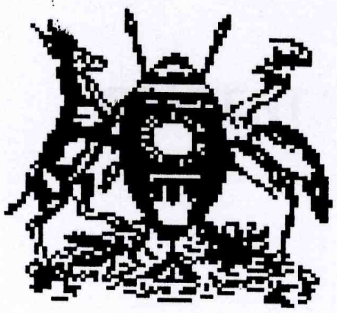

THE REPUBLIC OF UGANDA

UGANDA SCHOOL HEALTH POLICY

A healthy mind in a healthy body for better performance

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CONTENT

A LIST OF ACRONYMS

IEC	-	Information Education Communication
NCDC	-	National Curriculum Development Center
UNEB	-	Uganda National Examination Board.
ITEK	-	Institute of Teacher Education, Kyambogo
AMREF	-	African Medical Research Foundation
CBOs	-	Community Based Organisations
BCG	-	Bacillus Collumete Guerin (Vaccine)
DPT	-	Diphtheria Pertusis Tetanus (Vaccine)
TT Booster	-	Tetanus Toxoid Vaccine
BP	-	Blood Pressure
WHO	-	World Health Organization
MOES	-	Ministry of Education and Sports
UPE	-	Universal Primary Education
UNESCO	-	United Nations Education Scientific and Cultural Organisation.
UNICEF	-	United Nations International Children's Emergency Fund
PEAP	-	(Poverty Eradication Action Plan)
USE	-	Universal Secondary Education
ARI	-	Acute Respiratory Infections
RH	-	Reproductive Health
MOH	-	Ministry of Health
PTA	-	Parents Teacher Association
NGO	-	Non – Government Organization
KAP&B	-	Knowledge Attitude Practice and Behavior

ITMS	-	Insect Treated Materials
RIS	-	Residual Insecticide Spraying
PHC	-	Primary Health Care
SMC	-	School Management Community
BOG	-	Board of Governors
PTC	-	Primary Teachers' College
TTC	-	Teacher Training colleges
NTC	-	National Teachers' College
TV	-	Television
HCS	-	Health Care Services
SHEP	-	School Health Education Project
CAO	-	Chief Administrative Officer
DEO	-	District Education Officer
DIS	-	District Inspector of Schools
DDHS	-	District Director of Health Services
SNE	-	Special Needs Education

EXECUTIVE SUMMARY

Fifty percent of Uganda's population is under 15 years of age. The Universal Primary Education (UPE) program has enabled 7 million children, which is over 30% of the entire population, to be in school. When Universal Secondary Education (USE) is introduced, the number of children in school could rise to 9 million or 40% of the population.

A school child spends over 75% of his/her time at school. But the physical and psychosocial environments are not usually conducive for a healthy living. Inadequate health education, poor sanitation and nutrition, and unhealthy/risky lifestyles through peer influence worsen this situation.

However, it is now known that there is a positive and synergistic relationship between education, good health, quality of life, academic performance and economic/social productivity.

The school health policy puts together a number of measures to enhance this synergy. The measures include health education, physical education, safety and security measures, sanitation and safe water, creating conducive psycho-social environment, promoting health life styles, and provision of health care and good nutrition."

The measures will be implemented through a sector-wide approach, with the leading sectors being education and health. The key methods of implementation will be collaboration, coordination, integration, advocacy and sustainable capacity building.

1.0 Back Ground Information

1.1 Introduction

Uganda is among the least developed and poorest nations of the world with a per capita income of US$310. The country's population of approximately 22 million people has a high growth rate per annum of 2.5%. The population is still young with about 50% below 25 years of age typical of any developing countries. Key health indicators reveal that the health status of the population is still poor. Life expectancy for example is only 43% years. Mortality rates still remain unacceptably high and access to essential services like safe water and sanitation is still very low at 48% and 47.6% respectively.

Poverty and ignorance are major factors for the poor health status of Uganda's population. The Government has adopted a Poverty Eradication Action Plan (PEAP) with strategies which include: Universal Primary Education (UPE), Universal Secondary Education (USE) in the year 2003 and a minimum Health Care Package. The policy of the Ministry of Education and Sports (MoES) emphasises equity, access and quality education. These can only be achieved if the children have healthy minds and better performance. School health is a component of the minimum Health Care Package a cornerstone of the National Health Policy.

School health services will jointly be coordinated and monitored by the Ministry of Health and the Ministry of Education and Sports and implemented in an integrated coordinated multi-sectoral manner by all stakeholders. The programme covers the school child in Nursery, Primary, Community, polytechnics and Secondary Schools (3 – 24 year age group). It also supports Teacher Training Institutions to enhance the capacity of teachers to provide health education.

1.2 Health Status

Uganda has poor health indicators and a heavy burden of disease. The 1995 Burden of Disease study indicated that 75% of years lost to premature death are due to preventable diseases of which prenatal and maternal related conditions take up to 20% (Prevalence Rate), Malaria, 15.4%, Acute Respiratory Infections, 10.5%, AIDS 9.1% and Diarrhoea 8.4%. Others include Tuberculosis, Malnutrition, Anaemia, Intestinal worms, Trauma/Accidents, skin infections and Dental health.

The health status of the school child is not any better than that of the rest of the community. But the school child's health is not well researched and there is little or no disaggregated data. The school child spends over 75% of his/her total time in school environment where, the classrooms are often overcrowded and dusty. Schools have inadequate safe water supplies, latrines, medical and dental care and absent or poor feeding programmes. The school child is perpetually under the influence of bad peer and community lifestyles. Malaria remains a common cause of absenteeism from school. Adolescent

reproductive health problems also commonly cause children, especially girls, to drop out of school.

Health is affected by what children learn and do at school. Good health habits can be taught in classrooms, modeled by teachers, and learned from school health personnel. A child's health can be affected by the physical, emotional environment of the school and by its physical and nutrition education programmes.

1.3 Education status

The Ugandan Education System has expanded in enrolment and infrastructure. Primary school enrolment ratio increased at 3.7 percent per annum between 1990 and 1993. With the introduction of UPE in 1997 there was a remarkable increase in enrolment by more than 50%. Enrolment has now increased to about 6.8 million. The introduction of UPE has also brought on board 157,920 pupils with Special Needs Education (SNE) and these require adequate health facilities/ services to enable them cope in the mainstream section.

School infrastructure has also been expanding through public and private support programmes. By 1999 the total number of government and private primary schools stood at 9860 and 1536 respectively, a figure deemed to have doubled compared to a period of ten years back. To accommodate pupils graduating from primary schools under UPE, there has been an initiative to vocationalise education and community polytechnics and to establish many more private secondary schools. The number of secondary schools is expected to rise steeply from the current 1743 secondary schools. Government has promised to build about 900 secondary schools and 850 community polytechnics, one in each Sub-county.

The pace at which developments in the education sector has occurred has not been matched with the development of policy instruments and programmes on health in schools. Data available indicates that health related factors account for more than 50% of the school dropouts.

The World Health Organisation, UNESCO and UNICEF's argument for quality education and health of children as a measure to address the needs of children cannot be over emphasized. Furthermore, tackling the root causes of ill health and educational disadvantages are a key to alleviating children's educational and health problems and enhancing national development.

School achievement is affected by the child's health. Physical illness and injury, mental and emotional problems can result in absence from school, reduced alertness in class, dropout from school and be detrimental to learning. This calls for a planned and sustained campaign to eradicate or mitigate the causes and outcome of poor health in schools through appropriate policy instruments and programmes. The campaign will be done through:

- Health education that addresses the physical, mental, emotional, and social dimensions of health for school children
- Physical education, sports and recreation that promote physical fitness and transmission of health messages to community
- Medical and dental care services which provide prevention and early intervention, emergency care, referral to community health services, and management of chronic health conditions.
- Nutrition services that provide nutritious and appealing meals, an environment that promotes healthful food choices, and support for nutrition instruction
- Healthy school environment (both physical and psychosocial).
- Counseling, psychological, and social services for school children and staff
- Health promotion for staff
- School Parent and community involvement
- Safety and security in schools

1.4 Harmonising existing policies

There are various attempts to provide health services to the child and the community that have not been properly coordinated namely:
Child Health Policy, Uganda National Plan for Action for the Child, The Convention of the Rights of the Child, The Children Statute (1996), Food and Nutrition Policy, The Education White Paper (1992), National Health Sector Strategic Plan 2000-2005, Universal Primary Education Programme (1997) and Education For All (Dakar Conference 2000). All the listed policies / programmes address at least a component of the child's' welfare. Therefore, there is need to harmonise all the existing policies and programmes to rhyme with the current Government Policy.

The Government's policies of liberalisation and privatisation have brought on board various service providers all related to the welfare of the child. This calls for a policy to guide some of the operations of these private providers to ensure equity and quality.

1.5 Potential benefits from school health

(a) Health benefits

Diseases which are common among school children such as diarrhoea, HIV/AIDS, malaria, sexually transmitted diseases and unwanted pregnancies due to unsafe sexual practices can be prevented. This age group 3 – 24 years constitute 56% of the total population forming the largest and easily accessible demographic group for Health interventions. The effects anticipated to accrue from the proposed school health services will benefit families and communities where school children come from. This potential multiplier effect of health promotion services based in schools will create a big positive impact in health and result into significant improvement of national morbidity and mortality indicators.

Through school health services we can contribute to the goal of **Health For All**. The introduction, support and implementation of UPE and the proposed USE avail an opportunity for Uganda to move towards health for all. The school-going age children (5 – 24 years) who form 56% of the population are in their growing and receptive period. They are the potential household heads, parents, community and national leaders of tomorrow. Through this link between the school child and the community, it is possible to break through and influence lifestyles of individuals and communities. These health promotion school services will empower people to control and improve their own health and the health of communities.

(b) Educational benefits

School achievement is affected by physical, mental and emotional health of the learner and trainer. Poor health leads to poor class attendance, reduced alertness in class early drop out, repetition of levels, suffering and premature death. A healthy and conducive environment can make learning easiest and more attractive to pupils and students. Therefore provision of school health services will lead to increased morale regular attendance, alertness of pupils/students, reduce ill-health related absenteeism from school, school drop-outs, repetition of classes and foster better school/academic performance. Overall, this will result into optimum utilization of scarce resources which are put in the education sector.

(c) Economic benefits

There is a positive link between health, education, quality of life and economic productivity. Government has realized this synergistic relationship. To address issues of poverty alleviation, it has introduced UPE and proposed USE. School health services will ensure that the massive human resource output from schools produce a healthier working force, which will enhance increased productivity .

(d) Social benefits

There is positive link between health and quality of life. School health services will improve the quality of life particularly the girl child, children with disability and family life in general. Generally the school population will be empowered to reduce poverty and exploit their full potential.

2.0 Current situation

2.1 Health education:

- Health education in schools has been going on in primary schools since 1987. It is occasionally supplemented by talks given by health workers. A syllabus for secondary schools was developed but still lies in the shelves. Surveys conducted show high levels of awareness but these are not matched with health promoting behaviour.
- There are unhygienic practices in schools by school children, staff, PTAs and School Management Committees. There is a lot of soiling of latrines, very low use of Insecticide Treated Materials (ITMs) in boarding schools. All these could be due to lack of awareness and poor attitude among the various stakeholders.
- Inadequate health education in the teacher education curriculum.
- Health workers do not give adequate support to the curricula based health education.
- The current curricula-based health education does not lead to development of survival skills.
- Absence of health education in secondary schools.
- Lack of life skills education in all schools to enhance change of behaviour and practices.

2.2 Physical education, sports and recreation

- Physical education (P.E), though on timetable, is not taught practically.
- Most schools have inadequate playgrounds and indoor games. Yet all children need to play to keep healthy and fit.
- Most schools have games and sports but do not use them as vehicles to transfer health related knowledge, attitude and behavior.
- Sports pre-participation physical examination and infection control procedures are not observed in school sports.
- Lack of washing /bathing facilities for teachers and pupils after P.E.
- Lack of proper management of P.E and Sports activities leading to health hazards.
- In most schools only a few children get actively involved in games and sports.
- Many schools do not conduct health parades to promote personal hygiene.

2.3 Safety and security in schools

The status of safety and security in schools is worrying ranging from abductions in the North, the Kichwamba inferno in the West, reported arsons in several boarding schools, children being shot in schools, strikes etc. Besides, apparently there is a lot of child abuse in schools.

Also, the recently concluded school health baseline surveys show that:

- 24% of secondary and 5% of primary boarding schools have pupils / students sleeping in triple and quadriple decker beds a situation that can lead to being struck by lightening.
- Only 7% of the schools have at least a functional fire extinguishers
- Only 9% of the schools have some of their buildings fitted with lightening protective devices.
- Only 28% of the schools have adequate perimeter fencing.
- Many schools have buildings constructed in asbestos materials which pose health risk.
- Many school children are involved in road accidents.

2.4 Environmental sanitation

(a) Latrines / toilets

- Most schools do not have adequate latrines. They have latrine stance/pupil ratios of 1:90 or more, contrary to the recommended ratio of 1:40. Only 20% of the schools meet the standard ratio.
- Most latrines lack privacy and are of poor standards.
- 50% of the schools have soiled latrine walls and floors.
- About 22% of the schools have hand washing facilities.
- The majority of schools do not provide toilet tissues.
- Ventilation and lighting in latrines is very poor. Poor lighting leads to floor soiling at night.
- Classrooms are over-crowded with only 28% of schools providing the recommended space per pupils ($1.5m^2$) and teachers ($5m^2$). They are also not painted bright, therefore not stimulating.

(b) Refuse management

- There are some schools with good arrangements for collection and disposal of refuse. However many schools lack this arrangement.
- As a result there is indiscriminate littering of rubbish in the compound attracting pests, disease vectors, vermin and offensive smell.

(c) Compound

- Most schools have adequate compounds except newly constructed urban schools.
- Compounds are poorly maintained, lack trees (wind breakers), flowers, orderly arrangement of paths, and perimeter fencing.

(d) Boarding facilities

- In some mixed schools children of both sexes share dormitories.
- In most boarding schools accommodation facilities are inadequate with only 34% schools meeting the recommended space per pupil/student of ($4m^2$).
- About 5 to 10 percent of the school children sleep in triple and quadriple deckers, which are very risky. Use of more than two tier beds is risky. Children can fall, and can easily be struck by lightening.
- In about 25% of the primary boarding schools some children sleep on the floor.
- 29% of the boarding schools have cloth and shoe maintenance facilities and 27% have ironing facilities, 44% of boarding schools have wire lines for drying clothes.
- Many bathrooms in schools are un hygienic, water logged and have no privacy. Day schools have no bathrooms, which can be used after parades and also by adolescent girls.
- 22% of the schools provide facilities for disposal of sanitary towels.
- Many schools have inadequate arrangements to manage waste and water drainage.

(e) Classrooms

- With the introduction of UPE, significant overcrowding has resulted but classroom construction is ongoing.
- Only 28% of schools provide the recommended space per pupil ($1.5m^2$), and teacher ($5m^2$).
- Classroom construction is usually incomplete, not brightly painted and therefore not stimulating for learning purposes.
- Construction work is usually substandard, providing poor lighting and ventilation.
- At times there are unfinished classrooms which pose a great risk to children and the surrounding community.
- Classrooms are usually poorly maintained and untidy.

(f) Vector and vermin control

- Vector and vermin control in schools is poor leading to breeding of mosquitoes, bats, bedbugs, rats, flies, cockroaches and snakes. About 55% of the schools have bat infestation, 60% have cockroaches and 22% have rats in stores.

(g) Personal hygiene

The level of personal hygiene among school children and staff is low. Many school children are unkempt, keep long dirty nails, have body and head lice, jiggers and poor oral hygiene.

2.5 Safe water supplies

- 46% of the schools have safe water supply sources in form of piped water, borehole and protected springs within school compound. This leaves the majority of schools with poor access to water.
- Less than 50% of the boarding schools provide boiled or chlorinated water for drinking.

2.6 Psychosocial environment

- A good number of schools have reasonably conducive psychosocial environment. However, 28% of the primary and secondary schools have signs of bad lifestyles among school children such as smoking, alcoholism, drug abuse, sexual perversion, child abuse and violence.
- Most schools lack counseling and spiritual care services.
- Enrolment by gender and disability persons has increased but supportive facilities are lacking. Only 7% of the schools have some provision for children with disability.
- A number of teachers do not observe professional code of conduct.
- A number of teaching and non – teaching staff are not exemplary in many ways for instance, smoke, drink while in school compound.
- Bullying and teasing is common in schools.
- Schools exclude children with special needs in other activities.
- Excessive corporal punishment.
- Poor handling of adolescent girls who get pregnant.
- Poor dissemination and enforcement of school regulations.
- Access to pornographic materials/publications in schools.

2.7 Medical and dental care services

- Many schools have some kind of first aid boxes but these are not stocked.
- There are teachers and school children trained to provide first aid in some schools.
- Very few schools conduct health parades to check on personal hygiene.
- Very few schools conduct regular screening to detect sight and hearing defects, dental caries, nutritional problems, and other ill health among school children.
- Some schools have clinics/sickbays to provide care to sick children but only 15% of them have trained health care workers at the level of enrolled nurse and above.
- Very few schools keep medical records on children and staff.
- Sick children are not appropriately referred.

2.8 School feeding

- Studies have shown that only 26% of day schools have feeding programmes. in most schools the majority of school children go without a meal between 7.00 a.m and 6.00 pm. This adversely affects on education.
- Boarding schools have feeding programmes but the meals are monotonous, poor in quality and quantity, with little or no provision for animal protein, and fruits.
- Most schools do not have school garden/farms for experimental and illustration purposes.
- Poor handling of food is a common feature among school feeding programmes. Food, which is not hygienically prepared, stored and served, can be a source of health problems.
- The majority of school children particularly rural children are malnourished and anaemic.
- The majority school children are not provided with shoes or some sort of protective footwear. As a result school children harbour heavy loads of intestinal worms which compete for the little food available in their bodies.
- Schools particularly boarding institutions have dinning facilities but they are inadequate due to overcrowding in schools, as a result children eat under trees, dormitories and classrooms.

2.9 Health promotion for staff

- In 20% of the schools, teachers share toilets with school children
- Many school workers are leading bad lifestyles, they are sickly, dirty or untidy, and therefore poor models for school children and community.
- Teachers should be in good health so that they are alert and concentrate on training school children.
- There are no medical services for them in or near schools.
- Lack of meals for teachers.
- Very few schools conduct regular medical examination of their staff.

2.10 School – community interface

- School children and staff are not actively involved in community based Primary Health Care activities such as cleaning/protecting springs, cleaning paths/roads and promoting immunization etc.
- Parents, community members and leaders are actively involved in some schools based Primary Health Care activities such as construction works, inspection, planning services, passing bye-laws and media programmes promoting school health services etc. However their involvement is inadequate
- Lack of follow up of problematic pupils by teachers and parents.
- Lack of follow up of pupils' progress at school by parents and teachers.
- Inadequate support of pupils by parents with scholastic materials, personal effects and school development efforts.
- Lack of interaction between teachers and parents on pupils' performance.

- The curriculum is not responsive to community needs.

2.11 Coordination and net- working

- Stakeholders at various levels are implementing school health services but are poorly coordinated
- There is no explicit framework for co-operation and collaboration among stakeholders or established channels of information flows.
- Lack of understanding the inter linkages and guiding principles and policies of the various stakeholders in the delivery of school health services.
- Defining specific roles/responsibilities of stakeholders and coordination and monitoring mechanisms.
- Policy guidelines are lacking at all levels.

3.0 GOALS AND OBJECTIVES

3.1 Goals

- The overall goal of the school health policy is to improve the health status of school children, the staff and their families.
- A specific goal of the policy is to use the school child as a community change agent to attain good health practices.

3.2 Objectives

- To ensure access to primary health care services in educational institutions
- To strengthen basic health education and practices in educational institutions.
- To promote better nutrition and feeding practices in educational institutions
- To promote the provision, adequate and proper maintenance of safe water supply for drinking, bathing and washing in educational institutions.
- To promote the provision of adequate and safe sanitation facilities in educational institutions.
- To strengthen management of common health conditions in educational institutions including screening, immunisation and adolescent sexual reproductive services.
- To promote the provision of healthy and conducive psychosocial school environment accessible to including children with special needs in educational institutions.
- To promote provision of health services for all staff in educational institutions.
- To improve upon the provision of health services to cater for gender issues and persons with disabilities.
- To promote the inculcation of essential /basic health education in the teaching and learning practices

3.1 Target groups

(a) Primary target

School health services and behaviour change target school age population between 3 – 24 years, which constitutes approximately 56% of Uganda's population. This school age group is sub-divided as follows:

- 3 - 4 year olds pre-primary, constitute 8% of the population
- 5 – 9 years (nursery schools and lower primary 1 – 4) – the largest proportion of the target group, that makes 15% of Uganda's population.
- 10 – 14 years (upper primary 5 – 7) – these account for 13% of Uganda's population.
- 15 – 19 years (secondary 1 – 6) – these account for 11% of Uganda's population.
- 20 –24 years (Post Secondary and Tertiary Education) – these account for 9% of Uganda's population.

(c) Secondary targets

- Children out of school.
- Parents, Guardians, PTAs, SMCs, BOGs, Guardians, Foundation Bodies and other community leaders.
- Teaching and non-teaching staff.

4.0 STRATEGIES

4.1 Health education

- The government shall initiate a comprehensive pre-service and in-service training of teachers on health issues so as to have teachers qualified enough to teach health in schools.
- Review and strengthen the existing curricula on health education in primary, secondary and Technical Training Colleges, PTCs and NTCs to address physical, mental, emotional and social dimensions of health.

4.2 Physical education, recreation and sports

Every school/institution of learning shall be obliged to offer opportunities/facilities to enable pupils/student participate in physical education, recreation and sports activities.

- Co-curricula activities in educational institutions shall be strengthened and implemented by all schools to promote physical fitness for all school children and also to serve as channel for transmission of health messages.
- In addition, strategies for medical prevention initiatives such as pre-participation physical examination and infection control procedure shall be observed in sports.

- Adequate and child friendly play grounds shall be provided in all educational institutions

4.3 Safety and security

- Where there is insurgency, the security of school children shall be tightened
- All schools shall have adequate and strong perimeter fencing to ward off animals and intruders
- All schools shall have adequate and functional fire extinguishers in all building blocks
- All school building blocks shall be fitted with lightening protection devices
- Schools shall be constructed according to approved plans
- Highway code shall be taught in all schools, zebra crossing, road humps, and road signs shall be meticulously fitted in the school neighborhood.
- School compounds shall be well maintained.
- Dangerous objects, weapons, fire arms, pangas, shall not be in the school
- Mechanisms for dialogue shall be maximized in schools to avoid strikes
- Except in the area of insurgency, school guards shall have only light weapons and no firearms.
- Hand guards, rails shall be provided where necessary (stares, slopping surfaces)
- Regular checks in students, pupils, staff and visitors for dangerous weapons shall be carried out in schools.
- Pupils / students shall not be sent out of the school without prior information given to the parent/guardian.
- A teacher / staff member shall not be with the opposite sex school child in isolation.

4.4 Sanitation and water

Every institution of learning shall:

- Have access to adequate safe water for drinking, bathing and washing with in school compound.
- Have adequate sanitary facilities, which should be gender sensitive and disability friendly.
- Carry out disinfecting activities at least once a term.
- Conduct health parades and health clubs to promote personal hygiene.
- Have buildings in the school compound built according to approved plans.
- School children should be encouraged to wear shoes / footwear to avoid infestation with worms.

4.4 Psycho-social environment and healthy life style

- All educational institutions shall have regulations that promote Health and prohibit smoking, alcohol consumption and use of addictive drugs and substances in the school environment by staff, pupils and visitors.
- School children shall not be exposed to uncensored publications, (mass media): Video/TV programmes which teach bad lifestyles and violence.

- Causing school child drop out from school through early marriage or pregnancy shall be punishable.
- Sexual abuse of school children of any form shall be punishable.
- All forms of violence, bullying and sexual harassment shall be punishable.
- Corporal punishment in schools be abolished
- Children with disability and other vulnerable school children shall be protected.
- Peer education, guidance and counseling and health clubs shall be provided in all schools.
- Enforce teachers' code of conduct.
- Government shall put strategies to ensure continuation of education for Girl children who drop out on school due to teenage pregnancy and early marriage.
- Coaching, weekend class, and work overload shall be discouraged
- Use appropriate terminology to refer to school children, e.g." taller" instead of "older".

4.6 Medical and dental care

- Immunization certificate shall be a pre- requisite for enrolment in primary schools. Any child presented without evidence of immunizations should be immunized.
- All adolescents in school shall receive booster tetanus toxoid.
- Health parades shall be conducted in all schools on daily/regular basis.
- Screening for common health conditions (sight, skin, hearing, mental, speech dental, musculo-skeltal problems) shall be conducted at least once a year, and on admission.
- New pupils/students, teachers and other school staff shall undergo medical examination.
- First aid and facilities with a mat or sickbed to provide early intervention and emergency care must be available in all day schools, and sick bay facilities shall be available where possible.
- All boarding schools and special units for children with disabilities shall have a well equipped sick bay manned by a qualified health care worker at the level of enrolled nurse or higher.
- All educational, Institutions shall have first aid kits.
- Each school shall be linked to the nearest health unit for supervision and referral to provide management of chronic and complicated acute health problems..
- De-worming of students in all primary schools shall be done regularly at least once every six months.
- There shall be regular checks to detect common health conditions and adolescent health problems by a qualified medical worker.
- School health care workers shall be oriented to manage the school Health programme activities and teachers shall be oriented in communication and counseling skills to manage adolescent health services and provide First Aid Services.

4.7 Nutrition

- Day school children shall have lunch at school and adequate safe drinking water as a bare minimum.
- Boarding schools shall provide at least 3 meals (breakfast, lunch and supper) and have adequate safe drinking water. The meals shall be rich in proteins, carbohydrates, fats, minerals and vitamins.
- Micronutrients shall be availed (Iron, Vitamin. A and iodine)
- Both day and boarding schools shall have feeding programmes that are nutritious, well prepared and hygienic.
- Nutrition education and demonstration gardens for students shall be provided in all schools.
- Consumption of dangerous foods like fine sugars, selling unhygienic food in school canteens and un hygienic food vendors shall be banished from the school compound.

4.8 School, parent and community link

Strategies shall be put in place by school administration, to mobilize and encourage parents, families and community/local leaders to participate in planning, designing implementation and monitoring school based health programs; and also to encourage schools to participate in community based PHC activities.

Therefore:

- All schools shall hold school science day
- All schools shall have speech days
- All parents with children in a school shall be involved in school Health services/Practices
- SMCs, PTAs BOG, staff, children, families and other community leaders shall participate in school Health Service/ Practices.
- Schools shall have PHC activities in the surrounding community such as protecting wells, cleaning markets etc.
- The media shall promote health in schools.

4.9 Health promotion for school staff

- All the staff in any educational institution shall have sensitisation/training on health issues.
- All school staff shall be provided with health care services.

5.0 IMPLEMENTATION FRAMEWORK

5.1 Coordination

The guidelines outlined will be translated into action through programmes and projects developed by stakeholders at different levels i.e. national, district and community/school levels. At the national Level, the Ministries of Health and

Education will collaborate and coordinate the implementation of health promotions in schools. At the Ministry of Health, the programme shall be coordinated in the division of Child Health. At the Ministry of Education and Sports level, the office of the Director for Education will coordinate it together with Education Standards Agency. At the district level, DEO, and DDHS will ensure a coordinated implementation of school health services and practices in the district. For purposes of effective coordination and networking, there shall be established a National Coordination Committee and a similar Committee at the district level. The Chief Administrative Officer will head the district committee.

5.2 Multi-sectoral approach

Stakeholders will be involved in school health activities. Mechanisms for collaboration, networking, coordination with existing relevant Ministries, Districts and lower councils, educational institutions, local and international NGOs and CBOs and international agencies such as UNICEF, WHO, UNESCO will be put in place. Effective community and family participation will be emphasized as a means for attaining sustainability.

5.3 Integration

School health activities will be implemented within the existing arrangements for service delivery in Ministry of Education and Sports, Ministry of Health, Ministry of Local Government and other social services.

5.4 Advocacy

The Government, through the Ministry of Health and Ministry of Education and Sports, and other stakeholders, will use all available opportunities and mass media to advocate and create a safe and supportive social, economic and physical environment for School Health Services.
Advocacy will also emphasise the development and implementation of services, which are child friendly and sensitive to gender, disabled and disadvantaged children.

5.5 I.E.C.

Adequate and accurate information and life skills education training materials that will help the school child develop positive health behaviour shall be provided.

5.6 Capacity building

Building on the infrastructure that already exists, a lot of capacity building will take place at the centre, district, Health sub-district, sub-county, and school levels to empower the relevant actors implement a successful school-based Health services. This will include;

Human resource

Human resources development shall include:

- Training/orientation of teachers and health care workers in school health services (in service and pre service)
- Promotion of exchange visits between districts and between schools
- Support formation of school health promotion clubs and societies
- Regular review of primary and post primary school curricula.
- Developing training/educational materials.
- Sensitisation of the non teaching staff on health education

Infrastructure

- Equipment and infrastructure development shall be provided for at all levels.

5.7 Supervision, Monitoring and Evaluation

Supervision, monitoring and evaluation at all levels to steer the services on course shall include:

- Needs/capacity assessment
- Development of standards and monitoring tools/indicators
- Conducting baseline survey and establishment of a School Health Surveillance System.
- Providing technical and integrated support supervision to districts and schools.
- Providing monitoring and evaluation to assess progress, effectiveness and impact of the programme

5.8 Funding

The implementation shall be funded from:

- Central government
- Local government
- Parents and Community
- Foundation Bodies
- Local and international NGOs / CBOs
- Development partners

5.9 Legislation

Government shall enact relevant laws and regulations to enable the implementation of the policy.

5.10 The Roles of School Health Stakeholders

No.	Roles	Stake Holders
1.	Develop policy and policy guidelines	Political leaders at all levels Executive Judiciary Cabinet Ministry of Education and Sports, Ministry of Health
2.	Develop school regulations	Ministry of Education and Sports, Ministry of Health, PTAs and SMCs/BOG
3.	Provide implementation Guidelines and Standards	Ministry of Education and Sports, Ministry of Health, NCDC, UNEB, ITEK
4.	Planning school health activities / workplans and budgets	Political leaders at all levels Ministry of Education and Sports, Ministry of Health, MoLG, Districts, Schools and all other stakeholders.
5.	Advocacy and resource mobilization	Ministry of Education and Sports, Ministry of Health, MoLG, Districts, International Agencies: WHO, UNICEF, UNESCO, AMREF, World Bank, etc..
6.	Supervision, monitoring and evaluation	Ministry of Education and Sports, Ministry of Health, MoLG, Districts, Health Sub districts, political leaders at all levels.
7.	Change and innovation to make things happen	The in-charge of School Health activities in the Ministry of Health, Ministry of Education and Sports, Districts, Sub districts and Schools.
8.	Delivery of school health related services in schools and at various higher levels.	Schools, Sub districts, Districts, Implementing NGOs, CBOs and to some extent Ministry of Education and Sports, Ministry of Health Teachers Training Institutions, Community, Pupil/Students, Parents, Teachers, PTA, SMC/BOG, Foundation Bodies.