

South Africa case study:

Building support and policy change for integrated school health

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1. Introduction

This case study is implemented within the project 'Fostering policy support for child and family wellbeing - Learning from international experience'. Using a thematic and analytic framework for the project that draws on Kingdon's multi-streams theory² we are gathering and sharing evidence and learning on what has led to increased policy recognition of and policy change in family and child health and wellbeing (FCHW). In specific countries that have demonstrated policy recognition and change in FCHW post 2000, we are exploring within their context how different policy actors have come together to raise policy attention, develop policy options and promote their political adoption as processes for policy change, taking advantage of windows of opportunity for that change. The case studies were implemented with a local focal person with direct knowledge or experience of the policy process and include evidence from published and grey literature and interview of key informants involved in the policy processes.

This case study explores how change was built for integrated school health in South Africa combining health, educational and social services to ensure the wellbeing of learners.

In post-apartheid South Africa, the new political order made radical advances in child health and education introducing many affirmative health and education policies reflecting holistic, ecological views of child wellbeing. In this context, provincial health departments raised and framed the need for standardised school health services underpinned by national policy and strategy.

A committed academic group facilitated a comprehensive policy development process with provincial actors, resulting in the 2003 *National School Health Policy*. Through this, relationships were built between government departments, researchers, policy makers and others. That the policy became a Department of Health initiative was seen as a missed opportunity to build the collective effort across health, education and social development needed to realise the vision and potential of school health.

The main window of opportunity occurred in 2009, when a new administration with committed Ministers in Health and Basic Education advanced high-level inter-sectoral relationships and drove reforms that brought together local learning with regional and international experience, culminating in the *Integrated School Health Policy* in 2012. Regional and international organisations made important contributions to advancing integrated, holistic approaches to school health. This was accompanied by domestic learning and evaluations, which built support for a holistic, integrated view of school health services. Committed and influential academic groups, government officials and development partners collaborated to develop and implement policy options promoting this holistic view of school health and wellbeing within an increasingly receptive policy environment. The *Integrated School Health Policy* reconciled different modalities, facilitating its relevance in provinces, given the varying level of delivery of school health services across provinces.

2. The context

The Republic of South Africa is an upper-middle income country in the south of Africa. It has nine provinces and a population of 58.8 million (SSA, 2019a). South Africa is a parliamentary republic. Pre-2000, the apartheid regime of institutionalised racial segregation existed. The African National Congress (ANC), a banned liberation movement, was the main opposition during apartheid and drove its dismantling. The first free and democratic elections in 1994 achieved a new constitutional order committed to promoting inclusive development and righting past injustices (South African Government, 1994).

President Nelson Mandela's government of national unity was a broad coalition focused on tackling institutionalised racism and fostering reconciliation. The government inherited a stagnant economy with high levels of unemployment, a fiscal deficit of over 7% of gross domestic product (GDP) and high inflation (UN, 1998). The first full South African census in 1996 recorded a population of 40.6 million, 76% of which were Africans, 10.9% children under-5, and 33.9% under 15 years. Life expectancy in 1996 was 52.1 and 61.6 years for men and women respectively (SSA, 2001). South Africa has never been an aid-dependent country, but it did welcome technical assistance from development partners.



Map of South Africa. Source: Wikimedia commons

The new political order adopted a pro-poor policy framework under which equity-oriented, redistributive child health policies and programmes increased substantially. The health sector underwent fundamental transformation to a Primary Health Care (PHC) system, focused on equitable provision, prevention and health promotion implemented by the newly formed provinces. Free health care was provided for pregnant women and children under six, and a no-fee system was instituted in poorer schools (Sayed and Motala, 2012; Shung King, 2006). National and provincial directorates for Maternal, Child and Women's Health (MCWH) were established to develop, implement and monitor policies and programmes. In 1995, the government ratified the *Convention on the Rights of the Child* (CRC) (Reyneke, 2013). The Child Support Grant was introduced in 1998, at ZAR100 (PPP US\$37) per month for children under seven.

In 1996, the government introduced a new policy framework to stimulate faster economic growth to meet social investment needs. The policy was, however, criticised for prioritising economic growth over redistribution. While health expenditure was high, it was skewed towards a private sector that served a minority (Sanders and Chopra, 2006). The HIV epidemic in this period had a devastating impact, exacerbated by inequality, mobility and violence and an early denialist response by the Thabo Mbeki presidency. HIV prevalence among adults 15 to 49 years is 20.6%; 26.3% and 14.8% among females and males respectively. In 2017, an estimated 7.9 million people were living with HIV (Bradshaw et al., 2003; HSRC, 2017). In 2000, the HIV infection rate among children was 1.0%, rising to 1.7% in 2005 (Jacobs et al., 2005). More generally, in 1995, the infant mortality rate was 54.7/1000 and 7.3/1000 among black and white population sub-groups respectively (DOH et al., 2002; UN, 1998). The under-five mortality rate has now decreased overall from 81 in 2003 to 34 in 2016 (Hall et al., 2019). Life expectancy is 67.3 years for females and 61.1 years for males, with young people 15 to 34 years making up 35.7% of the population (SSA, 2018).

- Today, South Africa has one of the largest economies in Africa and spends the highest proportion of GDP on schooling on the continent. Despite this, the country remains one of the most unequal in the world. The Gini coefficient was 0.64 in 2015, having increased from 0.61 in 1996. Unemployment was 27.7% in 2017, with youth unemployment at 38.6% (World Bank, 2018). In 2014/15, 49.2% of the adult population were living below the upper-bound poverty line and 54.3% of children lived in income-poor households in 2013 (SSA, 2015; 2019b). Slow economic growth, unemployment and entrenched inequalities act as multiple, reinforcing determinants of child health and wellbeing, and insufficient resources constrain implementation of school wellness programmes.

3. The policy change

This section describes policy recognition and change for integrated school health services

The case study describes policy support and recognition for integrated school health services combining health, educational and social services to ensure the physical, mental and social well-being of learners and to maximise learning capabilities (DOH and DBE, 2012).

School health came onto the agenda at a time of significant democratic reforms and aspirations in which child wellbeing was promoted within a wider government agenda focussed on overcoming inequalities and ensuring that all children had the best possible start in life and the opportunity to realise their potential, including to invest in skills for future economic growth.

The *Health Promoting Schools* (HPS) initiative, adopted in 1994 with support from WHO and UNICEF, supported schools to develop as healthy settings for living, learning and working. HPS required considerable resources, coordination and collaboration among government departments to initiate a network of HPSs was challenging.

The Health Promotion Directorate of the Department of Health (DOH) developed draft national guidelines for HPS in 2000. In the absence of a national directive, however, they were never signed off. There were instances of excellent implementation integrating HPS and school health services and over 1,000 HPSs are recorded to have been established by 2006-07 (Macnab et al., 2014). Despite these successes, the initiative was not uniformly implemented, assessed or sustained.

Over several years, demand grew in the DOH for national institutionalization of the HPS concept. The DOH was also obliged under the CRC and the South African Bill of Rights to formulate and implement a school health programme (Shasha et al., 2011). From 1997-2003, a *National School Health Policy* (NSHP) was developed by the MCWH directorate with academics at the Children's Institute at the University of Cape Town (UCT) who worked with a range of state and non-state policy stakeholders at different levels over several years to develop the policy. The NSHP encompassed preventative and health promotion components, screening and health assessments and referral delivered by nurses in schools (DOH, 2002).

The policy was launched in 2003 emphasizing integration in district health systems and complementing policies such as the *Integrated Nutrition Programme* and social grants for children (Shung King, 2012). Evidence from evaluations, among other influences (discussed later), provided a basis for further policy development. These processes served to build the ground work after which substantive policy changes took place.

The main window of opportunity occurred in 2009, when Jacob Zuma's government introduced policy reforms that focussed on long-term planning and achieving outcomes. President Zuma's vision also included the unbundling of the Department of Education (DOE) into the Departments of Basic Education (DBE) and Higher Education and Training (DHET), and, for the first time, school health received attention from DBE, with Minister Angie Motshekga focussing on school Health in her budget speeches and calling for the extension of Grade 1 Health assessments to schools in the most disadvantaged areas.

In 2008, following developmental and piloting work, the DBE broadened its remit to focus on all aspects of school children's lives by rolling out the Care and Support of Teaching and Learning (CSTL) framework providing a multi-sectoral, ecological response to improve children's wellbeing by assisting children and youth to realise their rights to education, to safety and protection, and to care and support through an expanded education sector response.

At the same time, the new health Minister, Aaron Motsoaledi, was prompted by evaluations of the NSHP to prioritise school health in PHC reforms as part of the phased implementation of national health insurance (NHI) and wider commitments to universal health coverage (UHC) (DOH, 2011). With CSTL in DBE and PHC in DOH, compatible reform agendas combined with high-level support developed for the first time between the key government departments.

Presidential support for school health programmes was expressed in the 2010 State of the Nation Address (South African Government, 2010). On this basis, the DOH and DBE jointly developed the ISHP, drawing together CSTL, PHC, HPS and school health, leveraging the favourable policy environment in line with international initiatives and evidence. The ISHP was also supported by education bodies, teacher unions and national governing bodies.

The ISHP was jointly endorsed by the Ministers of Health and Basic Education and was launched by the president as a priority programme in 2012. This was a critical, collective commitment to the provision of good quality, accessible services attending to the wider determinants of child health and wellbeing. With the challenges of staffing and referral systems acknowledged, the ISHP sought to expand access and promote equitable coverage of school health services.

In a marked departure from the 2003 strategy, which mainly concentrated on visual and hearing impairment screening for pre-school grade R (reception) and grade 1 learners, the new policy contained a comprehensive health care package for all learners from grade R to grade 12 including health assessments, screening, health promotion and education, onsite services and referral.

The ISHP has an explicit equity focus. Reflecting learning from the NSHP, the ISHP includes a phased implementation plan, initially focussing on younger learners and schools in the most disadvantaged areas, extending to all students over time (Berry et al., 2013). The ISHP was also informed by international evidence, the *Millennium Development Goals* (MDGs) and the *Education for All* initiative.

Both the NSHP and the ISHP were part of a wider set of policy shifts, towards integrated and intersectoral working and collective responsibility for the health and wellbeing of all children, that occurred during significant democratic reforms. The ISHP was advanced as a priority programme within government initiatives to promote family wellbeing. The shift did not occur in isolation and was accompanied by several other laws, policies and programmes in support of child health and wellbeing.

A timeline of the key laws, policies and programmes at different stages covered by the case study is provided on the next page.

There is some evidence of impact. In 1998, school attendance was high, but attainment was poor with high drop-out rates (DOH et al., 2002). By 2007, over 96% of children attended some form of educational facility, increasing to 98% in 2017 (Hall et al., 2019; Pendlebury et al., 2009). In 2017, 89% of 10-11-year-olds completed grade 3, but only 69% of 16-17-year-olds completed grade 9. The attainment gap is reported to be established by the age of eight, with learners from poorer homes estimated to be five years behind richer counterparts.

Black children in rural areas also remain especially disadvantaged (Hall et al., 2019; Pendlebury et al., 2009). There is a maturing district health system and significant expansion of PHC facilities. A process evaluation of the new HPV vaccination programme reported good coordination and strong leadership, with 94.6% of schools reached and 86.6% of learners vaccinated (Delany-Moretlwe et al., 2018).

The 2016 DHS reports 16% of women 15-19 years have begun childbearing, which is unchanged since 1998 (DOH et al., 2016). National surveys in 2013 and 2006 recorded increasing obesity prevalence for black African boys and girls as 4.8% vs 2.1%, and 7.3% vs 4.7%; and for coloured boys and girls, 3.8% vs 3%, and 5.3% vs 4.8% (Shisana et al., 2013).

Timeline of policy and reforms on integrated school health services post-2000

Year	Policy/ law/ program/institution
1990s	<p>1994 <i>Reconstruction and Development White Paper and Programme (RDP)</i> enabled many child health and wellbeing policies focussed on redressing historical injustices</p> <p>1994 <i>Health Promoting Schools (HPS)</i> concept introduced by WHO and UNICEF</p> <p>1994 <i>Free Health Care Policy</i>. Free health services for children under 6, incrementally expanded to include free primary care, and at hospitals for children with disabilities</p> <p>1995 <i>UN Convention on the Rights of the Child</i> ratified</p> <p>1996 <i>Constitution of South Africa</i> enshrined children's rights to basic nutrition, shelter, health care and social services, basic and further education</p> <p>1996 <i>National Programme of Action for Children</i></p>
2000	<p><i>African Charter on the Rights and Welfare of the Child</i> ratified</p> <p><i>Draft national guidelines for development of Health Promoting Schools (HPS)</i></p> <p><i>Primary Health Care (PHC) package for South Africa - a set of norms and standards</i></p> <p>Sexuality education added to the Life Orientation/Life Skills curriculum</p>
2001	<p><i>National Policy Guidelines for Child and Adolescent Mental Health</i> recognised schools as social institutions in which mental health is influenced and interventions are implemented</p> <p><i>Love Life (NGO)</i> ground breakers programme youth volunteers for HIV prevention</p> <p>implementing various programmes, life skills, healthy sexuality and skills development</p> <p><i>National Policy Guidelines for Youth and Adolescent Health</i></p>
2003	<p><i>National Health Act</i> mandates provision of free primary care to all children, free provision of referral services for children under 6 years or with disabilities</p> <p><i>National School Health Policy and implementation guidelines (NSHP)</i> package of screening, referral, and health promotion services integrated with district health services</p>
2005	<p><i>Children's Act</i> mandates inter-sectoral cooperation for integrated service delivery. Children over 12 years may consent to medical treatment and receive contraceptives</p>
2008	<p><i>Care and Support for Teaching and Learning</i> DBE/SADC initiative supported by UNICEF, UNESCO and MIET to foster health and wellbeing of school-aged children, via multi-sectoral framework addressing all dimensions of school children's lives</p>
2009	<p>Zuma presidency (2009-2018) policy reform focussed on long-term planning and achievement of outcomes. Ministry of Basic Education announced.</p> <p>State of the nation address prioritised education</p> <p><i>Accelerated Schools Infrastructure Delivery Initiative</i> inappropriate structures replaced with state-of-the-art buildings and provision of basic services</p> <p><i>Expanded Programme on Immunisation (EPI-SA)</i> revised immunisation schedule</p>
2010	<p>State of the nation address calls for reinstatement of school health programmes</p>
2011	<p><i>Provincial guidelines for implementation of PHC re-engineering</i>, initially contained three streams, one of which was school health, with ward-based outreach teams and district clinical specialist teams focussed on maternal and child health</p> <p><i>DBE Action Plan to 2014: towards the realisation of schooling 2025</i> contained goals on learner wellbeing and use of the school as a site to promote access to public health</p> <p><i>National Development Plan 2030</i> prioritised Early Childhood Development to facilitate child health, and better school enrolment, retention and performance and completion</p>
2012	<p><i>Integrated School Health Policy (ISHP)</i> expanded service package inclusive of sexual and reproductive health services, phased equity-oriented delivery and integral involvement and commitment from DBE and DOH as co-signatories</p>
2015	<p><i>National Integrated Early Childhood Development Policy</i></p>
2017	<p><i>DBE National Policy on HIV, STIs and TB care in schools</i> promoted access to sexual and reproductive health services such as HIV testing and distribution of condoms.</p> <p><i>National Youth and Adolescent Health Policy</i> integrated with ISHP</p>

Sources: Bundy, 2011; CSTL and MIET AFRICA, 2011; DBE, 2011; DOH, 2002, 2009, 2017; DOH and DBE, 2012; DSD and UNICEF, 2015; Loewenson, 2013; South African Government, 1996b, 2003, 2005, 1996a

4. The story of the change

4.1 Raising the issue

This section describes the actors, processes and evidence that drew attention to school health, how these issues were framed, by whom and through which means.

In 1994, delivery of school health services varied widely across the country: *in white areas school health services were delivered effectively to all schools in the area several times each year. In the most disadvantaged areas, school health services were provided once every two or three years, or not at all* (Shung King, 2006:25).

The HPS initiative was introduced at this time. The initiative viewed schools as settings in which it was possible to pool resources, promote and protect the health of learners, staff and community members. The concept focussed on engaging with children and young people on health matters from a young age, providing children with the resources and opportunities to develop full, productive lives both in their own right and as a means to contribute to future economic productivity.

The concept resonated with policy concerns across the DOH and DOE around developing an inclusive society, in the post-apartheid period of *policy making on a grand scale* which was a critical window of opportunity at the time. HPS was further supported and informed by WHO and UNICEF (Loewenson, 2013).

Policy attention to and recognition of the HPS initiative was driven from the bottom up and intensively in the Western Cape province. The [School of Public Health at the University of the Western Cape \(UWC\)](#) ran winter and summer schools engaging nurses, educators and community mobilisers providing a platform for practice-based postgraduate training in intersectoral collaboration for community-driven solutions. The School of Public Health at UWC trained large numbers of practitioners, many of whom would go on to hold positions of influence and leadership, in health promotion and public health. In 1996, the first *National Conference on Health Promoting Schools* was held at UWC, followed by a *National Health Promoting Schools Workshop* in 1997.

Implementation of HPS was sporadic, however, and mainly driven by individual champions. In the Western Cape there was good leadership, infrastructure and resources, and HPS and school health services were well-integrated. Elsewhere, HPS and school health were in direct contestation. This was mainly due to structural arrangements.

The HPS initiative was located in the health promotion directorate of DOH, while school health services were located in the MCWH cluster, which had more of a focus on clinical service provision. As a result, HPS and school health often remained separate entities, which undermined integration and sustainability. While not ideal, sporadic implementation helped to focus attention on the issue of variable school health service delivery.

Despite the variable implementation, there was a broad acceptance of and traction with the HPS concept to improve the health and education of children in the country. Following its introduction, and responding to the variability in implementation, demand grew among national and provincial MCWH programme managers for institutionalization of the concept within a standardised service delivery, strategy and policy. Academics from the [Children's Institute](#) at UCT (established in 2001 from its predecessor, the Child Health Policy Institute) played critical roles responding to needs expressed by policy, planning and service delivery stakeholders across the country and raising, framing and advancing the issue. The processes and actors through which this occurred are described below.

In 1996, academics from the Child Health Policy Institute conducted informal assessments with provincial MCWH managers and staff in all nine provinces to ensure that the Institute's research agendas were relevant to the needs and priorities of those responsible for organising and delivering child health services.

Most provincial MCWH managers felt that ensuring standardised service delivery within the framework of a national school health policy was the most pressing need. This view was reiterated by the national MCWH programme. While the relationship between the HPS initiative and a national policy was a concern, the need for a national school health policy was: *uniformly expressed, irrespective of what the eventual relationship would be* (Shung King, 2006:26).

The following year, deputy director Dr Maylene Sung-King and researcher Eva Abrahams from the Child Health Policy Institute, together with the Child Health Unit at UCT and School of Public Health at UWC held a national roundtable on school health with representatives from the national and provincial DOH and DOE. The discussion refined priorities for service standardisation, practical guidance and integration with initiatives in education and HPS and the national MCWH programme committed to develop the policy and provincial guidelines for implementation. Academics observed the need for a national school health policy arriving onto the national agenda through the 1997 roundtable (Shung King, 2006; 2012).

In addition to engagements with provincial and district service delivery stakeholders, policy needs and gaps were brought to the academics' attention by clinicians from the Red Cross Children's Hospital, a tertiary-level hospital located close to the academic institution. Many clinicians were committed to health promotion principles and were active in child health advocacy. Fellow child health researchers and civil society groups are also reported to have raised the issue.

Involvement of NGOs in the provincial and district consultations was consistent but varied across provinces, with views, needs and participation from non-state groups happening as described above via the informal assessments. Children and parents were not involved in any explicit or deliberate way, which was seen as a gap in the process overall.

4.2 Developing the policy options

This subsection describes the various actors and processes through which policy alternatives were developed for school health services.

In 1999, academics from the Child Health Policy Institute were commissioned by DOH to organise a consultation and policy development process for a *National School Health Policy* (NSHP). The process was driven by the national DOH where the policy gap was recognised and partly located. In 2000, a national reference team was convened to develop the policy by the newly appointed national school health manager in the child-health sub-directorate of the MCWH and nutrition cluster. The task team was inclusive, with representatives from the national MCWH chief directorate, HPS, national DOE and Department of Social Development (DSD), NGOs with interests in school health and academics from the Child Health Policy Institute. The process was developed by the reference team and supported by development partners EQUITY, UNICEF and USAID.

From 2001-2003, academics from the Children's Institute prepared evidence reviews, developed service delivery model options, and held consultations in all nine provinces with stakeholders from the DOH, DOE, DSD and NGOs with interests in school health. Four policy option models were developed for participants to appraise and prioritise, within which there were two dominant policy positions in relation to vertical versus integrated school health service provision:

1. *No school health services*: school health services abolished, and school children's health needs met through routine health services. This option was not considered.
2. *Vertical school health services*: maintaining the prevailing pre-1994 model of stand-alone services, which was still being widely applied.
3. *Integrate school health services into PHC services*: services organised and delivered with other clinic activities and by the same nurse teams.
4. *Integrate school health services into DOE activities*: presented as an opportunity to develop a robust partnership between DOH and DOE. This option was omitted due to the absence of senior management input from DOE (Shung King, 2006).

In every provincial workshop, there was a high level of engagement and representation, with 40-50 participants from the DOH (different levels and sections and many school health nurses), the DOE, DSD and NGO partners. Through participatory consensus building processes, each workshop discussed how a more standardised approach to school health services could be achieved, considering school children's needs, service components, responsible groups, delivery mechanisms and relationships with HPS and DOE initiatives.

All provinces supported the idea of school health integrated into PHC versus retention of the vertical approach. This was in part a reflection of the overall direction of travel in the health system at the time, which was departing from vertical, siloed programmes to an integrated PHC system. There was some resistance to integration of school health services into PHC, generally among older school health nurses who stood to lose some control if the stand-alone programme was lost. However, the provinces generally favoured integration (Shung King, 2006, 2012).

The provincial workshop outputs were used to develop the policy in a national workshop, where the inputs were collated. This draft policy was then returned to the provinces for inputs and then taken to a final national workshop. The reference group agreed on advocacy and dialogue activities to gain commitment from decision makers. These included prompt distribution of the draft policy and engagement with the DOE, DSD, HPS and NGOs.

The researchers wrote the policy and implementation guidelines and circulated these to all nine provinces for comment. However, few responded. A costing was prepared and the policy and implementation guidelines were submitted for approval to the national DOH (Shung King, 2006). The final draft was reviewed with representatives from all nine provinces, national DOH, DOE, DSD, selected NGOs, members of the school health division and national and provincial divisions of the HPS initiative. This was described as the first real engagement of these stakeholders (Abrahams, 2001; Abrahams and Shung King, 2001).

The entire consultation took two years, and the final policy was drawn together based on inputs from over 400 actors. During the process, the Children's Institute facilitated coalitions of key policy stakeholders, advancing shared agendas (primarily in the DOH with inputs from the DOE, DSD and NGOs) and documented the process and outcomes in detail. This was an important contribution considering the absence of formal DOH policy development procedures that were often left to implicit processes and individual discretion (Shung King, 2012).

Meaningful engagement with the DOE was a challenge. While officials from the DOE participated in the provincial workshops, they were relatively junior, lacked decision-making power and withdrew from the national workshop. The lack of senior management input from and reference to the DOE was described as *a serious and unresolved point of contention* (Shung King, 2006:30). It limited the potential for collective efforts fundamental to realise the vision and potential of school health services. Indeed, at one point, the process was almost abandoned due to the Children's Institute academics' concerns over the lack of relationship between the DOH and DOE. The DOH officials were under pressure to complete the policy, however, and the process concluded with an assurance that the relationship would be developed at a later date.

There followed a long approval process. The delay was attributed to the practice in the DOH of developing operational guidelines rather than policies. While this supported provinces, it also reflected a degree of apprehension around policy-making (Shung King, 2012). The process was also described to have lacked interest and support from senior managers in the DOH. This in turn resulted in the lack of key high-level linkages with the DOE.

The process, progressed by the DOH child health directorate who recognised the policy gap, was ultimately facilitated by senior DOH officials with personal motivations (Shung King, 2006). The policy was finally approved by the National Health Council, the definitive decision-making body legislated for in the National Health Act and located in the national DOH in 2003. The policy was launched in 2004 (DOH, 2002).

The HPS initiative in the Health Promotion Directorate was meant to have developed a national policy at this time, but it had not happened. As a result, the NSHP developed in the absence of HPS as the overall initiative. Aside from financial support, development partners and NGOs did not feature highly in development of the NSHP, which was primarily shaped by operational contexts and actors in the DOH. The academics were regarded as objective technical experts, providing evidence reviews, among other roles, as part of the consultative process (Shung King, 2012). The DOE and DSD, HPS representatives and children and families had limited input. This impacted policy content and limited the potential for integration.

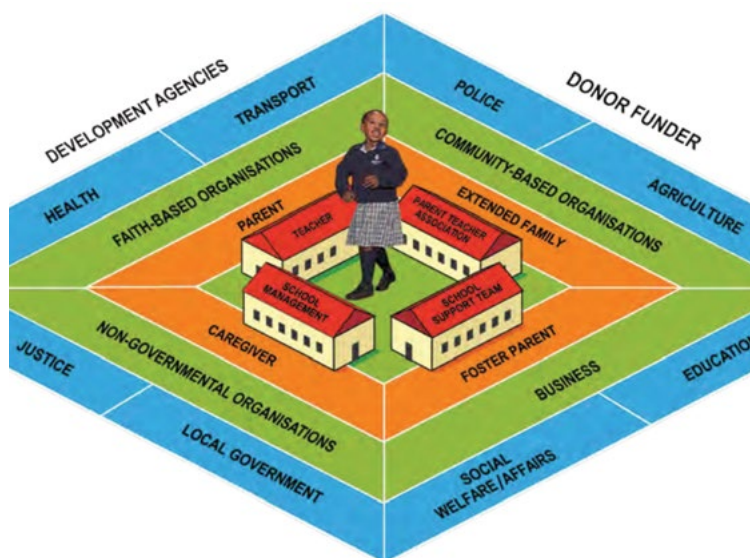
While all provinces implemented the NSHP, spurred on and supported by the Minister of Health, integration of school health services into PHC varied. Material support was limited, without allocation of additional resources by senior provincial managers and, in the absence of provincial champions, competing priorities often took precedence. Monitoring and evaluation was challenging and done differently across provinces. The relationship between the HPS initiative and school health also varied due to the lack of relationships, dedicated resources and a national HPS directive.

In 2009, evaluations revealed that despite some advances, the NSHP had failed to translate into improved outcomes. There were serious problems with: coverage (coverage of grade 1 health assessments as low as 10%); nurse to school ratios (from 1:8 to 1:357, average 1:20 to 1:30); and limited referrals following screening. This was compounded by lack of transport and human resources and an absence of intersectoral collaboration (Mohlabi et al., 2010; Shung King, 2012).

Integrating into the district health system was a significant challenge and school health services were often de-prioritised due to staff shortages and other clinic-based demands (Berry et al., 2013). The evaluations reflected systematically de-prioritised school health services, universally poor coverage, inadequate resources, and a policy that was poorly understood and largely unsupported by district health system managers. However, they also provided a basis for further policy development.

In parallel, important learning and development was happening around other policy options.

In 2006, a national conference on HPS consolidated a decade of experience and, in 2011, the *Stellenbosch Consensus Statement on HPS* was released (Macnab, 2013; Macnab et al., 2014). At the same time, senior government officials including Dr Saadhna Panday and Dr Faith Kumalo spear-headed the introduction of a health agenda in the DBE, broadening the department's mandate beyond the classroom, adopting approaches addressing all aspects of children's lives, applying an ecological perspective. This was reflected, in 2008 when the [Care and Support for Teaching and Learning \(CSTL\)](#) initiative was adopted. The strategy was adopted by the 15 member states of the Southern African Development Community (SADC), following a successful pilot in an initial five-year DBE programme (SADC Secretariat et al., 2018).



CSTL framework, SADC Secretariat et al., 2018

The CSTL initiative was developed in South Africa through a large number of organisations that worked together to develop and advocate for the approach. Media in Education Trust (MIET), a regional non-profit organisation founded in South Africa focussed on addressing barriers to learning and education, participated in the South African processes as the secretariat for the SADC initiative and advocated for the adoption by SADC.

The CSTL initiative provided a broad, multi-sectoral framework adding to the role and scope of school health, and promoting an inclusive, socially-cohesive and rights-based environment that addressed barriers to teaching and learning by strengthening education systems, especially among vulnerable and marginalised children (DBE, 2014). The CSTL initiative was taken up as a DBE initiative and supported by UNICEF, UNESCO and MIET enhancing quality of education and empowering young people (SADC Secretariat et al., 2018).

The NSHP policy development, implementation, evaluations, the consolidation of HPS and introduction of CSTL thus progressed complementary policy options to holistically focus on all aspects of learner’s lives, albeit in parallel and with different levels of implementation intensity. These developments generated momentum, engagement and learning around the necessity of relationships, primarily between the DBE and DOH, and, critically, were subsequently drawn together in a key window of opportunity, which, through the engagement and support of political actors, led to the *Integrated School Health Policy* (ISHP) in 2012. The processes through which this support was built and maintained among political actors and decision makers is described below.

4.3 Engaging and building support of political actors and decision makers

This subsection describes how and with whom the attention of political actors was engaged to support and advance integrated school health.

The main window of opportunity occurred in 2009, when Jacob Zuma came to power with a government focussed on long-term planning, achievement of outcomes, and monitoring and evaluation. There was also high-level commitment to education, which was reflected in the 2009 State of the Nation Address that prioritised education, and the 2010 State of the Nation Address that called for the reinstatement of school health programmes (South African Government, 2010). President Zuma also reorganised the DOE, announcing two new Departments: DBE and DHET.



CSTL national model South Africa. SADC Secretariat et al 2018

In this context, the DBE's recognition of the need for a holistic approach to schooling for learners, educators and the wider community crystallised and integration became a persuasive factor for policy adoption. The Minister of Basic Education, Angie Motshekga, focussed on school health in her budget speeches and called for the extension of Grade 1 health assessments in the most economically deprived schools.

As described above, the DBE had at this time extended its mandate and responsibilities beyond schools, to integrally support learners in all aspects of their lives. The CSTL initiative was an expression of this expanded mandate. Teacher unions also reaffirmed commitments to the [Quality Learning and Teaching Campaign \(QLTC\)](#) to remove barriers limiting children's potential. The QLTC aimed to build partnerships with all stakeholders, in particular, between the DBE and teacher unions, and was a holistic model that UNICEF supported (DOE, 2009).

School health was also prioritised by the new Minister of Health, Aaron Motsoaledi, who was a strong advocate of UHC and, through the introduction of NHI, drove a significant PHC revival, bolstering district health services. In 2010, the Minister and provincial Members of the Executive Council visited Brazil to learn about the *Family Health Strategy*, after which the [PHC Re-engineering Strategy](#) was developed and approved by the National Health Council. Initially, it consisted of three streams: school health, ward-based outreach teams (WBOTs) and district clinical specialist teams focussed on maternal and child health. The strategy aimed to bring services closer to people and schools were seen as an ideal location in which to achieve this (DOH, 2011).

Leveraging the favourable environment, an integrated school health policy was developed. Committed ministers in the national DOH and DBE advanced the necessary high-level inter-sectoral relationships, and codified commitments to school health in compatible reform agendas that brought together prior learning, and regional experience and advanced integration as an influential means of policy adoption. In the DOH, DBE, and to a lesser extent DSD, the ministerial mandate and administrative support enabled an integrated school health policy to be developed addressing a range of socio-economic barriers to teaching and learning.

Linked to the political adoption, the ISHP was developed to contain an increased service package including: health education, health screening, onsite services and immunisation (including HPV for Grade 4 girls) and for the first time sexual and reproductive health (SRH) services, psychosocial and mental health. School health teams, led by a professional nurse with an enrolled nurse and oral hygienist, were the main responsible group. Health promotion and education was to be provided by health promoters from WBOTs and by nurses and NGOs (DOH and DBE, 2012). Coverage was also expanded to the four main educational phases in primary and secondary school with an initial focus on schools in the most deprived areas. Equity intentions were explicit with progressive expansion planned. The school health nurse cadre was also reintroduced, and national grants made available for recruitment. In provinces where HPS existed, it was incorporated into the ISHP.

The policy thus reconciled different modalities, which ensured relevance in provinces where HPS and NSHP had been variously implemented. Administrative structures were also set up and met regularly, which helped to forge the relationships between sectors.

A policy development process was undertaken with support from UNICEF, with a focus on developing the relationship with the DBE. As described above, there was high-level input from Dr Saadhna Panday and Dr Faith Kumalo who drove the health agenda in DBE, and Dr Lesley Bamford a specialist paediatrician and academic from the DOH. Together they established and maintained intersectoral relationships.

International commitments, initiatives and evidence were also included in the policy. In 2011, the World Bank published a review with evidence from over 50 low and middle-income countries supporting the dual role of school health in the health and educational status of children (Bundy, 2011). The World Bank review indicated that school health contributes to the MDG agenda for better child health and education, as well as to the World Education Forum agenda of *Education for All*.

Several global, and national, imperatives also refocused attention on maternal and child health and the expansion of HIV testing and treatment. School health was thus seen as a credible vehicle for contributing to the achievement of broader policy goals, which further supported policy adoption.

In 2012, the [Integrated School Health Policy \(ISHP\)](#) was launched to provide a comprehensive package of health education, health promotion and essential health services as part of PHC and within the CSTL framework. The policy was jointly endorsed by the Ministers of Health and Basic Education and officially launched by the President as a priority programme in the DOH and DBE. At the launch, all major education bodies, including teacher unions, national governing bodies and principal associations supported the policy. Involvement of the DBE in implementation was seen as a means to address problems of the NSHP and the DOH and DBE were signatories. The service was described as for the first time being correctly prioritised in the DBE (CSTL) and DOH (PHC) (Shung King, 2013).

The expanded service package has been challenging. In a patriarchal and conservative environment, provision of SRH services in schools has been contentious among parents, teachers and faith-based organisations. Services such as distribution of condoms on school premises rather than education (which had been delivered through the life skills programme for many years) were perceived to encourage sexual activity. School governing bodies (SGBs) retained control over these components. While the DBE was initially opposed to SRH services in schools, UNICEF provided evidence-based advocacy convening stakeholders from civil society and academia and encouraging education officials that the time was right to move beyond health education, which had limited impacts, to make impacts on HIV.

The DBE was receptive and launched the *National Policy on HIV, STIs and TB Care in Schools* in 2017, providing clarity on the provision of comprehensive SRH services as a core component of the ISHP (Bamford, 2018; DBE, 2017). While this was a critical high-level shift to support and advance integrated school health, the SRH package nevertheless continues to require social mobilisation and advocacy with school communities, SGBs, parents and school management. Implementing partners ([UNICEF South Africa, Love Life](#)) and national campaigns such as *She Conquers* support a project-based approach to the delivery of these services. While sustainability and standard provision remains an issue, NGOs provide important support in piloting and implementing these components.

A national ISHP task team was established to maintain support and facilitate implementation with the DOH, DBE, DSD and development partners, including UNICEF. The task team defined roles and responsibilities, delineating the DBE as providing the enabling environment, structure and platform and the DOH providing services, with a coordinating mechanism through school-based support teams.

The DOH worked with UNICEF to develop a training programme for school health nurses, inclusive of values clarification on SRH. This training was extended to directors and ISHP coordinators. Provincial and district ISHP task teams were also established to provide co-ordination and implementation mechanisms, and the service package helped to ensure role clarity, as did recording and reporting tools.

Development partners have supported and sustained implementation. [Save the Children South Africa](#) funded through [DFID](#) supported implementation via the *Reducing Maternal and Child Mortality through Strengthening Primary Health Care* (RMCH) programme, which supported task teams in 24 districts. More recently, the [Deutsche Gesellschaft für Internationale Zusammenarbeit \(GIZ\) GmbH German Development Agency](#) have further enabled district task teams to strengthen ISHP implementation in the Eastern Cape through the *Multisectoral HIV Prevention* programme (MHIVP).

➤ The main implementation focus of the ISHP has been coverage and monitoring. To some extent, school health teams focus on the most disadvantaged schools, however, coverage is often limited by resources and a limited time in which it is possible to deliver services. This encourages school health teams to target more accessible schools (Bamford, 2017; Rasesemola et al., 2019). For the first time, however, teachers were involved in the deworming campaign in the first round of HPV immunisation in 2016 (Bamford, 2016). Designated funding remains a challenge.

While specific aspects are directly funded, such as for HPV and deworming, school health funding is considered as part of the 'equitable share'. This is an unconditional allocation of nationally-raised revenue to enable provision of allocated services and functions in provinces and motivating for resources is critical. While data indicate that 30% of Grade 1s and 22% of Grade 8s are screened, there have not been any formal evaluations of the policy to date, and wide provincial variations are observed (Bamford, 2018). Tracking referrals and outcomes through the school information system is a priority for future development and to sustain support, as is integrated planning, monitoring and evaluation and for referral services to respond to the expanded service package.



PREVENT CERVICAL CANCER

The government is introducing
HPV* vaccination for girls in Grade 4



Date of **1ST DOSE**

March 2014

Date of **2ND DOSE**

October 2014

Remember to ask your parents/caregiver/guardian to sign
 and return the consent form to be vaccinated.

Protecting young girls, future women of South Africa



Basic Education
 Health

* Human Papillomavirus

5. Summary of and learning on key drivers of the policy change

5.1 Summary of key drivers and processes fostering policy change

Integrated school health, combining health, educational and social services to ensure the physical, mental and social well-being of learners has gained extraordinary recognition and support in South Africa. Drivers and processes relate to government officials and practitioners bringing attention to policy gaps and raising the need for school health initiatives within government frameworks.

In addition, committed academics facilitated a participatory, evidence-based policy development process that supported school health as an integral part of PHC. In parallel, international and regional organisations developed learning and holistic frameworks prompting cross-sectoral working and further enriched domestic learning and evaluations. The main window of opportunity occurred in 2009, when a new administration with health and education ministers committed to school health provided key leverage point to bring these elements together in the ISHP in 2012. These are summarised below.

The post-apartheid reconstruction and development period was a critical window of opportunity in which radical advances were made for equity oriented redistributive child health policies. The HPS initiative was introduced at this time with WHO and UNICEF supporting schools to develop as healthy settings for living, learning and working. The initiative was supported and institutionalized albeit with substantial variability. As a result, consensus grew among MCWH practitioners, planners and managers that national policy and strategy for standardised school health services was a pressing need. The resulting NSHP policy development process was led by the national MCWH directorate and driven by health system priorities.

A reference team including representatives from the national MCWH and health promotion programme was convened, and academics were commissioned to conduct consultative workshops, and to write and cost the policy, and produce implementation guidelines. While many policies were engaging communities and children at this time, the NSHP development is not reported to have done so, which is seen as gap in the process.

Acknowledging that research was rarely used in policy, academics from the Children's Institute engaged in evidence-based advocacy and policy development. The academics had significant responsibility, providing evidence reviews, facilitating consultative workshops, and writing and finalising the policy. Dr Maylene Shung King documented the relevant processes, actors and outcomes in detail over many years.

This was an important contribution in a policy context with little formal structure and process. The NSHP was adopted in 2003 albeit without formal connection to HPS, with minimal involvement of the DOE, NGOs, children and families and with a relatively narrow service package. The policy, however, promoted integration in the new district health system, through which school health services were to be delivered as part of core services.

While important advances were made with the NSHP, evaluations revealed serious problems with coverage, equitable distribution of services and personnel, and referral. At the same time, senior officials in the DBE were broadening the department's mandate beyond the classroom, adopting approaches addressing all aspects of children's lives informed by an ecological perspective. The SADC regional CSTL initiative, which was developed and piloted in South Africa, was adopted by the DBE, expanding the scope of school health and providing an intersectoral framework for addressing all dimensions of schoolchildren's lives.

School health received renewed, high-level support in PHC reforms focussed on maternal and child health. The HPS experience was also consolidated, and a major review of school health brought international evidence and attention as did international initiatives such as the MDGs and Education for All.

Coupled with the main window of opportunity in 2009 (described above), there was a high-level political commitment and advancement of the school health agenda by the Ministers of Health and Education and presidential recognition of school health as a national priority programme.

The main premise of the ISHP was collaboration between the national DOH, DBE and of DSD (DOH and DBE, 2012). Technically, the 'fit' between the goals of education (CSTL) and health (PHC re-engineering), enabled a holistic, ecological view, with education providing an enabling environment, structure and platform and health providing services.

A strong operational focus and a willingness to collaborate among those at operational levels were further key enablers. The ISHP had integration and partnership between the DOH, DBE and DSD at its core. Prior to this, policies and programmes had been implemented and evaluated without coordination and prioritisation.

5.2 Learning and insights on changing mindsets and norms

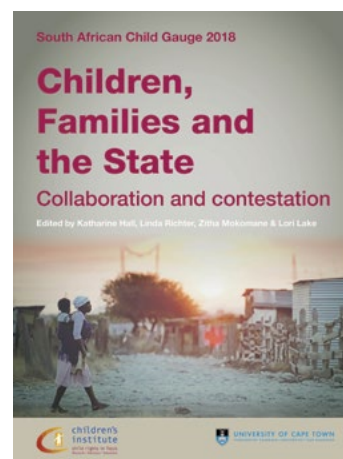
This section presents learning and insights that may be shared or adapted for those involved in promoting policy recognition and change in FCHW.

In raising and keeping the issue on the policy and political agenda: The initial issues were the situations and needs of children post-apartheid, the variable implementation of the HPS initiative, and the lack of standardised school health services, strategy and policy. Provincial MCWH managers and staff with voice and agency raised these issues with a well-respected academic group, convening coalitions of practitioners, planners, managers and other stakeholders.

Committed and influential academic groups and government departments and officials at national and provincial levels engaged meaningfully in collaboration to raise issues (and develop policy options). Over time, these were to be located within an increasingly receptive policy environment.

The status, understanding of and demand for change in children's situations was thus raised across different policy actors and constituencies: research and academia, policy, management and practice, and regionally and internationally. Through these processes and actors, high-level officials in government departments were able to recognise and respond to the need for more holistic, integrated approaches. School health was also seen as well-positioned to advance progress towards common goals, with important steps taken towards a public health approach, addressing barriers to learning to improve learners' health generally.

For the development and adoption of policy options: Policies and programmes concerning child wellbeing require coordination between different levels and sectors. A robust policy development process was enabled by a well-organised DOH that is well-connected to thought leaders. The Children's Institute at UCT and the School of Public Health at UWC are established and respected academic groups who are serious about sustained contributions to evidence-based policy. The Children's Institute produces and disseminates a range of materials and policy development procedures (including since 2005 the annual [Child Gauge](#) on child health and rights, legislation, and data, also provided as a separate resource [Children Count](#)).



Thirteenth South African Child Gauge, Hall et al, 2018.

Practitioners and academics also meaningfully engaged over time through postgraduate education and training. These processes built the ground work after which substantive policy shifts took place.

The 2003 NSHP was a DOH initiative. This was seen as a missed opportunity for collective efforts among the DOH, DBE and DSD, fundamental to realise the vision and potential of school health. While the ISHP has significantly expanded the service package, evidence points to fewer, more focussed and contextually-relevant interventions to enable impacts.

To enable development and delivery of a targeted service package, shared understandings of cross-departmental roles and responsibilities, and a practical policy focussed on implementation and cross-sectoral collaboration were, are and will be, important. International and regional initiatives were also relevant.

The CSTL initiative, through the focus on nutritional and psychosocial support, infrastructure, water and sanitation and health promotion throughout the education system provided an integrated platform through which the ISHP aligned with cross-sectoral governmental initiatives for child health and wellbeing: *[we] needed to create a common framework where everybody could find themselves.*

In building political and public support and sustaining implementation: School health requires sophisticated and sustained engagement and relationships. Expecting mid-level managers to develop and maintain these alliances may be unrealistic.

Ultimately, it was high-level political commitment and a new administration in 2009 that was the key leverage point, enabling the favourable policy environment espousing commitments to collective responsibility for school health. The new Minister of Health in 2009 advanced school health as part of wider health reforms and recognised the potential of school health to progress wider goals around the MDGs. The Minister of Basic Education was also driving a broader scope in education, with commitments to a holistic, ecological perspective of child wellbeing.

The ISHP was enabled through endorsement of high-level relationships. While reforms were initiated at the national level, provincial officials were always involved, which promoted collective ownership and relevant policy content. There was also learning from implementation of the NSHP and has been more focussed and vertically resourced (i.e. resourced on a thematic or activity basis) in some components, while being managed in an integrated way.

The WHO and UNICEF were key development partners. More recently Save the Children, DFID, GIZ, Love Life and She Conquers have supported implementation. The Children's Institute used well-developed and sensitive evidence-based advocacy to integrate school health services into PHC. UNICEF and DBE advocated for SRH services in schools. These helped to change mindsets and support implementation.

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Endnotes

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- 2 See Loewenson and Masotya (2018) for information on the conceptual and analytic framework used.