



# Healthy Active Kids South Africa

South Africa's Report Card on Physical Activity for Children & Youth

# 2007



# South Africa's overall health grade for children in 2007: C-

## Introduction

South Africa has made great strides in human development since its transition to democracy. Children and youth are the country's greatest resource in meeting current and future health challenges. These include high rates of cardiovascular disease, such as heart attacks and strokes, diabetes, cancer, early death due to accident and injury, as well as infectious diseases. Over half of deaths, worldwide, are caused by chronic diseases, and together, they explain nearly 40% of deaths in South Africa.

We recognize at least four major factors – determined by both social context and individual behaviour - that place young people at risk: tobacco use, poor diet, lack of physical activity, and overweight. A great opportunity exists to provide young people with a better understanding of the impact of their current behaviour on their future health. Simultaneously, opportunities exist to improve the social context within which behavioural choices are made.

This report card, modeled on a similar initiative, Active Healthy Kids Canada, serves as a “stock take” of the available evidence concerning the behaviours, factors and their determinants that place our children and youth at risk. It also reviews existing health promotion initiatives that may have an impact on these risk factors and behaviours. Initiatives include health education, school curriculum, and responsible health legislation .

Our “Healthy Active Kids South Africa” Report Card provides an overview of the current state of health behaviours and their determinants that place children and youth at risk for disease, disability and early death. It brings attention to areas in which we are succeeding as a nation and those which may require more action.

## Making the grade

The panel set specific criteria on which to base their “marking” or grades. “Reach” refers to the extent to which the practice is accessible to all or most South African children; “Impact” describes the effectiveness of the practice, intervention or legislation; “Adoption” refers to the extent to which the practice or intervention is implemented. These are explained briefly below.

A (80-100%)	Denotes the best practice to promote health and prevent chronic disease and/or in multiple settings with excellent reach and/or impact. Reflects those at lowest risk for future disease.
B (70-79%)	Best practice to promote health and prevent chronic disease with limited or unequal reach and/or impact/adoption. Reflects those at relatively lower risk for future disease.
C (60-69%)	Acceptable practice with potentially broad reach, but with limited adoption and impact. Reflects those at average risk for future disease.
D (50-59%)	Practice which is insufficient to adequately promote health and prevent chronic disease due to unequal reach or adoption and impact. Reflects those at higher risk for future disease.
F (<50%)	Either where no interventions, infrastructure or practices exist OR where these have been shown to be ineffective. Reflects those at greatest risk for future disease.
NE	Promising initiatives but for which there is no evaluation.

## Report card development, scientific advisory panel and data sources

The grade assignments are based on the analyses of the most recently available data sources (within past 8 yrs). These sources were either already in the public domain, and were peer-reviewed and published, or had been presented in a peer-reviewed forum. Some data are as yet, unpublished, but drawn from studies, the design of which have been peer-reviewed. Sources included: South African National Youth Risk Behaviour Survey (YRBS), National Food Consumption Survey (NFCS), Discovery Vitality Healthy of Nation Survey (HON), National Demographic and Health Survey, Birth-to-Twenty and THUSA BANA studies, Western Cape School Fitness and Health Survey, SRSA's Participation Patterns in Sport and Recreation Activities.

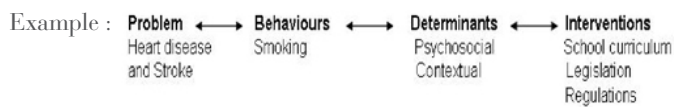
The scientific advisory panel is comprised largely of academics who have been directly or indirectly responsible for much of the data on which this report card is based and include: Prof. Priscilla Reddy (MRC Health Promotion Research and Development Unit), Prof. Yoga Coopoo, (Exercise Science and Sports Medicine, Wits), Dr. Shane Norris (Dept of Paediatrics, Wits), Prof. Thandi Puoane (School of Public Health, UWC) Prof. Salome Kruger (School of Physiology and Nutrition, NW University), Profs. Michael Lambert, Vicki Lambert and Dr. Tracy Kolbe-Alexander (Exercise Science and Sports Medicine, UCT), Dr. Nelia Steyn (MRC Chronic Diseases of Lifestyle Research Unit), Ms. Kathy McQuaide (Health Promotions, Sport Science Institute of South Africa).

Detailed information regarding primary data sources and the Report Card development will be posted on: [www.ssisa.com](http://www.ssisa.com)



## Health Promotion Model

The Healthy Active Kids South Africa Report Card uses the Health Promotion Model as a yardstick for meeting the challenges to prevent chronic diseases in the future. The model enables government, NGO's and other stakeholders to participate in helping young people by identifying the problems, behaviours and determinants that place them at risk for future disease; and through the development of best practice interventions. For this purpose, interventions have been grouped into a few major categories i.e. health education interventions such as curriculum within the life orientation programme, legislative interventions, social mobilisation interventions, and economic interventions. This model implies planning and ongoing evaluation.



## Risk factors, behaviours & determinants:

### Tobacco using behaviour:

#### Grade: D

South African adolescents have the highest reported smoking prevalence amongst African health surveys. Amongst these youth, 30% report ever having smoked a cigarette in their lifetime, 21% are current smokers (smoked cigarettes on one or more days in the past month), nearly 7% are frequent smokers (on 20 or more days in a month), and 6% had smoked their first cigarette before the age of 10 years. Of the current smokers, 47% had tried to stop smoking within the past year. Smokeless tobacco use within the previous month was also reported by 11% of learners.

### Physical inactivity levels:

#### Grade: C-

Physical fitness in South African urban youth appears to be on the decline, and recent studies suggest that about 40% of children and youth are getting little or no moderate to vigorous activity each week. Vulnerable groups for inactivity are girls, 16-19 year olds, and children from disadvantaged communities. There is a clear lack of a physical activity and sports participation culture in adolescents, with more than 1 in 4 indicating little or no interest. In fact, one of the most commonly reported leisure time activities in a recent survey is cell phone use. However, in terms of human-powered transport, more than twice the number learners from disadvantaged communities actively commute to school (as many as 87%), compared to those from advantaged settings. There is need for greater monitoring of physical activity, especially in rural settings, where there are little available data.

Estimates of screen time and inactivity in South Africa suggest that 25% of adolescents watch more than 3 hours of television per day. However, average time in sedentary activities has been reported to be as high as 9 hours per day. Even in smaller towns and rural areas, up to 64% of girls and 45% of boys report little or no moderate or vigorous activity.

Despite the fact that relatively few South African have access to private motor vehicles, the public transportation system is poorly developed and regulated, with road accidents in pedestrians contributing to nearly half of all road deaths in this country.

Personal safety and high levels of crime remain barriers to "walkability" in communities.

### Overweight, Obesity and stunting:

#### Grade: C for obesity, and D- for stunting

South Africa is a country of paradox, where obesity in our children co-exists with stunting and early nutritional deprivation. For example, more than 30% of adolescent girls, and nearly 10% of boys are either overweight or obese. The pattern is much the same for primary school children with 22% of girls and 17% of boys being overweight or obese. In a combined sample children under the age of 9 yrs, 17% were overweight or obese, and in this same group of children, stunting was present in 19%. Children in rural areas are at risk for stunting, whereas those from urban settings may be at greater risk for obesity. However, the risk of obesity in stunted children is nearly two-fold higher, with potentially long term negative health consequences.

### Unhealthy eating:

#### Grade: D

South African children and youth are not eating enough fruits and vegetables. For example, only 58% of youth report consuming fresh fruit and vegetables on 4 or more days per week. By way of comparison, 27% have cool drinks and sweets, and 47% eat cakes and biscuits with the same regularity. Urban primary school learners reported eating fruit or vegetables less than 3 times per week. And of these, only fruit juice was reported to be consumed more than 3 times per week. In these same children sugar was the most frequently reported food item, eaten almost daily. In some instances, lower fruit and vegetable intake were linked to increased risk for obesity.

Healthy eating is negatively impacted on by pricing issues (less healthy alternatives may be less costly, for example, cuts of meat), access and availability and knowledge. Food labeling and advertising legislation which might address some of these issues is still under development, and has not yet been implemented.

### School tuck shops, vendors and feeding schemes

#### Grade: D

Most children are able to identify healthy snacks. However, they are twice as likely to bring unhealthy foods from home, and 70% of children also make unhealthy choices when buying from the tuck shop. Chips, cheese curls, sweets, fried cakes and fizzy cool drinks are the most commonly bought snacks at the school tuck shops, with sandwiches at the bottom of the list. One in 4 learners in a regional survey reported not having breakfast, however, the national school feeding scheme is widely implemented, particularly in the most disadvantaged areas.

Of concern is that many schools rely on income generated from these tuck shops for additional funding. Informal vendors are also very common, and typically sell foods of low nutritional value, high in fats and sugars such as: fat cakes, and chips and sweets. Schools also commonly display commercial advertising for products such as cool drinks and chips.

## Areas for Action and interventions:

The following areas for action and interventions were considered in the South African context: legislation, curriculum, economic interventions and social mobilization.



## Tobacco prevention interventions :

### Legislation

#### Grade: A

South Africa was the first country in the world to declare nicotine an addictive drug by the Education Ministry. The Tobacco Products Control Act of 1993 and subsequent amendments include a ban on advertising of tobacco products, health warnings on packs of cigarettes, a ban on sales to minors, banning of smoking in public spaces, worksites, and in the presence of children under the age 18 yrs. Further, there are amendments dealing with quality control of tobacco containing products, to minimize risk, and provision for assistance for smokers to quit. South Africa has far reaching and effective legislation for tobacco control.

### Economic

#### Grade: B

Tobacco has been subject to taxation and price controls since 1994. Tobacco consumption has declined 25% in that period. Smoking legislation, the social mobilization of society, the banning of advertisement, and the creation of a smoke-free social norm in South Africa addresses many of the environmental determinants of smoking in children.

### Health education school curriculum:

#### Grade: NE

An innovative tobacco curriculum for schools has been developed and is currently under evaluation in 36 schools in conjunction with Departments of Health and Education and the MRC, directly in response to the government legislation. This curriculum includes a training module for teachers.

### Promotion of Physical Activity:

### Legislation: Sport and Education:

#### Grade: B (NE)

In 2005, a framework document for collaboration was created between the Departments of Sport and Recreation and Education. It highlighted the following factors which were impeding progress in the transformation of sport and recreation in South Africa: disenfranchised communities, including women and girls, rural communities, youth and people with disabilities, a lack of appropriate, safe and secure facilities and improvement to existing facilities, the lack of participation in physical education by educators and learners, the need for provision and capacity of educators and financial resources. The intention going forward is to formalise government's responsibility for physical education and to use school sport as a vehicle to entrench acceptable values among young people, to ensure and increase access to and accessibility of safe and secure facilities, to ensure human movement and physical education is provided as part of the school curriculum, to facilitate the integration of human movement and physical education to address the supply and demand of qualified personnel. The extent to which these objectives are being implemented is not reported.

### Physical education classes within Life Orientation:

#### Grade: D

Just over half of high school learners report that physical education is on their school time table on 1 or more days of the week. However, of those, less than 60% in total engage in vigorous activity during formal physical education classes, and in fact, over 30% do not do any physical activity during these classes. In primary school learners, engagement in physical education classes is even lower than in

high school. Further, there are clear differences in these offerings, at least in primary schools, between advantaged and resource-poor settings.

### Training of physical education teachers and coaches:

#### Grade: C-

There is a decline in the numbers of specialist physical education teachers being trained by tertiary institutions. Further, there are limited accredited regional or national coaching programmes. However, there are examples of sports federations which are implementing structured, community-based coaching initiatives.

### Social mobilisation: School & club sport participation

#### Grade: D

Lack of equity is present not only in terms of school physical education classes, but in school and club sports participation. More than twice as many learners from advantaged communities participate in school sports, compared to those from under-resourced settings. Only 6% of disadvantaged learners participate in two or more school sports vs 16% in the more affluent groups. However, in club sport, these differences are not as marked, particularly for boys. In some cases, boys from disadvantaged communities are even more actively engaged in sport outside of school. Factors which are implicated in low levels of participation in school sport have been lack of developed space and access to facilities and lack of school 'champions' or coaches to promote sports participation.

### Promotion of healthy eating; prevention of obesity and stunting

### Legislation: National School Nutrition Programme:

#### Grade: B

The National School Nutrition Programme is a poverty alleviation strategy introduced in 1994 by government. Now under the joint auspices of Departments of Health and Education, the programme seeks to contribute to the improvement of the quality of education by enhancing primary learners' capacities and school attendance through the temporary alleviation of hunger, to improve knowledge regarding nutrition in learners, teachers and parents, and to contribute to other areas of economic empowerment. This programme is being widely implemented throughout SA, but in some areas there are still problems with service delivery and logistics.

### Health education- Nutrition education training of Life Orientation teachers and learners:

#### Grade: C-

Nutrition is included in the training of teachers in Grades 1-3 and is integrated in Life Skills learning areas. It is also integrated in various learning areas for the Intermediary phase. Training in Nutrition is good for primary school, but very limited for high school teachers

In Life Orientation for Grade 10-12, there are 4 learning outcomes of which one is Recreation and physical wellbeing. Learners are encouraged to engage in personal physical activity and fitness programmes. Nutrition is, however, mentioned only in the Grade 11 curriculum, in which the learner should be able to apply their knowledge on the role of nutrition in fitness and health. There is a need to monitor the extent to which nutrition and physical activity are implemented within the Life Orientation curriculum across the country.



## Recommendations and areas for action

In summary, South African children and youth are at increased risk for chronic diseases later in life, mainly due to poor education of themselves and their parents, leaving them ill-equipped to make healthy choices; as well as poverty and deprivation that create the structural and environmental determinants that lead to chronic disease. These include inequitable access to good food, sport and recreational facilities, and health information. However, South Africa has promising and far-reaching legislation in place, which largely requires accompanying infrastructure and input from civil society. There is a need to create a culture of healthy lifestyles in our children and youth, through education, and by changing the social norms. This can only be achieved through the integration of the legislative mandate, with interventions targeting environments, schools and communities, parents and the youth, themselves. This will require planning of health promotive programmes by government, the private sector and communities. Such planning in turn requires data on which to base decision-making.

### Our specific, short-term recommendations include:

- **Ongoing surveillance and monitoring of behaviours and determinants of healthy/unhealthy lifestyle behaviours;** Within this recommendation, there is a need for to engage with adolescents, parents and teachers to explore knowledge, attitudes and practices, prior to the development of interventions.
- **Development and evaluation of promising interventions focused on barriers and determinants to healthy eating, physical activity, and tobacco control;** This recommendation includes approaches both within school curriculum, and external to the school environment, through media, NGO's and other sectors. Further, these interventions should aim to specifically target those vulnerable groups. Examples of integrated strategies for physical activity may include the appointment of "Sport Coaches" to a cluster of schools rather than one school, the affiliation of schools with various sporting codes, and the government's national programme for mass participation, and specifically, the upgrading of sports facilities, particularly in rural areas, or structured "sharing" of sports facilities between schools or between schools and communities. Further, promising "open school" initiatives are being practiced successfully around the world in similarly disadvantaged settings.
- **Development and implementation of interventions to combat stunting:** There is a need to recognize that the prevention of chronic disease requires a life-course approach ("womb to tomb") and that early life undernutrition may increase the susceptibility of our children to later life risk.
- **Ensuring that the promising legislative initiatives are implemented "on the ground" in a meaningful way, by ongoing monitoring.**

