



# INTERSECTORAL CASE STUDY

## THE HEALTHY SCHOOLS PROGRAMME IN SOUTH AFRICA

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The healthy schools programme in South Africa

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### SUMMARY

This case study describes the Health Promoting Schools (HPS) programme in South Africa post 1994 to date. The school provides a setting for across sectoral work between education, health and other sectors to prevent factors that place learners at risk, such as poverty, violence, substance abuse and HIV/AIDS. The case study is of a national level policy and programme, with further exploration of evidence from a rural primary school site in Western Cape initiated in 1996. The HPS programme was initiated in response to shared policy concerns across health and education sectors, and with support from WHO bringing options to address these concerns from international experience. The policy was developed through an alliance between government departments (particularly health and education) and between various disciplines, professionals, and sectors, based on shared goals. The case study shows the role of provincial departments, local authorities, technical support teams and community actors in taking the national concept to local level. The programme offered space for flexibility in application to facilitate local ownership and initiative, with support from provincial technical teams and management levels of schools. While there is limited evidence on evaluation of health impact, practitioners report greater cross sectoral collaboration and integration of health and achievement of process objectives. After several years there was a growing demand for processes to support institutionalization, including guidelines on roles and responsibilities, consistent training, budget support and formal tools for monitoring and evaluation. The role of parents and learners is not well reported in available documents and was noted by practitioners to need greater visibility in future work.

## 1. Introduction

This case study focuses on the school as a setting for community-based prevention of factors that place learners at risk, such as poverty, violence, substance abuse, learning difficulties and HIV/AIDS. The health promoting schools policy and approach was being applied nationally in South Africa as a strategy to address difficulties experienced by learners and by teachers. It focuses on school pupils and their communities to identify and prevent risks to learners, including through empowering communities to act together with health, education and other social services. Health promoting schools (HPS) aim to provide common ground for alliance between government departments (particularly health and education) and between various disciplines, professionals, and sectors. The 'bridging' function was seen to promote healthier public policy as well as more cost-effective, equitable and higher quality collective action to promote wellness (McNab 2013). The case study outlines the context, policy content and experience of the HPS in South Africa between 1994 to date, with further detail on innovative practice at a primary school in a disadvantaged community on the outskirts of Cape Town initiated in 1996. The case study report provides a general background and context for the HPS in South Africa, how the policy and programme was introduced, its main features as applied in South Africa and its impact and lessons learned.

## 2. Methodology

The case study is based on a review of documented literature. The case study work was initiated by a review of the background documents for the work, ie the WHO analytic framework on Health in All Policies and the Scoping review on status of implementation of intersectoral action in the African Region. From these documents, the case study database made available by WHO and the guidance for the case studies, three papers on specific case study areas were selected. The three cases were selected to reflect work in different regions of the continent (west, east and southern) and to work that met one or more of the inclusion criteria of collaboration (work) between more than one government sector; improvements to equity as a target outcome of intersectoral action, either implicitly or explicitly; or intervention to prevent inequities in health as an entry point of ISA. A source paper was used for the case. Published and grey literature on the case were then sourced through internet search of internet libraries and goggle using as key words the country and theme of the case study, in this case South Africa, school health with (using 'and' and 'or') intersectoral, and health equity. Further information was sourced by following up on references cited in the publications sourced. The case study work was contracted in May 2013 to be drafted by May 10 2013. Key informant interviews were not included in the TORs due to short time frames but the case studies are presented to be reviewed as drafts at a WHO AFRO regional meeting in mid-May. The case studies face the limitation of and information gaps from using publicly available documentation.

## 3. Context

South Africa, located in the south of Africa, is a constitutional, multiparty democracy. It has an estimated population of 49.9 million, amongst the lowest total fertility rates reported in sub-Saharan Africa and diverse cultures, languages and religious beliefs and both western' and 'traditional' knowledge systems (UWC 2006). Approximately 61% of the population live in urban areas (2008) (Schellack et al 2011). It is a middle income country with the largest most diversified economy in Africa. The service sector accounts for 65% of value-added while the secondary and primary sectors account for 23% and 12% respectively. Real GDP growth during 2003-2007 was strong and stable, averaging 5%, but declined thereafter, with the global financial and economic crisis constraining growth (ADB 2009). Despite the country's wealth income inequality is high, with a gini coefficient of 0.58. More than 25% of the population lives on less than \$1.25 per day and high levels of unemployment contribute to poverty, particularly in the rural Eastern Cape and Limpopo provinces (ADB 2011; Schellack et al 2011). The country has the paradox of relatively poor health

outcomes for its aggregate GP and level of health expenditure, with high levels of communicable and non-communicable diseases, child under-nutrition and of violence and injuries, including violence against women, relatively low life expectancy (53/55 (male/female in 2010) and high child and maternal mortality. The Global Hunger Index reports South Africa's nutritional situation as the same in 2010 as in 1990 and worse than expected for the country's income level. These health burdens are higher in the poorest groups (Schellack et al 2011).

Inequalities in health stem from a history of racial and gender discrimination, a migrant labour system and vast income inequalities (Schellack et al 2011). Since the end of apartheid in 1994, the government's policy agenda has sought to address social and racial disparities, although with limited redistribution across social groups in the economy. Most recently, in 2009, the Medium Term Strategic Framework (MTSF) for 2009 – 2014 seeks to improve the conditions of life of all South Africans and contribute to building a better country and a better Africa (ADB 2009). The Accelerated and Shared Growth Initiative for South Africa (ASGISA) in 2006 includes programmes that emphasise employment, land reform and agriculture revival. The government provides cash transfers through a state grant system, clinic-based free primary health care; compulsory education for children aged 7 - 13 years; subsidised housing, electricity, water, sanitation, trash removal and transportation; and transfer of township housing stock to those who have been resident in these properties for a set minimum period of time. In the education sector South Africa instituted a 'no-fee' school system post 1994 and the percentage of adults without schooling fell dramatically from 18% in 2001 to 7% in 2010, although with continuing inequality in access to education by region and racial group. (Schellack et al 2011).

Western Cape province, a site for the specific example explored in further detail in this case study is home to about 10.1% of South Africa's population. In terms of per capita income, Western Cape is the second richest province in South Africa after Gauteng but also has high poverty rates and high inequalities in the distribution of income between various population subgroups (with a gini coefficient on 0.63). Agricultural households and rural residents in the province are more disadvantaged, with poverty lowest in the city of Cape Town (17% in 2001) and highest in the Central Karoo (41% in 2001) (Provide project 2005). Western Cape has the same health profile and inequalities in health as the rest of the country. The primary school discussed in more detail in the case study is situated in a semi-rural town about fifty kilometres outside of Cape Town that has high levels of unemployment, crime, commercial sex work in teens, substance abuse and gangsterism, but also a community that seeks to promote a better future for children (Johnson and Lazarus 2003)

The education and health sectors, schools and teachers, communities and pupils are major stakeholder in the work reported in this case study.

The value of education for health is commonly perceived, and education was suggested as a 'social vaccine' to prevent the spread of HIV, particularly in girl children where it is argued to promote sexual autonomy and reduce their risk of contracting HIV (Jukes et al 2008). Improved gender parity in education is associated with aggregate improvements and reduced differentials in various indicators of health and health care uptake (EQUINET 2012; Kirby et al 2006). Education status affects control over behaviour, attitudes, practices and treatment decisions associated with health behaviours and uptake of services (Jukes et al 2008).

It is estimated that by 2020 between 14 and 17 million young people will be enrolled at schools in South Africa. Research shows that a large proportion of high school students drop out before reaching Standard 10 (secondary school completion) School age pupils in one study in Cape Peninsula were found to engage in risk-taking behaviours such as cigarette smoking, drug and alcohol abuse, interpersonal violence and unsafe road-related and sexual behavior (Fisher and Reddy 1995). South Africa has thus faced challenges of expending access to schooling, keeping pupils in school, improving the quality of education and

addressing the risk environments that pupils face that undermine learning. Since 1994 policies have sought to address these issues, in expanding universal coverage to free education as discussed earlier and in specific education needs. In 2000 the National Commission on Special Education Needs and Training (NCSNET) and the National Committee for Education Support Services (NCESS) were established to investigate and make recommendations on all aspects of 'special needs and support services' in education and training in South Africa. A 2001 White Paper on building an inclusive education and training system in South Africa prescribed the development of a four-tier support system aimed at assisting schools to become inclusive and supportive of physical, emotional, social or learning needs. In Western Cape Province for example, institution-based support teams called Teacher Support Teams (TSTs) were set up in many schools (Johnson and Lazarus 2003). These policies identified that while teaching and learning remain the core purpose of schooling, the many biopsychosocial barriers to learning call for the barriers to learning and teaching to be addressed within the school environment (UWC 2006). Further, schools provide a site for reaching adolescents as a group at a critical developmental stage for the acquisition of health-promoting skills and behaviours that can persist throughout adulthood and be disseminated to families, communities, and others.

The Department of Health has over-arching policies supporting health promotion, with a 2006 Health Promotion Policy, a 2003 School Health Policy and a 2006 Health and Wellness in Education framework (UWC 2006). At the same time given weak health promotion capacities in provinces and limited health promotion personnel in the health sector it was also recognised that alternative models of delivery needed to be developed (HST undated). The pooling of personnel through intersectoral collaboration was identified as a cost-effective way of effecting the shared policy concerns of both sectors and of thus reaching groups with high need and limited resources (Johnson and Lazarus 2003).

WHO has supported the concept of health promoting schools in Africa as one way of building this intersectoral collaboration, drawing on 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). A Health Promoting School (HPS) was identified as 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, to provide a healthy environment, school health education, school health services and school/community projects and outreach. The HPS was thus a means to build links between education, health and community.

#### **4. Initiation of the programme in South Africa**

As the context discussion above indicates, the concept of the HPS resonated with policy concerns in South Africa to both expand education and to overcome barriers to learning, including health barriers as noted above, particularly in disadvantaged communities. It was supported by all key departments (UWC 2006). This coincided with and was supported and informed by a global level policy thrust on HPS. From 1997 WHO/AFRO supported the initiation and implementation of HPS in about 32 African countries and about three hundred schools reported to be 'fully operational' HPS by 2007. The support from WHO was used to sensitise administrative and school authorities, and inform policies, services, curricula or extra curricula schedules on areas such as HIV/AIDS/STI prevention, violence, drug and tobacco prevention (WHO AFRO 2007).

As also noted earlier the policy context in South Africa was positive for a national level uptake of HPS. Efforts to improve scholastic performance that ignore health were seen to be ill-conceived, as were health improvement efforts that ignore education. South Africa adopted the HPS concept in 1994 in an attempt to address historical imbalances in both educational and health services. A 1996

School Register of Needs Survey covering 32000 schools was commissioned by the Min of Education (Swart and Reddy 1999 p49) The survey highlighted the resource and facility shortfalls and the serious implications that poor school infrastructure has on the health of children due to lack of water, electricity, toilets and telephones.

In 1994, the first health promoting schools workshop was held in Cape Town involving representatives from various governmental sectors, education institutions and non-governmental organizations. In 1995, a Reference Group for Health Promoting Schools, a voluntary multi-disciplinary network aimed at providing support for the development of health promoting schools in the Western Cape, was formed comprising individuals from the education, health, and welfare sectors, as well as non-governmental organizations. The first National Conference on Health Promoting Schools was held at the University of the Western Cape in 1996 and in 1997, in a National Health Promoting Schools Workshop, provincial representatives agreed that future activities around HPS be planned within local, provincial and national frameworks and integrated into existing government structures and frameworks to strengthen voluntary initiatives. In October 2000, a draft of national guidelines for the development of HPS's in South Africa was developed. The policy and programme was thus progressively institutionalized and integrated between 1994 and 2000, and in 2000 the National Committee for Education Support Services (NCESS) recommended that all aspects of the HPS strategy be adopted to ensure the development of healthy school policies, supportive learning environments, strong community links, personal skills development and the provision of appropriate education support services (Lazarus and Johnson 2003; UWC 2006; HST undated).

This complemented approaches being pursued by the health sector. The National Directorate of Health Promotion included the HPS in their five-year plans, and provided support through provincial structures. While the HPS was thus initiated with full support from international and national level, its uptake in the provinces depended on local contexts. The Western Cape is thought to have gone furthest with a strong provincial network and work on the ground including early childhood development, the rights of children and addressing malnutrition through vegetable gardens. In Gauteng, the Gauteng Integrated Schools Sanitation Improvement Programme (GISSIP) complemented the HPS as a joint initiative between the Departments of Education, Health and Public Works. In KwaZulu-Natal the Health Promotion Department, The Valley Trust and the Medical Research Council trained one health promoting school facilitator per district (Lazarus and Johnson 2003; UWC 2006; HST undated).

A more detailed exploration of the programme in one school in Western Cape also reveals the role of motivated community leaders, teachers and individuals in initiating the programme. The 1996-7 case study described how a governmental school health team introduced the HPS concept to the principal and that was adapted by staff to suit the needs of their school. A collaborative team approach was developed whereby staff members served on eight groups that addressed various aspects of development and growth. The school health nurse played a vital role in motivating and maintaining the project. She liaised with the relevant role-players and team coordinators for the provision of needed services to the school. The principal also played an active role in motivating and encouraging teachers and finding solutions to difficulties encountered. He also had a strong relationship with the parents and the greater community and was able to gain financial and other assistance for the school. The principal and staff incorporated HPS activities into the curriculum, contributing to the interest and motivation of the teachers. Parents and pupils motivation was raised when they saw the relationship between learners and staff and learning outcomes improving (Lazarus and Johnson 2003). McNab (2013) in an analysis of the programme highlight that introduction of a single health-promoting program in a school can serve as an entry point that can ultimately lead to its evolution into a HPS, with entry point topics depending on local priorities and early success with the initial topic building confidence to address other issues. Primary schools were identified as ideal starting venues, and health programmes for teachers as a further effective entry point.

## 5. The Health Promoting School Programme

The HPS programme between 1994 and the current date is an example of intersectoral work that involves health promotion and closing the health inequity gap. It further reflects the political will and process for implementation of health in all policies, at least between the health and education sectors and local authorities. It is a setting specific site for intersectoral action, covering primary and secondary school pupils, their families, teachers and local health workers. While the programme did not explicitly aim to address health equity, in its focus on overcoming barriers to learning such as violence, poor health and unhealthy environments it can be said to address equity given that such support would support learning in more disadvantaged groups exposed to these risks.

The objectives and features of the HPS as applied also in South Africa were noted earlier. An HPS is one that constantly strengthens its capacity as a healthy setting for living, learning and working, that fosters health and learning with all measures at its disposal; engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders to make schools a healthy place; integrates broad health promotion and education services, promotes individual and social wellbeing and the health of school personnel, families and community members and pupils; and works with community leaders to understand their role in both health and education (UNESCO 1998). The issues addressed in South Africa were many, including road safety, personal hygiene, substance abuse, HIV and nutrition, with processes such as teenage clubs, after care programmes for cultural activities, outdoor educational activities such as camps, and teacher support groups to support teachers own health promotion (Johnson and Lazarus 2003).

### 5.1 Roles and implementation

The role of the education and health sectors as key in the HPS has already been referred to. Health and education were both sectors where a number of areas of intersectoral collaboration were already in progress. For instance, in 1996, the government launched the National Programme of Action (NPA) for Children in South Africa overseen by an Interministerial Core Group and involving the Departments of Health, Social Welfare, Education, and Arts, Culture, Sports and Recreation. As noted earlier both health and education departments had policies and mechanisms to support their role and inputs to the HPS programme.

The National Department of Health established a Health Promoting Schools Committee with representatives from Health and Education (Vergnani et al 1998).

These intersectoral mechanisms were replicated within the provinces. For example Western Cape set up an intersectoral provincial reference group comprising members of the Departments of Health and Welfare and Education, community-based organisations, volunteers and members of the private sector to introduce and implement and sustain the HPS concept in schools. In all cases health and education departments seemed to co-lead.

Much of the published information on implementation of the HPS comes from the review meetings and conferences held on the programme. In particular the 2006 national conference held to review the HPS programme heard nine provincial presentations that described how the initiatives had developed over the last ten years. These presentations reported that in all contexts, the HPS strategy had been prioritized in the provincial health departments and, in many cases, more staff had been deployed in health promotion to support it in this area. A growing number of designated 'health promoting schools' were reported in each of the provinces, with the provinces using a formal process to introduce schools to the concept (as discussed earlier), and schools then being supported to become part of a HPS network of schools (UWC 2006).

Various instruments were reported to have been developed to help schools in this process, not all uniform across provinces but using broadly similar principles. Guidelines developed by WHO and the Department of Health's National Guidelines for Developing Health Promoting Schools/Sites in South

Africa (2000) were used by provinces. Once schools were given HPS status, they became part of annual quality assurance processes, using various evaluation and monitoring tools developed in the provinces. The monitoring and evaluation is discussed further under impacts.

Partnerships were built between different government departments, non-governmental organizations (NGOs), higher education institutions, as well as with the media. Partnerships with various business organizations were noted to be particularly prominent in the provincial initiatives in the 2006 Conference (UWC 2006). There is limited information on the budget allocations for the HPS, and although core personnel are covered in the routine budgets, there is note of resource constraints to meet the level of demand for health promotion (HST undated). The role of business may thus have helped to implement programmes not covered with budget resources. The programme also raised demand on leadership and implementation capacities within education and health departments and schools. This has been supported by training activities, such as the 1 week Health Promoting Schools Course offered by University of Western Cape (UWC) that introduces participants to some of the key concepts underlying the health promoting schools initiative, and addresses the challenges and opportunities faced by practitioners. The course is aimed at anyone working in a school setting, including: teachers, community health workers, school health practitioners, health educators and project managers (UWC 2013).

The provincial presenters in the 2006 UWC conference on HPS reported a range of health, lifestyle and environmental issues covered in the HPS activities, including disease priorities highlighted in the 2002 Medical Research Council's Youth Risk Behaviour Survey; social dislocation, drug and other forms of substance abuse, violence and safety issues, physical exercise, nutrition, soup kitchens, water and sanitation, vegetable gardens, unemployment, sport, HIV and AIDS and other infectious diseases, teenage pregnancy, worms, and trauma. In 2006 the department of Education was consolidating these initiatives by developing a Health and Wellness in Education framework. This initiative was taken in direct response to concerns about collaboration, the need for evaluation, and the need for inclusion of all voices in the development of guidelines for health and wellness in education. The Health and Wellness in Education framework was being prepared to provide a minimum package of support services to develop schools and other education institutions into 'centres of care and support', including preventative, developmental, care, support and referral psychosocial, food security, and school health services covering both pupils and teachers (UWC 2006).

The more detailed information provided in the HPS in Western Cape provides further insight on implementation and roles. Every staff member was involved in the project sharing the burden across all teachers. The project was incorporated into school management structures which supported organization and management, with further support from education support service personnel, including for skills development. There was an effort to bring in health and other services that were in the past viewed as inaccessible through involving service providers directly in teacher training and consultation and setting up a coordinating team involving these multi-disciplinary providers. This co-ordinating team met quarterly to assess the progress and to report on successes and failures. The meetings provided a forum for ideas to be generated and assistance to be obtained and the team, as a coordinating body, coordinated all the activities related to developing the school into a HPS (Lazarus and Johnson 2003).

*(Note: No online information could be found on the specific tools cited in this section).*

## **6. Impact and Lessons Learnt**

### **6.1 Achievement of objectives**

The review of the Western Cape School highlighted that the HPS programme objectives set were being achieved. In 1996/7 this school was noted to have overcome many of the difficulties facing schools

at that point in time. For example, the issue of a lack of resources was being attended to by reaching out to the parents and the greater community. Various governmental and non-governmental education support services were being accessed. Teachers were trained to deal with a wide range of problems experienced by learners. Teachers were gaining new skills and as a result were more enthusiastic about their work. (Lazarus and Johnson 2003).

Although it took longer to achieve, it appears that other schools were progressively achieving HPS objectives in other provinces, although with some variability in both pace and form (UWC 2006). In the 2006 review conference, district and provincial personnel reported on the progress: A critical mass of 'health promoting schools' had developed across the nine provinces. Policies and programmes in health and education had incorporated important aspects of the HPS approach in their Frameworks - "integrated, infused and institutionalized" as one presenter noted (UWC 2006). The functioning of the district support team (specialist learner and educator support professionals (e.g. psychologists, learning support facilitators, therapists), curriculum advisors, circuit managers, and finance advisors) was identified as critical to support practice and address challenges.

The HPS framework was recognised as a strategic, holistic, comprehensive response to the challenge of barriers to learning and a successful strategy for creating safe and supportive environments in schools as centres of care and support. The approach used was seen to be addressing factors that place learners, teachers and others at risk. For example 'Life Orientation', one of the focus areas within the HPS five pillar framework, was seen to be a key 'lever' to address many of these challenges in a collaborative manner, including by incorporating local and indigenous knowledge. The Life Orientation Learning Area is now a compulsory part of the primary school curriculum, integrates health promotion and indigenous knowledge, with educators innovating on approaches in mentoring, innovative assignments, and storytelling (UWC 2006).

The 2006 review of experience at the conference also highlighted gaps or challenges around the objectives of the HPS. Local creativity and development were highly valued and important but those involved called for more support from national guidelines and instruments and tools for evaluating and monitoring the development of HPS. While the previous section highlights work underway in the Department of education to provide guidelines, it is unclear whether these or the tools for monitoring and evaluation have now been developed. In Western Cape, one of the most successful provinces for the programme, implementers reported on the competing priorities, overlapping of policies and programmes and lack of collaboration that present a risk of a downswing in the trajectory of the development of HPS. In particular the concurrent expectations of delivery on numerous policies and programmes (new curricula, inclusive education, constant reviewing of job descriptions, whole school evaluation systems, a human capital development strategy, and a social capital development strategy) raised a risk of overwhelming teachers and administrators. While the desire to reach the objectives was high, conference delegates noted the 'transformation stress' being experienced by educators in schools.

## **6.2 Impacts**

McNab (2013) notes from South Africa and other settings that HPS depend more on a change in mindset rather than the provision of major new resources, and that when properly engaged with the range of collaborative partners needed for success, they can provide a useful link between the 'top down' influence of public policy and the 'grass roots' of constructive community engagement. In this respect the HPS fulfil an objective of being a vehicle for positive social change with benefits to the wellness of citizens, communities, and societies.

Mukoma and Flisher (2004) reported, however, that there are no formal evaluations of HPS in Africa. Their review of eighteen published evaluations of HPS in other settings showed positive changes in school policies and organizational structures to facilitate health promoting activities, including integration



into the school curriculum, parent and local community involvement. The evaluations utilizing a quasi-experimental approach with comparison schools reported better performances in the intervention schools for certain areas, but no differences in others. One recommendation that they and others make therefore is for more structured evaluation of these programmes, including to close the gap between theory and practice often found in health promotion (Vergnani et al 2009; Mukoma and Flisher 2004). As noted in the prior subsection, the HPS have been able to integrate health promotion within the education sector. In the more detailed review of the school in Western Cape in 1996-7, Lazarus and Johnson (2003) report that the school operated in a more holistic manner in addressing the needs of the learners; and learners were encouraged to pursue the development of their physical, psychological, social and educational potential. The authors report an increase in learners self-esteem, in positive relationships amongst all members of the school community; new health-promoting environments such as in the establishment of a vegetable garden and animal enclosure and greater involvement of learners, teachers and parents in their health.

There is limited other documented evidence of impact on the learning difficulties and health outcomes the HPS sought to address. It is also necessary to assess impact on the context of wider developments within schools and health services, as even small impacts may take huge effort in a context where significant inequalities in resources and incomes exist. Vergnani et al (1998) note for example that schools were in 1998 still affected by the wider context of fragmented school health services and gaps in resources and staff. They report that inequalities in access to resources continued to affect school health services, including in terms of visits to schools by health personnel. With most of the budget being spent on salaries, they observed that there is little extra money being made available for services and resources.

There is thus more evidence relevant to process, ie in terms of the implementation of the programmes and the links and collaborations built, than impact.

(Note: No online information could be found on sustainability).

### **6.3 Opportunities and facilitating factors**

The literature on the experience of HPS in South Africa raise a number of factors that facilitate the positive implementation of HPS and the delivery on their objectives. As noted in the next subsection, there are difficulties in an environment that is plagued by uncertainty, change and a lack of resources. The factors below facilitate the channeling of collective energy towards a shared goal:

- The earlier sections raise the policy support for the initiative from both health and education sectors that were key to this initiative. Both saw the benefit of the HPS approach to their own domain of work, and the value of collaboration and integration of processes to their own desired outcomes.
- If key and respected role-players are convinced of the value and importance of the proposed intervention (e.g. principal, senior staff) it is easier to convince the school community to try a different practice. Leadership and constant support, guidance and feedback, from both technical and higher management personnel, is important for the motivation, orientation, support and acknowledgement of role-players, as is the development of new skills in the process (Lazarus and Johnson 2003; UWC 2006).
- The identification of a common shared goal and opportunity for local stakeholders and community to take own initiative on that goal makes it easier to build collaborative work. The common goal may be the development of the school into a HPS, or a more focused goal such as dealing with violence, substance abuse or teenage pregnancy. A wide understanding of health creates opportunity for entry points that are relevant to different communities (Lazarus and Johnson 2003):
- A sense of empowerment is noted to be created when teachers are able to take charge of an initiative and adapt it according to their particular needs. This means that implementers need to be placed in control of initiatives that will benefit them and to experience success in order to be encouraged to

sustain a programme. Small, reachable goals should be set at first and this should develop into larger, more challenging goals (Lazarus and Johnson 2003):

- › The development of formal structures and formal guidance is important to operationalize, manage the process, to set goals, organize teams, evaluate progress and improve practice. Within this there is need to identify one or more respected focal persons to link the schools to the wider community (Lazarus and Johnson 2003; UWC 2006).

#### **6.4 Challenges and barriers**

The different pace and degree of implementation of the HPS exposed barriers and challenges in the programme, and in the work across sectors on health. There is some debate on the limitations of education and cognitive inputs in changing behaviour when risk environments are profound or overwhelming (Jukes et al 2008). There was a concern that the Departments of Health and Education integrate their relevant frameworks, ie the Health and Wellness in Education framework of the Department of Education, and the National Guidelines for Developing Health Promoting Schools/Sites in South Africa of the Department of Health (UWC 2006).

Generally, however, barriers were not located in the policy intentions or broad design of the HPS, but in the policy implementation (UWC 2006).

- › Initiation was blocked in some settings by lack of co-operation and co-ordination across departments of health and education; by demotivation in the education system due to overloaded syllabi and overcrowded classes; and by financial and personnel constraints (Swart and Reddy 1999).
- › Implementation was affected by a capacity gap in health promotion. Two levels of training were identified as urgently needed: Firstly for undergraduate health workers (especially environmental health officers to help fast track the shift in environmental health), and secondly for post graduate specialist studies open to a wide range of graduates contributing to health promotion practice (HST undated).

Provincial presenters in the review conference raised a number of institutional challenges in both the vertical integration across levels of government and in the horizontal collaboration within the same levels.

- › These included the lack of adequate staffing to provide the necessary support to schools; the disappearance of school nurses as a result of their withdrawal from education support services; frustrations relating to departmental bureaucracy; lack of adequate budget to support provision to schools; lack of basic infrastructure in the education system (UWC 2006).
- › Implementers also raised challenges of 'working together' with various partners; made more complex by the absence for many years of and national standards to guide the work (UWC 2006)
- › Schools cited in one review the lack of involvement of parents in the life of the school as a major problem. Parents were seen to be disinterested in school activities, even though they are usually deeply involved in and affected by their children. This suggests that the processes used for engaging parents in needs to be creatively addressed (Lazarus and Johnson 2003). There was limited documents on the perspective from parents and learners in even formal review processes like the 2006 National conference on HPS.

*(Note: No online information could be found on the distribution of these challenges to be able to comment on their impact on equity. It is possible that they most affect the least resourced areas but other factors such as leadership, social cohesion also intervene)*

## 7. Conclusions and recommendations

The coincidence of strong global support for HPS, and a perceived need and political and policy window in post-apartheid South Africa in 1994 to address health and social barriers to learning created fertile ground for the HPS as an intersectoral intervention. The policy intention to overcome barriers to learning associated with disadvantaged areas (violence, ill health, poor nutrition) meant that the initiative could have a positive impact on inequalities in health. The HPS did however include health issues such as cigarette smoking, drug and alcohol abuse, interpersonal violence and unsafe road-related and sexual behaviour that are relevant across socio-economic groups, and HPS were located in a spectrum of economic settings, including low income rural settings such as that described in Western Cape.

The experience suggests that the shared goals and mutual interest across health and education provided a basis for collaboration and leadership for wider partnerships in the HPS. At the same time some health promotion does not displace core obligations of the state, and clear division of duties and authorities within the state to provide fundamental obligations, such as safe water and toilets at schools.

The case study demonstrates a significant change process integrating the institutional cultures, systems and goals of two sectors (health and education) to overcome barriers to learning that exist across many communities, and particularly disadvantaged communities. It highlights the possibility of building a national programme while allowing for local diversity of practice.

The opportunities and barriers raised are not unusual in an institutional change process and suggest the need to plan and invest in the dynamics and challenges, knowledge, skills and institutional mechanisms and guidelines to facilitate change. For example provincial presenters highlighted at the 2006 National Review meeting that explicit attention be given to training adequate staff, to integrate the HPS framework in all educator training, and to provide resources to strengthen partnerships. While the flexibility for local innovation and ownership was seen as a positive contributor to the HPS, there was also an identified need for national standards and guidelines; for assessment and evaluation tools to support schools in their development as health promoting settings and for reward for good practice (UWC 2006). Such concerns would have wider relevance in other intersectoral programmes.

The 2006 National Conference on HPS provided several pages of practical recommendations for strengthening the programme (UWC 2006). These included areas that are more generally relevant to such programmes, including

- › Finding a common language and using a holistic concept of health that includes social, psychological, spiritual and environmental dimensions;
- › Integrating policy and cross referencing frameworks across departments;
- › Supporting planning by regular surveys on risk factors, perceptions and practice;
- › Ensuring that collaboration structures operate at all levels (national and subnational) to facilitate vertical linkages, and clustering sites of implementation to support horizontal linkages;
- › Setting clear guidelines that encourage, support and provide a framework for local innovation, setting out values, role definitions, capacity demands and budget responsibilities, so that they can be used in local planning;
- › Ensuring provision of national training for the capacities needed for initiatives such as the HPS, and the inclusion of training for such capacities within core training;
- › Deepening involvement of communities, including in the development of policy design, formal guidelines, and in measures for social reporting and accountability on the initiatives;
- › Organising skills and teams to provide support to implementers, in between implementation sites (such as at district level for schools) and within implementation sites, such as the teams and committees within schools.

- › Integrating monitoring and process and impact evaluation in the process, with a national assessment tool that also gives latitude for local and community based reflection and review;

The papers available on the experience in South Africa have a number of gaps in information that would be useful to further explore to better assess the HPS as a vehicle for intersectoral action and its role as an economic actor that can leverage wider levels of 'health in all policies'.

For example while there is report of vegetable gardens and animal husbandry in some schools, it isn't clear whether or how far the HPS approach changes the relationship between schools and agencies providing food for schools, in terms of demand for healthy nutrition. Did the HPS as a significant economic actor in an area tender for and procure food in ways that supported producers of fresh, locally available produce and that encouraged improved food safety standards? Did the HPS team target vendors inside and outside schools to make fresh snack options available and acceptable to children?

Further, the literature is rather silent on the role and views of parents and pupils as a driver of intersectoral practice. In the 2006 National Conference many presenters and participants highlighted the need to listen to all voices in developing HPS in South Africa, and particularly marginalized voices of local communities and indigenous wisdom, and of the learners themselves. The views of parents and pupils would need to be further explored, and their voice to be stronger for the effectiveness, sustainability and equity of the initiative.

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