

Integrated School Health Policy

2012



Health
Basic Education





FOREWORD

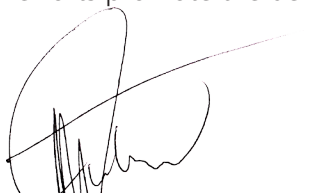
As signatories to the Convention on the Rights of the Child, South Africa has pledged to put children first, thereby giving their needs the highest priority. However ill health and other challenges still prevent many children from growing into productive, capable citizens, who can help their communities grow and prosper. In order for learners to achieve their potential, they must be healthy, attentive and emotionally secure.

In 2010, in his State of the Nation address, the President committed the government to reinstating health programmes in public schools in South Africa. Strengthening of school health services represents one of the key components of the health sector's efforts to re-engineer and strengthen primary health care delivery, whilst within the education sector provision of school health services is a key component of the Care and Support for Teaching and Learning (CSTL) programme which aims to realise the educational rights of all children, including those who are most vulnerable, through schools becoming inclusive centres of learning, care and support.


It is therefore with great pleasure that we present this Integrated School Health Policy, which outlines the role of our respective departments in addressing the health needs of learners, with the aim of ensuring that a strong school health service operates according to clear standards across the country.

This policy focuses on addressing both the immediate health problems of learners (including those that constitute barriers to learning) as well as implementing interventions that can promote their health and well-being during both childhood and adulthood. In 2012, more than twelve million learners were enrolled in public schools in South Africa. Whilst provision of school health services will initially focus on ensuring that services are provided to learners in the most disadvantaged schools, ensuring that coverage is progressively extended to all schools and learners will remain a priority.

We would like to thank everyone who has participated in the development of this policy, and to recognise the work of many educators, health workers and others whose untiring efforts promote the development and well-being of our children.



Dr PA Motsoaledi, MP
Minister of Health



Mrs AM Motshekga, MP
Minister of Basic Education

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Treatment
BMI	Body Mass Index
CSG	Child Support Grant
CSTL	Care and Support for Teaching and Learning Programme
cTOP	Choice on Termination of Pregnancy
DBE	Department of Basic Education
DBST	District-Based Support Team
DOH	Department of Health
DSD	Department of Social Development
ECD	Early Childhood Development
EFA	Education for All
EPI	Expanded Programme on Immunisation
FET	Further Education and Training
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPS	Health Promoting Schools
INP	Integrated Nutrition Programme
ISHP	Integrated School Health Programme
MTSF	Medium Term Strategic Framework
MMC	Male Medical Circumcision
NGO	Non-governmental Organisation
NSNP	National School Nutrition Programme
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission (of HIV)
SGB	School Governing Body
SIAS	National Strategy on Screening, Identification and Support
SBST	School-Based Support Team
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
WHO	World Health Organization
YRBS	Youth Risk Behaviour Survey

Definition of Quintiles

A system of ranking and funding schools which takes into account the socio-economic circumstances of learners. The intended objective is to ensure that public funding is skewed in favour of the poorest learners.

1. BACKGROUND AND INTRODUCTION

The South African Government has pledged to “put children first” by becoming a signatory to the United Nations Convention on the Rights of the Child¹ and by according children special recognition in the Bill of Rights of the South African Constitution². This commitment aims to ensure that children’s rights are upheld, and that provision is made to enable all children to reach their full potential. This is especially important in the formative school years, during which providing special attention to children’s optimal health will improve not only their survival, growth and health, but also their learning outcomes and development.

Ensuring optimal development of all children poses a considerable challenge to South Africa. In addition to addressing the effects of apartheid and underdevelopment, the country is recognized to be facing four concurrent epidemics. Whilst poverty-related illnesses such as childhood infectious diseases and malnutrition remain widespread, many children face barriers to optimal health and development as a result of the HIV/AIDS epidemic. Violence and injuries constitute a further cause of premature deaths and disability, whilst a growing burden of non-communicable diseases is also evident³. As a result children face many health, social and other challenges (See Annexure A for more details).

The World Health Organization (WHO) defines a school health programme as a combination of services ensuring the physical, mental and social well-being of learners so as to maximize their learning capabilities. The WHO Expert Committee on School Health argue that school health programmes can advance public health, education, social and economic development, and that the global expansion of school health programmes attests to the value placed internationally on such programmes⁴.

Likewise, a joint strategy session at the World Education Forum held in Dakar in 2000 made a strong case that provision of effective school health services is an important strategy for achieving Education for All. Provision of school health services not only responds to a need, but also increases the efficacy of other investments in child development, ensures better educational outcomes, achieves greater social equity and is a highly cost effective strategy⁵. The forum further recommended that the following basic components of a school health programme should be provided together in all schools:

- Health-related school policies
- Ensuring a healthy physical, learning environment, emphasizing safe water and sanitation
- Skills-based health education
- School-based health and nutrition services

Most children spend up to thirteen of their formative years, from early childhood to young adulthood, in a classroom environment. This provides an ideal opportunity for health education and interventions that aim to address the many health and socio-economic factors which affect children in South Africa as outlined above. Once educated, these children can potentially become influential sources of health information and models of healthy behaviour for their families and the broader community. Through them the health system would be able to reach far beyond the walls of health facilities and other health institutions.

School health services also have the potential to provide a safety net for children who do

not access preventive health services during their pre-school years and are able to identify avoidable health problems that may constitute barriers to learning. An effective school health programme will ensure that we are able to capitalize on this invaluable opportunity for the healthy development of children and the communities in which they live.

Twelve million learners were enrolled in public schools in South Africa in 2010⁶. This number is likely to increase as the transformation and strengthening of the education system enables it to retain more learners for longer. Although school health services have been provided in South Africa for some time, implementation has been variable and sub-optimal, with low coverage in some areas of the country.

In 2010, in his State of the Nation address, the President of the Republic of South Africa committed the government to reinstating health programmes in public schools in South Africa⁷. This commitment is in line with the health sector's aim of providing health services to all sections of the population through the primary health care (PHC) approach which embodies all elements of health care, with specific emphasis on preventive and promotive health care⁸. Likewise the road map document for the South African education sector ("Schooling 2025 and Action Plan to 2014"⁹) includes provision of public health and poverty reduction interventions for learners through the Care and Support for Teaching and Learning (CSTL) programme. The goal of the programme is to realise the educational rights of all children, including those who are most vulnerable, through schools becoming inclusive centres of learning, care and support.

The new Integrated School Health Programme (ISHP) aims to build on and strengthen existing school health services, albeit with some important changes. These include:

- A commitment to close collaboration between all role-players, with the Departments of Health (DOH), Basic Education (DBE) and Social Development (DSD) taking joint responsibility for ensuring that the ISHP reaches all learners in all schools.
- Provision of services to learners in all educational phases. These include the foundation phase (Grades R-3); the intermediate phase (Grades 4-6); the senior phase (Grades 7-9); and the Further Education and Training (FET) phase (Grades 10-12).
- Provision of a more comprehensive package of services, which addresses not only barriers to learning, but also other conditions which contribute to morbidity and mortality amongst learners during both childhood and adulthood.
- More emphasis being placed on provision of health services (as opposed to screening and referral) in schools, with a commitment to expanding the range of services provided over time. Mechanisms for ensuring that learners who are assessed as requiring additional services receive these services need to be in place.
- A more systematic approach to implementation. The phased approach (as outlined in the 2003 School Health Policy) which focused on district level implementation, did not translate into adequate coverage at sub-district, school and learner levels. Although the ISHP will initially target the most disadvantaged schools, sequenced plans for progressive implementation aim to ensure that all learners are reached.
- Implemented within the Care and Support for Teaching and Learning Framework that is currently being used by the DBE to cohere all care and support initiatives implemented in and through schools including school health services.

Implementation of the school health policy requires strong intersectoral collaboration on the part of different sectors. The DOH, DBE and DSD are the key role-players. However, other relevant government departments, other educational structures such as School Governing Bodies (SGBs), teacher unions and learner organisations, academic institutions, civil society and development partner organizations are also expected to contribute to the development of sustainable and comprehensive school health programmes.

1.1 Legislative, policy and programmatic context

The Integrated School Health Policy and Programme is located within a legislative, policy and programmatic context in which significant transformation is currently taking place. Key legislation and policies, as well as international, regional and national initiatives which govern and influence the ISHP are listed below, and outlined in more detail in Annexure B.

Legislative Framework

Several acts have particular relevance to implementation of the ISHP. These include:

- The Constitution of South Africa (Act No.108 of 1996)
- The Children's Act (Act No.38 of 2005) as amended.
- The South African Schools Act (Act No. 84 of 1999)
- The National Health Act (Act No. 63 of 2003)
- The Mental Health Care Act (Act No. 17 of 2002)

Key Health Policies and Programmes

- The Negotiated Service Delivery Agreement¹⁰ and restructuring of PHC
- The Health Promoting Schools Initiative¹¹
- The Youth and Adolescent Health Policy¹²
- National Strategic Plan on HIV, STIs and TB: 2012-2016¹³.
- HIV Counselling and Testing (HCT) Policy Guidelines¹⁴
- Household and Community Component of the Integrated Management of Childhood Illness Strategy¹⁵.
- South African National Oral Health Strategy¹⁶
- Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia Policy and Implementation Guidelines¹⁷
- Child and Adolescent Mental Health Policy Guidelines
- Mini Drug Master Plan for the Health Sector 2011/12-2013/14
- Immunisation Policy
- Policy Guidelines for the management and prevention of Genetic Disorders, Birth Defects and Disabilities¹⁸
- Integrated Nutrition Programme (INP)¹⁹

Education policies and programmes

Policies within the DBE are geared towards providing a healthier and more enabling school environment and intersect with many of the sentiments embodied in health policies and programmes. Policies and programmes which provide the blueprint for the education

system are outlined below.

- The 2000 Dakar Framework for Action which aimed to achieve Education for All²⁰
- Care and Support for Teaching and Learning²¹
- Schooling 2025 and Action plan to 2014²²
- White Paper 6: Special Needs Education - Building an Inclusive education and training system²³.
- National Strategy on Screening, Identification and Support (SIAS) SIAS aims to respond to the needs of all learners, in particular, those who are most vulnerable and likely to be marginalized and excluded.
- National School Nutrition Programme (NSNP) ²⁴
- Whole School Evaluation²⁵
- DBE Integrated Strategy on HIV, STIs and TB, 2012-2016

Social Development policies and programmes

- The National Integrated Plan on Early Childhood Development (ECD)²⁶.
- Child Support Grant (CSG)
- The National Strategy for Prevention of Child Abuse, Neglect and Exploitation²⁷
- The National Action Committee for Children Affected and Infected by HIV and AIDS (NACCA)²⁸

1.2 The current school health programme

The previous School Health Policy and Implementation Guidelines were launched in 2003. Although the programme has been incorporated as a component of the PHC Package, implementation has been slow in many areas, with low coverage at sub-district, school and learners levels.

The current sub-optimal provision of school health services in most parts of the country is attributed to a range of factors including:

- Managerial variation in the value attached to delivery of school health services.
- Insufficient collaboration between DOH and DBE historically
- Inequitable distribution of resources in both urban and rural settings.
- The challenge of integrating previously vertical and fragmented services into comprehensive PHC services.
- Competition for limited resources.
- The demand for curative services (aimed at short-term survival) outweighs the preventive and promotive services (aimed at long-term improvement in health and quality of life).
- Poor data management impacts on the reporting of school health services.

School health services are currently delivered by designated School Health Nurses who form part of the PHC staff component. A review undertaken of implementation of the school health policy showed that nurses identified a number of issues that impact on the provision of quality services. These included ²⁹:

- Insufficient staff and infrequent visits to schools; this limits their ability to give children

- the time and attention that they need
- Lack or insufficient basic equipment such as scales to weigh children
- Lack of a conducive environment in classrooms for screening and examining children properly, including mental health assessment due to lack of privacy
- Referral systems are not always available to respond to identified health needs
- Follow-up is rarely conducted, as nurses generally visit schools once a year
- Unavailability of transport, poor roads and infrastructure curtails access to hard to reach schools.

Generally the implementation environment needs to be improved to facilitate the implementation of the School Health Policy. The number of school health nurses needs to be increased in order to deliver school health services in all areas; to greatly improve coverage and to reduce the current inequities between urban and rural area. Staff also need to be primarily designated as school health staff, which becomes their core responsibility, rather than as an add-on to other duties.

1.3 The policy development process

The draft policy has been widely distributed for comments and inputs within both the health and education sectors. The aim is to have a reviewed school health policy which encompasses improvement of learner coverage, quality, and intersectoral delivery of a school health programme that will contribute to the optimal development of school going-children.

2. SCHOOL HEALTH POLICY

2.1 Vision

The optimal health and development of school-going children and the communities in which they live and learn.

2.2 Goal

To contribute to the improvement of the general health of school-going children as well as the environmental conditions in schools and address health barriers to learning in order to improve education outcomes of access to school, retention within school and achievement at school.

2.3 Principles

The Integrated School Health Programme is part of the comprehensive primary health package which operates within the DBE's CSTL Framework and should:

- Focus on achievement of health and educational outcomes;
- Be implemented within a child's rights approach. This means that children should not be passive recipients, but must be empowered actors in their own development;
- Ensure full coverage of all learners starting in the most disadvantaged schools;

- Ensure that appropriate assessment, treatment, care and support services are available and accessible to all learners who are identified as requiring them;
- Be informed by local priorities;
- Take into account quality and equitable distribution of resources;
- Be implemented as a partnership between the Departments of Health (DOH), Basic Education (DBE), Social Development (DSD) and all other relevant stakeholders and role-players;
- Be guided by ethical standards as outlined in the principles of professional bodies (such as the South African Nursing Council and Health Professions Council of South Africa).

2.4 Objectives

General Objective

To guide the provision of a comprehensive, integrated school health programme which is provided as part of the PHC package within the Care and Support for Teaching and Learning (CSTL) framework.

Specific Objectives

- To provide preventive and promotive services that address the health needs of school-going children and youth with regard to both their immediate and future health
- To support and facilitate learning through identifying and addressing health barriers to learning
- To facilitate access to health and other services where required
- To support the school community in creating a safe and secure environment for teaching and learning.

The School Health Policy objectives will be achieved by means of the following key strategies:

- Health Promotion and Health Education
- Provision of an essential package of health services in schools
- Coordination and Partnership
- Capacity Building
- Community Participation

2.5 Target groups

The target group for the school health programme is the entire population of learners including learners with special needs. The service will be tailored according to the different developmental stages of childhood and specific health needs in various communities and schools. As outlined above, the ISHP will be delivered in partnership with the target population.

Primary target group

The primary target group of this policy is all children and youth, regardless of age, who attend learning sites. This covers children in Grade 1 to Grade 12, and those in Grade R

where this is attached to formal schools.

Secondary target group

Whilst the ISHP focuses on school-going children, the school community (which includes educators, school management, school administrators and auxiliary staff, as well as parents and other caregivers) should also benefit from the programme. The school community should work in partnership with the school health programme in shaping, informing and sustaining the “healthy” status of learning sites. The wider school community has much to gain from access to health information, opportunities to develop skills for healthy lifestyles, support in improving the health status of children and enjoyment of a healthy environment and/or community setting.

Children not covered by this programme

Various policies and programmes are currently in place to address the health needs of children not included in the target group of this policy. These children include pre-school children, children of school-going age not attending school for various reasons and those who have completed grade 12.

2.6 School health package of services

This section outlines the activities that make up the package of health services that should be provided as a minimum in all schools.

Health education and promotion

Health education is a critical component of the ISHP, and provides the best opportunity to impact on the immediate and long-term health behaviour of children and youths. Health education is incorporated into the school curriculum and provided through the Life Orientation learning areas. However life skills teaching should be supplemented with additional co-curricular/school-based activities especially in secondary schools where the time tabling may not provide adequate time to fully address issues related to sexual and reproductive health as well as other health and social issues.

Issues to be covered through Life Orientation and supplemented through co-curricular activities include:

- Nutrition and exercise
- Personal and environmental hygiene
- Chronic illnesses (including HIV and TB)
- Abuse (sexual, physical and emotional abuse, including bullying and violence)
- Sexual and reproductive health
- Menstruation
- Contraception
- Sexually Transmitted Infections (STIs) including HIV/AIDS
- Male circumcision including Male Medical Circumcision (MMC)

- Teenage pregnancy, Choice of Termination of Pregnancy (cTOP), PMTCT
- HIV Counselling and Testing (HCT) and stigma mitigation
- Mental health issues including drug and substance abuse, depression and anxiety and suicide

Learner Assessment and Screening

The ISHP aims to individually assess every learner once during each of the four educational phases. Additional individual assessments should also be offered to all learners who are repeating grades or at the request of an educator, parent or at the request of the learner (self-referral). These assessments should be conducted by a professional nurse.

Assessments during the foundation phase focus primarily on identifying health barriers to learning, as well as identifying children who have or are at risk for long-term health, psychosocial or other problems. Although this focus is maintained during the later educational phases, more emphasis is placed on ensuring that learners receive or have access to sexual and reproductive as well as mental health services where these are required.

The following assessments will be done on all foundation phase learners:

- Conduct vision, speech and basic hearing screening.
- Measurement of height, weight and Body Mass Index (BMI). Appropriate nutritional interventions must be planned accordingly.
- Check for fine and gross locomotor problems.
- Conduct oral health screening.
- Screen for chronic illness or long-term health conditions - this includes both communicable diseases (such as TB and HIV/AIDS) as well as non-communicable diseases.
- Perform a basic mental health and/or psychosocial risk assessment.

Learners in the senior and FET phases should also be screened for weight and body mass index, vision, oral health, chronic illness or long-term health conditions and mental/psychosocial health issues. Girls should also be screened for anaemia. All boys should be provided with information on the health benefits of male circumcision, and access to MMC should be facilitated through referral.

All learners should be counselled with regard to sexual and reproductive health. For sexually active learners, this should include the offer of provision of dual protection contraception and HCT, and screening for STIs. Where required, the school health nurse can provide these services on-site or refer the learner to a health facility where he/she should receive the service.

The school health package is summarized in table 1 below.

Health Screening	On-site service	Health Education
Foundation phase (Gr R-3)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment (Gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • Parasite control: De-worming and bilharzia control (where appropriate) • Immunisation • Oral health (where available) • Minor ailments 	<ul style="list-style-type: none"> • Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)
Intermediate phase (Gr 4-6)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • Deworming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral for services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Medical and Traditional Male circumcision • Abuse (sexual, physical and emotional abuse including bullying, violence) • Puberty (e.g. physical and emotional changes, menstruation & teenage pregnancy) • Drug & substance abuse
Senior phase (Gr 7-9)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH, and provision of or referral for services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide
Further Education and Training (FET) (Gr 10-12)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH needs, and provision of or referral for services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide

Health Screening	On-site service	Health Education
All schools		
	Environmental assessment <ul style="list-style-type: none"> • First aid kit • Water and sanitation • Cooking area • Physical safety • Ventilation (airborne infections) • Waste Disposal • Food gardens • Recycling 	

Table 1: Package of School Health Services

Provision of onsite services

A package of on-site services should be provided at schools. These include:

- Parasite control: Deworming and bilharzia control (where appropriate)
- Immunisations
- Treatment of minor ailments especially treatment of skin conditions
- Sexual and Reproductive Health services where indicated. These will focus on provision of dual protection (to prevent pregnancy and STIs including HIV infection) and provision of HCT.
- Environmental assessment, including provision of first aid kits, adequate water and sanitation, physical safety and issues related to food safety and suitability. These assessments should be undertaken by Environmental Health Officers.

It is anticipated that the package of on-site services will be expanded over time. For now school health services are strongly encouraged to provide additional services on-site, especially where this will significantly reduce the number of learners who require referral. These services may be provided by existing DOH services (e.g. dental therapists who might visit the school together with the school health nurse or at a separate time) or by other providers on a regular or intermittent basis (e.g. services provided by NGOs or by professional societies on a voluntary basis).

Follow-up and referral

Where learners are identified as requiring health and other services that cannot be provided on-site through routine school health services, mechanisms must be in place for ensuring that learners access these services.

Health services will be provided using a number of mechanisms, including:

- Service provision by specialised school health mobiles is the mechanism of choice. These mobiles will provide PHC services, including oral health and dental services and optometric services.
- In areas where specialized mobiles are not operating, learners should receive services at fixed facilities including PHC clinics, community health centres and hospitals. Plans must

be in place to ensure that learners can be seen at appropriate times (i.e. in the afternoon or during the school holidays). These arrangements must be made with the facility prior to the screening of learners.

- Services may also be provided using existing mobile services, both PHC mobiles and specialized mobiles (such as dental mobiles or optometric mobiles). These services may be provided by DOH employees or by other providers on a regular or intermittent basis (e.g. services provided by NGOs or by professional societies on a voluntary basis).

The DSD will be responsible for assisting learners to access services, particularly where financial barriers to accessing services are present. This includes providing transport to health facilities where necessary.

Coordination and Partnership

International evidence shows that implementation of successful school health programmes depends on strong partnerships between education and health sectors, teachers and health workers, schools and community groups and learners and persons responsible for school health programmes⁴.

The establishment of effective partnerships between government, trade unions, private sector, academic institutions, civil society and NGOs to assist in the formulation, implementation, monitoring and evaluation of priority areas for school health will facilitate implementation of the school health programme.

The National and Provincial DOHs, DBE and DSD must ensure co-ordination between all the relevant service providers related to the school health programme. Regular meetings are necessary to ensure that the collaboration required for the implementation of the policy is achieved at all levels.

Community Participation

Community structures play an important role for improved health of learners in schools. Community mobilization should be conducted to create awareness for people to take positive action towards improving health of learners in schools. Active involvement of the school governing bodies, community leaders (such as traditional and faith-based leaders and ward councillors) is required as well as the buy-in of the entire school community for the success of the IHSP.

Learner Participation

The participation of learners through Student Representative Councils and other organization such as Boys and Girls Education Movement clubs will further ensure successful implementation of the ISHP. Learners need to be consulted and encouraged to support the implementation of the ISHP through platforms created at school and community level.

2.7 Consent and assent

Learners below the age of 18 years should only be provided with school health services with

written consent of their parent or caregiver. However learners who are older than 14 years may consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver. No learner who does not assent to being screened or provided with services should be coerced into receiving services.

3. IMPLEMENTATION GUIDELINES

Implementation of the ISHP requires collaboration and linkages of different sectors, most importantly, the DOH and DBE, as well as the DSD. It is for this reason that the revised policy is co-signed by both Ministers of Health and Basic Education.

3.1 Roles and Responsibilities

Whilst the DOH is responsible for provision of the package of school health services the DBE plays a key role in creating an enabling environment for the provision of the ISHP. This includes planning, managing and monitoring of the programme, facilitating access to schools and services, and liaising with other role-players at all levels of the system.

Roles and responsibilities for the different implementation levels are outlined below.

National Level

The national level will support provinces in development, monitoring and implementation of the ISHP. In this regard the steps that need to be taken by the DOH, DBE and DSD are as follows:

Establish a National ISHP Task Team which brings together officials responsible for the ISHP from the Departments of Basic Education, Health and Social Development, as well as other stake-holders.

The task team will:

- Provide technical support regarding the content of the ISHP, as well as strategic direction with regard to its implementation.
- Develop a five-year implementation plan for the ISHP.
- Develop standardized guidelines for implementation and service provision with corresponding training packages.
- Develop appropriate norms and standards for all aspects of the ISHP.
- Ensure that the resources necessary for implementing the ISHP are in place - this includes human, financial and other (such as equipment, materials and medication) resources.
- Monitor and evaluate the implementation and impact of the ISHP.
- Review the policy and package of services at appropriate intervals.
- Identify research priorities for school health.

Provincial Level

Provincial task teams with representatives from DOH, DBE, DSD and other key stake-holders need to be established. These provincial ISHP Teams are responsible for ensuring that school health services reach all learners. Key responsibilities include:

- Developing a five-year implementation plan for the ISHP in the province, as well as a detailed implementation plan for the first year.
- Securing the required financial, material and human resources.
- Identifying and prioritising the most disadvantaged schools which should be targeted during the early phases of implementation.
- Ensuring that appropriate referral facilities and processes are in place.
- Ensuring that an appropriate and adequate training programme for new and existing staff is in place.
- Monitoring implementation of the ISHP in the province.

District level

Implementation of the school health programme is invested at district level, with accompanying responsibility to ensure that the programme is implemented in all sub-districts and reaches all schools and learners.

Each district should establish and/or convene a team which is responsible for overseeing school health services. Where a District-Based Support Teams (DBST) has been established to implement other initiatives (such as CSTL) this team may play this role, or a smaller team which reports to the DBST may be established. The team should develop an implementation plan with clear objectives and indicators which forms part of the district health plan. The team is jointly responsible for overseeing and co-ordinating the ISHP within the district. This includes ensuring progressive coverage of all schools and learners (starting with the most disadvantaged schools); co-ordination of other partners who provide components of the school health package; and reporting on school health activities to both the DOH and DBE.

Each district will need to:

- Ensure that the ISHP plan is developed and integrated into the district health and other relevant plans.
- Allocate a person to oversee and manage the ISHP.
- Conduct an audit of existing capacity for the delivery of the ISHP.
- Appoint School Health Teams who are responsible for providing and co-ordinating provision of the school health package to all targeted learners.
- Strengthen existing systems for communication, transport, equipment and referral.
- Monitor implementation of the ISHP as outlined in the ISHP monitoring and evaluation plan.
- Conduct capacity building of both health professionals and educators.

PHC facility level

PHC facilities have a key role to play in ensuring that all schools are reached. Each School Health Team will be based at a PHC facility, and will report to the facility manager.

The facility manager is responsible for overseeing the day-to-day activities of the School Health Teams, and for ensuring that they are provided with the necessary logistical support, as well as supplies and medicines. Statistics on the ISHP will be incorporated into the facility statistics, as outlined in the ISHP monitoring and evaluation plan.

PHC facilities also play an important role in providing services to learners who are referred. Mechanisms for allowing School Health nurses to ensure that referred learners have accessed services and to provide ongoing follow-up must be in place.

School level

Implementation of the ISHP at school level is the responsibility of the School-Based Support Team (SBST) under the guidance of the school principal. This team should include the life skills/orientation teacher, members of the School Health Team (including health promoters), representatives from the school governing body, representatives of relevant NGOs or CBOs, peer educators and learners. The Life Skills/Orientation Teacher or designated member of staff will coordinate all the ISHP activities within the school.

Specific tasks include:

- Mobilising and liaising with the school community including educators, the school governing body and other role-players.
- Ensuring that all components of the ISHP package are provided to all learners.
- Ensuring that data on the ISHP is collected, collated, stored and forwarded as outlined in the ISHP monitoring and evaluation plan.
- Managing any equipment that is provided to the school as part of the ISHP.
- Building partnerships with external providers including NGOs and other community organizations.

With regard to learner assessment and provision of on-site services, the SBST should:

- Develop a schedule for learner assessments and ensure that DBE officials are available to support the activity.
- Manage distribution and preparation of consent and assent forms and Road to Health Cards.
- Orient learners on what to expect on the day.
- Identify an appropriate space for learner assessments and ensure that the necessary infrastructure is available.
- Ensure that a list of learners who are referred is kept, and that the learners access the services to which they have been referred.
- Ensure that letters for follow-up reach parents or caregivers.
- Liaise with DSD if parents are unable to access referral services in collaboration with the DBST.

The SBST should also play a role in providing ongoing support and assistance to learners with long term health conditions. This may include educators administering medication to learners providing the learner's caregiver has provided the school with written permission.

3.2 Human Resource Implications

The School Health Team should be led by a professional nurse. The recommended norm for delivering of individual learner assessments is one professional nurse for every 2,000 learners to be assessed per year. The professional nurse will be assisted by an enrolled nurse or an enrolled nursing auxiliary.

The professional nurse is primarily responsible for co-ordinating the implementation of the ISHP, conducting individual learner assessments and providing on-site services. She is also responsible for ensuring referral and follow-up of learners when required, for ensuring that information on learners is recorded and stored appropriately and that collated data are submitted to the PHC facility as outlined in the ISHP monitoring and evaluation plan.

The health education and promotion components of the ISHP should ideally be delivered by health promoters - these may be full-time members of the School Health Team or may be based at facilities or part of PHC outreach teams. Health education and promotion activities may also be provided by other cadres (such as Community Health Workers) and by non-government or community-based organisations.

Staff for school health activities may be drawn from:

Existing school health nurses

Where school health nurses and posts currently exist, such staff and posts must be ring-fenced so that they are utilised first and foremost for the delivery of the ISHP.

PHC nurses

Where there are insufficient school health nurses to deliver the ISHP, PHC nurses should assist in the delivery of the service.

Other PHC staff and health workers from other health programmes

Other appropriate health worker categories, such as enrolled nursing assistants and health promoters, must be considered as additional categories of staff to deliver the health promotion components of the school health package. The professional nurses within each district must play a mentoring role to these staff categories until such time that staff are sufficiently skilled to deliver the service on their own.

Employing additional staff

Where districts assess that current staff capacity is not sufficient to deliver the ISHP package, districts will have to employ additional staff to perform this function. This may include retired nurses. Provincial and national budgets must take this possible requirement into account and support these districts by giving priority to school health budgets.

Training requirements

Training and re-orientation is required for all categories of staff who will be implementing the ISHP.

Categories of staff that will require training/re-orientation

- DBE and DOH officials and managers will require orientation and training on the ISHP.
- New school health nurses will require training in all aspects of the ISHP.
- Existing school health personnel will need to be orientated to function in an intersectoral and interdisciplinary manner and to work with staff of different backgrounds, qualifications and training. Particular attention will need to be paid to ensuring that school health nurses are comfortable dealing with issues related to adolescent sexual and reproductive health, and that services are provided in an adolescent-friendly manner.
- Experienced staff might also need training on how to fulfill a mentoring role to new staff who are inexperienced in delivering the school health package.

4. MONITORING AND EVALUATION

The joint National ISHP Task Team must establish mechanisms for monitoring and evaluating the school health policy. Reporting, monitoring and evaluation of the ISHP must be integrated with existing district and provincial health information systems as well as interfacing with the education management information system.

Monitoring and evaluation need to focus on:

- Coverage of services
- The impact of the service on the health of learners and on access to schooling, retention and achievement of learners
- Quality of services
- Sustainability of school health services in all districts

The M&E framework must propose a set of national indicators that will be used to monitor the ISHP.

5. CONCLUSION

The ISHP has the potential to contribute substantially to improving health and learning outcomes for school-going children. Successful implementation of the ISHP will depend on a number of critical factors which are outlined below:

- **Coordination:** A need to strengthen co-ordination between this service and other programmes to ensure that school health services are delivered in the most efficient and effective way. Therefore, joint steering by the Departments of Health, Basic Education and Social Development in the development and provision of the service is important.
- **Resource availability:** Implementation of the ISHP has substantial resource implications

with regard to staffing, transport, equipment and medication. Successful implementation will only be possible if these resources are made available at district and sub-district level.

- **Adequate referral and follow-up of learners who are identified as having health or other problems.** In some areas this will require development and strengthening of services in order to ensure that learners have access to the services which they require.
- Advocacy, communication and social mobilisation should be conducted in collaboration with essential role-players at national, provincial and district levels. These include all government departments, other health programmes and NGOs rendering health services to the school community, SGBs, parents and learners.
- **Prioritisation:** Priorities for the ISHP should be based on the understanding of the integral link between health and education and its impact on learners' successful development and educational outcomes.
- **Capacity Building for the ISHP depends on:**
 - The involvement of schools in the development and delivery of the ISHP.
 - Re-orientation and training of PHC personnel to assist and support the delivery of the school health service within the ISHP
 - The development of the capacity of school communities to take responsibility for their health needs through informed interaction with the health and development sector.
- Effective Monitoring and Evaluation will depend on active reporting, monitoring and evaluation of the programme to ensure learner coverage and identify gaps and barriers to implementation. Identification of research priorities in school health programme would also assist with policy review, programme planning and implementation at all levels of care.

ANNEXURE A: SOCIO-ECONOMIC AND HEALTH CONTEXT OF SCHOOL-AGED CHILDREN

A review of South African literature shows a range of factors that impact negatively on the health and development of children as described below.

Socio-economic factors

Seventy percent of South Africa's children live in rural areas, and many live in households with incomes below the poverty line³⁰. A high proportion of children depend on social assistance primarily through the child support grant (CSG).

The 2008 General Household Survey indicates that there were approximately 3.95 million orphans in South Africa. This includes children without a biological mother, father or both parents and accounts for approximately 21% of all children in South Africa³¹.

A child-headed household is a household in which all members are younger than 18 years. The older child assumes the role of caring for the siblings. Research suggests that child-headed households often exist for a short period for example, after the death of an adult and prior to other child care arrangements being made³¹. The challenges experienced are mostly related to poverty, hunger and various forms of abuse, with resultant absenteeism and school drop-out. Together with educators, social workers and the school community, school health services should ensure that orphans and other vulnerable children are identified and referred appropriately to psycho-social support services.

The proportion of children living in households that reported child hunger fell from 30% in 2002 to 18% in 2008³². Yet, malnutrition remains common and stunting affects one in five children. Chronic malnutrition has a significant impact on child development, especially during the first three years of life when the brain is still developing. The high prevalence of stunting in this age group is therefore a cause for concern and is likely to have serious implications for future school performance.

The 2005 National Food Consumption survey found that 18% of children were stunted, 9.3% were underweight and 4.5% were wasted.³³ Levels for all three indices were higher in young children (1 – 3 years) than in older children (7 – 9 years). Stunting was higher in children living in rural farming areas (24.5%), tribal areas (19.5%) and urban informal areas (18.5%). The 2008 Youth Health Behaviour Risk Survey (YRBS) showed that 13% of secondary school learners suffered from stunting (low height for age), while 8% were underweight (low weight for age) and 4% had wasting (low weight for height). With regard to over nutrition, the prevalence of being overweight was 20% and that of obesity was 5%³⁴.

As in other parts of the world, bilharzia and soil-transmitted helminth infections (STH) ("worms") are prevalent amongst school-going children, especially amongst disadvantaged children who live in densely-populated rural and under-serviced areas such as informal settlements. High levels of infection with STHs have been documented amongst children in all provinces of South Africa, especially in low-altitude, coastal areas. International and local studies have demonstrated that synchronised and regular deworming of school-

age children can reduce the prevalence and intensity of worm infections and significantly improve growth, learning and school attendance especially when supplemented by other nutritional and environmental health control interventions^{35,36,37}.

Access to basic services has increased with the proportion of children with access to basic sanitation increasing from 47% in 2002 to 63% in 2009. However, approximately 6.8 million children still used unventilated pit latrines, buckets or open land³⁸. While most children (80%) live in households with access to electricity, many households cannot afford electricity or appliances and continue to rely on unsafe energy sources such as paraffin, wood and coal, which are associated with increased risk of acute respiratory infections and burns³⁹.

South Africa made good progress in increasing the number of schools with on-site water from 17 366 in 1996 to 22 254 in 2006. In 2006, 61% of schools had acceptable sanitation on site. In 2010, 1307 and 536 schools were without water and sanitation respectively. The DBE has collaborated with the Department of Water Affairs and Energy to implement and manage the provision of water, sanitation and electricity infrastructure, and has developed the Accelerated School Infrastructure Delivery Institute (ASIDI) in order to eliminate all backlogs in schools including water, sanitation, electricity, fencing and inappropriate structures by 2014. Education on good hygiene practices is a key component of school-based health promotion activities.

Early Childhood Development

The Commission on the Social Determinants of Health has called for greater investment in comprehensive early childhood development that links families and young children to health, education and nutrition services⁴⁰. The Children's Act (Act No. 38 of 2005)⁴¹ and the National Integrated Plan for ECD²⁶ provide a framework for the provision of services for children under five, to address children issues of child protection, children's rights, growth monitoring, immunization, childhood illness, early learning stimulation, infant and young child feeding, psychosocial care and appropriate referral. Early Childhood Development has also been recognized as a key priority of the DBE

Social assistance

The Child Support Grant (CSG) is a key programme for alleviating child poverty in South Africa. By April 2011, 10.5 million children received a CSG⁴². Beneficiaries are also exempted from paying school fees.

Health-related factors

Hearing, vision and speech impairment

Hearing, speech and vision impairment are significant barriers to a child's learning and development. The 2001 census conducted by Statistics South Africa showed a disability prevalence of 5% in the general population with 0.7% of the population having a hearing impairment and 0.2% having a communication or speech impairment⁴³.

International literature shows that the prevalence of vision impairment amongst pre-

school and school-aged children to be between 2.4% and 6%. Refractive errors are the most common visual impairment problem in the paediatric population, and many of these are not identified until children enter schools⁴⁴. A study undertaken in and around Durban documented a lower than expected prevalence of reduced vision in school-age African children. Where problems were identified these were predominantly as a result of uncorrected refractive error. In contrast, the prevalence of corneal and other anterior segment abnormalities was higher than expected, and was thought to reflect the inadequacy of primary eye care services in the area. Of note was that 81% of children with significant refractive errors had not been provided with spectacles⁴⁵.

At an international level, the incidence/prevalence of hearing loss in school-age population is estimated to be approximately 11.3%⁴⁶. Few such studies have been conducted in South Africa, and those that have been completed are limited to small groups that are unrepresentative of the diverse South African population. Prevalence of middle ear pathology in different studies have shown levels of between 13.4 and 29.4%.

Oral health

The national child oral health survey undertaken in 2003 found that 60% of six year old children had dental decay and 55% of them were not treated⁴⁷.

HIV and AIDS

The HIV and AIDS epidemic in South Africa affects children in many ways. Estimates suggest that there are approximately 300 000 HIV-infected children in South Africa with 50 000 new infections occurring each year⁴⁸. HIV prevalence figures indicate that the proportion of young people infected with HIV increases significantly between childhood (2 – 14 years) and youth (15 – 24 years), suggesting that as children progress from childhood to youth their vulnerability to HIV infection increases substantially⁴⁹.

In addition to ill-health, children infected or affected by HIV and AIDS are more likely to drop-out of or underperform at school due to a range of psycho-social factors including financial pressures⁵⁰, high levels of grief and related mental health problems as a result of the (often multiple) illnesses and deaths in the family⁵¹ and discrimination and stigma which takes various forms, including emotional, verbal and physical abuse as well as social exclusion and isolation⁵². Adherence to ARVs is essential for adolescents living with HIV and the specific sexual and reproductive health needs of adolescents also need to be considered within the ISHP.

In 2008, 65% of learners indicated that they had been taught about HIV and AIDS in school. Twenty-one percent of learners had had an HIV test, with no significant variation by gender.

Mental health

Mental health is a fundamental component of health. Although there are no nationally representative epidemiological data on the prevalence of psychiatric disorders in adolescents in South Africa, estimates suggest that approximately 17% of youth between the ages of 6-16 years have poor mental health. Local studies indicate high prevalence rates for anxiety

disorders, post-traumatic stress disorders, depression, and conduct disorders amongst children and adolescents⁵³.

Various biological, social, and psychological factors are known to contribute toward the high prevalence of mental disorders among young people; whilst poor mental health is associated with, amongst other things, educational underachievement, social disadvantage and poor health and well-being. The mental health needs of children and adolescents can be addressed on numerous levels and intervention sites, and schools can play an important role⁵⁴.

Risk behaviour

Substance abuse and other risk behaviour are key mental health issues that need to be addressed especially in the adolescent period. The 2008 YRBS provides useful information regarding the prevalence of mental health problems and high risk behaviours among secondary school learners in South Africa⁵⁵.

Substance abuse

The 2008 YRBS reported that almost one in three learners (29.5%) reported ever having smoked cigarettes in their life time and one in five learners (21%) were current smokers. Nationally, one in two learners (49.6%) had drunk at least one drink of alcohol in their lifetime. With respect to age of initiation, 11.9% of learners reported having had their first drink before the age of thirteen years.

The prevalence of dagga use on school property increased with age. Significantly fewer learners aged 13 years (4.2%) than learners aged 17 years (9.8%) and 19 years or over (11.3%) reported using dagga⁵⁵.

Sexual behaviour

The YRBS found that just less than forty percent (37.5%) of learners reported ever having had sex, with 12.6% having had their first sexual encounter before the age of 14 years. Approximately 40% of sexually active learners reported having had two or more sexual partners in their lifetime. Sixteen percent of learners used alcohol before having sex and 17.9% reported not using any method of contraception. Forty-five percent of learners used condoms for contraception, although only 30.7% used condoms consistently. Nineteen percent of learners reported having been pregnant or having made someone pregnant⁵⁵.

Nationally, the 2008 YRBS report showed that of learners reported having had sex, 4.4% had a sexually transmitted infection with half of them reporting having received treatment for their infection.

Trauma and violence

Young people also experience high levels of violence and trauma. The number of cases of violence-related deaths increases in the 15-19 year age group and peaks in the 25-29 age category⁵⁶.

The YRBS found that one in ten learners (8.2%) reported carrying a gun and one in six learners (16.4%) reported carrying a knife, in the month prior to the survey. In their lifetime, 15.1% of learners had been assaulted by either their boyfriend or girlfriend, 13.5% had assaulted their boyfriend or girlfriend, and 10.0% of learners had been forced to have sex, while 9.0% had forced someone else to have sex⁵⁵.

ANNEXURE B: INTERNATIONAL, REGIONAL AND NATIONAL CONTEXT

The ISHP is located within the context of a number of international and regional initiatives which aim to improve the quality of education and the health of learners. These are outlined briefly below.

Millennium Development Goals

South Africa is committed to achieving the Millennium Development Goals (MDGs). The MDGs require countries to (by 2015):

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

School health programmes have an important role in ensuring that MDGs 2 and 3, which focus on achieving universal primary education and eliminating gender disparities in primary and secondary education, are met. Likewise an increased focus on sexual and reproductive health during the later educational phases will contribute to combating HIV and AIDS, and to reducing maternal mortality through reducing teenage pregnancy rates. School nutrition programmes and improved access to social support will also contribute towards achievement of MDG 1.

The 2000 EFA Dakar Framework for Action to achieve Education for All

Among the EFA goals in health and education, the following are of particular importance to school health:

- the fight against HIV and AIDS in schools
- to expand and improve security and education in early childhood, including the most vulnerable and disadvantaged children
- to ensure that by 2015 all children, particularly girls in especially difficult circumstances and those belonging to ethnic minorities, have access to free and compulsory quality primary education⁵⁷.

The 2000 EFA Dakar Framework for Action stresses in one of its six goals that youth-friendly programmes must be made available to provide information, skills, counselling and services needed to protect young people from the risks and threats that limit their learning opportunities and challenge education systems, such as school-age pregnancy and HIV and AIDS⁵⁸.

Care and Support for Teaching and Learning Programme

The Care and Support for Teaching and Learning (CSTL) Programme⁵⁹ is a Southern African Development Community (SADC) Initiative that was adopted in 2008 by SADC Education Ministers. The goal of the CSTL Programme is to realise the educational rights of all children, including those who are most vulnerable, through schools becoming inclusive centres of learning, care and support. The CSTL Programme intends to prevent and mitigate factors that have a negative impact on the enrolment, retention, performance and progression of vulnerable learners in schools by addressing barriers to learning and teaching. South Africa is one of six countries (others are Swaziland, Zambia, Madagascar, Democratic Republic of Congo and Mozambique) implementing Phase 1 of the Programme between 2008 and 2014.

Through this initiative, the DBE aims to fulfill two roles namely:

- To deliver and expand appropriate care and support services in and through schools and
- To create an enabling environment within the education system for other stakeholders such as the DOH and DSD to support learners and educators.

As a comprehensive, co-ordinated multi-sectoral response to address barriers to teaching and learning, CSTL offers an overarching framework to cohere the range of care and support initiatives currently implemented in and through schools. It promotes mainstreaming or a systemic response to the care and support needs of learners based on a strong policy mandate both within and outside of the education sector. The following nine priority areas have been identified for programme implementation:

- Nutrition
- Health Promotion
- Infrastructure, Water and Sanitation
- Social Welfare Services
- Safety and Protection
- Psychosocial Support
- Curriculum Support
- Co-curricular Support
- Material Support

The Health Promoting Schools Programmes (HPSP)

The HPSP is a WHO/AFRO initiative, based on actions called for in both the Ottawa Charter for Health Promotion and the Jakarta Declaration for Promoting Health. WHO began to foster the concept of Health Promoting Schools on a global level in 1995, through its Global School Health Programme (GSHP). The Programme strives to increase international, national and local capacity for the development of Health Promoting Schools (HPS), whose aim is to improve the health of school personnel, families and community members as well as students.

The main goal of GSHP is to increase the number of schools which are assessed as being "Health Promoting Schools". A Health Promoting School is one which:

- Fosters health learning with all the means at its disposal
- Engages health and education officials, educators, pupils, parents, and community leaders in efforts to promote health
- Strives to provide a healthy environment, school health education, school health services and school/community projects and outreach
- Strives to improve the health of school personnel, families and community members as well as pupils and works with community leaders to help them understand how the community contributes to help or undermines health and education.
- Implements policies, practices, and other measures that respect the individual's self-esteem, provide opportunities for success, and acknowledge good efforts and intentions as well as personal achievements⁶⁰.

National context

The ISHP is one of several health programmes that operate within the health and education domain. Significant transformation is currently taking place within both sectors. The ISHP therefore needs to take cognisance of relevant health and education policies and programmes and to be delivered in a co-ordinated manner.

This section outlines the key health, education and social development legislation, policies and programmes that will impact on the development and implementation of the school health policy.

Legislative Framework

Several pieces of legislation have relevance to implementation ISHPs. These include:

- The Constitution of South Africa (Act No. 108 of 1996)
- The Children's Act (Act No. 38 of 2005) as amended.
- The National Health Act (Act No. 63 of 2003)
- The Mental Health Care Act (Act No. 17 of 2002)

National Service Delivery Agreements

The health sector has committed itself to achieving the following four strategic outputs:

- A long and health life for all South Africans
- Reducing maternal and child mortality
- Combating HIV/AIDS and TB
- Strengthening the health system

Health Policies and Programmes

The Health Promoting Schools Initiative (HPS)

The Health Promoting Schools (HPS) is a WHO recommended programme that has been established in South Africa. It is underpinned by a health promotion philosophy and has five components, namely:

- The development of healthy school policies that will assist the school community in consistently addressing its health needs.
- Improving access to appropriate services to address the health needs of the school community.
- The development of personal skills of members of the school community, thus enabling them to improve their own health and influence the healthy development of others.
- The development of the school as a supportive environment for the development of healthy attitudes and practices.
- Community action that involves the school and broader community in taking ownership of and seeking ways to address their collective health needs by accessing resources for health⁶¹.

Household and Community Component of Integrated Management of Childhood Illness Strategy

This is an integrated child care approach that aims at improving key household practices that are likely to have the greatest impact on child survival, growth and development. The child-to-child or child family approach is based on the idea that learners will share child health knowledge and practices with other family and household members⁶².

The Youth and Adolescent Health Policy

This document presents a holistic and integrated approach to health that covers children and youth aged 10 to 24 years, both in and out of school. The policy outlines a range of strategies to address health priorities, such as promoting a safe and supportive environment, providing information, building skills, providing counselling and improving health services. Schools are identified as one of seven intervention settings where these strategies can be applied⁶³.

The HIV and AIDS and STI National Strategic Plan 2012 - 16⁶⁴

The NSP is the strategic guide for the national response to HIV, STIs and TB for the period 2012-2016. The plan builds on the achievements of the previous NSPs and addresses the drivers of the HIV and TB epidemics. The NSP has the following broad goals:

- To reduce new HIV infections by at least 50% using combination prevention approaches;
- To initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation;
- To reduce the number of new TB infections as well as deaths from TB by 50%;
- To ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP; and
- To reduce self-reported stigma related to HIV and TB by at least 50%.

HIV Counselling and Testing (HCT) Policy Guidelines

This document provides guidelines with regard to HIV counselling and testing in South Africa, and was used as the basis for implementation of the HCT campaign which was conducted between April 2010 and June 2011. The policy makes provision for children

and adolescents to be tested within the context of a youth-friendly service, and provides guidance with regard to pre-and post-test counselling and consent, taking into account issues related to age and maturity of those undergoing HCT⁶⁵.

South African National Oral Health Strategy

The purpose of the national oral health strategy is to improve oral health of the South African population by promoting good oral health and appropriately addressing oral diseases through prevention, screening, treatment. The oral health strategy aims to reduce dental caries and gum diseases amongst children by instituting school oral health preventative services which focus on provision of health education (including tooth-brushing campaigns) and on application of tooth fissure sealant where resources permits⁶⁶. Children in need of treatment should be referred to fixed health facilities.

Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia Policy and Implementation Guidelines

The document provides a technical basis for introducing Helminth control programmes, which include regular treatment of children for soil-transmitted helminth infections and bilharzia. Successful implementation of such programmes is dependent on close collaboration between the Departments of Health and Basic Education at all levels⁶⁷.

Child and Adolescent Mental Health Policy Guidelines, 2001

The policy guidelines adopt a holistic approach in addressing various risk factors that may affect the mental health of children and adolescents. The school is an important setting for the provision of interventions to address mental health since it has potential to reach large numbers of children and adolescents in a cost-effective manner⁶⁸. The policy guidelines adopt a holistic approach in addressing various risk factors that may affect the mental health of children and adolescents. The policy acknowledges the school as an important setting for the provision of interventions to address mental health since it has potential to reach large numbers of children and adolescents in a cost effective manner.²²

Drug Master Plan for the Health Sector 2011/12-2013/14

In terms of the National Drug Master Plan the DOH is tasked with the provision of specific services with regard to responding to substance abuse problems. The Mini Drug Master Plan for the Health Sector outlines the activities/strategic interventions that the health sector will implement in responding to substance abuse in accordance with the NDOH's 10 point Strategic Plan 2010-2013. It also outlines areas in which the Health Sector will work with key partners to improve both preventive and curative services and ensure better health access.

Immunisation Policy

This document provides the technical basis for the immunisation programme for vaccine preventable diseases. Children admitted to school should have documentary evidence of being up-to-date with the immunisation schedule, and school health programmes should

ensure that all children complete the schedule timeously.

Policy Guidelines for the management and prevention of Genetic Disorders, Birth Defects and Disabilities

This policy provides a framework for the prevention, identification, management and rehabilitation of genetic disorders, birth defects and disabilities⁶⁹.

Integrated Nutrition Programme (INP)

The INP highlights the essential role played by nutrition for survival, health, growth, mental and physical development, performance and productivity from childhood into adulthood. The focus areas addressed within this programme includes household and food security, growth monitoring and promotion, control of micronutrients deficiencies, nutrition education, disease specific nutrition support as well as food service management. The school nutrition programme therefore forms an important pillar of the INP⁷⁰.

The Health Promoting Schools (HPS)

The Health Promoting Schools (HPS) is a WHO recommended programme that has been established in South Africa. It is underpinned by a health promotion philosophy and has five components, namely:

- The development of healthy school policies that will assist the school community in consistently addressing its health needs.
- Improving access to appropriate services to address the health needs of the school community.
- The development of personal skills of members of the school community, thus enabling them to improve their own health and influence the healthy development of others.
- The development of the school as a supportive environment for the development of healthy attitudes and practices.
- Community action that involves the school and broader community in taking ownership of and seeking ways to address their collective health needs by accessing resources for health⁷¹.

Education policies and programmes

Policies within the DBE are geared towards providing a healthier and more enabling school environment and intersect with many of the sentiments embodied in health policies and programmes. Policies which provide the blueprint for the education system are outlined below.

The South African Schools Act (Act No. 84 of 1999 as amended in 2007)

This Act covers issues of attendance, admission and school fees, thus identifying “children at risk”. The policy outlines a number of programmes such as the HIV and AIDS Life Skills Education programme, the National School Nutrition Programme, and provides guidelines on issues such as school safety, gender equity and drug and substance use. School health

programmes serve as a support system in dealing with at risk children and families in a sensitive manner⁷².

Schooling 2025 and Action plan to 2014

South Africa has developed a 'South Africa Vision 2025' development plan aimed to move away from a focus on inputs and bureaucracy and to focus more on outcomes. This revised approach is also articulated in the new sector plan for education, Schooling 2025⁷³ and the Action Plan for achieving twenty-seven associated goals by 2014. In particular there are six of these goals that the current Integrated Strategy 2012-2016 addresses:

- Goal 10: Ensure that all children remain effectively enrolled in school up to the year in which they turn 15.
- Goal 22: Improve parent and community participation in the governance of schools
- Goal 24: Ensure that the physical infrastructure and environment of every school inspires learners to want to come to school and learn, and teachers to teach.
- Goal 25: Use the school as a location to promote access amongst children to the full range of public health and poverty reduction interventions.

The Action Plan to 2014 is born out of the national Delivery Agreement 1: Improved Quality of Basic Education⁷⁴ which is one of 12 negotiated charters signed by the Minister of Basic Education and key partners with direct responsibility for the improvement of basic education (e.g. DOH, Department of Arts and Culture, Department of Science and Technology, Department of Public Works). This agreement stems from one of the 12 key targets set out in the 2009-2014 Medium Term Strategic Framework (MTSF) which sets out the strategic mandate of government. The MTSF identifies strategic priorities and targets that serve as the basis for determining the government's implementation plans for the period to 2014.

White Paper 6: Special needs and Inclusive Education

Education White Paper 6 provides a framework for the development of an inclusive, holistic and integrated education and training system that is able to respond to diverse learning needs. It focuses on the transformation of services currently available for learners who experience barriers to learning and development of mechanisms to enable the system to accommodate all such learners. This policy includes the development of facilities and services to address barriers to learning and requires close co-ordination with policies such as the school health policy⁷⁵.

National School Nutrition Programme (NSNP)

The NSNP was started as a presidential initiative in 1994 as part of the Reconstruction and Development Programme. At inception, the DOH was responsible for implementation of the programme, but this was transferred to the Department of Education from April 2004. The aim of the programme is to provide nutritious meals to learners in disadvantaged communities. Currently all learners in quintiles 1, 2 and 3 public primary and secondary schools benefit from the programme.⁷⁶

The National Policy on HIV/AIDS for Learners and Educators⁷⁷

This policy outlines the response of the education sector with regard to HIV and AIDS. Educators are responsible for providing sexuality and life skills education, whilst parents and guardians should also be encouraged to provide their children with sexuality education, and guidance regarding sexual abstinence until marriage, and faithfulness to their partners. The DBE is currently developing an Integrated Strategy on HIV and AIDS, 2012-2016⁷⁸ that will be used as a basis to revise the current policy.

Social Development policies and programmes

National Integrated Plan on Early Childhood Development (ECD)

The Integrated Plan on ECD is an intersectoral document aimed at facilitating greater synergy and coordination to programmes undertaken by various departments in the area of ECD. The primary aim of this plan is to provide children an early healthy solid foundation of physical, psychosocial, cognitive development. However, strengthening of ECD services is critical in order to ensure that all pre-school children benefit from preventive and promotive services, including screening for developmental and other barriers to learning⁷⁹.

Child Support Grant (CSG)

The CSG is a key programme for alleviating child poverty in South Africa. The beneficiaries are also entitled to free health care services and education.

National Strategy for Prevention of Child Abuse, Neglect and Exploitation

This intersectoral strategy provides guidelines for the prevention and protection of children against all forms of abuse. The strategy facilitates implementation of the Children's Act (Act No 38 of 2005), which makes provision for the mandatory reporting of all suspected forms of child abuse, neglect and exploitation⁸⁰.

National Action Committee for Children Affected and Infected by HIV and AIDS (NACCA)

This is an intersectoral committee aimed at addressing the welfare of all children affected and infected by HIV and AIDS. Care and support for these children at school calls for active involvement of the entire school community⁸¹.

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