and also due to the complexity of the process. The retrospective knowledge obtained regarding the limitations that an academic institution has

in political process issues, especially with regard to decision-making and relationship-fostering between government departments, will assist the CI in having more realistic expectations of the process and in being able to negotiate a clearer role in future processes.

This policy process further clearly demonstrates the powerful influence of key individuals at a national level, as the personal concern of one of the national deputy director-generals got the flailing process of approval kick-started, whilst on the other hand, a Western Cape senior official's non-belief in school health nearly destroyed the service in the province.<sup>§</sup>

#### **6.4. THE POLICY FRAMEWORK FOR NON-COMMUNICABLE CHRONIC CONDITIONS IN CHILDREN**

The initial stages of the Chronic Diseases Policy followed very similar steps to that of the previous two policies. The CI played the role of initiator and supporter and was invited to be part of the reference team that gave input and advice to the director who wrote the policy. While the policy has been completed and partially approved, the development of the accompanying implementation guidelines has been a long and protracted process and is still not done. The policy will only become official once the guidelines have been completed.

This case study covers five areas:

- The background to how the issue came onto the policy agenda
- The process of policy development and approval
- Current status of the process
- Strengths and challenges in the process
- Lessons learnt

##### **6.4.1 Background to the development of a service policy for children with long-term health conditions**

As in the previous two case studies, the CI structured regular interactions with groups involved with child health to identify priority areas and policy and service gaps. In this instance the interaction was with a group of paediatricians from the Red Cross Children's Hospital. The paediatricians were unanimous in their request that the CI assist in the development of a national policy for services to children with chronic health conditions. They felt that the lack of attention to this area was very problematic. As with other aspects of child health services, significant inequity in service delivery existed between and within provinces.

The CI conferred with a number of other groups to ascertain if this was a common concern, as the particular bias of a group of paediatricians attached to a specialist children's hospital may not have been a shared experience.

Having established that the concerns were shared by many different groups, the CI organised a national policy roundtable in September 1999.

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<sup>§</sup> Personal communication: Ms. L. Olivier, previous deputy director for Maternal Child and Women's health, Western Cape Province. December 2006.

At the time of the workshop, the situation regarding children with chronic health conditions in the country could be summarised as follows:

- Chronic health conditions in children covered many individual conditions, but in the country there were probably no more than 10 conditions that had a reasonably high prevalence. However, regardless of what the exact conditions were, the service requirements were common and a good service could deal with any specific condition that presented itself.
- Chronic health conditions affected about 10% of all children. The exact epidemiology of the conditions was not known, so estimates were based on international experiences and a few prevalence studies in South Africa. HIV, essentially a chronic health condition, was on the increase and would add significantly to the burden of chronic diseases in children.
- Services were sparse, not standardised and generally not available to large numbers of children from poorer areas and in particular to those from rural areas. Given the long-term nature of these conditions and the relatively high costs of medication and other interventions to improve children's health, particular attention had to be paid to developing good relationships between levels of care in order to ensure good continuity of care for children and their families.

#### **6.4.2 The policy process**

The policy roundtable took place in September 1999 (Child Health Policy Institute, 1999). Approximately 40 participants from national and provincial departments of health, service providers from different levels of care, rehabilitation workers and researchers from various academic departments attended the workshop.

Unlike the previous two roundtables, the background discussion papers did not consist of a single review done by the CI, but of several papers developed by experts in the area. A total of six papers were developed and presented at the workshop. The papers included a concept paper providing a definitional framework, as well as papers examining existing epidemiological evidence, examining the potential models for chronic health services, describing service experiences at different levels of care and examining certain 'sentinel' conditions such as asthma and HIV as examples of what the challenges and service implications are.

The roundtable again yielded a number of service gaps and requirements, a number of research questions, and the need for a coherent national policy that would guide service delivery at all levels. One of the important results that the workshop yielded was a clear definition of what constituted a chronic condition and that it was more desirable to refer to this aspect of child health as a 'long-term health condition'. The specific rationale for this was that these conditions often affect children into their adolescent years and stigmatising them with a label such as 'chronic disease' might cause psychological harm. In many instances conditions are really quite well controlled and children don't feel ill at all. For example, children with asthma that is well controlled don't see themselves as having a 'chronic disease'.

A tense moment arose when it came to delegating responsibility for the policy development, as neither the director of Chronic Diseases, Disabilities and Geriatrics nor the chief director for Maternal, Child and Woman's Health wanted to take the responsibility as both these persons felt that the responsibility lay with the other directorate. This might also reflect the

lack of priority felt in the area of chronic diseases, which in turn justified the concerns about the general lack of policy and guidance at a national level. With some gentle persuasion from the workshop facilitator (CI), agreement was reached that the director for Chronic Diseases, Disabilities and Geriatrics would take responsibility for developing the policy. Once the policy was accepted, the process would be handed over to the MCWH programme for implementation.

In 2000, the director for Chronic Diseases, Disabilities and Geriatrics convened a reference team to assist her with the development of the policy. The team consisted of a number of persons from other programmes/directorates in the national Department of Health, paediatricians from five or six different provinces (urban and rural alike) and a member of the CI. One of the paediatricians was from the Red Cross Children's Hospital and was part of the original group who had lobbied for the policy gap to be addressed.

Three or four reference group meetings were held over a period of two years. In between the reference group meetings, various drafts of the policy were sent out to the reference group members for comment. Difficult and contentious issues were discussed at the face-to-face meetings. A further two years elapsed when there was little contact with the policy writer and most reference group members were not sure where the process was at. This policy, in contrast with the School Health Policy for example, did not involve provincial level role players and was not circulated for comment other than to other programmes/directorates within the national Department of Health.

The final draft of the policy was completed in December 2002. After repeated enquiry, the CI learnt that the policy had been handed over to the MCWH directorate, who had to ensure that it got official approval and that it was implemented across the country. The process came to a complete halt at this stage as no-one from the MCWH directorate was assigned responsibility for seeing the process to its conclusion.

The CI, together with the paediatrician from the Red Cross Children's Hospital, offered to develop the implementation guidelines to the policy on behalf of the directorate MCWH. In 2004, a Red Cross paediatrician took a six-month sabbatical at the CI to commence writing the guidelines. In 2005 a second paediatrician from Limpopo also worked on the guidelines during her sabbatical with the School of Child and Adolescent Health at the University of Cape Town. Having input from a paediatrician from a rural province where services to children with long-term health conditions are sub-optimal added an important perspective to the guidelines.

#### **6.4.3 Current status**

In August 2005 the CI convened a small 10-person meeting to discuss what the next steps in the process would be. The participants included paediatricians from three provinces, a rehabilitation specialist, a member from the national Department of Health and members who were involved with the development of the policy and the implementation guidelines. Up to this point there was very little involvement of the national MCWH programme and the costs of developing the guidelines were being borne solely by the CI as the institute had a very strong commitment to seeing the process through.

At the second workshop, there were representatives from four provinces whose expertise spanned several disciplines and levels of health care provision. They provided a very rich input into the draft implementation guidelines and into the process as a whole. Agreement was reached at the end of the workshop that, as soon as the guidelines were completed, they would be handed over to the national MCWH cluster which would have the official

responsibility of getting the policy launched and implemented, even if only in a few pilot sites initially.

The guidelines took nearly another year to be refined as both paediatricians have very heavy clinical, service and teaching loads and were doing this completely in their spare time. The guidelines are not yet completed and have not yet been approved by the national Department of Health.

To date the policy and implementation guidelines still have to be officially taken over by MWCH and launched. It is now seven years since the national policy roundtable was held.

#### **6.4.4 Strengths, challenges and lessons**

The strength of this process was that the MCWH director who initially led the process was very focused and determined to see the policy through. Although it was clearly a policy that was not (and still is not) a priority in the MCWH programme, she did take it on and saw it through to completion.

This determination was also unfortunately a weakness in the process, as it was very hard to persuade her on contentious points. The most difficult issue in this policy was the determination on the part of the director to leave HIV out of the policy, as she saw long-term health conditions as being non-communicable (or non-infectious) conditions and felt that HIV, being an infection, had to be dealt with by the HIV directorate. This was in spite of the fact that HIV is the most pressing long-term health condition of all, and that in time it will affect more children than all the other chronic conditions combined. The reference group lobbied very hard to change the title of the policy from non-communicable long-term conditions to long-term health conditions so that it covered all conditions, infectious and non-infectious, irrespective of aetiology. That battle was lost.

A decision was made during the development of the implementation guidelines to address this omission by explicitly referring to HIV in the guidelines and by using HIV/AIDS as one of several sentinel conditions around which the guidelines were developed.

Perhaps one of the key lessons learnt during this process was that policies will not make sense if not developed in an integrated fashion between the various directorates in the Department of Health. Another lesson was that unless the driver of the next step in the process (in this instance the driver of the implementation phase) is clearly identified from the outset and remains part of the policy development process, then implementation has even less chance of being given priority – a sad reality in this case study.

## 7. Overall conclusions

There have been many books and articles written on policy development, as well as on the relationship between evidence and policy. These conclusions articulate only the specific lessons learnt and experience gained from the three case studies.

Policy development is not a random chaotic process, but can be done in a very systematic way, as depicted in the 'stages model' and demonstrated in the three cases presented here.

It does however require good collaboration between many different role players, not the least of which are research and academic institutions which can play very useful roles in the process through the provision of evidence and playing an useful objective role in various phases of the policy development process. External organisations also have a very important advocacy role to play in the initiation, development and completion of policies as outlined in the various roles that the CI played in the three case studies.

It is evident from the three policies that in South Africa there is no consistent way of approaching the development and writing of child health policies. Given the different approaches that the three policies required beyond the steps that the CI took responsibility for, it will greatly benefit the development of good quality child health policies if a more consistent policy development model and policy format is developed at a national level. This is especially important in ensuring that certain basic issues are taken into consideration when developing child health policies, such as ensuring that the policy is developed in a child rights framework, that implementation guidelines are provided and that cost estimates for implementing the policy are done.

For policies to be successfully developed and seen through to implementation, it is imperative that clear role definition, role understanding and an appreciation of limitations are identified at the outset. It is critical for each policy to have a committed consistent driver within government, as the way that processes unfold from initiation to completion are ultimately ruled by the structure and processes within government. The speed with which the Western Cape Developmental Screening Policy was completed (two years as compared to six years for the School Health and Chronic Conditions Policies) can largely be attributable to the zeal and fervour of the driver of the process in the Western Cape, as the complexity and bureaucracy of the process is not necessarily any less in the provinces that it is at national level.

It is also evident that political buy-in from the highest level is essential from the outset. This was borne out in the difficulties with the ministers of health and education not connecting at all during the School Health Policy process. Also the difficulty with Department of Health officials getting Department of Education officials at a national level on board remained an obstacle throughout the process, an issue which could have been facilitated by means of a political connection between the respective ministers from the outset. As a result the policy does not include any roles for the Department of Education. It could potentially have been much more effective had there been full collaboration between departments of Health and Education from the outset. On the positive side the health minister's subsequent interest in the School Health Policy caused provinces to pay greater attention to implementation than might otherwise have been the case. Political buy-in can greatly enhance (and lack thereof can greatly hamper) successful policy development and implementation.

All the cases demonstrate that organisations external to government cannot fully lead or control the policy process, especially where the structural relationships and political

processes within government are concerned. This was very clearly demonstrated in all three cases in, for example, the undue delays, blocks in processes and difficulties in forging critical relationships.

Regarding co-ordination between clusters within the Department of Health, it is imperative that policies aimed at a particular target group (in this case, children) are well co-ordinated between different directorates/programmes within a particular government department and between different government sectors. The Chronic Condition Policy demonstrates that it does not make sense to exclude a critical section in a policy simply because it rests with another directorate/programme. The sensible approach is to develop a single comprehensive and coherent policy as a collective effort between all the relevant divisions that relate to child health. Similarly in the School Health Policy, some innovative advances in service delivery to school children could have been made by sensibly pooling resources and ideas between the departments. An overarching framework for child health and child health services is required so that individual policies are able to slot into a jigsaw puzzle that makes a sensible and complete picture when put together. Lack of communication between government departments and lack of co-ordinating mechanisms greatly hamper holistic solutions to major policy gaps.

From an academic organisation's point of view, participating in policy development means that one is in it for the long haul as it seldom takes less than five years from start to finish. Policy research institutes such as the CI thus have to plan for a long-term agenda and commitment when they commence engagement in policy processes. Given that organisations like the CI are completely donor-funded, such long-term projects are not always easy to sustain, especially since donor agendas also change periodically. For the CI itself new priorities also arise and sometimes a conscious choice to stop participation in a process has to be made. This is something that has caught the CI off-guard at times as new priorities and opportunities arise. Exiting from the process before its conclusion leaves a sense of incompleteness and in some instances failure. Making a decision on when to stop participation in the process, especially when the completion of the process rests in the hands of government, is difficult and at times emotive, as commitment to a five-year process taps into both energy and resources. However, pragmatism has to prevail and if new priorities emerge against a process that is trickling along, then withdrawing from the process may be necessary. This is the current situation with the Chronic Conditions Policy where the process has been taken as far as it can by the CI and now it has to be left up to the MWCH directorate at national level to take the final responsibility for it.

In retrospect the best role that organisations such as the CI can play is to bring the best possible evidence to the table to guide policy decisions, to help create interactions through roundtables as external facilitators and to do objective evaluations where required. In a country where technical expertise is not always readily available within the ranks of government officials, academic institutions do have an important role to play in providing such technical expertise and this can be seen as part of their social responsibility mandate. Involvement in writing policy for government and in some of the intricacies that come with the policy development territory is therefore unavoidable. Part of this responsibility is to reflect, record, analyse and write about policy development processes, such as has been attempted in these case studies, and to feed back the lessons learnt to the relevant role players to stimulate ongoing reflection and dialogue to improve policy development.

However, when research organisations are required to be integrally involved in the policy development process and in writing the policy, caution must be taken not to compromise researcher objectivity as the pressure on government officials to produce policy in a particular way can strongly influence the ultimate policy process and content. This can be



avoided by research organisations understanding their role and limitations in these processes, recognising where their ability to influence stops and starts, and adapting their role accordingly.

## **8. Recommendations for child health policy development in South Africa**

- a) Child health policy must be prioritised in the Department of Health to avoid critical policies being delayed for five years or more. This prioritisation must be emphasised at ministerial level and must permeate all decision-making bodies in the department.
- b) There is a need for a clear, overall integrated framework for child health and child health services. Out of that process the specific policy and practice gaps must be identified by drawing on the types of methods used by the CI.
- c) Integrated policy development between the various Department of Health programmes and between that department and other relevant sectors, such as the Department of Education, must be an absolute condition of the policy process.
- d) Each policy process must have a clearly identified leader who is equipped to take the lead, is given the time and resources to do so, and has the commitment to see the process through to the end. It will greatly facilitate the process if all programme staff and managers at national and provincial level have formal training in policy development and implementation.
- e) Each policy must use the best possible available evidence to avoid non-sensical policies from being developed.
- f) The Department of Health must develop a set of guidelines for policy-making so that the process, format and content of the various policies are standardised, rather than being left up to individual policy-makers to decide.
- g) Each policy should be accompanied by a set of implementation guidelines and a costing where possible.
- h) Each policy should have a standardised reporting format, monitoring and evaluation system from district to provincial to national level in order to monitor policy implementation and to identify problem areas for review.
- i) Policies must have “sell-by” dates and periodic reviews of at least once every 10 years (preferably less where feasible) should be built into the process.

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