Republic of Zambia

# Ministry of General Education

# Guidelines for the Implementation of the School Health and Nutrition Programme

**TABLE OF CONTENTS**

FOREWORD ..... i
ACKNOWLEDGEMENT ..... ii
LIST OF ACRONYMS AND ABBREVIATIONS ..... iii
1 INTRODUCTION ..... 1
1.1 RATIONALE ..... 1
1.2 VISION AND POLICY OBJECTIVES OF THE SHN PROGRAMME ..... 2
1.3 INTENDED USERS ..... 2
1.4 INTENDED BENEFICIARIES ..... 2
1.5 SHN SERVICE PROVIDERS ..... 3
1.6 ROLES AND RESPONSIBILITIES OF KEY STAKEHOLDERS ..... 3
1.7 SCHOOL HEALTH AND NUTRITION COMMITTEES ..... 6
1.8 ACTION PLAN ..... 6
1.9 RESOURCE MOBILIZATION ..... 6
1.10 ACCREDITATION ..... 6
1.11 HOW TO USE THE GUIDE ..... 6
2 BACKGROUND ..... 7
3 SITUATION ANALYSIS ..... 8
3.1 NUTRITION ..... 9
3.2 SEXUAL AND REPRODUCTIVE HEALTH ..... 9
3.3 HIV AND AIDS ..... 10
3.4 ENVIRONMENTAL HEALTH ..... 10
3.5 LOCAL SITUATIONAL ANALYSIS ..... 10
4 SCHOOL HEALTH AND NUTRITION ACTIVITIES ..... 11
4.1 SCHOOL HEALTH SERVICES ..... 11
4.1.1 HEALTH PROMOTION ..... 11
4.1.2 SEXUAL AND REPRODUCTIVE HEALTH ISSUES ..... 12
4.1.3 VACCINATIONS ..... 12
4.1.4 ASSESSMENT, TREATMENT AND REFERRALS ..... 13
4.1.5 COMMUNICABLE DISEASES ..... 13
4.1.6 NON-COMMUNICABLE DISEASES ..... 16
4.2 NUTRITION ..... 18
4.2.1 HEALTH AND NUTRITION EDUCATION ..... 18
4.2.2 MICRONUTRIENT SUPPLEMENTATION AND DE-WORMING ..... 19
4.2.3 HOME GROWN SCHOOL MEALS (HGSM) PROGRAMME ..... 19

4.2.4 GROWTH MONITORING AND PROMOTION (GMP) ..... 19
4.2.5 HEALTHY EATING, ENVIRONMENT AND HABITS ..... 20
4.3 AGRICULTURE ..... 20
4.3.1 SCHOOL MODEL GARDENS ..... 20
4.4 WATER SUPPLY, SANITATION AND HYGIENE (WASH) AND ENVIRONMENT ..... 21
4.4.1 WATER SUPPLY ..... 21
4.4.2 SANITATION ..... 22
4.4.3 PERSONAL HYGIENE ..... 22
4.4.4 ENVIRONMENTAL HEALTH ..... 23
4.5 OTHER ..... 23
4.5.1 LIFE SKILLS ..... 23
4.5.2 ENSURING SAFE SCHOOL ENVIRONMENT ..... 23
4.5.3 LEARNING DISABILITIES ..... 25
4.5.4 PHYSICAL DISABILITIES ..... 26
4.5.5 GUIDANCE AND COUNSELLING SERVICES ..... 26
4.5.6 BULLYING AND HARASSMENT ..... 27
4.5.7 DISTANCES TO SCHOOL ..... 27
5 MONITORING AND EVALUATION ..... 28
5.1 STANDARD MONITORING AND EVALUATION TOOLS ..... 28
5.2 SCHOOL HEALTH RECORD ..... 29
6 TECHNICAL TERMS ..... 30
7 BIBLIOGRAPHY ..... 32
APPENDIX A: MONITORING AND EVALUATION FRAMEWORK ..... 34

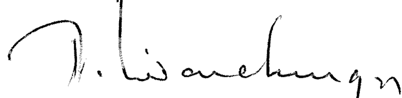
**FOREWORD**

The School Health and Nutrition (SHN) guidelines have been developed to strengthen the implementation of SHN programmes. The guidelines are aimed at promoting the provision of quality and effective health and nutrition services to all learners in order to improve learning and its outcomes. SHN interventions include the provision of essential health, nutrition, and education services designed to create an optimal environment for good health and education.

These guidelines are developed to help education providers and other stakeholders to understand and use the SHN strategies to address and promote the health and nutrition status of learners. The SHN package has potential to improve learners' health and nutrition status, cognitive development and learning potential, and to reduce illness-related absenteeism.

We believe that if learners learn and practice good health and nutrition habits, and develop caring attitudes, they will be able to disseminate health and nutrition information to their communities and to future generations.

These guidelines were developed through wide consultations with stakeholders involved in the implementation of School Health and Nutrition services. The guidelines clearly define the activities which need to be implemented under the SHN programme. It is important that these guidelines are followed by teachers, learners, communities and other stakeholders so that schools become models of health and nutrition promotion.



Hon. Dr. Dennis M. Wanchinga, MP
**MINISTER OF GENERAL EDUCATION**

**ACKNOWLEDGEMENT**

The Ministry wishes to express its profound gratitude to the individuals and organizations who contributed to the development of these important School Health and Nutrition (SHN) guidelines. Firstly, sincere gratitude goes to Healthy Learners for their technical and financial support and to top management of the Ministry of General Education for their guidance and commitment.

The development of this document saw the involvement of all relevant partners including all the Directorates at the Ministry of General Education resulting in a broad-based approach.

Lastly, special thanks go to the following Ministries, institutions, organizations and individuals for participating in the development of this document: Ministry of Health, National Food and Nutrition Commission, Drug Enforcement Commission, Ministry of Community Development and Social Services, Road Transport and Safety Agency, Ministry of Agriculture, Ministry of Fisheries and Livestock, Ministry of Local Government, Ministry of Water Development, Sanitation and Environmental Protection and the cooperating partners, particularly UNICEF, World Food Programme and Healthy Learners.

Dr. Jabbin Mulwanda
Permanent Secretary - Administration
**MINISTRY OF GENERAL EDUCATION**

## LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| BMI | Body Mass Index |
| CSO | Central Statistics Office |
| DEBS | District Education Board Secretary |
| DEC | Drug Enforcement Commission |
| DHO | District Health Office |
| ECD | Early Childhood Development |
| ECE | Early Childhood Education |
| EHT | Environmental Health Technologist |
| GMP | Growth Monitoring and Promotion |
| HIV | Human Immunodeficiency Virus |
| HL | Healthy Learners |
| HPV | Human Papilloma Virus |
| IEC | Information Education Communication |
| ITN | Insecticide Treated Net |
| IYCF | Infant and Young Child Feeding |
| MCP | Multiple and Concurrent Partners |
| MHM | Menstrual Hygiene Management |
| MOGE | Ministry of General Education |
| MOH | Ministry of Health |
| MOT | Modes of Transmission |
| MUAC | Mid Upper Arm Circumference |
| NGO | Non-Governmental Organisation |
| PPE | Personal Protective Equipment |
| PTC | Parent Teacher Committee |
| SDGs | Sustainable Development Goals |
| SHN | School Health and Nutrition |
| SRGBV | School Related Gender Based Violence |
| STI | Sexually Transmitted Infection |
| SUN | Scaling Up Nutrition |
| TT | Tetanus |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| USAID | United States Aid for International Development |
| WFP | World Food Programme |
| WHO | World Health Organisation |
| ZDHS | Zambia Demographic and Health Survey |

# 1 INTRODUCTION

The policy of the Ministry of General Education, "Educating Our Future", recognises that good health and nutrition are essential pre-requisites for effective learning. Studies have shown that integrated health and nutrition interventions in schools enhances both educational and health outcomes of learners, which can improve the long-term earning potential and livelihoods (Bundy et al., 2017).

In 2006, the Government of the Republic of Zambia launched the SHN Policy, which serves as the genesis for this document. The general objective of the School Health and Nutrition (SHN) programme is to strengthen and standardize the provision of equitable services in learning institutions through integrated health and nutrition interventions, in collaboration with the community and partners.

## 1.1 RATIONALE

The education system strives to ensure that all learners access quality education. Ensuring that learners are healthy is an essential component of an effective education system.

According to WHO, UNESCO, UNICEF and the World Bank (2000), good health and nutrition are not only essential inputs, but also important outcomes of high-quality education. Firstly, learners must be healthy and well-nourished to fully participate in and gain from education. Therefore, schools can enhance learning and educational outcomes by improving learner health and nutrition. Secondly, good quality education can lead to better health and nutrition outcomes for learners. Thirdly, maternal education is strongly linked to reduced stunting and improved health among children (Makoka & Masibo, 2015; Semba, et al., 2008). Finally, a healthy, safe and secure school environment can help protect learners from hazards.

The education sector plays an important role in improving the basic and underlying causes of poor health, as schools are a platform for reaching children with health and nutrition interventions. Poor health and chronic under-nutrition are associated with delayed school entry, early school termination, poor school performance, and reduced work capacity (USAID, 2014). This undermines the potential of the future adult populations, as higher educational attainment, improved adult health outcomes, and higher economic attainment are strongly interdependent (Bundy et al., 2017).

The Ministry of General Education strives to put in place a school-based health and nutrition programme that will address the health and nutrition concerns of learners. This is necessary to sustain the "Education for All" initiative and to achieve the Sustainable Development Goals (SDGs). In this way, the education sector's investment in school health and nutrition services can lead to increased rates of enrolment, retention and progression, reduced absenteeism, repetition and drop out, as well as improved health and nutrition related outcomes.

Thus, these guidelines are designed to help all implementers understand and use the SHN strategies. In doing so, this will help to establish, guide and implement the activities of the SHN programme.

## 1.2 VISION AND POLICY OBJECTIVES OF THE SHN PROGRAMME

The **vision** of the SHN programme is to promote and provide high quality, cost-effective health and nutrition services to all learners in order to improve learning.

The **objectives** of the SHN programme are to:

I. Improve learners' access to and utilization of health services;
II. Promote and improve nutrition status of learners to enhance and sustain their physical, social and mental well-being;
III. Promote and maintain the health status of learners through the initiation of effective health promoting activities;
IV. Improve collaboration among line Ministries in planning and implementation of SHN interventions;
V. Strengthening school and community-based health and nutrition activities;
VI. Provide health and nutrition education and promotion activities at all levels of the education system;
VII. Promote and sustain a safe and healthy learning environment; and
VIII. Ensure capacity building among stakeholders on the implementation of the SHN programme.

## 1.3 INTENDED USERS

The School Health and Nutrition interventions require a multi-sectoral approach encompassing different Ministries at the national, provincial, district and sub-district levels. The key line Ministries of health, education, community development and social services, agriculture, fisheries and livestock, local government, water development, sanitation and environmental protection, and other stakeholders, play an important role in the implementation of the SHN programme. The province shall provide technical support, while the district is responsible for overseeing implementation of the guidelines. The intended end-users of these guidelines are the schools and health facilities. It is, therefore, necessary that the intended users are orientated and trained in the use of the SHN Guidelines by the Technical Team tasked with the coordination of the SHN programme.

## 1.4 INTENDED BENEFICIARIES

The guidelines provide direction for the implementation of the SHN Programme for early childhood education centres, community schools, Government primary and secondary schools, faith-based schools and private schools. The intended beneficiaries of the SHN programme are learners from early childhood to secondary school (3-19 years). These include vulnerable children, such as learners living with HIV/AIDS and children with special needs.

## 1.5 SHN SERVICE PROVIDERS

The SHN service providers include teachers, health workers (i.e. clinical officers, medical officers, nurses, EHTs and health promotion/education officers), members of the parent teacher committees, agricultural extension officers, community champions, education advisors and community members. It is the responsibility of the Head Teacher at each school, through the School Health and Nutrition (SHN) teachers and under the supervision of the District Education Board Office, to ensure that all SHN programme standards are met.

## 1.6 ROLES AND RESPONSIBILITIES OF KEY STAKEHOLDERS

The SHN interventions require a multi-sectorial approach that includes the Ministries responsible for health, education, community development and social services, agriculture, fisheries and livestock, and local government. The roles and responsibilities of stakeholders at the national, district and sub district levels include the following:

| National Level | Roles and responsibilities |
|---|---|
| **SHN Director** | I. Providing policy guidance for the SHN programme |
| **Line Ministries** | I. Periodically reviewing existing policy guidelines relating to SHN provisions;<br>II. Mobilizing and allocating resources for the implementation of health services, WASH in Schools (including MHM), and other SHN activities;<br>III. Conducting budget tracking to ensure effective resource utilization;<br>IV. Coordinating the School WASH National Technical Committee, ensuring linkages with other line Ministries including Ministry responsible for water sanitation and Ministry of Health, as well as all other partners-local or international; and<br>V. Monitoring and providing technical support in the implementation of the SHN programme in the country. |
| **Provincial level** | **Roles and responsibilities** |
| **Line Ministries** | I. Planning, budgeting and monitoring of financial and other resources to ensure equitable allocation of resources;<br>II. Coordination of SHN activities;<br>III. Conducting quarterly monitoring of SHN activities; and<br>IV. Ensuring districts adhere to set guidelines and standards. |

| District level | Roles and responsibilities |
| --- | --- |
| **SHN Coordinator** | I. Coordinating the SHN Programme; |
| **Line Ministries** | I. Conducting district budget tracking to ensure effective resource allocation;<br>II. Supporting schools to implement SHN activities according to set designs, guidelines and approved standards;<br>III. Coordination of partners implementing SHN related activities;<br>IV. Ongoing monitoring of SHN activities to ensure school adherence to guidelines; and<br>V. Monitoring of school infrastructure to ensure *equitable* provision of an environment conducive to teaching and learning. |
| **Community** | **Roles and responsibilities** |
| **Head Teacher** | I. Coordinating school level SHN activities;<br>II. Overseeing planning and implementation of SHN activities;<br>III. Ensuring that SHN guidelines are followed;<br>IV. Actively participating in SHN activities;<br>V. Ensuring learners receive deworming tablets and vitamin A supplements in accordance with prevailing guidelines;<br>VI. Assigning staff members to specific SHN activities;<br>VII. Ensuring that IEC materials are available;<br>VIII. Supervising and supporting the SHN teachers;<br>IX. Promoting the active support of the entire school community in SHN activities; and<br>X. Providing reports and information on SHN activities to district office through appropriate channels. |
| **School Health and Nutrition (SHN) Teachers** | I. Ensuring adherence to SHN guidelines;<br>II. Supporting the head teacher and SHN Coordinator in organizing SHN activities;<br>III. Implementing SHN activities;<br>IV. Training and supporting fellow staff on how to effectively integrate SHN activities into their teaching; and<br>V. Identifying, assessing and referring unwell learners. |
| **Teachers** | I. Implementing SHN activities in accordance to the SHN guidelines;<br>II. Implementing SHN activities; and<br>III. Integrating SHN into teaching and training other teachers on SHN activities and guidelines. |

| | |
|---|---|
| **Learners** | I. Actively participating in SHN subcommittee;<br>II. Actively participating in age appropriate SHN activities;<br>III. Participating in 'buddy groups' to help look after the health and wellbeing of other learners in their class;<br>IV. Promoting health behaviours among peers; and<br>V. V. Learning key messages during SHN activities. |
| **Parent and Teacher Committees** | I. Supporting SHN teachers in implementing SHN activities; Engage other parents in implementing SHN activities (e.g. garden maintenance at schools);<br>II. Providing security and maintenance of SHN materials and resources at schools;<br>III. Ensuring transparency and accountability in the utilization of SHN materials and resources; and<br>IV. Sensitizing the community on SHN activities and the importance of school health and nutrition. |
| **Agriculture Extension Officer** | I. Providing technical assistance in garden establishment and maintenance;<br>II. Encouraging community to take part in the school garden and the replication of the gardens at the community or household level. |
| **Health Workers** | I. Growth monitoring and promotion;<br>II. Health and nutrition education;<br>III. Training and mentoring of SHN teachers;<br>IV. Implementing the fast-track referral system for learners;<br>V. Supporting mass drug administration as per prevailing MOH guidelines;<br>VI. Screening for diseases; and<br>VII. Conducting routine inspections of school premises, including water and sanitation quality monitoring. |

The following guiding principles need to be adhered to at all levels:

1. Assure rights of all children, including those with disabilities, are respected;
2. Adhere to guidelines as spelled out in this document;
3. Activities need to be carried out in an accountable and transparent manner; and
4. Encourage information sharing with peers and other stakeholders.

## 1.7 SCHOOL HEALTH AND NUTRITION COMMITTEES

Each school must form School Health and Nutrition (SHN) committees in addition to existing school structures, such as PTCs and Education Boards. These structures should be used for discussing Health and Nutrition concerns, planning activities and mobilizing the community and resources.

The SHN committee should be comprised of the school's head teacher, a member of the PTC executive committee, SHN coordinator and a representative from the nearby health facility responsible for the catchment area. The head teacher shall be the chair of the committee. The school shall assess its technical capacity to implement the activities and determine action plans to improve. Schools within the same zone are encouraged to hold joint meetings to promote collaboration.

The SHN committee must meet at least once per term to review the progress of activities, identify health and nutrition concerns and plan the appropriate interventions to address these concerns. The committees should also meet as need arises, such as in response to a disease outbreak. Minutes should be recorded for all SHN committee meetings and made available for review by the DEBS office.

## 1.8 ACTION PLAN

Each school will be required to produce a SHN Action Plan jointly with other stakeholders, including the catchment's health facility staff, school administrators, SHN Coordinator and teachers, learners and community. The SHN Action Plan will address the *who, what, when, where* and *why* of SHN implementation and management. It will also address short and long-term objectives.

## 1.9 RESOURCE MOBILIZATION

Internal and external resources can be sourced through the existing system and procedures. A school may also wish to use leadership from various organisations but only through established structures and mechanisms. Additional resources raised should be accounted for within the normal Government procedures. Therefore, accountability, transparency and other internal controls need to be developed to safeguard the sourced funds. Sourced funds and materials will become public funds and resources and will be audited as such.

## 1.10 ACCREDITATION

Schools shall be accredited according to the Health Promoting School criteria set at School, Zonal, District, Provincial and National levels. Each level of the education system will formulate its own incentives for recognizing performance based on the SHN guidelines. Accreditation shall be based on prevailing guidelines and checklists.

## 1.11 HOW TO USE THE GUIDE

The guidelines will complement the Education Policy and the implementation of the National Development Plan.

## 2 BACKGROUND

Good health and nutrition are key to children's development and learning (WHO 2010). Health adversity during late childhood and early adolescence has been shown to impede intellectual and physical growth, slow skills-development, increase school absenteeism, and diminish academic performance (Best et al., 2010, Bundy et al., 2017, Wei et al., 2019). Additionally, while the prioritized window of opportunity for nutrition intervention is the period between conception and two years of age, targeting school-aged children is important for attaining some amount of recovery from damage caused by infant malnutrition (Bundy et al., 2017).

The emphasis of global child health programmes in the last several decades has largely focused on the first five years of life. Health programmes often miss the health needs of children of school going age (Bundy et al., 2017, Wei et al., 2019). While routine child health programmes have been developed and implemented for children under five years of age, global standards of care for school-aged children above the age of five are far less defined (Best et al., 2010).

School children above five years of age remain highly exposed to a number of treatable and preventable illnesses (Bundy et al., 2017). Unsafe drinking water and poor sanitation contribute to parasitic infections, which undermine the health and nutritional status of learners. Among the most common illnesses encountered include malaria, respiratory infections, worm infestation, diarrheal diseases, anaemia, skin infections and schistosomiasis. These illnesses not only impair a child's quality of life, but they also impede physical, social, psychological and cognitive development and result in increased school absenteeism, reduced academic performance and higher drop-out rates (Best et al., 2010, Bundy et al., 2006, Lesley et al., 2002).

Schools are a highly efficient platform for the provision of low-cost health services (Bundy et al., 2017, Wei et al., 2019). The education sector is the custodian of children from age three up to their twenties when they are in tertiary education. Because most school-age children are enrolled in school, they are given a rare opportunity for sustained contact with the majority of school-aged children. Through the education sector, behaviours (positive or negative) are formed or reinforced. Equipping the education sector to use its comparative advantage to influence health, life and food choices can be one of the most impactful strategies for improving health nutrition in the medium to long term (Bundy et al., 2017).

The World Health Organization (WHO), the World Bank, and United Nations Educational, Scientific and Cultural Organization (UNESCO) promote schools as a practical platform to deliver an integrated package of health and nutrition interventions to school-aged children. School-based interventions are able to effectively reach the majority of children due to the rapid increase in school enrolment attained in the past two decades (Bundy et al., 2006, Creative Associates International 2005, WHO 2019).

## 3 SITUATION ANALYSIS

In 2018, the population of Zambia was estimated at 17.4 million people (CSO 2013). The population is 44% urban and becoming increasingly more urban each year (United Nations 2018). Zambia has a young population with a median age of 17.2 years. Population growth rate was 2.9% in 2019, ninth highest in the world (CSO 2013).

Zambia has made significant progress in improving the health of children under five years of age. However, the health status of children above five years has received less attention and remains a challenge (Best et al., 2010, Bundy et al., 2017). Recent evaluations indicate high prevalence of preventable and easily treatable illnesses among school-age children (Wei et al., 2019). Poor health in school-aged children increases absenteeism and negatively impacts educational attainment and literacy (JPAL 2012, World Bank 2016). Illnesses such as intestinal worm infestation can exacerbate malnutrition and anaemia, both of which impair children's physical and cognitive development.

Stunting continues to be a major public health concern in Zambia. Stunting reflects the failure to receive adequate nutrition over a long period of time and can also be affected by recurrent and chronic illness. In 2018, the rate of stunting among under-five children stood at 35% (ZDHS, 2018). The effect is reduced opportunity and ability to learn among school-age children (Best et al., 2010, JPAL 2012, Hotez et al., 2006, WHO 2010). Targeted health and nutrition interventions for school-aged children can help reduce stunting by extending the period of catch-up growth (Bundy et al., 2017).

The education sector plays an important role in improving the basic and underlying causes of poor health. Schools offer an exceptional opportunity for the promotion of health and nutrition for children, including adolescents, and could have an important role in the nutritional status of the future generation (Bundy 2011, Bhutta et al., 2013).

Zambia's school Health and Nutrition (SHN) activities were piloted from 2001-2003 and 2005-2009 in Eastern Province, supported by the USAID CHANGES I & II programmes on behalf of the Ministry of Education and in collaboration with the Ministry of Health. The pilots demonstrated that schools are able to take on an important role in the health of learners. The programmes found that school health programmes reduce illness-related absenteeism, can efficiently distribute deworming medication and micronutrient supplementation and that teachers can effectively deliver front-line health services. End of project recommendations suggested that school health programmes were "viable, cost-effective and worthy of long-term investment" (USAID 2009).

A program initiated in 2015 by the local NGO, Healthy Learners, in partnership with the Ministry of Education and in collaboration with the Ministry of Health, established a comprehensive model of school health to monitor and respond to the health needs of school-aged children. The program trained teachers in community health, provided capacity building for school administrators and health facility staff, engaged parent teacher committees, streamlined procedures and systems for bi-annual deworming and vitamin A supplementation, established robust referral and feedback systems and strengthened linkages between schools and health facilities. An external controlled evaluation found that the program led to significant improvements in healthcare access

and utilization, with a 38% reduction in morbidity, a 48% increase in deworming and Vitamin A coverage, a 22% increase in health knowledge, and a 52% reduction in the odds of stunting (Wei, et al. 2019).

## 3.1 NUTRITION

Growth during adolescence is faster than any other time in an individual's life except for the first year of life (Save the Children 2015). Chronically malnourished girls are more likely to remain undernourished during adolescence and adulthood, and when pregnant, are more likely to deliver low birth-weight babies, who are in turn more likely to remain stunted as infants (Salam et al., 2016) (WHO 2006). Adolescent mothers bear a double burden: one involving their own growth and development, and another one involving the intra-uterine growth and development of their offspring (WHO 2006).

School health and nutrition is also important to reach adolescent girls as mothers of the next generation. Moreover, in many households in rural communities, school children are also caregivers for their siblings. As a result, effectively engaging school children can influence long lasting positive health and nutrition behaviours within the community and society at large.

## 3.2 SEXUAL AND REPRODUCTIVE HEALTH

Girls face additional challenges that negatively impact their education. School dropout rates are higher for girls than boys in nearly every grade in primary school (Ministry of Education 2016). The highest disparities between male and female dropout rates occur in grades 7, 8, and 9, which corresponds with the onset of menses (Ministry of Education 2013). As a result, the mean years of schooling for women is 5.8 years vs. 7.3 years for men. Additionally, Zambia has high rates of gender-based violence and child abuse. 8.2% of girls age 15-19 report having experienced sexual violence, and 29.3% report having experienced physical violence (Zambia Central Statistical Office, Ministry of Health and ICF International 2014)

In Zambia, 29 percent of adolescent girls aged 15-19 years are either pregnant or have already given birth to child (Central Statistical Office, Ministry of Health and ICF International 2014). Early pregnancy is associated with a higher incidence of preterm birth and low birth weight, and thus poses significant threats to infant morbidity and mortality. Research has shown that improved caregiving and infant and young child feeding practices can reduce the negative effects of poverty and low maternal education on child nutritional outcomes (Hackett et al., 2015). In a society like Zambia, where teenage pregnancies and early marriages are rife, adolescent nutrition is key in controlling stunting and general malnutrition. However, the knowledge of adolescent girls on appropriate infant and young child feeding practices, including exclusive breastfeeding and dietary diversity, is generally low (Alam et al., 2010, Hoddinott et al., 2016, Gopal, Premarajan and Lakshminarayanan 2014, CSO SUN and WFP 2016).

Improving maternal education is important, as it is strongly associated with young child nutrition outcomes (Makoka and Masibo 2015, Semba et al., 2008). Chronic under nutrition is associated with delayed school entry, early school termination, poor school performance, and reduced work capacity (USAID 2014).

## 3.3 HIV AND AIDS

Although the Republic of Zambia has made progress in reducing HIV prevalence among adult (15-49 years), which declined from 13.3% in 2014 (Central Statistical Office, Ministry of Health, & ICF International, 2014) to 11.6% in 2016 (Zambia HIV Impact Report 2016), the HIV epidemic reamins as a major public health concern. The HIV prevalence among young people (15-24 years) is estimated to be 7%. HIV prevalence among adolescents (15-19 years) is estimated at 4.8% and 4.1% among boys and girls respectively (Central Statistical Office, Ministry of Health, & ICF International, 2014). According to Modes of Transmission (MOT) Study 2009, the HIV epidemic in Zambia is driven by heterosexual transmission, including multiple and concurrent sexual partnership (MCP).

Approximately 90% of infections are attributed to unprotected heterosexual activities. According to the ZDHS (2013/2014), the percentage of women and men aged 15-49 who know that the risk of HIV transmission can be reduced using condoms is 82% and 85% respectively. More than 50% of sexually active young people (aged 15-24 years) report not using condoms when having sex.

## 3.4 ENVIRONMENTAL HEALTH

Between 1990-2015, Zambia made moderate progress towards reaching its drinking water supply targets under the Millennium Development Goals. However, Zambia made 'limited or no progress' towards achieving targets set for sanitation (WHO 2010). Inadequate water, sanitation and hygiene (WASH) is a significant contributor to poor health in Zambia and a cause of infectious outbreaks, such as cholera (WHO 2010).

Lack of access to adequate WASH facilities in schools negatively impacts learners and contributes to dropout rates, especially among girls. Girls are more likely to remain in school and have increased employment opportunities if they can comfortably manage their menstruation at school (WHO 2010).

## 3.5 LOCAL SITUATIONAL ANALYSIS

Every school shall be required to carry out a situation analysis standardized tools. This shall look at school compliance with the SHN guidelines and overall issues related to health and welfare of learners, school environment, availability of local health services, food security, safety of the school and socio-cultural activities related to SHN. Information shall be used to develop a comprehensive SHN Action Plan for improving implementation of the SHN programme. Additionally, the analysis will help to advocate for support from all sectors including the community. Lastly, it will be used to evaluate and ascertain learners' benefits.

# 4 SCHOOL HEALTH AND NUTRITION ACTIVITIES

The School Health and Nutrition Programme plays an important role in the promotion of health and nutrition for all learners. This chapter highlights the key areas in the implementation of the guidelines as they relate to health and nutrition issues. It specifically looks at health and nutrition programmes, health service delivery, life skills and guidance and counselling.

## 4.1 SCHOOL HEALTH SERVICES

Health is an essential component in enhancing the learning and educational outcomes of learners. The SHN guidelines support the monitoring of learner health, screening of learners for health-related issues, and the delivery of health promotion services. The guidelines outline how the MOGE supports children to receive the promotive and curative care they need, including the establishment of efficient and effective referral systems between schools and health facilities.

### 4.1.1 HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over and improve their health. It is a comprehensive process that not only embraces actions directed at strengthening the skills and capabilities of individuals, but also actions directed towards changing social environmental and economic conditions. Health promotion impacts positively on public and individual health. Participation by all stakeholders is essential to sustain health promotion action.

Therefore, schools and ECE centres shall ensure:

I. High standards of personal and environmental hygiene are always observed;
II. Participation of the community in health promoting activities;
III. Teachers provide regular and effective health promotion lessons for learners;
IV. Teachers actively and consistently monitor the health of learners within their classes to identify those who require assistance;
V. Health screenings/examinations are completed for learners by certified staffs;
VI. Provision of health services (e.g. deworming and vitamin A);
VII. Learners interact with the community to share ideas on health issues;
VIII. Provision of health promotion information to community through appropriate committees and outreach activities;
IX. Establishment of networks with other schools to share ideas on health issues;
X. Learners are placed into 'Buddy Groups' to help look after the health and wellbeing of their peers (see technical terms on page XX);
XI. Guest speakers and/or celebrities are invited to give talks on specific health issues; and
XII. Activities contributing to health promotion, for example, drama and festivals are developed.

### 4.1.2 SEXUAL AND REPRODUCTIVE HEALTH ISSUES

During the transition from childhood to adolescence, both girls and boys experience physical and physiological changes in their bodies. These changes lead to different patterns of sexual behaviours, which may be based on insufficient or incorrect information. Consequently, this may lead to risky sexual behaviours, such as early sexual debut.

Therefore, schools and ECE centres shall ensure that:

I. The school staff are role models exhibiting high moral standards;

II. Learners understand the physical and physiological changes that they may go through;

III. Learners are taught about growth and development in terms of sexuality and reproduction, including lessons on menstruation for learners in grade 5 and above;

IV. Adherence to all MoGE menstrual hygiene management guidelines;

V. Information given is gender responsive and age appropriate;

VI. Learners are made to understand the risks of initiating sex at an early age and their consequences (i.e. early marriages, teenage pregnancies, STIs/HIV/AIDS);

VII. Guidance on healthy girl/boy relationships is provided;

VIII. School related Gender Based Violence (SRGBV), including sexual harassment and abuse (physical and verbal), are explained and discouraged;

IX. Reproductive health services are provided by trained health professionals;

X. Learners are taught the socio-cultural issues about sexual and reproductive health; and

XI. Learners are taught the consequences of early marriages such as early bearing complications and deprivation of education, social and economic benefits.

### 4.1.3 VACCINATIONS

Vaccination is aimed at reinforcing immunity. All vaccinations must be administered by trained health personnel. Schools and ECE centres shall:

I. Check the relevant health documents such as under-five clinic cards for vaccinations received and ensure that all children entering school receive all recommended vaccinations as per vaccination schedule and as appropriate for the age group during ECE and grade 1 enrolment;

II. Ensure that learners receive age-appropriate vaccinations, such as Tetanus and Human Papilloma Virus (HPV), and are sensitized on the importance of getting all vaccinations as recommended by the Ministry of Health (i.e. a total of five Tetanus vaccinations in their reproductive life and any other relevant vaccination); and

III. Arrange vaccination for learners who have not yet received all vaccinations per prevailing guidelines.

### 4.1.4 ASSESSMENT, TREATMENT AND REFERRALS

Working closely with the District Health Office (DHO), schools and ECE centres shall have the following in place:

I. Health room (see technical terms on page XX);
II. School Health and Nutrition (SHN) teachers trained to recognize, assess, and manage sick learners and refer necessary cases to the nearby health facility;
III. Well-equipped and stocked first aid kit is available, and there are SHN teachers trained and accredited to use it according to prevailing medical guidelines;
IV. Systems to monitor the health of learners and identify those who are unwell and may require additional care; and
V. SHN teachers receive ongoing training and mentorship.

**Services to be offered**

I. Conduct Growth Monitoring and Promotion;
II. SHN teachers assess unwell learners using approved tools;
III. The school, through SHN teachers, provides management, first aid treatment and referral for unwell learners according to prevailing medical guidelines;
IV. Follow-up on learners referred from the school to a health facility to ensure they are getting better;
V. Monitor school attendance through class registers to identify and follow-up on learners absent from class;
VI. Liaise with caregivers to support learners absent from class due to illness to access appropriate medical care;
VII. Collaborate with the health facility, local authority and community in cases of major health conditions/outbreaks affecting learners;
VIII. Liaise with parents /caregivers on the health conditions their children are experiencing;
IX. Collaborate with the health facility to implement the school health 'fast-track system' (see technical terms on page XX);
X. Provide psychosocial support to learners and parents of learners; and
XI. Treat learners for bilharzia and common worms with appropriate medication according to prevailing medical guidelines.

### 4.1.5 COMMUNICABLE DISEASES

Communicable Diseases are those that can be passed on from one person to another through air, touch, food, water and physical/sexual contact. Communicable diseases include examples such as HIV and STIs, tuberculosis, dysentery, cholera, salmonella (food poisoning), lice, some skin diseases etc. Schools and ECE centres, in liaison with local health authorities, shall Institute measures to prevent and control communicable diseases as follows:

I. Isolate all learners with communicable diseases as recommended in prevailing medical guidelines;
II. Educate learners on the dangers of exchanging clothes and any other personal effects that may convey diseases;
III. Ensure the school provides safe and clean drinking water;
IV. Ensure availability of properly positioned handwashing and sanitation facilities;
V. Promote hand washing and healthy hygiene practices;
VI. Ensure the use of appropriate sanitation, including waste disposal; and
VII. Utilize data from SHN activities to identify disease trends and potential outbreaks within the school and alert the appropriate authority.

#### 4.1.5.1 HIV/AIDS and Other Sexually Transmitted Infections

HIV and AIDS is a major problem in Zambia. Learners coming from affected families and those living with HIV and AIDS may not be able to attend school for many reasons, including opportunistic infections. Therefore, schools shall:

I. Teach learners about HIV and AIDS and other STIs;
II. Promote communication between parents/caregivers, teachers and learners;
III. Educate learners on where to access HIV counselling and testing services;
IV. Provide guidance and counselling services in school and refer as necessary;
V. Ensure that learners living with HIV and AIDS and those affected are not stigmatised and discriminated against;
VI. Provide support to learners living with HIV and AIDS and those from affected homes;
VII. Have SHN teachers who are knowledgeable and trained in handling minor opportunistic infections and able to refer learners with serious infections to health facilities;
VIII. Encourage abstinence and educate learners on the dangers of unsafe sex;
IX. Establish or strengthen existing AIDS Awareness clubs within the structure of the school's health club;
X. Have health promotion materials on HIV and AIDS, STIs and sexual and reproductive health;
XI. Have peer educators within the school community;
XII. Ensure confidentiality of health information of learners; and
XIII. Liaise with parents/caregivers to support adherence to HIV treatment (ART) among learners.

#### 4.1.5.2 Malaria

Malaria continues to be a major public health problem in Zambia and is one of the leading causes of illness and death. However, malaria is preventable and treatable and,

as such, the Ministry of Health has put in place several strategies and tools to fight the disease. Schools and ECE centres shall contribute to malaria elimination by ensuring that:

I. Learners are encouraged to sleep under an insecticide-treated net every night;
II. Indoor residual spraying in all sleeping quarters and classrooms at least once per year (for boarding schools);
III. Learners are advised to keep the school surroundings clean to get rid of any possible breeding sites for mosquitoes;
IV. SHN teachers support the early identification and referral of learners with malaria symptoms;
V. Learners seek medical attention within 24 hours of onset of malaria symptoms (fever, nausea, headache, muscle ache, etc.);
VI. Learners diagnosed with malaria are encouraged to complete the prescribed treatment regime as instructed by the health service provider;
VII. All positive malaria cases are recorded, and data given to relevant authority immediately for follow-up; and
VIII. Malaria prevention and control messages are disseminated to the school community.

#### 4.1.5.3 Water and Food Borne Diseases

Water and food borne diseases such as cholera, typhoid, dysentery and other diarrheal diseases are caused by bacteria found in water or food sources that have been contaminated. They are commonly found in areas with inadequate water treatment, poor sanitation and hygiene. Water and food borne diseases can be prevented by healthy hygiene practices, such as washing hands before eating food, after using the toilet and after changing the baby's napkins. To ensure that these diseases are contained, the Ministry of Health has prescribed some measures that should be adhered to by all institutions.

Schools and ECE centres shall contribute to the fight against water and food borne diseases by doing the following:

I. Ensuring a steady supply of safe drinking water in the school;
II. Providing hand washing facilities with safe running water;
III. Ensuring that water is chlorinated all the time;
IV. Ensuring a steady supply of cleaning materials;
V. Ensuring that preventive maintenance is reinforced, and that all learners participate;
VI. Observing regular cleaning of the school surrounding by members of staff and the learners;
VII. Conducting cleanliness competitions and reward best performing classes;
VIII. Ensuring that sanitation facilities are built at least 30 meters away from the water sources;

IX. Ensuring there are adequate sanitation facilities to cater for all learners and members of staff; and

X. Ensuring that sanitary officers are engaged to clean the sanitation facilities regularly.

#### 4.1.6 NON-COMMUNICABLE DISEASES

Non-communicable diseases are those that are non-infectious and cannot be transmitted from one person to another. Examples include diseases such as obesity, diabetes, high blood pressure, sickle cell anemia, epilepsy and heart disease. Schools and ECE centres shall ensure that:

I. Teachers acquire knowledge on non-communicable diseases and provide relevant support and information to learners;

II. Teachers identify, manage and refer learners with non-communicable diseases as necessary; and

III. Learners with non-communicable diseases take their medicines appropriately.

##### 4.1.6.1 Drug, Alcohol and Substance abuse

Substance, alcohol and drug abuse can cause dependence/addiction, malnutrition and other ill health problems that negatively affect normal bodily functions, such as metabolism. Therefore, schools and ECE centres should ensure that:

I. Smoking, use of drugs and consumption of alcoholic beverages within school premises is prohibited and addressed through functional school rules and procedures;

II. Information on the dangers of substance abuse is provided by teachers and relevant experts from Drug Enforcement Commission and other institutions to discourage abuse;

III. Learners and teachers abusing substances of dependence are referred to Education and Counselling Unit of Drug Enforcement Commission and other stakeholders for treatment interventions and rehabilitation services;

IV. Learners requiring support are referred to relevant resource centre for further care;

V. Drug dependent persons should be provided for with appropriate nutritious foods to aid recovery;

VI. Drug dependent persons, persons committed to rehabilitation and those who have been rehabilitated from substance dependence are not be stigmatised or discriminated against;

VII. A weaned report from the relevant drug counsellors to the school authorities is generated for records and monitoring processes;

VIII. Drug Abuse Awareness clubs are formed as is mandatory in all learning institutions (government, community and private schools); and

IX. Teachers act as role models and exhibit healthy behaviours to learners.

#### 4.1.6.2 Mental health

Mental health is a state of psychological well-being and may also be referred to as an absence of mental illness. School going children may experience emotional, behavioural, psychological and other mental health disorders that impair their function at home or school. Mental health problems may be caused by trauma, drugs, alcohol, substance abuse, or other risk factors. Mental health problems may interfere with the learning process in schools and can have negative socio – economic consequences.

Schools play an important role in the mental health and well-being of learners and staff. Schools and ECE centres shall:

I. Educate/orient staff to recognize stress and other factors that may lead to mental health problems as well as early signs of mental illness;
II. Have teachers share information on mental health with learners;
III. Have teachers trained to identify signs and symptoms of mental health problems in learners and to respond with appropriately action;
IV. Have a health room for privacy and confidentiality. All health information should be treated with confidentiality;
V. Have teachers trained to make health referrals from within the school setting for learners with suspected mental health problems. Written consent should be obtained for all learners referred due to mental health per prevailing guidelines. Referrals should be monitored for patient adherence to the treatment recommended and evaluated for effectiveness; and
VI. Provide members of staff with opportunities to consult a doctor or clinical psychologist to examine difficult situations or learner behaviours.

#### 4.1.6.3 Oral Health

Oral health is the state of the oral tissues free from disease that enables an individual to eat, speak, smile, and socialize without embarrassment. The World Health Organization defines oral health as "a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing."

Through good oral health, the overall health, wellbeing, education and development of children, families and communities are enhanced. The most common dental diseases are dental caries (tooth decay) and periodontal disease (gum disease).

Dental caries and gum disease are a major problem among school children in Zambia. Pain caused by these conditions contributes to absenteeism and impaired concentration during lessons. Good oral hygiene practice and nutrition can prevent dental caries and other oral diseases. Therefore, schools and ECE centres, in collaboration with local health authorities, shall institute measures to prevent and control oral diseases as follows:

I. Teachers to share information about oral health among themselves;
II. Teachers to share information with learners on good oral hygiene practices;

III. Trained SHN Teachers identify and refer cases of oral diseases;
IV. Share information with learners on appropriate behaviors for good oral health;
V. Promote communication between parents/caregivers, teachers, and leaners; and
VI. Provide support to learners affected by oral diseases.

## 4.2 NUTRITION

Nutrition plays an important role in the physical and mental development of the learner. Children need good nutrition to enhance their overall learning capacity and ability to pay attention and concentrate in class. Good nutrition will also prepare learners for a healthy and productive life in future. Educators need to use various platforms to inform parents/caregiver about the importance of good nutrition. As such, the schools and Early Childhood Education (ECE) centres shall carry out the following activities to promote nutrition status of learners:

### 4.2.1 HEALTH AND NUTRITION EDUCATION

Good health and nutrition practices come about when learners acquire knowledge and skills at an early age. Therefore, schools and ECEs shall ensure the following:

I. Teach basic health and nutrition principles at all levels;
II. Promote physical education, nutrition education and free play activities among school learners to promote good health and prevent obesity;
III. Teach learners the dangers of losing too much weight or gaining too much weight and how they can avoid such health problems;
IV. Encourage learners to be change agents in the community by disseminating health and nutrition information;
V. Apply the integrated implementation of SHN interventions as prescribed in the curriculum framework document;
VI. Promote the consumption of micronutrient rich foods, such as dark, green leafy vegetables, fruits, tubers, legumes, indigenous foods, and animal source foods, including fortified foods;
VII. Educate learners and communities on how to read and understand food labels, symbols and how to make good choices when buying food: paying attention to manufacturing and expiry dates (Best before/Use by date) and nutritional value;
VIII. Encourage learners and the community to eat a variety of foods (dietary diversity);
IX. Educate learners on healthy eating habits, such as appropriate time for meals, to avoid malnutrition;
X. Initiate and promote nutrition clubs in schools; and
XI. Encourage families to pack a variety of healthy foods for learners.

### 4.2.2 MICRONUTRIENT SUPPLEMENTATION AND DE-WORMING

I. The head teacher, with support from the health facility, shall ensure learners participate in health promotions activities such as vitamin A supplementation and deworming tablets twice a year and keep records/statistics;

II. A SHN coordinator from each school should initiate the demand for health support services, including regular checkups for learners to identify those with micronutrient deficiencies, such as iron deficiency anemia, particularly in pregnant adolescent girls;

III. The SHN coordinator, in collaboration with the health facility, shall ensure, where possible, intermittent iron and folic acid supplementation for adolescent girls, (according to IYCF implementation guidelines); and

IV. Schools shall encourage girls to go to the nearest health facility as soon as they suspect they could be pregnant to obtain iron and folic supplementation and receive any other pregnancy related health services.

### 4.2.3 HOME GROWN SCHOOL MEALS (HGSM) PROGRAMME

The objective of Zambia's Home Grown School Meals (HGSM) programme is to improve the learners' education outcomes (i.e. enrolment, attendance, retention and progression). The Government, through the Ministry of General Education, plans to reach as many learners as possible across the country through the HGSM to improve learning outcomes. The Government of Zambia is implementing the programme, which links smallholder farmers to school markets within the same district, and creates a ready market for the produce of small holder farmers. To ensure sustainability of the programme, schools and communities must be encouraged to include locally grown crops in the food basket. In the HGSM model, the government will be able to impact on learners' education, promote agricultural production among smallholder farmers. Consequently, the nutrition of both learners and households will improve dietary diversity and food consumption.

The HGSM programme has proven to have positive impact on education outcomes therefore the programme should be scaled up to all Zambian primary schools and ECE centres. Studies have shown that providing school meals increases school enrolment and attendance and reduces dropout rates (Molinas & de la Mothe, 2010), especially for girls (Lawson, 2012).

### 4.2.4 GROWTH MONITORING AND PROMOTION (GMP)

Growth Monitoring activities focusing on weighing learners, providing nutrition education, food preservation, dietary diversity and other health and nutrition activities are conducted in the communities to support child development. Some of the activities that can be implemented under GMP include the following:

I. Teachers encouraging parents/caregiver to take pre-schoolers (children under five years) for growth monitoring and promotion during outreach services in communities or routinely at the health facility;

II. Assessment of learners' height and weight should be conducted bi-annually;

III. Monitor the health and nutrition of learners in schools and ECE centres twice a year which should be captured and updated on the child's record card;

IV. Encourage relevant teachers to integrate the Early Childhood Development package into their class schedule, and train them on the use of the ECD counselling card; and

V. Schools should have the tools to assess nutritional status i.e. height, weight and Mid-Upper Arm Circumference (MUAC) and the charts for assessing nutritional status (including the Body Mass Index (BMI) for age.

#### 4.2.5 HEALTHY EATING, ENVIRONMENT AND HABITS

Documented evidence has shown that providing food at school promotes and fosters improved learning, health and nutrition of learners. Therefore, schools should:

I. Ensure the establishment of a clean safe environment for food supply and services;

II. Encourage the establishment of a school tuck-shop and ensure the selling of healthy foods only. Unhealthy foods, such as chips, crisps, sweets and fizzy drinks should not be allowed;

III. Encourage caregivers to pack nutritious foods from home for learners and ensure that learners wash their hands before eating;

IV. Ensure appropriate storage facilities for food and cooking utensils to prevent food borne illnesses and retain nutrients;

V. Ensure that food handlers employed by the school are medically fit and practice personal hygiene;

VI. Ensure all food vendors are oriented on hygiene, sanitation and food safety, so that foods sold in school are appropriately prepared, packaged and stored;

VII. Ensure regular screening of volunteer food handlers by qualified health personnel; and

VIII. Create designated eating areas and garbage disposal facilities for learners in the school premises.

## 4.3 AGRICULTURE

### 4.3.1 SCHOOL MODEL GARDENS

A school model garden is a piece of land that is cultivated within the school premises to impart agricultural skills and values among learners. As such, learners should be encouraged to participate in agricultural activities. In addition, gardens, orchards and production units in schools can also promote knowledge among learners and communities in improved food production, crop diversification and nutrition.

In collaboration with the Agriculture Camp Extension Officer (CEO), parents/caregivers, communities and other stakeholders, schools shall establish and maintain gardens, orchards and agricultural production units to:

I. Teach learners about growing a variety of food crops, vegetables and fruits as well as keeping small livestock and fish farming;

II. Teach learners about food processing, preservation methods and agricultural entrepreneurship;

III. Support the establishment of fruit tree nurseries by learners at home;

IV. Promote the consumption of indigenous foods including forest food sources such as wild fruits and vegetables, mushrooms and edible insects;

V. Ensure that all learners benefit from the products of the gardens, orchards and agricultural production units, e.g. through the home-grown school meals programme and to sell the surplus to purchase additional foods that cannot be produced by the school and to re-invest in the garden inputs such as seeds and tools;

VI. Promote sustainable agricultural methods that promote environmental conservation;

VII. Encourage community participation in the school gardening activities so as to influence agricultural practices in the community. The school gardens should be a centre of excellence within the community; and

VIII. Ensure gardens are not used for punishment of learners.

## 4.4 WATER SUPPLY, SANITATION AND HYGIENE (WASH) AND ENVIRONMENT

It is important that schools have access to safe and clean drinking water, have adequate sanitation, and maintain an environment that is safe and conducive for effective learning. The water and sanitation facilities should be all-inclusive, age appropriate and account for the special sanitary needs for girls with regards to menstruation. Each school shall act as a model unit and teachers shall serve as role models. The school shall share good practices with the community and learners shall act as agents of change.

### 4.4.1 WATER SUPPLY

Water supply is the provision of water by public utilities, commercial organizations, communities or individuals through a system of pumps and pipes. Access to safe and clean water is a basic human right. Therefore, schools and ECE centres shall ensure the following:

I. Continuous supply of safe and clean drinking water;

II. Adequate group hand washing facilities;

III. Supervised group hand washing with running water and soap are conducted; and

IV. Timely operation and maintenance of existing water sources.

### 4.4.2 SANITATION

Sanitation is a system used to keep health standards in a place where people live, especially by removing waste products and garbage safely. Schools and ECE centres shall ensure:

I. Adequate and clean sanitary facilities that are gender friendly and well sited;
II. Sanitary facilities have access ramps and hand-bars for learners with special needs;
III. Sanitary facilities that are Menstrual Hygiene Management friendly with lockable doors for privacy and disposal facilities for used menstrual materials;
IV. Availability of menstrual hygiene management (MHM) materials for emergency purposes;
V. Availability of Personal protective equipment (PPE) (e.g. gloves to enhance cleaning of sanitary facilities);
VI. Educate learners on the practice of face washing with water and soap to prevent eye diseases such as trachoma and conjunctivitis;
VII. Sensitise learners on hygiene education and provide information on the importance of good environmental health and personal hygiene, e.g. hand washing, MHM, solid waste and water management;
VIII. Safe, clean and well-ventilated classrooms that are **not** overcrowded;
IX. Establishment of implementing committees such as SHN committees/ School Wash Clubs with greater involvement of PTC and the general community to enhance community participation and promote ownership;
X. Collaboration with health personnel for guidance on sanitation; and
XI. Frequent collection and/or disposal of waste to ensure a clean and well-maintained environment.

The WASH activities implemented at the schools will be in line with the School Led Total Sanitation (SLTS) programmes.

### 4.4.3 PERSONAL HYGIENE

Personal hygiene is essential for promoting good health. Personal hygiene habits such as washing hands and brushing and flossing teeth help reduce harmful bacteria and viruses. For the learners to develop and enhance good personal hygiene habits, schools and ECE centres shall ensure that:

I. Class teachers carry out basic physical examination of all the learners before they enter the classroom by observing the following: nails, hair, uniforms, teeth and ears;
II. The school collaborates with the health facility to screen the learners at least once a year on personal hygiene;
III. Class teachers educate learners on best personal hygiene practices; and
IV. Schools to engage parents/caregivers in enhancing best personal hygiene practices both at school and at home.

### 4.4.4 ENVIRONMENTAL HEALTH

Environmental health is a branch of public health that is concerned with all aspects of the natural and built environment that affect human health. Therefore, it is important that the school environment is kept clean, safe and conducive for effective learning. Each school shall act as a model, and teachers as role models for good environmental health. The school can influence communities through learners who are in touch with a larger proportion of the households in the community. Therefore, under environmental health, the schools and ECE centres shall ensure the following:

I. Adequate rooms and age appropriate furniture and equipment for learners and teachers;
II. Accessible classrooms and facilities for learners with special education needs to get to their classes more easily;
III. Learners are sensitised on the dangers of pollution;
IV. Teachers are trained and knowledgeable on best practices related to environmental health;
V. Facilitate regular inspection of surroundings, structures and facilities by local authorities;
VI. Structures are safe for use and regularly maintained;
VII. Collaboration with the community to maintain school facilities; and
VIII. Collaboration with health personnel for guidance on environmental health issues.

## 4.5 OTHER

### 4.5.1 LIFE SKILLS

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. It helps learners to acquire and practice good health behaviours along with the underlying knowledge and positive attitudes. The school shall ensure that:

I. SHN activities are learner-centered, interactive and participatory in approach;
II. Learners are equipped with psychosocial, practical, vocational and entrepreneurship skills;
III. Stakeholders participate in teaching life skills;
IV. Sexual and reproductive health lessons are offered; and
V. Communities are made aware of the importance of life skills.

### 4.5.2 ENSURING SAFE SCHOOL ENVIRONMENT

Environment is the surrounding or conditions in which persons, animals or plants operate. Schools have legal obligations to ensure a safe and healthy environment for their learners, members of staff and the public that visit the school. If an emergency occurs, the school should ensure a prompt and effective response. Emergencies are life-threatening conditions that require quick action to save lives. Some of these

emergencies include: acute illnesses, disease outbreaks and accidents such as drowning, electrocution, fire and road traffic injuries.

#### 4.5.2.1 Road and Traffic Safety

To maintain safety and emergency preparedness, schools and ECE centres shall ensure that:

I. There are adequate road signs and markings on the roads. These should include informative, regulatory/warning signs and Zebra crossings at least 5km radius at 1km interval from school;

II. At least 5 speed breakers (at 1km intervals) are provided by the relevant authorities on all roads leading to the schools to help regulate the speed of motorists and other road users;

III. At school locations where the traffic density is noticeably high, overhead crossing facilities (e.g. flyovers) should be constructed by the relevant authorities to help discourage risky road behaviours;

IV. Traffic wardens are routinely deployed to assist learners to cross busy roads around schools;

V. Systematic implementation of the Road and Traffic Education Training;

VI. Approved road safety awareness programme is in school through reproduction of the approved Road Safety Books;

VII. Information on road safety rules is provided;

VIII. School recreational facilities (e.g. playgrounds/pitches) are located as far away from the roads as possible to guard against learners running into the roads without warning; and

IX. Side rails or cross bars shall be fixed on school locations with high road traffic densities to promote organised crossing of the roads by the learners and staff.

#### 4.5.2.2 General Safety and First Aid

To maintain safety and emergency preparedness, schools and ECE centres shall ensure that:

I. Teachers are trained in emergency handling skills and on how to prevent and respond to accidents;

II. Stakeholders and other partners provide adequate teaching and Information Education Communication (IEC) materials on safety and emergency;

III. School communities are knowledgeable in handling emergencies;

IV. Individual safety measures are observed when handling accidents and infectious diseases;

V. Emergency cases are referred to the nearest health facility;

VI. The school environment is made as safe as possible with appropriate and well labelled emergency exits;

VII. There is a well-stocked first aid kit in an accessible place;

VIII. There are SHN teachers who are trained in first aid by accredited trainers;

IX. Safety rules are formulated and enforced;

X. Serviced firefighting equipment is available;

XI. Emergency preparedness checklist is updated periodically;

XII. Safety and emergency detection system is in place;

XIII. Safety and emergency drills are done periodically;

XIV. Design, provide and maintain school places which are safe and without risk to health;

XV. Identify any hazards (actual or potential) and take measures to reduce or eliminate them;

XVI. Ensure that safe learning practices are developed and implemented;

XVII. Take reasonable steps to avoid potentially dangerous work involving manual handling and provide manual handling training where required;

XVIII. Provide protective clothing where required and appropriate warning signs;

XIX. Clearly marked fire assembly point is established; and

XX. Emergency evacuation plan is put in place.

#### 4.5.3 LEARNING DISABILITIES

Learning disability is a term that describes specific kinds of learning problems. A learning disability can cause a person to have trouble learning and using certain skills. The skills often affected are:

I. Reading;
II. Writing;
III. Listening;
IV. Speaking; and
V. Understanding mathematical concepts.

Learning disabilities vary from learner to learner. Learners with learning disabilities may have different learning challenges. When a learner has a learning disability, he or she may:

I. Have trouble learning the alphabet, rhyming words, connecting letters to their sounds;

II. Make many mistakes when reading aloud and repeat and pause often;

III. Not understand what he or she reads;

IV. Have difficulties with spelling;

V. Have very messy handwriting or hold a pencil awkwardly;

VI. Struggle to express ideas in writing;

VII. Learn language late and have a limited vocabulary;

VIII. Have trouble remembering sounds that letters make or hearing slight differences between words;

IX. Mispronounce words or use wrong words that sound similar;

X. Have trouble organising what he or she wants to say or may not be able to think of the word he or she needs for writing or conversation;

XI. Not be able to re-tell a story in order; and

XII. Not know where to begin a task or how to go from there.

**Teachers shall:**

I. Praise the child when he or she does well;

II. Find out ways that the child learns best;

III. Let the child help with classroom chores;

IV. Encourage learners and their parents/caregivers to make homework a priority;

V. Pay attention to the child's mental health;

VI. Give the child more time to finish work or take tests;

VII. Let the child with writing difficulties use a computer with specialised software that spell checks, spelling and grammar checks or recognises speech;

VIII. Meet with parents/caregivers and help develop an education plan to address the child's needs;

IX. Break tasks into smaller steps and give verbal and written directions during tasks; and

X. Establish a positive working relationship with the child's parents/caregivers.

### 4.5.4 PHYSICAL DISABILITIES

Schools and ECE centres shall ensure that they adequately cater for learners with physical disabilities by providing appropriate infrastructure such as:

I. Ramps/Walkways for wheel chairs;

II. Marked parking spaces for drop off and picking up; and III. Wheel chair accessible facilities.

### 4.5.5 GUIDANCE AND COUNSELLING SERVICES

Provision of guidance and counselling services in a school should consider issues of reproductive health, dangers of sexually transmitted infections, HIV/AIDS, substance abuse and other issues that may have a bearing on the health and nutrition status of learners.

For effective guidance and counselling the schools shall ensure:

I. Provision of guidance and counselling services by trained staff;

II. Records of guidance and counselling are maintained in confidentiality;

III. Interaction with parents/caregivers if need be;

IV. Gender sensitivity and age appropriate counselling;

V. Referrals to appropriate institutions is provided when problem requires further professional attention;

VI. Availability of a trained teacher in guidance and counselling; and

VII. SHN teachers are trained to support guidance and counselling teacher.

### 4.5.6 BULLYING AND HARASSMENT

Bullying in the school setting is a health and safety issue. It can lead to health problems and give rise to further safety issues. The teachers have a duty of care to all learners, to ensure they are both mentally and physically safe at school and that their health is not adversely affected by anything or anyone in the learning environment. The school is legally responsible for the harassment or bullying directed at learners and carried out by co-learners or teachers at the school. This duty of care means schools must behave and respond reasonably in such matters:

I. Every learner shall be treated with dignity in the school place;

II. The school shall seek to ensure a safe environment for all its learners;

III. The learners shall be sensitised on what constitutes harassment and will be advised to discuss it with a teacher;

IV. Complaints should be dealt with sensitively, fairly, seriously and expeditiously;

V. School shall be required to have policies and procedures on bullying and harassment and ensure that teachers and learners are familiar with them;

VI. Schools shall implement the bullying and harassment policy;

VII. The School Place Charter shall be displayed in all school places and shall be clearly visible to all teachers and learners; and

VIII. The school shall create peer to peer support structures that will ensure that learners who are bullied or have any other problems are supported by their peers and inform the school authorities on the occurrence of bullying behavior.

### 4.5.7 DISTANCES TO SCHOOL

Access to higher secondary education is often hampered by the distances to schools. This necessitates the availability of adequate numbers of affordable and safe boarding facilities and the construction of zonal secondary schools.

Districts and schools should ensure that:

I. There are adequate number of boarding facilities available;

II. Boarding facilities are affordable;

III. Boarding facilities are safe and secure;

IV. Matrons are available at the boarding facilities; and

V. Zonal secondary schools are scaled up to reduce distances to school.

# 5 MONITORING AND EVALUATION

Monitoring and Evaluation is an integral part of school health and nutrition interventions. Therefore, monitoring and evaluation should be carried out by various stakeholders at every administrative level. Each school should equally carry out monitoring and evaluation of school health and nutrition interventions in their respective schools and ensure that measurable parameters to get essential data are used, i.e. standardized forms, questionnaires and check lists. There is also need to monitor and determine effectiveness of school health and nutrition programmes and the health instructions being provided to schools. This will help determine how the programme has contributed to the improved health status of learners, the environment and the learning outcomes, through the measurement of its progress and the extent to which the school health and nutrition objectives are being achieved.

## 5.1 STANDARD MONITORING AND EVALUATION TOOLS

A standard monitoring and evaluation tool should be used to measure performance of SHN as contained in the SHN Programmes M&E Framework (see Appendix A). In collaborating with other stakeholders, the Ministry of General Education will facilitate a periodic review of the SHN interventions in schools and ECE centres. The District SHN Committee will help to carry out an assessment annually. The information collected from monitoring should help them in planning and reviewing SHN activities. Schools shall use a standard reporting format to compile data for onward transmission to national level through district and provincial levels as required.

The following should be monitored:

I. Presence of and compliance to SHN guidelines;
II. Number of classroom teachers trained and operating as SHN teachers;
III. Impact of SHN services provided in the school;
IV. Impact on learners' attendance/absenteeism in school;
V. Appropriateness of the school environment and infrastructure;
VI. Number of beneficiaries reached disaggregated by SHN interventions and sex;
VII. Identification, assessment, treatment and referral of learners;
VIII. Deworming and vitamin A treatments provided and overall coverage; and
IX. Management of SHN records.

The following strategies shall be used to evaluate the SHN programme implementation:

I. Conduct periodic review of the SHN programme interventions;
II. Leverage multi-sectoral data to inform SHN implementation; and
III. Utilize the existing data management system to track progress.

The SHN programme will endeavor to achieve the following:

I. Improved enrolments, retention, progressions, completion and reduced absenteeism;
II. Improved availability and reliability of SHN data at school, district, province and national levels;
III. Improved use of SHN data for decision-making at all levels;
IV. Improved nutrition status of the learners;
V. Improved healthcare coverage and utilization among learners; and
VI. Improved health status of learners.

## 5.2 SCHOOL HEALTH RECORD

School health record means those records maintained by the school or ECE centre for each learner. These records provide relevant information about the developmental domains of learners' physical, developmental, intellectual, personal, social and environmental factors which affect their health and education. The school should ensure that:

I. Pre-entry form containing essential health information supplied by parents and primary health caregiver must be filled and submitted to the school;
II. A health record file or register (SHN Card) is provided for each learner at school entry (ECE and grade 1-12). The health information goes with the learner from class to class or if learner transfers to another school. Information from the pre-entry health form should be entered into the learner's health record.
III. A record keeping system providing for consistency, confidentiality and security of records in documenting significant health information and the delivery of health care services is in place;
IV. The SHN card is kept confidential; and
V. Teachers keep nutrition and health information for each child confidential.

The School Health record should contain:

I. Relevant personal and family history;
II. History of past illnesses/hospitalization with relevant information on treatment received and whether follow-up is necessary and being carried out;
III. Dates and types of immunization;
IV. History of screening tests;
V. History of Body Mass Index for age based on heights and weight taken at regular intervals to help in appraisal record of Physical growth of each child; and
VI. Documentation of assessments, treatment and referrals completed.

Each entry into the learner's record must be dated and authenticated by the staff member making the entry indicating name and title.

## 6 TECHNICAL TERMS

| Term | Definition |
|---|---|
| **Adolescence** | A transition period from childhood to adulthood It covers the puberty stage or teenage years of life and may range from 10 - 19 years. |
| **Body Mass Index(BMI)** | Body Mass Index is a value derived from the mass and height of an individual. It is body mass divided by the square of the body height and is universally expressed in units Kilogram per square meter. |
| **Buddy Group** | Learners are assigned into small groups of 3-5 to promote healthy behaviours and monitor the health of their peers. Learners are to inform a SHN teacher when a member of the group is unwell or needs support. Teachers may use the buddy groups to follow-up and obtain information on learners absent from class. |
| **Bullying** | School place bullying is ***repeated*** inappropriate behaviour, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of learning and/or during learning. An isolated incident of the behaviour described in this definition may be an affront to dignity at school but as a once off incident, is not considered to be bullying. |
| **Deworming** | The treatment given to learners to get rid of intestinal worms. Deworming is to be provided to the learners by the school twice per year in accordance with prevailing guidelines. |
| **District SHN Committee** | Coordinating committee for the school health and nutrition programme in the district. It is multi-sectoral committee with memberships from different government departments. |
| **Drug Abuse** | Abnormal use of Chemical substance which interacts with our body system to change social or occupational functions. |
| **Evaluation** | Evaluation is the systematic and objective assessment of the design, implementation and results of an ongoing or completed project, programme, or policy. |
| **Fast-Track Referral System** | Referral system set up between schools and health facilities in which learners referred from the school are able to bypass queues at the facility. The system is designed to improve healthcare access, promote healthcare utilization and promote healthy behaviours for learners. |

| Term | Definition |
|---|---|
| **Harassment** | Harassment is any act or conduct including spoken words, gestures or the production, display or circulation of written words, pictures or other material which has the purpose or effect of violating a learner's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment. Harassment is a form of unwanted conduct related to any of the discriminatory grounds, e.g., gender, religion, marital status, disability |
| **Health Room** | A designated room at the school for SHN activities. The room should be equipped to properly manage sick learners, providing first-aid and oral rehydration salts, and conduct basic assessments of unwell learners as necessary. Schools shall develop a timetable to ensure that there is at least one SHN teacher on duty within the health room at all times. |
| **Immunity** | Immunity is the ability of the body to fight diseases. |
| **Malnutrition** | Malnutrition is a condition of under or over nutrition. |
| **Meal** | An eating occasion that takes place at a certain time and includes prepared food served to the learners at school. |
| **Micronutrient** | Micronutrient is a substance that is required in trace amounts for the normal growth and development of learners. |
| **Monitoring** | Monitoring is the systematic and objective checking on whether project or programme implementation meets standards as defined by the project document. |
| **Nutrition** | Nutrition is the intake of food and using it for growth, metabolism and repair; also, the intake of food considered in relation to the body's dietary need. |
| **SHN Coordinator** | Class teacher trained in School Health and Nutrition and selected by the school's administration to help coordinate school health and nutrition activities. Also known as 'school health focal point person'. |
| **SHN Teachers** | Class teachers trained and certified in school health and nutrition. SHN teachers, also known as 'school health teachers', support the implementation of the guidelines, which include, but are not limited to, monitoring the health of learners, identifying and assessing sick learners, making referrals from the school to the health facility, providing basic first aid treatment, distributing mass drug administration and providing health promotion education. A school should have at least one trained SHN teacher for every 300 learners enrolled |

## 7 BIBLIOGRAPHY


Alam, N., Roy, S., Ahmed, T., & Shamsir Ahmed, A. (2010). Nutritional status, dietary intake, and relevant knowledge of adolescent girls in rural Bangladesh. *J Health Popul Nutr, 28*(1), 86-94.

Best C, Neufingerl N, Van Geel L, van den Briel T, Osendarp S. (2010). The nutritional status of school- aged children: why should we care? *Food and nutrition bulletin*, 31(3): 400-17.

Bhutta, Z., Das, J., Rizvi, A., Gaffey, M., Walker, N., Horton, S., Black, R. (2013). Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *Lancet, 382*, 452-77.

Bundy, D. A., Silva N., Horton S., Jamison, D., Patton, G., Editors. (2017). *Child and Adolescent Health and Development. 3rd edition*. The International Bank for Reconstruction and Development/The World Bank.

Bundy, D. (2011). *Rethinking school health - a key component of education for all. Directions in development; human development.* Washington: Word Bank.

Bundy D, Shaeffer S, Jukes M, Beegle K, Gillespie A, Drake L, et al. (2006). School-based Health and Nutrition Programs. Disease Control Priorities in Developing Countries. The International Bank for Reconstruction and Development / The World Bank.

Central Statistical Office, Ministry of Health, & ICF International. (2014). *Zambia Demographic and Health Survey 2013-2014.* Rockville, Maryland, USA: Central Statistical Office, Ministry of Health and ICF International.

Creative Associates International. (2005) Health and Education Working Together: A Case Study of a Successful School Health and Nutrition Model.

CSO (2013). Population and Demographic Projections 2011-2035. Zambia.

CSO SUN, & WFP. (2016). *Multilevel barriers to HIV prevention and adequate nutrition among adolescent girls.* Lusaka.

Gopal, A., Premarajan, K., & Lakshminarayanan, J. (2014). Knowledge and attitude regarding reproductive health issues and family formation among adolescent girls of Puducherry. *Online Journal of Health and Allied Sciences, 13*(4).

Hackett, K., Mukta, U., Jalal, C., & Sellen, D. (2015). A qualitative study exploring perceived barriers to infant feeding and caregiving among adolescent girls and young women in rural Bangladesh. *BMC Public Health, 15*, 771.

Hoddinott, J., Karachiwalla, N., Ledlie, N., & Roy, S. (2016). Adolescent girls' infant and young child nutrition knowledge levels and sources differ among rural and urban samples in Bangladesh. *Maternal & Child Nutrition, 12*, 885-897.

Hotez PJ, Bundy DA, Beegle K, Brooker S, Drake L, de Silva N, Montresor A, Engels D, Jukes M, Chitsulo L, Chow J. Helminth infections: soil-transmitted helminth infections and schistosomiasis. Oxford University Press and World Bank.

JPAL. (2012). Deworming: a best buy for development.

Lawson, T. (2012). *Impact of school feeding programs on educational, nutritional and agricultural development goals: a systematic review of literature.*

Makoka, D., & Masibo, P. (2015). Is there a threshold level of maternal education sufficient to reduce child undernutrition? Evidence from Malawi, Tanzania and Zimbabwe. *BMC Pediatrics, 15*, 96.

Molinas, L., & de la Mothe, M. (2010). The multiple impacts of school feeding: a new approach for reaching sustainability. In S. Omamo, U. Gentilini, & S. Sandstrom, *Revolution: from food aid to food assistance* (pp. 217-230). Rome: WFP.

Partnership for Child Development. (1997). Better health, nutrition and education for the school- aged child. Transactions of the Royal Society of Tropical Medicine and Hygiene, 91(1):1-2.

Salam, R., Hooda, M., Das, J., Arshad, A., Lassi, Z., Middleton, P., & Bhutta, Z. (2016). Interventions to improve adolescent nutrition: a systematic review and meta-analysis. *Journal of Adolescent Health, 59*, s29-s39.

Save the Children. (2015). *Adolescent nutrition - Policy and programming in SUN+ countries.* London: Save the Children.

Semba, R., de Pee, S., Sun, K., Sari, M., Akhter, N., & Bloem, M. (2008). Effect fo parental formal education on risk of child stunting in Indonesia and Bangladesh: a cross-sectional study. *Lancet, 371*, 322-28.

UNICEF. (2018). Zambia Nutrition. Accessed December.

United Nations. (2018). World Urbanization Prospects 2018.

USAID. (2009). USAID/Zambia Education Program Evaluation.

USAID. (2014). *Multi sectoral Nutrition Strategy 2014 - 2025.*

Wei, D., Brigell, R., Khadka, A., Perales, N., & Fink, G. (2019). Comprehensive school-based health programs to improve child and adolescent health: Evidence from Zambia. *PloS one*, *14*(5).

WHO. (2006). *Adolescent Nutrition: A review of the situation in selected South-East Asian countries.* New Delhi: WHO.

WHO. (2010). Working to overcome the global impact of neglected tropical diseases: first WHO report on neglected tropical diseases. Geneva: World Health Organization.

WHO. (2019). School health and youth health promotion. Available from: https://www.who.int/school_youth_health/en/

World Bank. (2016). School Health and Nutrition.

World Bank. (2019). Mortality rate, under-5.

World Bank. (2019). Population Growth (annual %). Zambia HIV Impact Report. (2016).

## APPENDIX A: MONITORING AND EVALUATION FRAMEWORK

| PILLAR | Indicators | Frequency of Reporting | Reporting Level[1] | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **HEALTH SERVICES** | | | | | |
| **H1** | **Health Promotions** | | | | |
| | 1. Number of health education lessons provided to learners | Monthly | 1 | Records of work | Termly |
| | 2. Number of teachers providing health lessons | Monthly | 1 | Record of work | Termly |
| | 3. Percent of learners passing health knowledge assessment | Termly | 1,2,3,4 | Assessment Results | Termly |
| | 4. Number of health promotion activities provided by health professionals | Monthly | 1 | Activity Report, Log book | Termly |
| | 5. Number of activities conducted by a school health club | Monthly | 1 | Activity Report | Termly |
| **H2** | **Sexual and reproductive Health** | | | | |
| | 1. Number of female learners provided sanitary pads | Monthly | 1 | Distribution List | Termly |
| | 2. Number of counselling sessions provided | Monthly | 1,2,3,4 | Case Report(s) | Termly |
| | 3. Number of learners provided with counselling | Monthly | 1 | Case Report(s) | Termly |
| | 4. Number learners referred for sexual & reproductive health services | Monthly | 1 | Case Report(s) | Termly |
| | 5. Number of learners referred for gender-based violence services | Monthly | 1 | Case Report(s) | Termly |
| | 6. Number of learners referred due to suspected child abuse | Monthly | 1 | Case Report(s) | Termly |
| **H3** | **Vaccinations** | | | | |
| | 1. Proportion of ECE and grade 1 learners fully vaccinated at enrolment | Annual | 1,2,3,4 | Enrolment form | Annually |
| | 2. Number of learners referred by the school for catch-up vaccination | Annual | 1,2,3 | Enrolment form | Annually |
| | 3. Number of learners provided with routine vaccines at school | Annual | 1,2,3,4 | Activity Report | Annually |

[1] 1 = School, 2 =District, 3 = Province 4 = National

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **HEALTH SERVICES** | | | | | |
| **H4** | **Assessment, Treatment and Referrals** | | | | |
| | 1. Number of unwell learners assessed by a SHN teacher | Monthly | 1 | Screening Register | Termly |
| | 2. Number of learners provided with first aid treatment by SHN teacher | Monthly | 1 | Screening Register | Termly |
| | 3. Number of unwell learners referred to a health facility | Monthly | 1 | Screening Register | Termly |
| | 4. Number of learners referred for being unwell who were followed-up by the school within five days | Monthly | 1 | Screening Register | Termly |
| | 5. Number of learners who were referred that were attended to by health care provider | Monthly | 1 | Screening Register, Feedback form | Termly |
| | 6. Number of learners provided w/ health check by healthcare provider | Annual | 1 | Activity Report | Annually |
| **H5** | **HIV/AIDS** | | | | |
| | 1. Presence of active AIDS Action Club | Annual | 1 | Activity Report | Annually |
| | 2. Number of activities carried out by the club | Annual | 1 | Activity Report | Termly |
| **H6** | **Malaria** | | | | |
| | 1. Number of learners reported having been diagnosed with malaria | Monthly | 1 | Screening Register, Feedback Form | Termly |
| | 2. Number of health education talks on malaria conducted | Monthly | 1 | Records of work | Termly |
| | 3. Proportion of learners who own a long-lasting insecticide treated net (for boarding schools) | Termly | 1 | Observation Counts | Termly |
| **H7** | **Drugs, Alcohol and Substance Abuse** | | | | |
| | 1. Number health talks on alcohol/substance abuse | Monthly | 1 | Records of work | Termly |
| | 2. Number of learners identified to be abusing drugs/alcohol | Monthly | 1,2,3,4 | Minutes | Termly |
| | 3. Numbers of learners provided with counselling services on drug and alcohol abuse | Monthly | 1 | Case Report(s) | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **HEALTH SERVICES** | | | | | |
| **H8** | **Mental Health** | | | | |
| | 1. Number of learners identified with a suspected mental health condition | Monthly | 1 | Case Report(s) | Termly |
| | 2. Number of with mental health condition referred to a health facility | Monthly | 1 | Case Report(s) | Termly |
| **H9** | **Oral Health** | | | | |
| | 1. Number of learners suspected with oral health conditions | Monthly | 1 | Screening Register | Termly |
| | 2. Number of learners with oral health conditions who were referred to the health facility | Monthly | 1 | Screening Register, Feedback Forms | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **NUTRITION SERVICES** | | | | | |
| **N1** | **Health and Nutrition Education** | | | | |
| | 1. Number of Nutrition Education talks given | Monthly | 1 | Records of work | Termly |
| | 2. Number of teachers trained in Physical Education [for secondary schools] | Termly | 1 | Staff Register | Termly |
| | 3. Number of learners assessed in nutrition status | Monthly | 1 | Screening Register | Termly |
| | 4. Proportion of learners found to be malnourished | Monthly | 1,2 | Screening Register | Termly |
| **N2** | **Micronutrient supplementation and De-worming** | | | | |
| | 1. Proportion of adolescent female learners receiving iron supplementation | Monthly | 1,2,3 | Distribution Register | Termly |
| | 2. Number of adolescent female learners referred for folic acid or iron supplementation | Monthly | 1,2,3 | Referral Forms | Termly |
| | 3. Number / proportion of learners receiving Vit A | Monthly | 1,2,3 | Distribution Register | Termly |
| | 4. Number / proportion of learners dewormed | Monthly | 1,2,3 | Distribution Register | Termly |
| | 5. Proportion of schools receiving at least one deworming round in a year | Annual | 2,3 | Activity Report | Annual |
| | 6. Proportion of schools receiving two deworming rounds in a year | Annual | 2,3 | Activity Report | Annual |
| **N3** | **School Feeding / Agriculture** | | | | |
| | 1. Proportion of schools on the School Feeding Programme | Annual | 1,2,3,4 | Schools in district with programme | Termly |
| | 2. Number of learners fed (record highest daily number) | Monthly | 1,2,3,4 | Qty food given, Attendance Record | Termly |
| | 3. Number of learners reached with messages on growing a variety of crops | Termly | 1 | Attendance Register | Termly |
| | 4. Number of local farmer groups registered with the | Termly | 1 | Register of Farmer Groups | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **NUTRITION SERVICES** | | | | | |
| | school to supply locally produced crops | | | | |
| | 5. Quantity of locally produced food supplied to the school (in Kgs) | Termly | 1 | Stock cards, Stores document | Termly |
| | 6. Number of times nutrition experts visited the school to provide education lessons | Monthly | 1 | Activity Report, Log book | Termly |

| | | | | | |
|---|---|---|---|---|---|
| **N4** | **Growth monitoring and promotion (GMP)** | | | | |
| | 1. Number of times GMP services conducted at ECE centre | Monthly | 1 | Log Book / Activity Report | Termly |
| | 2. Proportion of learners weighed requiring nutritional attention | Monthly | 1,2 | Activity Report | Termly |
| **N5** | **Healthy Eating, Environment and Habits** | | | | |
| | 1. Availability of appropriate feeding shelters at school per prevailing guidelines | Annually | 1,2 | Observation | Annually |
| | 2. Availability of appropriate cooking utensils per prevailing guidelines | Annually | 1,2 | Observation | Annually |
| | 3. Number of medically certified food handlers | Termly | 1,2 | Certificate of Medical Examination | Termly |
| | 4. Appropriate solid waste management facilities per prevailing guidelines | Termly | 1,2 | Observation | Termly |
| **N6** | **Agriculture – School Model Gardens** | | | | |
| | 1. Number of lessons taught sustainable agriculture and livestock/fisheries | Termly | 1 | Attendance Register, Record of work | Termly |
| | 2. Proportion of schools in a district with established school gardens | Termly | 2,3 | Distribution List | Termly |
| | 3. Proportion of schools in district with established fruit tree nursery | Termly | 2,3 | Distribution List | Termly |
| | 4. Quantity of surplus food produced by the school production unit | Termly | 1,2,3 | Stock Cards, Stores record | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **WATER SUPPLY, SANITATION AND HYGIENE (WASH) AND ENVIRONMENT** | | | | | |
| **W1** | **Water Supply** | | | | |
| | 1. Proportion of schools accessing water from a protected source (e.g. Piped from water utility company, borehole, protected well) | Termly | 2,3 | Observation, Report(s) | Termly |
| | 2. Proportion of schools stocking chlorine for water treatment | Termly | 2,3 | Activity Report | Termly |
| | 3. Proportion of schools with hand washing facilities | Termly | 2,3 | Annual School Census Form | Termly |
| **W2** | **Sanitation** | | | | |
| | 1. Proportion of schools passing environmental or sanitation inspection | Termly | 2,3 | Observation, Report(s) | Termly |
| | 2. Proportion of ECE centres passing environmental / sanitation inspection | Termly | 2,3 | Observation, Report(s) | Termly |
| | 3. Proportion of schools meeting the pupil-sanitary facility ratio as per prevailing guidelines | Termly | 2,3 | Observation, Report(s) | Termly |
| | 4. Proportion of schools with sanitary facilities for Learners with physical disabilities per prevailing guidelines | Termly | 2,3 | Observation, Report(s) | Termly |
| | 5. Proportion of schools with sanitary facilities that meet Menstrual Hygiene Management Friendly criteria | Termly | 2,3 | Observation, Report(s) | Termly |
| | 6. Proportion of schools with available sanitary towels for emergency use for learners to access at anytime | Termly | 2,3 | Observation, Report(s) | Termly |
| | 7. Proportion of schools with available Personal Protective Equipment to enhance cleaning of | Termly | 2,3 | Observation, Report(s) | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **WATER SUPPLY, SANITATION AND HYGIENE (WASH) AND ENVIRONMENT** | | | | | |
| | sanitary facilities per prevailing guidelines | | | | |
| | 8. Number of lessons conducted for learners on environmental health | Monthly | 1 | Activity report | Termly |
| | 9. Proportion of schools that held at least 1 meeting with the health personnel on WASH | Monthly | 2,3 | Meeting Minutes Activity report | Termly |
| **W3** | **Hygiene** | | | | |
| | 1. Number of lessons conducted for learners on personal hygiene practices | Monthly | 1 | Meeting Minutes Activity report | Termly |
| | 2. Proportion of schools that held at least three (3) group handwashing lessons with soap | Termly | 2,3 | Activity Report | Biannually |
| | 3. Number of lessons conducted on face washing with water and soap to learners for the prevention of eye diseases | Monthly | 1 | Activity report | Termly |
| **W4** | **Environmental Health** | | | | |
| | 1. Proportion of schools with age appropriate furniture and equipment for ECE learners per prevailing guidelines | Termly | 2,3 | Termly Report | Termly |
| | 2. Proportion of ECE centres with age-appropriate infrastructure for young learners as per prevailing | Termly | 2,3 | Termly Report | Termly |
| | 3. Proportion of schools with appropriate infrastructure for learners with physical disabilities per prevailing guidelines | Termly | 2,3 | Termly Report | Termly |
| | 4. Number of sensitization lessons conducted by teachers on environmental pollution | Termly | 1 | Termly Report | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **WATER SUPPLY, SANITATION AND HYGIENE (WASH) AND ENVIRONMENT** | | | | | |
| | 5. Number of teachers oriented on aspects of environmental health | Termly | 1,2 | Termly Report | Termly |
| | 6. Number of structures certified fit for use out of the total number of structures inspected | Termly | 1,2 | Termly Report | Termly |

| PILLAR | Indicators | Frequency of Reporting | Reporting Level | Means of Verification | Frequency of monitoring |
|---|---|---|---|---|---|
| **GENERAL MANAGEMENT OF SHN PROGAMME** | | | | | |
| **G1** | 1. Number of SHN committee meetings held | Termly | 1,2 | Minutes | Termly |
| | 2. Availability of an active SHN Committee in school | Monthly | 1,2 | Minutes | Termly |
| | 3. Number of SHN committee led meetings held with the Community | Termly | 1 | Activity report | Termly |
| | 4. Number of meetings held with parents/caregivers discussing good personal hygiene practices | Monthly | 1 | Meeting Minutes Activity report | Termly |
| | 5. Number of activities conducted by a school health club | Monthly | 1 | Activity Report | Termly |
| | 6. Number of school maintenance projects done in collaboration with the PTC | Termly | 1,2 | Termly Report | Termly |