**School Health Policy**

**and**

**Implementation Guidelines**

**February 2011**

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**Foreword**

It is with great pleasure that we present the revised National School Health Policy and Implementation Guidelines, which responds to the needs of learners in all learning sites, to ensure their optimal growth and development.

Having signed the United Nations’ Convention on the Rights of the Child (UNCRC), South Africa has joined the global village in **‘*putting children first’***. This means the State has an obligation to ensure that all segments of society work towards optimum investment in the health, education and social well-being of children, in order for them to develop into successful adult citizens.

For children to maximally benefit from the education programmes, they must be healthy. This strong linkage between health and education, therefore, identifies the school as an opportune environment, where the children’s health and well-being can be addressed. Furthermore, it is critical to strengthen collaboration between the Departments of Health and Basic Education, other government departments, civil society, the private sector and relevant development partners. Through coordinated efforts, the country can achieve long term gains of reduction in morbidity and mortality amongst children and young people.

The main pillar of this policy rests upon an integrated approach within the comprehensive primary health care package. Therefore, actualizing implementation of this policy will ensure that all school going children, including those in remote areas, have access to quality health services.

We would like to acknowledge the work of many health workers and educators, whose untiring commitment continues to make a positive impact on the lives of children. We also thank everyone who has participated in the review of this important policy and implementation guidelines.

Let us all remember that the level of development of any country is measured by the health status of its children.

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**Minister of Health Minister of Basic Education**

**Acknowledgement**

The National Department of Health extends sincere gratitude to all who contributed to the review of the School Health Policy and Implementation Guidelines (2003).

Special appreciation is directed to the Provinces, Academic Institutions, Non-Governmental Organisations, relevant Government Departments and Development Partners.

The Department further acknowledges the World Health Organization (WHO) Country Officer for the technical support provided through the services of Madame Odete Cossa (WHO/ Inter-country Support Team).

**Glossary of terms**

**School health programme**

Based on the WHO description, the school health programme is a combination of services ensuring the physical, mental and social well-being of learners so as to maximize their learning capabilities.

**Health Promoting Schools Initiative**

A broader initiative facilitating implementation of comprehensive school based programmes, with a critical focus on empowering the entire school community.

**Integrated service**

A service located within the administrative, functional structures and resources of comprehensive primary health care services.

**Learners**

School-aged children attending schools and other structured learning sites.

**School community**

The entire community involved directly or indirectly with a school i.e. learners, parents/caregivers, educators, school management (including the principal and members of the school governing body), administrative personnel and other auxiliary staff.

**Target group**

The main beneficiaries of this policy are all children attending learning sites, regardless of age.

**Vertical service**

A specialised service that operates separately from other primary health care services, within a separate administrative structure and with its own resources.

**Acronyms**

**ART**

Anti Retroviral Treatment

**CHPI**

Child Health Policy Institute (now Children’s Institute)

**UNCRC**

United Nations Convention on the Rights of the Child

**DOBE**

Department of Basic Education

**EPI**

Expanded Programme on Immunisation

**HPS**

Health Promoting Schools

**IMCI**

Integrated Management of Childhood Illness

**NDOH**

National Department of Health

**NGOs**

Non-governmental Organisations

**NHC**

National Health Council

**NPA**

National Programme of Action for Children in South Africa

**NSDA**

Negotiated Service Delivery Agreement

**PHC**

Primary Health Care

**PPA**

Provincial Programme of Action for Children in South Africa

**SHP**

School Health Programme

**SHS**

School Health Services

**YFS**

Youth Friendly Services

**YRBS**

Youth Risk Behaviour Survey

**WHO/SA**

World Health Organisation/ South Africa

**WHO/AFRO**

World Health Organisation/ Africa Regional Office

**Executive summary**

According to the World Health Organisation, school health programmes can reduce common health problems in learners, thereby increasing the efficiency of the educational system. The WHO Expert Committee on School Health confirms that school health programmes can advance public health, education, social and economic development. The global expansion of school health programmes attests to the value placed internationally on such programmes. 1

For children to benefit from the education programmes, they need to be healthy. This strong link between health and education therefore, identifies schools as a perfect environment where the children’s well being can be supported and maintained.

Having ratified the United Nations’ Convention on the Rights of the Child (UNCRC), 1996, South Africa has joined the global village in prioritizing children. 2 The UNCRC as well as the Constitution of South Africa (Act 108 of 1996), highlights the importance of adopting a *‘rights based’* approach in implementation of the School Health Programme.3

Furthermore, the implementation of this programme requires a multi disciplinary effort to ensure comprehensive care to all learners in schools. The benefits of targeting the school population include increased public awareness, community participation and sustainability of implemented programmes.

Currently the majority of learners in the country, especially in the remote disadvantaged communities, do not receive school health services. In a few districts where this service is provided, challenges mainly of inadequate human resources and transport create barriers to implementation.

The school health policy therefore aims to provide a clear framework on what the school health programmes entail and how it could be implemented.

**Vision**

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

**Goal**

To contribute to the improvement of the general state of health of school-going children as well as the environmental conditions in schools and address health barriers to learning.

**Objectives**

**General Objective**

To guide the provision of a comprehensive, integrated school health programme that operates within the framework of the Health Promoting Schools Initiative.

**Specific Objectives**

1. To provide preventive and promotive services that address the health needs of school-going children, including those children who have missed the opportunity to access services during their pre-school years.
2. To provide schools health services.
3. To support the school community in creating health promoting schools.
4. To support educators and school health nurses in their school health activities.
5. To ensure sustainable coordination and multi-sectoral partnership.
6. To mobilize resources for the implementation of the school health policy.

**Institutional framework for implementation of the School Health Policy**

Implementation of the school health policy requires strong inter-sectoral collaboration with different sectors. Most importantly, the key Departments of Health (DoH), Basic Education (DoBE) and Social Development should form the basis for implementation of this policy. However, relevant government departments, academia, civil society and partner organizations are expected to contribute in sustaining comprehensive school health programmes.

**Monitoring and evaluation** of the school health programme will be integrated within the district health information system as well as interfacing with the education information system. The policy contains a set of indicators for monitoring the school health programme, which, in this revised policy, will measure implementation at sub district level.

**Implementation guidelines**

The implementation guidelines section of this document outlines the implementation framework which can be amended to suite the workstation at local level. A list of responsibilities for the Department of Health is provided for the co-ordination and development of the school health programme at the national, provincial and local levels.

School health is a non-negotiable integral part of the comprehensive package of primary health care services that must be delivered to every school in the district.

The guidelines further provide the requirements in terms of the district structure, management, delivery, staffing, training and supervision. In addition, the guidelines outline categories of staff required for successful sub district level implementation of this policy.

**SECTION 1:**

**SCHOOL HEALTH POLICY**

**1.1 INTRODUCTION**

**1.1.1 Background**

The South African Government has pledged to **“put children first”** by becoming signatories to the United Nations Convention on the Rights of the Child (UNCRC) 2 and by according children special recognition in the Bill of Rights of the South African Constitution.3 This commitment aims at ensuring that the rights of children are upheld and provision is made to enable them to reach their full potential. This is important especially during the formative school years, wherein, providing special attention to their optimal health will improve their survival, growth and development.

In order to realize children’s right to health, a number of policies and programmes have been formulated, based on the principles of primary health care (PHC). This approach embodies all elements of health care, with specific emphasis on preventive and promotive health care.5

A comprehensive school health programme allows children access to health promotion and education during their early years of learning. It also allows for the identification of potential barriers to learning and thus maximizes children‘s learning potential.

Developing a comprehensive school health programme poses challenges of integrating activities that focus on children of school-going age, within and outside the health sector.

The 2009 Education Statistics in South Africa showed that 12 227 963 learners were enrolled in schools in the country.6 This number is likely to increase as the transformation and strengthening of the education system enables it to retain more learners for longer.

The School Health Policy and Implementation Guidelines 2003 adopted a phased approach to implementation. The phased approach, which focused on district level implementation, did not translate into school and learner coverage. Furthermore, district level implementation masked the low sub-district coverage. The revised policy will focus on comprehensive sub district level implementation thereby replacing the phased approach. This will facilitate that services reach each individual learner in all the schools within sub - districts.

The current provision of the school health programme in most parts of the country is sub optimal and faces several challenges. This policy takes into consideration these challenges and provides the necessary framework for reorganization of the school health programme.

**Definition of school health**

Based on WHO description, the school health programme is a combination of services ensuring the physical, mental and social well-being of learners so as to maximize their learning capabilities. The school health policy directly targets all children attending learning sites. This includes the entire school community i.e. staff, parents, the community and learners.1 In the South African context this policy will also include learners in Early Childhood Development (ECD) sites especially were Grade R is attached to formal schools.

**1.1.2 SOCIO-ECONOMIC AND HEALTH FACTORS OF SCHOOL-AGED CHILDREN**

**Socio economic factors**

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

***Poverty***

According to the Child Gauge (2010) seventy percent of South Africa’s children live in rural areas, and many live in households with incomes below the poverty line. Most children depend on the child support grant, mainly due to unemployment and death of one or both parents (orphan-hood). There is also an increase in child-headed households. A number of learners in disadvantaged quintile 1 to 3 schools suffer alarming levels of poverty continue to require government subsidy for exemption from school fees.7

***Orphaned and vulnerable children***

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 Africa. 7

***Child headed households***

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 made.6 The challenges experienced are mostly related to poverty, hunger and various forms of abuse, with resultant absenteeism and school drop-out. The role of the school health services becomes critical in collaboration with educators, social workers and the school community in identification and appropriate referral of these children.

***Environment***

Literature reveals that in South Africa, children’s access to basic sanitation increased from 47% in 2002 to 61% in 2008. Approximately 8 million children still use unventilated pit latrines, buckets or open land. 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 burns. Most schools especially in rural and under privileged areas continue to lack water, sanitation and hand washing facilities. This situation results in spread of diseases e.g., diarrhoea, helminthes and skin infections.7

***Hunger and food security***

The proportion of children living in households that reported child hunger fell from 30% to 18% between 2002 and 2008. 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 school feeding programme, currently located under the Department of Basic Education, makes provision for protecting needy learners from hunger and its consequences.7

***Nutritional status***

Research has shown that the national prevalence of underweight (weight for age) amongst the under 10 year of age population, was 8.4%; stunting (height for age) was 13.1%, wasting (weight for height) was 4.4%; 19.7% of learners were found to be overweight and 5.3% of learners were classified as obese. The Northern Cape, North West, Limpopo and Free State provinces showed a higher prevalence of under nutrition ranging between 2.6% to 9.1%.8

***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 services. The Children’s Act (Act no 38 of 2005) and National Integrated Plan for ECD 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. 9

***Social security***

The Child Support Grant (CSG) is a key programme for alleviating child poverty in South Africa. As at May 2010, the CSG supported more than 9.7 million children aged 0-16 years. The beneficiaries are also entitled to free health care services and education.7

**Health related factors**

***Hearing, vision and speech impairment***

Hearing and vision impairment are significant barriers to a child’s learning and development.

International literature shows that the prevalence of vision impairment amongst pre-school and school-aged children is between 2, 4% and 6%. It also reveals that refractive errors are the most common visual impairment problems in the paediatric population and many of these are unidentified until children enter schools.9 Furthermore, there is a need for a clear protocol and referral mechanism regarding children that require assistive devices spectacles, hearing aids, wheel chair etc.

A review of the studies on hearing impairment amongst school children in a number of countries show a prevalence of between 4,5% and 6%. It concludes that: “… any school health programme without well-organised audiometric screening neglects an important aspect of child health.”10

Census 2001 conducted by StatsSA showed a disability prevalence of 5% of the general population. And of that 0, 7% is hearing impairment and 0,2% communication or speech impairment.12 South Africa has not conducted specific studies for hearing and communication disorders among school going children to determine the prevalence and incidence rates for these disorders. Kumar and Mello cited an incidence/prevalence of hearing loss in school-age population of about 11.3%, however, they conceded that accurate estimates of incidence and prevalence are difficult to establish because of differences among investigators about the definitions applied, the population sampled, test methods used and the way in which the data were analysed.11

The following studies provide information on hearing and vision impairment and highlight its relevance for school health services in Southern Africa:

A prevalence study of ear and hearing disorders in a sample of grade one schoolchildren in Swaziland found 16, 8% had an ear disorder and 80% had normal hearing. The most common disorder was impacted wax, with a prevalence rate of 74/1000. Middle ear disorders were common, with a prevalence rate of 30/1000 for children with active middle ear disease. Of these, 17/1000 suffered a hearing loss. The prevalence rate for children with inactive middle ear disease was 21/1000 of whom 5/1000 suffered hearing loss; 8/1000 had sensor neural losses, 5,3/1000 unilateral and 2,1/1000 bilateral losses.12

***Oral health***

The national child oral health survey found that nationally 60% of 6 year old children have dental decay and 55% was treated in 2009.13

**The YRBS Report (2008), revealed the following:**

***Mental health***

Substance abuse and risk-taking behaviour are key issues that need to be addressed especially in the adolescent period.

* ***Suicidal ideation***

Nationally, 21.4% [19.4 - 23.5] of learners had made one or more suicide attempts in the past six months, with no significant variation by gender or by grade.

* **Substance abuse and risk-taking behaviour**
  + ***Smoking***

Research has shown 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. Having ever smoked was most prevalent in the Western Cape and Gauteng provinces, whereas current smoking was highest in the Western Cape, Northern Cape and Gauteng provinces, and use of smokeless tobacco was highest in Mpumalanga province, followed by Limpopo and North West provinces.

* + ***Alcohol***

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. More males than female learners used alcohol on school property.

* + ***Drugs***

Like alcohol abuse, more male than female learners used dagga on school property. 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%).

**Sexual activity, reproductive health and HIV and AIDS**

The growing HIV epidemic has a profound impact on children who are infected and affected. HIV and AIDS constitute a key health challenge to the health system as a whole and pose particular challenges in dealing with children of school-going age. The Life Orientation area of the curriculum places emphasis on sexuality education. This is also addressed through the DoBE’s HIV and AIDS life skills programme.

* ***Sexual behaviour***

The YRBS report (2008) has further revealed that 37.5% of learners reported ever having had sex, with 12.6% having had their first sexual encounter before the age of 14 years. A proportion of sexually active learners (41.1%) reported having had two or more sexual partners in their life time. In addition, 16.2% used alcohol before having sex with a significant higher prevalence of learners (36.5%) reported using alcohol before having sex in the Western Cape Province than the National average. Further more, 17.9% reported no method of contraception used. While 45.1% learners used condoms for contraception, 30.7% used condoms consistently, 19% had been pregnant or made someone pregnant. In addition 17.7% reported having had child/children, 8.2% had or their partner had an abortion at a clinic/hospital.

* ***Sexually transmitted illnesses (STI)***

Nationally, the 2008 YRBS report showed that of learners reported having had sex, 4.4% had a sexually transmitted infection with 55.0% of them reporting having received treatment for their infection. In the Eastern Cape Province 66.2% learners who have ever had an STI reported a significantly higher prevalence than the national average, while learners in the Northern Cape and Limpopo Provinces had significantly lower prevalence than the national average.

* ***HIV and Aids***

The YRBS Report (2008) further reveals that 65.4% of learners indicating that they were taught about HIV and AIDS in school. Western Cape Province reported a significantly higher percentage of learners (81.9%), having been taught about HIV and AIDS. Learners in Limpopo Province (49.5%) had a lower rate of having been taught about HIV and AIDS than the national average. In addition, 21.5% of learners had had an HIV test, with no significant variation by gender.

***Trauma, violence and mental health***

The YRBS report (2008) report showed 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 were assaulted by either their boyfriend or girlfriend, 13.5% 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 sex. Gauteng had the highest provincial prevalence of having been involved in a physical fight with Limpopo Province reporting the highest percentage of learners that required medical treatment after having been involved in a physical fight.

The YRBS (2008) further showed that the epidemic of trauma and violence is another major health challenge, given that trauma and violence are currently the most common cause of death in children between the ages of four and 18 years.

**1.1.3 Rationale for a school health policy**

Children first make contact with the health system at birth. After 24 months, when the last dose of the immunisation schedule is delivered, children often only make contact with the health system again when they receive their vaccination at six years and 12 years, become ill or need reproductive health services in their teens. School health services have the potential to provide a safety net for children who do not access preventive health services during their pre-school years and are well placed to identify avoidable health problems that may constitute barriers to learning.

Most children spend up to 13 of their formative years, from early childhood to young adulthood, in a classroom environment. During this time they are a captive audience for health education and interventions that will influence their health status and health practices. 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 the clinic and other health institutions.

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.

**1.1.4 The policy development process**

Implementation of the School Health Policy since 2003 is at various levels in the nine provinces. Seven years later, the NDOH acknowledges that there are several changes in the socio-political environment that has affected the health, education and well-being of learners in all the settings. These include inter-alia the increasing scourge of HIV and AIDS poverty, child-headed households, high teenage pregnancy, violence, and introduction of a Tetanus Diphtheria (Td) vaccine to children 6 years and 12 years, deworming of learners in schools, introduction of ART, HIV counseling and testing as well as intentional and non-intentional injuries.

The NDOH therefore identified a need to review the existing school health policy to accommodate the current developments. The policy was widely distributed for comments with support from WHO/SA and WHO/AFRO. The inputs were consolidated and the policy was refined. 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 would contribute to the optimal development of school going-children.

1.1.5 Regional and international context

***Education for All (EFA)***

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

* the fight against HIV / 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 education. 14

**T*he 2000 Education for All (EFA) Dakar Framework for Action***

The 2000 Education for All (EFA) Dakar Framework for Action17 stresses in one of its six goals that youth-friendly programmes must be made available to provide the 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 AIDS. 15

[***The Health Promoting Schools Initiative (HPSI)***](#_Toc280010902)

The HPSI 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 global level in 1995, through its Global School Health Initiative, (GSHI). The Initiative 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 GSHI is to increase the number of Schools which can be called “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, teachers, 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 achievements.16

**1.1.6 National context**

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

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

**Legislative Framework**

Several pieces of legislation have relevance to implementation school health programmes. These include:

* The Constitution of South Africa (Act No 108 of 1996)
* T[he Children’s Act (Act No 38 of 2005](#_Toc280010874)) as amended.
* National Health Act (Act No 63 of 2003)
* The Mental Health Care Act (Act No 17 of 2002)
* The Choice on Termination of Pregnancy Act (Act No. 92 of 1996) {CTOP**}**

**Health Policies:**

***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. Empowered school health nurses and school teachers teach older children who go home with better knowledge about child health. This is a child to child or child family approach.17

***The Youth and Adolescent Health Policy, 2001***

This document presents a holistic and integrated approach to health that covers children and youths aged 10 to 24 years both in and out of school. Youth attending tertiary education institutions benefit from health services provided by these institutions. It emphasizes several health priorities for this group. It proposes the use of many 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 could be applied.*18*

***The HIV & AIDS and STI National Strategic Plan 2007-2011***

The National Strategic Plan aims at reducing the incidence of new HIV infections by 50% and minimizes the impact of HIV and AIDS on individuals, families, communities and society by improving access to suitable treatment, care and support. Inventions within the Plan will occur within four priority areas: (1) prevention; (2) treatment, care and support; (3) research, monitoring and surveillance; and (4) human rights and access to justice. The teachers, health promoters, school health nurses and the entire school community have an important role to play in realizing these priority areas in schools.19

***South African National Oral Health Strategy (2002)***

The purpose of the national oral health strategy is to improve the oral health condition of the South African population by promoting oral health and appropriately addressing oral diseases through proper treatment, prevention and evaluation. The oral health strategy aims to reduce dental caries and gum diseases amongst children by instituting school oral health preventative services in the form of fissure sealant and tooth brushing programme where resources permits.*20*

***Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia Policy and Implementation Guidelines, 2008***

The document provides a technical basis for introducing Helminth control programmes, which include regular treatment of children for STH infections and Bilharzia. Successful implementation of such programmes is dependent on close collaboration between the Departments of Health and Basic Education at all levels.*21*

***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 manner.*22*

***Immunisation Policy***

This document makes provision for technical basis on the immunisation programme for vaccine preventable diseases. Children admitted to school should have a Road to Health Chart up to date for age with the immunisation schedule and ensure that both boys and girls receive Td vaccination at 6 and 12 years of age. ***Further more, all children, who are not up to date with their immunisation schedule, should be referred to the primary health care facility for catch up immunisation.*** Where mobile facilities with appropriate cold chain maintenance are available, it becomes best practice of “taking” the services to the learners, thereby improving accessibility.*23*

***Policy Guidelines for the management and prevention of Genetic Disorders Birth Defects and Disabilities Human Genetics***

This policy provides a framework for the prevention, identification, management and rehabilitation of genetic disorders, birth defects and disabilities.*24*

**Integrated Nutrition Programme (INP)**

This programme 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 INP.*25*

**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.
* 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 health. *26*

**Education policies**

The policies in Basic Education are all geared towards providing a healthier and more enabling school environment and intersect with many of the sentiments embodied in health policies and programmes. Policies providing the blueprint for the education system are outlined below.

***Tirisano***

This is a two part document, the first of which is titled “*A Call To Action: Mobilizing Citizens To Build A South African Education and Training System for the 21st Century”*. Nine priorities form a focus for action. These include: schools becoming centres of community life, creating healthier school environments and dealing urgently with the HIV/AIDS emergency.

The second document contains the Tirisano implementation plan comprising five core programme areas of which HIV/AIDS, School effectiveness and teacher professionalism and organizational effectiveness of education departments are of particular relevance.*27*

***Special needs and inclusive education***

The policy on special needs 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 with special needs and the 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 policy.*28*

***Whole School Development***

This policy sets out a national model for school evaluation aimed at improving and assuring the quality of education. Nine areas of evaluation are identified, including school safety and security.*29*

***The South African Schools Act (No. 84 of 1996)***

This Act **(South African Act 84 of 1996)** covers issues of attendance, admission and school fees, thus identifying “children at risk”. School health programmes serve as a support system in dealing with children and families “at risk” in a sensitive manner.*30*

***Measures for the Prevention and Management of Learner Pregnancy (2007)***

A dual-pronged approach (prevention of pregnancy and management of pregnancy where it does occur) is framed within the ‘the right to equality, the right to education, and the rights of the child (including the newborn child)’. *31*

***The National Policy on HIV/AIDS for Learners and Educators (10 August 1999)***

This policy states that there are high levels of sexually active persons within the learners population group in schools. It also notes that this increases the risk for HIV transmissions in schools considerably. It further notes that besides educators providing sexuality education, morality and life skills education, parents and guardians should be encouraged to provide their children with healthy morals, sexuality education, and guidance regarding sexual abstinence until marriage, and faithfulness to their partners.*32*

**Social Development policies**

***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 to benefit all the pre-school children from the preventive and promotive services. This include activities such as screening so as to identify developmental and other barriers to learning are often not implemented and many children enter the formal schooling system with unidentified health problems that may impact on their ability to learn effectively.*33*

***Child Support Grant (CSG)***

The Child Support Grant (CSG) is a key programme for alleviating child poverty in South Africa. The beneficiaries are also entitled to free health care services and education.*34, 35*

***National Strategy for Prevention of Child Abuse, Neglect and Exploitation, 2003***

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 exploitation.*36*

***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 community.*37*

**CURRENT SITUATION REGARDING IMPLEMENTATION OF SCHOOL HEALTH PROGRAMME**

Implementation of the School Health Policy is at various levels in the 9 (nine) provinces. Since 2003, implementation has been slow, with low coverage at sub-district level. To date, the programme has been incorporated as a component of the Primary Health Care Package.

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 school health services.
* Inequitable distribution of resources in both urban and rural settings.
* The challenge of integrating previously vertical and fragmented services into comprehensive primary health care 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 of comprehensive programmes impacting on reporting school health services.

School health services are currently delivered by designated School Health Nurses who form part of the primary health care staffing. The 2010 report on the review of the school health policy implementation showed that nurses have expressed the following views on issues that impact on the provision of quality services:

* + 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 weighing scales
  + 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 are rarely conducted, as nurses generally visit schools once a year
  + Unavailability of transport, poor roads and infrastructure curtails access to hard to reach areas.

Generally, the implementation environment needs to be improved, to facilitate the implementation of the School Health Policy. The number of school health nurses is not sufficient to deliver school health services, resulting in disparities in the degree of implementation in each province. In cases where the staff is available they are also recalled to relieve in areas where there is staff shortage and also have to assist with all the health campaigns during the year, thus neglecting their core responsibility.

Supportive supervision by line managers is minimal.

A number of schools are generally dilapidated in both rural and urban areas. There is no place for privacy for screening of learners. In addition, poor sanitation in many schools due to lack of water remains a challenge.

Table 1 below illustrates the Strengths, Weaknesses, Opportunities and Threats for implementation of the school health programmes.

**Table 1: Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for school health programmes**

|  |  |
| --- | --- |
| **STRENGTHS** | **WEAKNESSES** |
| * Political support for SHS. * Availability of policy guidelines. * Availability of SHS focal person at the National Office. | * Weak intersectoral collaboration – school health still perceived as a DOH responsibility. * Poor supervisory support visits mechanisms - supervisors engaged in several programmatic responsibilities, school health is not prioritized. * Provincial Autonomy - National office has no control over the provincial activities including indicators and targets. * Lack of resources: * Human: Non availability of school health nurses at implementation level * Equipment * Financial * Transport |
| **OPPORTUNITIES** | **THREATS** |
| * Collaboration with the Department of Basic Education is possible. * Schools have the potential/ capacity to be accredited Health Promoting Schools. * Provincial School Health coordinators * School Health weeks provide and opportunity to improve learner coverage. * Intra sectoral collaboration is possible – business unusual. * Community partnership. * Donor support. | * Lack of resources: * Human: school health nurses * Equipment * Financial – budget for school health services * Transport * Poor information management – unavailability of readily accessible data on public primary schools and total number of learners. This includes poor data management from the implementation site to the National office. * Poor referral system to address the learner health needs identified- e.g. non availability of social workers * Non coterminous districts for the Departments of Health and Basic Education. |

**1.2 SCHOOL HEALTH POLICY**

**1.2.1 Vision**

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

**1.2.2 Goal**

To contribute to the improvement of the general state of health of school-going children as well as the environmental conditions in schools and address health barriers to learning.

**1.2.3 Principles**

The principles that underpin pursuit of the School Health Policy vision and goal concur with those of the primary health care approach and are outlined below:

* The School Health Programme should be implemented in partnership between Departments of Health and Basic Education and all other relevant sectors;
* The School Health Programme should be implemented within a child’s rights approach;
* The School Health Programme is part of a comprehensive primary health package;
* The School Health Programme should be integrated within PHC;
* The School Health Programme should be informed by local priorities;
* School Health services should take into account quality and equitable distribution of resources.
* The School Health Programme should maintain partnership with the target population and the school community.

**1.2.4 Objectives**

**General Objective**

To guide the provision of a comprehensive, integrated school health programme that operates within the Primary Health Package.

**Specific Objectives**

To provide preventive and promotive services that address the health needs of school-going children, specifically those children who have missed the opportunity to access services during their pre-school years.

* To provide schools health services.
* To support the school community in creating health promoting schools.
* To support educators and school health nurses in their school health activities.
* To ensure sustainable coordination and multisectoral partnership.
* To mobilize resources for the implementation of the school health policy.

**1.2.5 Summary of strategies**

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

* Provision of School Health Services
* Health Promotion and Health Education
* Coordination and Partnership
* Capacity Building
* Community Participation

**1.2.6 School health service package**

This section outlines the package of activities that make up the school health service and that must be rendered in each health sub-district. A manual containing standardised protocols and providing details of resource requirements and the manner of implementation will accompany this policy.

**School health services**

* ***Health assessment of new learners:***

Health assessments will be done of all Grade 1 learners in a primary school. These assessments should focus on identifying barriers to learning. The following assessments will be done at least once a year:

* + Hearing assessment
  + Vision screening
  + Speech impairment
  + Physical examination for gross loco motor dysfunction
  + Oral health checks
  + Anthropometric assessment (weight and height)
  + Nutritional status and parasite control
  + Immunization
* ***Additional assessments that might be required include:***
* Identifying and responding to intentional and non intentional injuries and child abuse
* Mental health assessments
* Genetic disorders
* Counselling
* Other health developmental needs
* ***Referral:***

Children with health problems will be referred to appropriate local health facilities. In order to facilitate follow-up, the main referral facilities should be the primary health care facilities from which the school health team is deployed. This will ensure that health workers who deliver the school health service are able to follow through on referrals when they return to the facilities in which they are based.

Once learners have been referred, the responsibility of ensuring that they visit the referral centre rests with the school community.

* ***Follow-up:***

All referrals and children who are identified as having health problems should be followed up either by educators or health workers to ensure that the identified health problems have been adequately addressed.

* ***Other activities:***

School health services will include the following additional activities:

* Responding to disease outbreaks such as cholera and measles.
* Provision of treatment for minor ailments where appropriate.
* Management of skin infections.
* Identification and referral of children on chronic medicine.
* Malaria, TB and HIV and AIDS.
* Non Communicable diseases related conditions: Obesity, cardiovascular conditions.

**Health Promotion and Health Education**

Health promotion and health education are crucial activities within the school health programme and provide the best opportunity to impact on the immediate and long-term health behaviour of children and youths. Health promotion activities should ideally be incorporated into the school curriculum to ensure ongoing input throughout the school years.

Issues to be covered by health promotion and education include:

* Life skills.
* Child abuse.
* Oral Health.
* High risk behaviours, including substance abuse and violence.
* Road safety and overall safety within homes and communities.
* Environmental health, including water safety, and sanitation.
* Healthy lifestyles including physical activity and healthy diets.
* Sexual and Reproductive health, including promoting healthy sexuality.
* Referral and early booking for basic antenatal care of pregnant learners.
* Self-care for learners with chronic non-communicable diseases.
* Basic hygiene and appropriate hand washing.
* Action against malaria and other diseases in schools.
* HIV prevention including counseling and testing, STI, teenage pregnancy, and other epidemics in schools.

**Coordination and Partnership**

Establishment of effective partnerships between government, private sector, academic institutions, and NGOs assist in the formulation, implementation, monitoring and evaluation of priority areas for school health will facilitate implementation of school health service programme.

The National and Provincial Departments of Health and Department of Basic Education must ensure co-ordination between all the relevant health service providers related to school health. Regular meetings are necessary to ensure that the collaboration required for the implementation of the policy is achieved at the highest possible level of decision-making. The school health team will interact with the primary health team on a regular basis.

**Capacity Building**

The team required to deliver the school health package needs to be proficient in the skills necessary to provide the school health services package. It is not intended that any single individual should have all of the skills, but that the team as a collective must possess the full range of skills outlined. Training and re-orientation is required for all categories of staff who will be delivering the school health service. Special supervision and input may be sourced from experienced school health staff and other health workers who previously worked in school health.

**Community Participation**

Community structures play an important role for improved health of learners in schools. Community mobilisation 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 (traditional/faith based/ward councilors) and the entire school community should have a buy in for the success of school health services.

**1.2.7 Target groups**

The target group for the school health service 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. The school health service will be delivered in partnership with the target population.

**Primary target group**

The primary target group of this policy is all children and youths, regardless of age, who attend learning sites. This covers children from Grade 1 to Grade 12 and Grade R where attached to formal schools.

**Secondary target group**

Whilst school health programme focus 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 school health programme. The school community should work in partnership with 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 and other related school health issues**

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.

Health needs of children up to the age of six years are currently addressed by a fairly comprehensive set of preventive, promotive and curative health programmes that are delivered through existing primary level health services.

**1.3 INSTITUTIONAL FRAMEWORK FOR THE IMPLEMENTATION OF THE SCHOOL HEALTH POLICY**

**1.3.1 Organisation of the system**

The school health policy requires collaboration and linkages with different sectors, most importantly, the Departments of Health and Basic Education. The Joint National Health and Education Team brings together technical staff on school health from the two Ministries.

The implementation of the school health policy within the Department of Health takes into account the different levels of governance. The Primary Health Care approach is adopted to facilitate availability of resources in realizing the objective of the service.

The Department of Basic Education oversees issues related to school curriculum, health in education and early childhood development.

**1.3.2 Planning and management**

Successful implementation of this policy rests upon the Ministry of Health and Ministry of Basic Education working collaboratively. It is from this premise that the revised policy is co-signed by both Ministers of Health and Basic Education.

The Directorate: Child and Youth Health in the DOH is responsible for the provision of technical support to provinces in the planning and management of the school health programme.

Implementation of the school health programme is invested at district level, with accompanying responsibility to saturate sub district level implementation. School health teams will be coordinated at the District office.

The Primary Health Care facilities serve as a vehicle through which schools in their catchment area receive health services.

The different decentralized levels (national, province and district) roles are outlined below.

**Table 2: Roles: Departments of Health and Basic Education at National, Provincial and District level**

| **LEVELS** | **HEALTH** | **EDUCATION** |
| --- | --- | --- |
| **NATIONAL** | * Provide strategic direction in the implementation of school health programme * Coordinate the implementation of the school health policy * Facilitate the integration of health programmes impacting on learners in schools * Standardization of implementation of school health services * Development of orientation manual for school health services * Advocate for the necessary human resources * Resource mobilization for the implementation of the school health policy * Conduct capacity building of both health professionals and educators. * Monitoring and evaluation * Identify researchable areas for school health | * Mobilize teachers and the school community on the implementation of school health programmes in the school setting * Facilitate linkages between school health nurse and teachers * Advocate with relevant local Government on water supply and sanitation in schools * Avail appropriate environment for screening of learners * Collaborate with DOH in capacity building of both educators and health professionals * Provide for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package. |
| **PROVINCIAL** | * Appoint a school health focal point. * Develop implementation plan for school health programme taking into account the need to cover all school and all learners as outlined in the school health policy * Integrate health services within the PHC approach * Collaborate with Basic Education in the develop a schedule for school health activities * Systematically collect data on school health services * Adapt the national school health policy to suit their local setting * Adaptation and translation into local languages of school health materials * Appoint school health nurses * Conduct capacity building of both health professionals and educators * Conduct supportive supervision * Resource mobilization for the implementation of the school health policy at local level * Establish a school health steering committee with relevant stakeholders * Convene school health meetings at the provincial level with relevant role players | * To ensure that there is school health focal point * Provide total number of schools and learners upon the enrollment at beginning of school calendar * Collaborate with Health in the develop a schedule for school health activities * Mobilize teachers, learners, parents, school governing bodies , and the community on the implementation of school health programmes in the school setting * Facilitate linkages between teachers and school health nurse * Advocate with relevant local Government on water supply and sanitation in schools * Avail appropriate environment for screening of learners * Conduct capacity building of both educators on Health Promotion and Education and first aid * Participate in the steering committee * Provide for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package |
| **DISTRICT** | * To ensure that there is school health focal point * Develop implementation plan which fits into the district integrated development plan, with clear objectives and indicators * Establish a school health steering committee with relevant stakeholders * Convene school health steering committee meetings at the district level with relevant role players * Strengthen existing system: communication, transport, equipment and proper referral system * Conduct joint supportive supervision (health and education) * To systematically collect data on school health services * Conduct capacity building of both health professionals and educators * To integrate health services within the PHC approach * Establish linkages with communities and local leaders * Collaborate with Basic Education in the develop a schedule for school health activities * Appoint school health teams | * To ensure that there is school health focal point * Provide total number of schools and learners upon the enrollment at beginning of school calendar * Collaborate with Health in the develop a schedule for school health activities * Mobilize teachers, learners, parents, school governing bodies , and the community on the implementation of school health programmes in the school setting * Facilitate linkages between teachers and school health nurse * Advocate with relevant local Government on water supply and sanitation in schools * Avail appropriate environment for screening of learners * Conduct capacity building of both educators on Health Promotion and Education and first aid * Participate in the steering committee * Provide for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package * Avail first aid kits, scales, and measuring tapes in schools |

1.4 MONITORING AND EVALUATION

The joint national health and education working group will establish mechanisms for monitoring and evaluating the school health policy. The Monitoring and evaluation mechanism will draw on lessons learnt from previous systems and information generated by newly developed school health monitoring systems that exist in some provinces. Monitoring and evaluation of the school health programme must be integrated with existing district and provincial health information systems as well as interfacing with the education information system.

Monitoring and evaluation need to focus on:

* Coverage of services
* The impact of the service on the progress of learners
* Quality of services
* Sustainability of school health services in all districts

This section proposes a set of national indicators that could be used to monitor the school health programme.

**Table 3: Indicators for school health programmes**

|  |
| --- |
| **Indicators** |
| Number of schools implementing school health programme |
| Number of primary schools visited to conduct learner assessment |
| Proportion of learners referred for visual impairment |
| Number of Grade 1 learners screened at primary schools |
| Proportion of learners referred for hearing impairment |
| Proportion learners referred for speech impairment |
| Proportion of learners referred for oral health. |
| Proportion of learners referred for Tetanus Toxoid (Td) 6 years old learners |
| Proportion of learners referred for Tetanus Toxoid (Td) 12 years old learners |
| Proportion of learners referred for mental health problem or other health condition |
| Proportion of learners referred for social support |
| Number of learners who received deworming medication |
| Proportion of follow-up made by school health nurses |

**SECTION 2**

**IMPLEMENTATION GUIDELINES**

**IMPLEMENTATION GUIDELINES**

**2.1 INTRODUCTION**

Although these guidelines provide a framework for the implementation of the school health policy, ultimately implementation of this service depends on the prevailing conditions within provinces and districts. The guidelines must therefore, be adapted to suit the local needs. Provinces and districts are required to develop their own implementation plans, using the framework provided by these guidelines.

The guidelines are based on inputs from more than 300 health workers, academia, education and NGO personnel during provincial and national workshops held during the policy development process. They also take into account:

* A recap of the implementation context
* A set of critical success factors for implementation
* Responsibilities for the national, provincial and district levels
* The proposed package of services outlined for each phase
* A set of guidelines for the implementation of the proposed package
* A set of indicators for the monitoring and evaluation of the service
* The costing estimates

It is important to note that the guidelines do not imply that a single programme, for example the MCWH programme, has to be the sole implementer of the service. The service must be coordinated at national, provincial and district level and must be a collaborative effort between MCWH programmes, health promotion, the education sector, oral health, nutrition, NGOs and any other relevant role-players.

**2.1.1 Summary of key recommendations**

The guidelines propose the scaling up of the school health programme to the sub-districts with specific focus on the total number of school health nurses implementing the minimum level of school health services in all the sub-districts. This should address availability of school health programme including:

* + Focal persons in all the sub-districts
  + Schools visited for provision of school health services
  + Learner coverage on assessment of key learning barriers

The guidelines outline a set of responsibilities for the support, management, structuring and implementation of the service at national, provincial and district levels. These take account of areas where primary level health facilities are currently under-resourced.

**2.2 IMPLEMENTATION CONTEXT**

School health services have the potential to impact significantly on the health and well-being of children by identifying barriers to learning, improving knowledge on essential health issues, providing a safety net for children who have not received the necessary preventive or curative health services prior to entering school and contributing to the prevention of health problems in the population. However, the context in which the policy will be implemented poses many challenges.

**School health services do not function in many parts of the country.** Generally all the provinces are implementing school health services. Nine districts within the nine provinces have no service at all. Of the districts implementing the programme, only few schools and learners receive the services as shortage of resources impacts negatively on both the number of schools visited and learners assessed.

One province has only two professional nurses, each stationed in a district to render school health services. There are areas with coverage of less than 25%. Of note is that in some provinces the programme exists in some part of a district whilst some sub-districts has not services at all.

This service particularly requires staff and vehicles in order to operate successfully. Dedicated staff and vehicles for school health is determined largely by the primary health services at the sub-district level.

**2.3 Critical success factors for implementation**

The following are important to the successful implementation of a school health programme:

* **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 Basic Education and Health or at very least, co-ordination between these departments in the development and provision of the service is important.
* **Policy imperatives:** The integration of school health and health promoting schools from the national policy level to the district implementation level.
* **Advocacy, communication and social mobilisation (ACM)** for school health should be conducted in collaboration with essential role-players at national, provincial and district levels. These include all government departments, other health programmes and key NGOs rendering of health services to the school community.
* **Prioritisation:** Priorities for the School Health Programme should be based on the understanding of the integral link between health and education and its impact on learners' successful development.
* **Capacity Building for SHS depends on:**
  + Re-orientation and training of primary health care personnel to assist and support the delivery of the school health service within the HPS framework.
  + The involvement of schools in the development and delivery of the school health service.
  + The development of the capacity of school communities to take responsibility for their health needs through informed interaction with the health and development sector.
* **Monitoring and Evaluation and ongoing improvement of the service depends on:**
  + Active reporting, monitoring and evaluation of the programme to ensure learner coverage and identify gaps that are barriers to implementation.
  + Identification researchable areas in school health programme would also assist with policy review, programme planning and implementation at all levels of care.

**The school health activities**

The package of school health activities is made up of two key components:

* The first is the Grade 1 assessment that includes the follow-up visit to monitor and support those children who have been identified as having health problems.
* The second is the health promotion activities that include liaison with and support of the educators and care-givers.

These two components require a slightly different approach. Whilst the Grade 1 assessment is primarily an activity that should be executed by professionals with a clinical knowledge of child health, the health promotion activities provide many creative opportunities for collaboration and integration with other initiatives within education and the NGO sector. It is important therefore to note that whilst the proposed package will in some instances be managed by PHC nursing staff in districts, it does not imply that nurses must provide all the activities within the package.

**2.4 Responsibilities: National, provincial and district**

**National**

The national level will support provinces in supporting, monitoring and ensuring a coordinated approach to the implementation of this policy. In this regard the steps that need to be taken by the National Health and Basic Education as follows:

* ***Coordination of intersectoral meetings***
  + These meetings are necessary to ensure that the collaboration required for the implementation of the policy is achieved at the highest possible level of decision-making.
  + In addition, the possibility of integrating proposed school health activities into the education curriculum and relevant education initiatives, such as the whole schools development initiative, must be explored as this provides the most sustainable option for health activities within schools.
* ***Coordination of the School Health Policy with the Health Promotion Policy and other health partners.***
  + Given the overlap between the two policies and the fact that school health nurses have been the key initiators of Health Promoting Schools, the decision as to how the two policies will be coordinated must be finalised at national and provincial levels.
  + The implementation of this policy must also be coordinated with other health programmes currently servicing school-going children such as the School Nutrition Programme, oral health initiatives, HIV education programmes and other life skills and health promotion activities.
* ***Resource mobilisation required for implementation of the policy.***
* ***Development of a set of practice protocols with a training manual to ensure the standardized implementation of the service.***
* ***Development of a health manual for educators.***
  + The purpose of this manual is to increase educators' understanding of common health conditions in learners, such as physical barriers to learning, chronic health conditions, infections such as HIV, first aid and understanding minor ailments such as skin conditions.
* ***Monitoring, evaluation and research.***
  + Develop and review standardised data collection tools on school health programme.
  + Monitoring and Evaluation of implementation of the school health programme
  + Evaluate the impact of school health services in the country.

**Provincial**

Treasury has allocated additional funds to provinces to provide for roving school health teams at District level. The specific activities to be assumed by provinces include the following:

* ***Developing a five-year implementation plan for the school health programme.***
* ***Securing the required financial, material and human resources.***
  + Where school health nurse posts currently exist, provinces should retain these posts and assign staff in these posts to deliver the school health service. Where posts do not exist, an audit of current staff capacity must be conducted to ascertain the additional staff capacity that would be required for the delivery of the service.
* ***Prioritising the most disadvantaged sub-districts.***
  + Provinces should concentrate on getting the service implemented first in the districts with the poorest health indices such as those coinciding with the rural development and urban renewal nodes. Where strong district capacity exists, best practice sites could be set up so that other districts could benefit from the lessons and experiences of these sites.
* ***Allocating a specific person to support districts.***
  + Provincial support should cover implementation as well as the monitoring and evaluation of school health services.
  + Ensuring that appropriate referral facilities and processes are in place beyond the district level.
  + Ensuring that an appropriate and adequate training programme for new and existing staff is in place.

**District level**

The role of the district is most essential, this being the level of implementation. Therefore, careful planning and resource allocation at this level is required to ensure an effective school health service. Provinces must actively support districts to achieve this.

**Each district will need to:**

* ***Allocate a person to oversee and manage the school health service.***

The management of the school health service, in terms of operational planning and implementation, will fall directly under the district health management team. In cases where the district health management team is not yet well established, the responsibility must be assumed by the provincial MCWH team until the district is able to take on this responsibility.

* ***Conduct an audit of existing capacity for the delivery of school health services.***

This audit will inform the planning process. The baseline information required in each district would be:

* The total number of schools that need to be served in the district (primary and secondary schools).
* The total number of learners (primary and secondary school learners).
* The total number of Grade 1 learners that would need the Grade 1 assessment.
* The total number of current school health nurses (where they still exist).
* The current extent of the Health Promoting Schools Initiative in the district.
* How current HPS activities would intersect with the school health service. For example, do they have strong inter-sectoral forums that could provide the platform for the planning of the school health service?
* Current professional nurse: patient ratio (in order to get some idea of what primary health care capacity is in the district and if spare capacity exists).
* The total number of professional nurses that could be allocated to deliver the school health service.
* The total number of other staff categories that could become part of the school health team. These include enrolled nurses, staff nurses, enrolled nursing auxiliary (assistant nurses), health promoters and staff from other programmes such as the PNSP.
* The total number of other staff categories that will become part of the school health team, these include nursing assistant, occupational therapists, physiotherapists, dietitians, health promoters and oral hygienists.
* Other health and development resources that can respond to the health needs of the school community.
* Non-governmental organisations that is able to contribute to and support the school health service.
* Resources available to school health service, such as vehicles, equipment, phones etc.
* ***Co-ordinate the service.***

The District Health Management Team must ensure co-ordination between all the relevant health service providers related to school health – provincial departments of health, local authority health departments and non-governmental organisations. In addition, co-ordination with education and other relevant sectors must occur. The district therefore must establish a forum for all the role-players from different departments within health and other sectors that currently deliver activities within schools. Where forums already exist, such as Health Promoting School forums, these should be used. The purpose of the forum will be to ensure efficient joint planning, delivery and optimum use and sharing of resources.

* ***Integrate the school health service with other primary level health services.***

Timetables for primary level services must be redrawn to incorporate school health as part of the total services delivered by primary health care facilities.

**2.5 Staffing of the service**

Human resources are the most important resources in the delivery of the school health service. This section provides guidelines that must be considered when allocating staff for the school health service.

It is important to note that whilst the proposed package will in most instances be managed by PHC nursing staff in districts, this does not imply that all the activities within the package must be exclusively provided by PHC nursing staff. As a start, a chief/senior professional nurse together with two professional nurses will form the core of the roving school health team.

**Principles to guide staffing**

The following section contains guidelines for possible staff configurations for the service:

* Staff allocated to school health activities will form part of the total primary health care team and will be required to participate in other primary health care activities. However, it is imperative that district management prioritises school health activities and does not allow the service to be discarded in favour of other PHC activities.
* Existing school health staff must be integrated into primary health care teams as part of the comprehensive management of district-based health services. However, the school health service responsibility of such staff must be retained to allow for continuity of the service. This means staff should be specifically allocated to the service as part of their PHC duties, rather than rotating staff too frequently.
* Based on the number of learners and available staff, the district must work out the current staff: learner’s ratio. If it is below the recommended ratio, then the district must identify ways of supplementing staff to render a viable school health service.
* Primary health care staff must be identified for in-service training for the delivery of the school health service. Existing school health staff would be able to conduct in-service training and act as mentors for staff newly allocated to school health services. Teams should ideally have a mix of experienced and inexperienced staff to allow for mentoring and ongoing in-service development and training. This also applies to any other non-PHC staff that might be involved in the delivery of the service.
* Districts, in conjunction with the provinces, are responsible for ensuring that the appropriate referral facilities and processes are in place.

**Skills required for service providers**

The team required to deliver the school health package needs to be proficient in the skills listed below. It is not intended that any single individual should have all of the skills, but that the team as a collective must possess the full range of skills outlined.

***Grade 1 assessment***

* Conduct vision, speech and basic hearing screening.
* Measure height and weight on Grade 1 learners and use the heights and weights as an indicator to classify the school into a high, intermediate or low prevalence school for malnutrition. Appropriate nutritional interventions must be planned accordingly.
* Check for fine and gross loco-motor problems.
* Conduct oral health screening.
* Perform initial counselling for children with emotional or psychosocial problems where required and then refer for appropriate further management.

***Health promotion and support to educators***

* Establish Health Promoting Schools.
* Undertake health promotion activities.
* Assist schools to stock, maintain and use first aid kits and check the expiry date on the stock.
* Advise educators on child health issues including the management of children with acute and chronic conditions.
* Be able to institute the appropriate response for ad hoc problems such as disease outbreaks at a school.
* Advise learners with chronic diseases and disabilities on self-care.
* Know the referral resources in the district.
* Encourage community involvement and development.

***Networking and management***

* Liaise and network with schools, school committees and other referral resources in and outside the district.
* Network and plan with all other programmes and groups that interact within the school environment.

**Staffing norms**

The recommended norm for delivering the Grade 1 assessment by a appropriately skilled health team is 4,000 Grade 1 learners per annum.

The recommended norm for health promotion activities is one team for every 15,000 to 25,000 learners in Grades 1-12.These norms are based on the practical experience, recommendations of participants in provincial and national workshops, norms and standards in the PHC package and calculations done during the costing exercise.

**Staff mix**

Based on the report on *Human Resources for Health for South Africa* (Pick 2001), the desired category of health worker to lead a school health team is a chief/senior professional nurse, given the skills required for the delivery of the service. The professional nurse would be supported by two other professional nurses and various other categories of health workers and related professionals.

However, other categories of professionals such as nursing assistants, staff nurses or health promoters if given additional training, will be able to deliver aspects of the school health service. Given the insufficient numbers of professional nurses in many districts, this must be given strong consideration. For example, health promoters that work within the Health Promotion programmes are ideally placed to deliver the health promotion aspects of the school health service and might, with additional training, be able to assist with Grade 1 assessments. Other programme staff, such as those engaged in the Primary School Nutrition Programme, might also be able to deliver aspects of the school health service with the appropriate training and orientation. With a good mentoring system, such staff might be able to assume greater responsibility for the delivery of the total set of activities.

**Human resources**

**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 a school health service. They will also be deployed to assist with other duties at primary health care facilities during periods when schools do not operate. This will ensure that the current capacity is maintained and not further depleted.

* **Primary health care nurses**

Where there are insufficient existing school health nurses to deliver the revised school health service, but sufficient primary health care nurses to assist in the delivery of the school health service, such staff need to undergo in-service training in the delivery of school health services.

They should be deployed into the district team responsible for school health services. Ideally staff should not be rotated frequently as this inhibits continuity of care to schools. Staff members who are familiar with the school health services should be charged with playing a mentoring role to newly allocated staff.

* **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 school health services. 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 school health service, districts will have to employ additional staff to perform this function as well as support general primary heath care activities. Provincial and national budgets must take this possible requirement into account and support these districts by according school health budgetary priority. For District level implementation, additional funds were allocated for initiation of the programme.

**Training requirements**

Training and re-orientation is required for all categories of staff who will be delivering the school health service. Special supervision and input may be sourced from experienced school health staff or possibly from health workers who have previously worked in school health and have since been re-allocated to other duties.

***Categories of staff that will require training/re-orientation***

* Existing school health nurses must be trained and re-orientated to enable them to work in an integrated manner within the comprehensive primary heath care service. These staff might also need training on how to fulfill a mentoring role to staff inexperienced in delivering the school health service.
* All other staff who have not previously delivered school health services will need a period of training.
* Other categories of staff - for instance, nursing assistants and health promoters – who lack skills in relation to the functions required by the school health service, will need significant upgrading of their skills to enable them to over functions currently performed by professional nurses.
* All staff in the school health service will need to be orientated to function in an inter-sectoral manner and to work with staff of different backgrounds, qualifications and training.
* Primary health care managers and school educators will also require orientation and training on the school health service, so as to provide the staff delivering the service their full support and guidance.

**Conclusion**

The convention on the Rights of the Child (CRC) in harmony with other regional and national instruments, recognise that children are custodians of their own rights. This therefore means that children should not be passive recipients, but must be empowered actors in their own development.

The vision of “A World Fit for Children” compliments the Millenium Development Goals (MDGs) which encompasses primary goals to be achieved by 2015. Reaching the MDGs therefore, require a stronger focus on children and realisation of their rights.

In South Africa, like in many other developing countries, some children continue to experience poverty – a factor that is not conducive to their development. Due to poverty, some children do not attend school, are denied the right to education, a right to which governments have committed to under the Children’s Rights Convention (CRC). Access to health, education, safe water and sanitation, especially in rural, hard-to-reach areas still remains a challenge. Poor nutrition, especially in orphaned and vulnerable children (OVC) and child headed households, continue to leave children vulnerable to diseases, thereby curbing their educational progress.

All these challenges, therefore, demand strong intersectoral collaborative links between various government departments as well as civil society.

It also means joining hands as a country to protect children from harm in all settings. The current violence erupting in schools must be stamped out as it steals their right to be “children”. It is therefore everyone’s role to ensure that Children’s Rights are protected and upheld. We need to go back to the concept of “Every child is my child – your child is my child – our child”.

Last but not least – “**IT TAKES THE WHOLE VILLAGE TO RAISE A CHILD**”.

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