

**THE UNITED REPUBLIC OF TANZANIA**



**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,  
GENDER, ELDERLY AND CHILDREN**

**IN COLLABORATION WITH**

**MINISTRY OF EDUCATION, SCIENCE AND  
TECHNOLOGY**

# **Policy Guidelines on School Health Services in Tanzania**

*Department of Preventive Service  
Health Promotion Section  
National School Health Programme*

2018

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## Foreword

The Government of Tanzania is committed in enrolling all eligible children and improving their health status to fulfil key targets of both Millennium and Sustainable Development Goals. School health program is an integrated set of planned, sequential, school - affiliated strategies, activities and services designed to promote the optimal physical, emotional, social, and educational development of learners. Tanzanian children are attending school for longer period of their formative lives making schools to be the most cost-effective avenue to improve their well - being and competences. Yet bridging the health and education goals requires careful planning and strong collaboration of all stakeholders and school health program globally has demonstrated that ability.

Schools provide wider coverage and ideal learning environment for their learners. It is due to this fact schools are seen to be excellent avenue that guarantee healthy nation as standardized health knowledge and skills will be able to reach every citizen without extra resources.

Health based initiatives that target school-age children and adolescents are relatively fewer compared to the actual need, making the school-going population to become under-served for health services and education. This fact on its own justifies or intensifies the need for strengthening a link between school health and education programmes. Furthermore, health and education sector policies have evolved since the year 2000 when the last school health guidelines were developed, and therefore, it is the right time now when the 2018 guidelines replace the 2000 guidelines.




Additionally, there has been an increase in number of stakeholders engaged in school health initiatives, yet they are inadequately coordinated, they lack shared vision and lack ability to plan strategically to realize a shared vision. These guidelines provide the framework for a comprehensive approach to school health. All stakeholders are required to adhere with the laid school health guidelines in order to ensure that all school-based health interventions are coordinated, complemented and synergetic.

The purpose of this guideline is to describe the institutional framework for implementation of school health programme as well as specific provisions that shall guide interventions and activities. With this regard, it is strongly recommended that this guideline remain as a cornerstone of all school health interventions in both public and private schools.

It is our expectation that this guideline will significantly contribute to the improvement of both health and educational advancement of learners, school staff, parents and surrounding communities.



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## Abbreviations and Acronyms

BEST	Basic Education Statistics in Tanzania
CCHP	Council Comprehensive Health Plans
CD	Communicable Disease
CSHP	Comprehensive School Health Programme
CVDs	Cardio Vascular Diseases
ENT	Ear Nose and Throat
FRESH	Focus Resource on Effective School Health
GSHS	Global School-based Student Health Survey
HPS	Health Promoting School
HPSI	Health Promoting School Initiative
HPSS	Health Promotion and System Strengthening
HPV	Human Papilloma Virus
MDAs	Ministerial Department and Agencies
MOE	Ministry of Education
MOEST	Ministry of Education, Science and Technology
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MUHAS	Muhimbili University of Health and Allied Sciences
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NSHP	National School Health Programme
NSHSP	National School Health Strategic Plan
NTDs	Neglected Tropical Diseases
PCD	Partnership for Child Development
PEDP	Primary Education Development Programme
PORALG	President Office Regional Administration and Government
PPP	Public Private Partnership
SCDs	Sickle Cell Diseases

## Definition of terms

**Advocacy:** A combination of individual and social persuasive actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health target.

**Burden of disease:** A measurement of the gap between a population's current health and the optimal state where people attain full life expectancy without suffering major ill-health.

**Children with special needs:** are children with a variety of, physical, mental, social, and emotional, disabilities that require special intervention, services, or support.

**Collaboration:** A recognized relationship among different sectors or groups, which has been formed to act on the matter in a way that is more effective or sustainable than might be achieved by one sector or group acting alone.

**Community:** A specific group of people, usually living in a defined geographical area, who share common values, norms, culture, and customs that are arranged in a social structure according to relationships which has collectively developed over a period of time. Such group gains personal and social identity by sharing common beliefs, values, religion and norms which have constantly been developed in the past and may be modified in the present or in the future.

**Health:** A state of complete physical, mental, social, emotional and spiritual well-being, and not merely the

absence of diseases or infirmity (WHO constitution of 1948). This definition provides a foundation for health promotion concept that need to be conceptualized by health care workers and those engaged in education and social welfare.

**Health development:** Health development is the process of continuous, progressive improvement of the health status of individuals and groups in a population.

**Health education:** Is a social science that draws from the biological, environmental, psychological, physical and medical sciences aimed at promoting health and preventing disease, disability and premature deaths through education-driven and voluntary behaviour change activities. It is a combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes. Health education comprises of consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community.

**Health promotion:** Is the process of enabling people to increase control over the determinants of health and thereby improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. Health promotion represents a comprehensive social and political process, which embraces actions directed at strengthening the skills and capabilities of individuals, and action directed towards changing social, environmental and economic conditions

so as to alleviate their impact on public and individual health.

**Health promotion approaches:** Are modes of actions or interventions undertaken to alleviate a prevailing problem or improving a situation: Approaches in health promotion can be viewed in two broad ways depending on the type of interventions undertaken or the location, problem and beneficiaries relating to an intervention. From the type of interventions perspective, there are five commonly used approaches: Disease prevention, behaviour change, educational advancement, empowerment and social change. From the location of interventions, problem addressed and population targeted, there are three main approaches: the settings approaches, the issues approach and the population approach.

**Health promoting school:** means a place where all members of the school community cooperate to provide learners with integrated and positive experiences and structures which promote and protect their health. This encompasses the formal and informal curricula in health, the creation of safe and healthy school environments, the provision of appropriate and adequate health services, as well as the involvement of parents and the total community in efforts to promote health.

**School age:** is the age range of children normally attending school. Policy Guideline for Education and Technical Education of 2014, section 3.1.2 and 3.1.3 on page 24, provides demarcation of ranges school children; nursery education is age of 3 - 5 year and primary education is standard I to VII, while secondary education is form I to VI



**Gender:** refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

**School Health Education:** is a continuum of learning which enables school children to voluntarily make decisions, modify behaviours, and change social conditions in ways that enhance health.

**School health and caring services:** are those services provided in and for a school to ensure a sound opportunity to bring health to learners and staff. They include health screening, first aid, immunization, care for special cases, health and hygiene, injuries and violence, guidance and counselling (psychological care) and referral to health facility

**Healthy and safe school environment:** A healthy and safe school environment implies a positive and welcoming school climate for all learners. Such an environment includes both the physical and social dimensions and enables promotion of safety, inclusiveness, academic support, healthy interpersonal relationships, and freedom from discrimination and abuse. This is achieved through: policies, procedures, implementation plans, and training for evidence-based strategy interventions for learners and staff; facilities/spaces equipment that meet current safety standards and are kept in good repair; and activities that enable learners to respect and promote environmental health and a positive learning community.

**School Nutrition:** refers to provision of not just meals but a balanced diet to all learners during their stay in school for

growth and health maintenance. This includes provision of nutritious breakfast like porridge, and lunch, with fruits and safe drinking water

## Executive Summary

National School Health Program as a combination of services is geared to ensuring the physical, mental and social well-being of learners so as to maximize their learning capabilities. School setting is therefore a potential avenue to reduce common health problems in learners, staff members thereby increasing the efficiency of the educational outcomes. In order for children to benefit from the education programme, they need to be healthy. This strong link between health and education therefore, identifies schools as a perfect environment where the children's well-being can be supported and maintained. The World Health Organisation (WHO) Expert Committee on School Health confirms that school health programme can advance public health, education, social and economic development. The global expansion of school health programme attests to the value placed internationally on such programme.

Furthermore, the implementation of this programme requires a multi-disciplinary effort to ensure comprehensive care to all school aged both in school and out of school as well as staff and surrounding community which impacts school health. The benefits of targeting the school population include increased public awareness, community participation and sustainability of healthy attitudes, behaviour and practices that determine the future well-being of citizen. The need for the revised Policy Guideline is derived from the understanding that the NSHP is one of the pillars in the country's health and education sector development.

Recently many stakeholders have realized the value of using school as an effective avenue to deliver various health interventions. These stakeholders lack shared vision and their efforts are not synergistically and strategically coordinated. This revised version is geared to fulfil the Sustainable Development Goals related to child health, gender, equality, universal education and environmental sustainability. It will also serve as a tool to strengthen and leverage on the new and up-dated global and regional initiatives which have demonstrated to be effective. Furthermore, the guideline is intended to mainstream child protection and gender based violence which have proved to negatively impact child and adolescent's health and education outcome. Additionally, this revision addresses the policy changes in both education and health sectors such as free basic education with a target to deliver the health-related knowledge in a programmatic and sequential manner.

This guideline focuses on three major areas of implementation which include health services, healthful school environment and health education. It specifies policy statements or provisions which cover broad programme areas as well as specific areas reflected in the context of thematic areas. The guideline also provides institutional framework to enhance collaboration, coordination and partnership.

The development of this document is the result of a participatory process involving various stakeholders of NSHP between 2012 and 2018. They constitute a framework for coordinating and supporting revitalization and implementation of National School Health Programme (NSHP). Since implementation of the NSHP has been

slow and uncoordinated, it has to be revamped to reach all learners from Pre-school to secondary school and improve the quality of interventions. Revitalization will be facilitated by using the health promotion approach which enables broader participation of sectors and players and mandate comprehensive, integrated health related activities than it was provided for in the 2000 policy guideline.

The revised school health policy guideline therefore aims to provide a clear framework on what the school health programme entail and how it could be implemented.

**The policy guideline document comprises:**

- (1) Background/Situational analysis on NSHP in Tanzania Mainland
- (2) Key public policies, conventions/treaties and legal instruments related to NSHP,
- (3) Rationale and guiding principles,
- (4) Vision, Mission and Objectives,
- (5) Specific policy provisions for NSHP broad programme areas,
- (6) Policy guidelines on interventions
- (7) Research, monitoring and evaluation and knowledge management, and
- (8) Institutional framework.

A corresponding NSHP Strategic Plan (2018-2023) outlines the implementation Framework and its operations

# CHAPTER ONE

## 1.0. BACKGROUND

School Health Program is envisaged as an important tool for the provision of preventive, promotive and curative health services to the school population. The program targets to provide effective interventions to learners and surrounding community. This chapter describes the background information for school health implementation in Tanzania Mainland,

### 1.1. Aim of this document

This document puts together current technical guidance for the National School Health Programme (NSHP). The document describes the institutional framework for implementation of school health as well as specific provisions that shall guide interventions and activities. The document is intended for use by government Ministries, Departments and Agencies (MDAs), vertical programmes development partners, Local authorities, Non-governmental Organization, actors and academic institutions, which have stake in school health.

### 1.2. Education and Health

The school is an effective and important setting for improving the health of learners, staff members (teaching and non-teaching) parents, peers, relatives and the entire surrounding community. This is so because school age children (as per these guidelines, pre-school to secondary school) form a large proportion of the country's total population. There is increasing evidence which shows that health and education are closely linked. Learning can have a positive impact on most of the health knowledge, behaviours and outcomes of the school going population.

Healthy learners are usually better learners and are more likely to complete school. It is also known that people with a better education have more chances of choosing healthier options than those with little or no education. This is especially the case for girls and women in general. The survival and development of children born to mothers with education are better than for mothers without an education. It has also been shown that there is a link between the implementation of successful school health programmes such as school meal, menstrual hygiene management and academic achievement.

### **1.3. Historical Perspective of School Health Programme in Tanzania Mainland**

Health services for school children in Tanzania mainland were initiated in 1921 under Colonia rule. These services concentrated mainly on health screening in coastal and urban areas with minimal health services. In 1923, the Ministry of Education recommended the introduction of health education as part of primary education.

After independence of the country in 1961, mobile school health teams comprising health inspectors, nurses and school inspectors were set up to provide learners with vaccinations, basic treatment, and screening together with interventions aimed at improving environmental sanitation. In the mid-1960s school health services began to deteriorate and by 1970, only a few schools in Dar es Salaam were still receiving limited services. School health services collapsed mainly because of inadequate funding for running the mobile teams and shortage of clear guidelines for implementation.

In 1978, the Tanzania Government revived school health services because it had become clear that the school age is appropriate for uptake and development of healthy behaviours and those healthy learners grow into better citizens. School health was given even more impetus by a population census which had shown that due to increased enrolment, school age children constituted 25% of the population. Most importantly, the health policy emphasized provision of basic health services to school children.

During the late 1970s and the 1980s surveys conducted by the Ministry of Health indicated that schools had poor environments (water supply, sanitation and hygiene, inadequate agriculture that did not benefit learners to provide school meals). Those surveys coincided with revision of the curriculum for primary schools, replacing domestic science with health subjects for standards/grades I to III.

Following those surveys, a pilot project was started in two regions to provide first aid, vaccination, annual health checkups, health education, school meal, maintenance of latrines, safe water, personal hygiene and teacher training through the Ministries of Health and education and Culture. Within the first phase (3 years), most services were being provided in nearly all schools in the pilot areas. From 1980 to 1987, the school health services had reached only 10% (110) of the schools in the country.

From the pilot experience, School Health Guidelines (Mwongozo wa Huduma za Afya Shuleni) were prepared in 1988 by the Ministry of Health. Emphasis was on learners' health check-ups at the beginning of each academic



year, curative services, school meal, and environmental sanitation (water and latrines). There was also health education, personnel training and monitoring and evaluation of the activities. There was some collaboration between the Ministry of Health and the Ministry of Education and other relevant ministries, religious organizations and donor agencies, at the national regional and district levels. The collaboration resulted into some achievements.

In 1993 the school health project was extended to three other regions. The project was reported to have contributed to improvement in school attendance, environmental sanitation and provision of basic health services to learners. In 1994, the School Health Guidelines were revised to include more comprehensive interventions which included school basic health services, health education, safe school environment, teacher's training on health and community involvement. The Project expanded from kindergarten primary schools, secondary schools, and teacher training colleges.

Financial support to school health has not increased proportionately given the huge number of learners in preschool, primary and secondary schools. Support from NGOs and donors has been erratic focusing on narrowly defined specific areas of support such as water and sanitation, family life education, school buildings, deworming and priority communicable diseases.

In 1997, the Irish Government provided a three-year grant for strengthening national capacity for implementation of NSHP interventions at district level in line with Government reforms. Given this support, the government increased

investment in school health, and since 1998 the following developments were recorded:

- (1) Establishment of a consolidated National School Health Programme,
- (2) Development of two NSHP strategic plans, the second being only in draft form,
- (3) Capacity building through workshops for district and regional school health coordinators from both health and education sectors on NSHP management and related implementation and content matter
- (4) Various studies have been carried out: National School Health Surveys done in 1999-2000, National School Based Schistosomiasis Survey done in 2004-2005 and National Global School Based Student Health Survey (GSHS) done in 2014. Their reports were released in 2017 to create an information base on school health. Information and data generated from these surveys have informed the new Policy guideline for NSHP
- (5) Adoption of the WHO Health Promoting School Initiative (HPSI) that supports implementation of the Health Promoting School activities
- (6) Production of a National School Health Resource Directory for networking and collaboration (2000 updated 2002 and 2012)
- (7) Collating and analysing various national policies and laws that relate to school health

## CHAPTER TWO

### 2.0. SITUATIONAL ANALYSIS ON NSHP IN TANZANIA MAINLAND

#### 2.1. The health status of school age children in Tanzania Mainland

According to the global school-based health survey in Tanzania carried out between 2008 and 2014 there is a wide range of diseases and health conditions affecting the school-age children in Tanzania Mainland. The common diseases and health conditions identified include malaria, injuries, schistosomiasis, soil-transmitted helminths, skin diseases, tooth decay, eye and ear infections, malnutrition, anaemia, fungal infections, respiratory infections, nose bleeding, diarrhoea and tuberculosis

On joining school, children are expected to show evidence of vaccination but a larger number have no evidence on that. Environment for preschool are very poor in most places and not all teachers have been well trained. In this regard, teachers' understanding of health education is limited.

In Primary and secondary schools, use of alcohol, tobacco and drugs is common among learners, and those who are used to have such habits often start before the age of 14 years. Dietary behaviour is poor among learners and they usually bring along or buy snacks high in fat, sugar and salt and especially carbonated drinks. Only few are physically active during their free time at school.

Mental health problems in terms of loneliness and suicidal behaviour among learners is said to be fairly common. Violence among learners and unintentional injury are also common. Some learners engage in physical fights which result in serious injuries, and other learners are often bullied. Poor personal hygiene practices and risky sexual behaviours are reported to be common among learners. While learners reported brushing their teeth daily, many of them do not wash their hands after using the toilet.

According to the same survey, child marriage is common among adolescent girls and is associated with poverty and dysfunctional family settings. Early pregnancy is more common in girls from poor families and among rural girls. Condom use among learners is reported to be low, and when combined with multiple sexual partners, can facilitate the spread of HIV. Some adolescents especially boys even report paying for sex. Only few girls reported use of any modern family planning methods.

## **2.2. The Status of education in Tanzania Mainland**

The Government initiative of constructing at least one secondary school for each Ward all over the country increased total enrolment (Form 1-6) in secondary schools by 54.1% (from 1,222,403 learners in 2008 to 1,884,272 learners in 2012), with the majority of this group being in forms 1-4 learners. AS a result of the Free Education policy and system operational in Tanzania Mainland since 2016, the total number of school enrolment for both primary and secondary schools has shot up tremendously to over 10 million. The Government is also addressing the challenge of desks and classrooms by an ongoing campaign to produce desks and construct classrooms needed per school.

Historical data over a number of years show that, out of school children (those who never enrol in school and those who drop out of school) remained high. School attendance in early years is similar by gender, but girls especially in rural areas start to drop out of school at age 12, and the gap widens with increasing age. Nevertheless, the recent survey reports school absenteeism drop-out is much higher to boys than girls due to economic factors such as petty business.

On average 3.3% of learners were absent from school every week due to illness in 2010, and 0.91% dropped out of school annually because of diseases or social problems in 2010. Among the learners who dropped out, the reasons were truancy (75.5%), pregnancy (0.9%), death (3.0%), unmet basic needs including WASH and menstrual hygiene management (5.4%), illness (1.5%), taking care of sick relatives (0.5%) and others (13.0%). However, in 2016 only 2% of school-age children were not in school. (BEST 2016)

Needless to point, the education infrastructure in Tanzania Mainland is inadequate, especially in rural communities, where sometimes children must travel long distances to reach school. Positively, the current national policy and efforts of Free Education in Tanzania Mainland aims to enrol and retain all school-age children in basic education (currently meaning pre-school to form 4). This policy seeks to align with and even surpass the pledged international education targets under the Dakar Framework for Action of Education for All goal of universal primary education.

### **2.3. The current status of the NSHP**

The Program has continued to expand over the years and is coordinated jointly by the Ministries responsible for Health and Education. The Ministry responsible for Health takes the lead role in issues pertaining to the provision of school health services and relationship between schools and local health services while Ministry responsible for Education takes care of matters relating to curriculum and teacher development.

The management of schools is now under President's Office, Regional Administration and Local Government (PO-RALG). The NSHP works multi-spectrally with other MDAs as well as NGOs and Private Partners. The main focus of implementation is at the District level.

The current Education and Training Policy produced in 2014 recognizes the role of the school in the improvement of health. The emphasis of the new policy is on provision of free, compulsory education from preschool to Form Four. The Government has committed to providing other services in school that shall contribute greatly to NSHP; these include; basic services such as school meal, communication, electricity, clean and safe water. Others include health services, safe environment for provision of education, equal education opportunities for all children including those with special needs, and removal of obstacles that learners face from completing effectively in school, use of ICT in providing education, environmental conservation, and integrated skills for self-prevention of HIV/AIDS in the school curriculum and monitoring and evaluation.

At the level of the school, the participation of teachers, health workers, /learners, parents and the surrounding community on school health is encouraged but is not yet fully optimal. There are some linkages with health facilities in the vicinity of the schools especially for purposes of vaccination, referral, screening and treatment.

#### **2.4. Key achievements, challenges and priority actions required to improve the NSHP**

The National School Health Program has realized some achievements but is also experiencing a number of challenges.

Key achievements are:

- (1) Collaboration between the Health and Education sectors at the national level for the implementation of the program has continued to be strengthened
- (2) School health policy guidelines jointly approved by MoHCDGEC and MoEST in 2000 with the corresponding strategic plan are in place and have been revised
- (3) Currently, the main school health activities and interventions are jointly implemented by the education, health and local government sectors
- (4) School Health staff from Health and from Education jointly manage and coordinate school health activities at national regional and district levels; and the majority have been trained; although the coverage is not adequate

- (5) Ward Education Officers & School Committees/ Boards deal with school health
- (6) Provision of school meals is done by support of community and parents
- (7) A Student Health Card exists to monitor health indicators for learners from initial enrolment.
- (8) Some school health surveys have been undertaken; and provide insight of health behaviour and attitudes that impacts learners
- (9) Community involvement and participation for all school health and education-based interventions have been improved.

## **2.5. Key Challenges**

- (1) Despite the fact that there are existing policies including those focusing on school health yet there is no clear structure or modality for integrating activities, forging partnerships and enhancing collaboration across MDAs and with other players in school health initiatives
- (2) Implementation of NSHP is hampered by inadequate technical capacity. There is low understanding of the global conceptual framework such as Health Promoting School, (HPS) and Focusing Resources for Effective School Health (FRESH) and especially the need to implement comprehensive or integrated interventions



- (3) NSHP interventions hardly address the priority health problems of the children including social, economic and environmental conditions impacting on health in addition to individual risk factors and risky behaviours. Some of the methods used to further health promotion in the school are not appropriate, (lecturing Visa viz skill-based education)
- (4) There is a substantial increase of stakeholders who are optimizing school as an effective and sustainable avenue to carry forward various interventions. These standalone interventions are not integrative, lack shared vision and also lack the ability to plan strategically to make such vision a reality
- (5) School meals provided in most of the Tanzanian schools are sometimes inadequate in quantity and nutritional contents
- (6) Community involvement and full participation in children protection in Tanzanian schools are not well observed.
- (7) Many schools lack or have inadequate clean and safe water supply, lack improved sanitation such as waste disposal, lack security like fence surrounding the school and a school guide -. Furthermore, Children with special needs are not fully catered for.
- (8) School, community and health facility linkages for the implementation of NSHP is weak

- (9) Efforts for NSHP resource mobilization are uncoordinated and there is inadequate capacity for resource mobilization
- (10) Operational research, monitoring and evaluation as well as knowledge management are not fully embedded in the NSHP.

## **2.6. Priority actions**

Actions are needed in the following areas:

- (1) Providing a supportive environment for NSHP implementation
- (2) Strengthening management and technical capacity to ensure the NSHP is revitalized and implemented effectively and efficiently
- (3) Providing guidance on integration of health issues requiring actions such as food and nutrition, water, physical and psychosocial environments, child protection, Non- communicable diseases (NCDs), communicable diseases (CDs), neglected diseases, emerging diseases, child protection, adolescent reproductive health, and life skills etc.
- (4) Ensuring implementation of comprehensive, interventions which can effectively address inter-related physical, psychosocial, environments, behaviours and knowledge relating to health challenges and major health problems touching Health determinants

- (5) Ensuring adaptation of conceptual framework which have demonstrated to be effective globally or regionally such as Health Promoting School (HPS)
- (6) Focusing Resources on School Health and Comprehensive School Health Program (CSHP) and well as mainstreaming Child Protection and Gender Based Violence (GBV) to safeguard well-being of school aged children both in and out of school environment
- (7) Putting in place mechanisms that support coordination, partnerships and collaboration among diverse NSHP players this include stipulating the roles of each stakeholder as well as coordination framework
- (8) There is need to ensure rational use of resources for NSHP
- (9) Operational research, monitoring and evaluation as well knowledge management need to be embedded in the NSHP.

## CHAPTER THREE

### **3.0. KEY POLICIES, CONVENTIONS/TREATIES AND LEGAL INSTRUMENTS RELATED TO NSHP**

A number of national policies, conventions/treaties and legal instruments related to NSHP have been developed. The key documents are listed below: -

#### **3.1. Key Policies**

##### **3.1.1. The Constitution of the United Republic of Tanzania, of 1977**

The Constitution of the United Republic of Tanzania produced in 1977 emphasizes the equality of each person, respect for each person's humanity and right to justice before the law. Implicitly, it safeguards gender freedom, security of life, and right to education to one's desired level.

##### **3.1.2. The National Health Policy of 2007**

The National Health Policy of 2007 aims to deliver acceptable, sustainable and quality essential health services to all citizens of Tanzania. One of its mission is to reduce the morbidity and mortality rates by providing acceptable quality services thus increasing the life expectancy of people. More emphasis is placed on provision of quality services to vulnerable groups including children below 5 years of age particularly infants, school age children including those at school, youths, and the elderly. Other vulnerable groups are, people with disabilities. and pregnant and lactating girls terminated from schools

##### **3.1.3. National Health Promotion Policy Guideline of 2014**

The National Health Promotion Policy Guideline of 2014, justifies the need for addressing underlying determinants of

health. It Emphasizes the use of comprehensive, integrated approach to health actions. Moreover, it encourages the use of the settings approach to health promotion and is the basis of the concept of the health promoting schools.

#### **3.1.4. Education and Training Policy of 2014**

This Policy among other needs empowers regions and districts to administer education and training needs. The MoEST deals with policy issues and PO-RALG operational issues to bring efficiency and responsibility in schools. It advocates for improved quality of education and training through strengthening in-service teacher training programmes. Moreover, it deals with promotion of access and equity through making access to basic education available to all citizens as a basic right, expanding and improving girls' education, and developing programmes to ensure access to education to disadvantaged groups. Furthermore, the policy deals with provision of counselling and Guidance services in schools.

On the other hand, the government focuses on Basic Education which now covers nursery schools, primary schools ordinary and advanced secondary schools where most children attend. Compulsory education is given free in all public schools. The government shall also ensure that: -

- i) Basic services including nutritious food, health services, clean and safe water supply, communication infrastructure and electricity, are available in schools;
- ii) School environments are good and safe for provision of education;

- iii) There are equal opportunities in education for all children including those with special needs and marginalised, and alleviate their disability by handling them to complete the education cycle
- iv) There is adequate use of ICT in teaching and learning circumstances
- v) Environmental conservation is abided to respective or level of school curricula
- vi) Skills for adolescent on reproductive health; life skills; communication and behavioural change; school child protection and self-prevention of HIV/AIDS in school curricula are Integrated
- vii) Monitoring and evaluation of curricular implementation and capabilities of the graduates is regularly done

### **3.1.5. National water Policy of 2002**

Water is one of the most important basic social services to enable Tanzania achieve her Development Vision objectives (both social and economic). The National Water Policy of 2002 is in line with Tanzania Development Vision 2025 which amongst others, aims to universal access to clean and safe water.

### **3.1.6. Food and Nutrition Policy, 1992**

The objectives of the Food and Nutrition Policy in Tanzania includes; integrate food and nutrition activities undertaken by various sectors, enable each sector to play its part in the elimination of the malnutrition problem, and improve the

nutritional situation of the Tanzanian community especially children and women. In addition, the policy puts more emphasis to young children below 5 years' age, and to children of the age between 7 and 14 years who deserve sufficient food for healthy growth and development.

### **3.1.7. Other Policies that Relate to NSHP**

- i) Community Development Policy – 1996 of the Ministry of Community Development, Women Affairs and Children
- ii) National Youth Development Policy - 1996 of the Ministry of Labour & Youth Development.
- iii) Letter of Section Policy: 2nd Integrated Roads Project–May 1998 of the Ministry of Communications and Transport
- iv) National Telecommunications Policy- 1997 of the Ministry of Communication
- v) Child Development Policy - 1997 of the Ministry of Community Development, Women Affairs and Children
- vi) Policy on Women in Development in Tanzania - 1992 of the Ministry of Community Development, Women Affairs and Children
- vii) National Poverty Eradication Strategy - 1998 of the Vice-President's Office
- viii) Policy Paper on Local Government Reform - 1998

of the: Ministry of Regional Administration and Local Government National Population Policy - 2006 of the President's Office – Planning Commission.

### **3.2. Conventions or Treaties**

#### **3.2.1. Convention on the Elimination of Child Labour**

Tanzania signed in 1992 and ratified in 1993

#### **3.2.2. Convention on the Elimination of Discrimination Against women**

Tanzania signed and ratified in 1985

### **3.3. Legal Instruments**

#### **3.3.1. The Penal Code (1972)**

- i) Legal age: Any person below the age of 12 is legally a child not responsible for actions. Any-one over 18 years is an adult.
- ii) Negligent Act likely to spread infection: Any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be likely to spread the infection of any disease dangerous to life, is guilty of a misdemeanour.
- iii) Sale of Noxious Food or Drink: Any person who sells, or offers or exposes for sale, as food or drink, any article which has been rendered or has become noxious, or is in a state unfit for food or drink, knowing or having reason to believe that the same is noxious a food or drink, is guilty.

#### **3.3.2. Marriage Act, 1971**

A girl may legally enter into a marriage contract at the age of 15



### **3.3.3. Tanzania Employment and Labour Relation Act, 2004**

A person may become employed at the age of 15.

### **3.3.4. Public Health Sewerage and Drainage Laws, 1995**

This law stipulates requirements for sanitation in boarding and day schools.

### **3.3.5. Law of the Child Act, 2009**

According to the Law of the Child Act No.21 of 2009, a child is any person who is below the age of eighteen years.

Tanzania adopted the UN Convention on the Rights of the Child of 1989, and the Government enacted the Law of the Child Act, No. 21 of 2009. These Rights include the right to:

- i) Healthy environment
- ii) Physical environment
- iii) Sufficient food
- iv) Acceptable housing -
- v) Acceptable medical care
- vi) Social care of the handicapped
- vii) Free education
- viii) Play and recreation
- ix) Immediate aid in the event of disaster and emergencies
- x) Protection from cruelty, neglect and exploitation.

### **3.3.6. Public Health Act 2009**

The Public Health Act addresses children health issues specifically in areas of prevention and control of infectious diseases or communicable diseases whereby emphasis is given to vaccination against childhood communicable diseases. The Act makes it mandatory for the Immunization Card to be presented during school enrolments. The Act has identified public health requirements for operating a school.

### **3.3.7. The Person with Disability Act, 2010**

The Persons with Disabilities Act, 2010 states that every child with a disability shall have equal rights in relation to admission to the public or private schools. It also states that it shall be an offence for a person to be denied access to school because of his disability.

### **3.3.8. Sexual Offences Provisions Act, 1998**

The Sexual Offences Provisions Act prohibits sexual exploitation or harassment of children. This includes making influence over any form of sexual abuse or indecent exhibition or show.

### **3.3.9. Environmental Management Act, 2004**

The Environmental Management Act States that the Director of Environment shall, in consultation with the relevant Sector Ministries, take appropriate measures for the integration of environment matters in schools, colleges and institutions of higher learning.

## CHAPTER FOUR

### 4.0. RATIONALE AND PRINCIPLES

#### 4.1. Rationale

The NSHP is recognized as a pillar in the country's health sector development agenda. Implementation of the NSHP has been less than optimal mainly because of resource limitations. The NSHP now requires revamping so as to accelerate achievement of program objectives thereby contributing more effectively to improvement of the health of the people of Tanzania. This guideline is therefore, expected to help the NSHP to expand so as to reach all learners from nursery-schools to secondary schools and also improve the quality of interventions.

Revitalization shall be facilitated by using the health promotion approach. This approach enables broader participation in programming by a wide range of sectors and players. The approach shall also ensure implementation of more comprehensive activities than provided for in the 2000 policy guideline. The revision exercise shall be informed by the relevant Health and Education sector policies together with policies and legal instruments from other public sectors. The revision is justified on the following grounds: -

- (i). Existing guidelines are over fifteen years old. During this period, a number of changes have occurred in education and health sectors and also in regard to other national policies, for example there is now an Education and Training Policy of 2014, a Health Sector Policy of 2007 (under

revision), a Policy on Health Promotion and another on Community Hof 2014. Moreover, structures stipulated in the 2000 NSHP policy guidelines need to be reviewed to cater for involvement of MDAs and other players such as the private sector organizations as well as communities.

- (ii). The current education sector policy states that basic education is free and compulsory, caters for the period from pre-school to Form Four (age group 3–6 to 16). This is the new target for the NSHP which now includes high school. This means that the NSHP must be tailored to this specific target group in terms of the package of interventions as well as methodology
- (iii). Many new threats to health are being experienced. These threats include rapidly increasing NCDs as a major contributor to the burden of disease, emerging diseases such as Zika, SARs, Avian flu, Ebola, Coronavirus, Rift Valley Fever and Neglected tropical diseases (NTDs) such as helminths. However, there are several advances to control NCDs such as development of vaccines against Human Papilloma Virus (HPV)
- (iv). The process of globalization poses new challenges. For example, global sources negatively contribute to unhealthy behaviours relating to diet, physical inactivity, substance abuse, misuse of technology especially ICT and media, increasing violence and abuse of children some of which is gender based. These threats were not considered when preparing the existing policy guidelines.

- (v). The existing NSHP policy guideline has gaps with regard to principles, specific policy provisions and methodological issues which are now addressed in the new policy guideline.

## **4.2. Guiding Principles**

The NSHP shall adopt a number of guiding principles that shall underpin implementation:

### **4.2.1. Comprehensive implementation**

NSHP shall develop and implement comprehensive and integrated interventions and activities. This implies that activities need to address cognitive, physical, services, caring and linkage dimensions in order to ensure effectiveness of the Program. Such interventions shall be based on the underlying broad determinants of health and not just diseases and health conditions. This enables the focus of the program to be directed at prevention and protection, with service aspect coming in as appropriate. This approach shall also go beyond health to encamp wellbeing.

### **4.2.2. Universal access to health services and nutrition**

Health of every school learners has to be safeguarded through access to quality health services. School settings are expected to be an avenue to promote the child's health. Through partnership with surrounding communities and other stakeholder mechanism to access nutritional services will be established. Emphasis of the services shall focus on the most disadvantaged children.

### **4.2.3. Access to safe school environment**

Schools shall provide accessible and safe physical environment to all people including those with special needs. The schools shall be responsible for minimizing the risk of physical injury and disease transmission by ensuring that adequate protective measures are put in place. There shall be no tolerance for sexual harassment, abuse and other form of juvenile exploitation.

### **4.2.4. Access to health information**

All learners have the right to access relevant health information, knowledge and skills that are appropriate for their age, gender, culture and context.

### **4.2.5. Non-discrimination**

There shall be no discrimination on the basis of sex, ethnicity, race, family status, religion, locality, political affiliation, disability or illness.

### **4.2.6. Equity and Gender Responsiveness**

On implementing school health programme schools shall conform to specific needs of girls, learners with special needs, orphans and other vulnerable children. Additional services such as counselling and other forms of assistance shall be offered to such children. Programme implementation shall be sensitive to the needs of girls and boys.

### **4.2.7. Privacy and confidentiality**

Rights for privacy and confidentiality shall be observed particularly those related to child's health status. Disclosure shall seek child's consent or legal guardian acting in the best interest of the child. Health information shall only be

accessed with medical personnel, teachers and parents in order to provide medical advice or treatment or to prevent the spread of diseases.

#### **4.2.8. Ethical Practice**

All NSHP practice shall be ethical and anchored in relevant policies and laws in addition to this policy guideline

#### **4.2.9. Partnership and Participation**

The NSHP shall endeavour to promote and support active partnership and participation of learners, teachers, other staff, as well as surrounding communities in programme design, implementation and evaluation.

#### **4.2.10. Coordination**

All school-based health related initiative shall be coordinated through NSHP to meet the shared vision with the view to enhance synergy and complimentary.

## CHAPTER FIVE

### 5.0. VISION, MISSION AND OBJECTIVES OF NSHP

#### 5.1. Vision

A healthy society with improved social wellbeing that shall contribute effectively individual, family, community and national development

#### 5.2. Mission

Promote, protect and restore health and wellbeing of learners and their communities by ensuring that health and related services are planned, managed and delivered through the settings approach so as to achieve sustainable public health and education development.

#### 5.3. Objectives of the NSHP

- (i). Provide an enabling environment in revitalizing implementation of the NSHP
- (ii). Strengthen capacity for governance of NSHP
- (iii). Strengthen implementation of comprehensive and integrated interventions through schools
- (iv). Ensure effective coordination, collaboration and operational relationships that support NSHP
- (v). Monitor rational and complementary resource mobilization, allocation and use
- (vi). Ensure operational research, monitoring, evaluation and knowledge management are fully embedded in NSHP



- (vii). Bridge the health and educational, goals of basic education in Tanzania

## CHAPTER SIX

### 6.0. SPECIFIC POLICY PROVISIONS FOR THE NSHP BROAD PROGRAMME AREAS

#### 6.1. Providing an enabling environment for revitalizing the NSHP

The NSHP is set to become a flagship program for health and related development because of the large target population involved a multiplicity of players and also the wide range of interventions being implemented.

#### ***Key issues***

- i). Ownership and management of schools rests on local government, while technical aspects of the program are handled by Ministries responsible for Health and Education. This leads to complex interactions between the two ministries which the existing structure of the program may not handle effectively.
- ii). Currently, most NSHP interventions are implemented in piecemeal, depending on funding source. The focus has been on communicable diseases, at the expense of NCDs, emerging and neglected diseases, vaccination against HPV and risk behaviours and environments that favour general health and wellbeing.

#### ***Policy Statements***

- (1) The NSHP structures shall be reviewed to reflect the complex implementation context and also to delineate more clearly the specific roles of various

players in NSHP. Mechanisms for revitalizing these structures shall be defined

- (2) An integrated package of issues to be addressed shall be developed. This package shall include both communicable, non-communicable diseases and conditions, emerging health issues and neglected tropical diseases according to national priorities. The focus shall be on the behaviours and practices that help prevention of these issues
- (3) The NSHP shall provide opportunities for the private sector, faith-based organizations and other players to support the NSHP.

## **6.2. Comprehensive, integrated interventions**

### ***Key Issues***

- i). There is no clear understanding of the concept of the broad determinants of health and therefore there is a need to mount comprehensive health promotion-based interventions to address these determinants
- ii). Implementation of the NSHP has been focusing on narrowly defined problems that are usually time limited
- iii). Many stakeholders use school platform to implement school-based interventions, but lack shared vision and ability to strategically plan to optimize resources and ensure sustainability. Standalone approach significantly compromises the learners' centred target.

### ***Policy Statements***

- (1) The NSHP shall promote use of the health promotion approach to enable integration of the issues addressed through NSHP. This requires combining health services, counselling, health behaviours, healthy physical environments, linkages among the school, nearby health facility and the community as well as healthy school regulations/policies
- (2) Interventions shall be targeted at five levels: (i) Creating environments that support school health, (ii) developing and implementing relevant regulations/rules, (iii) developing individual skills, (iv) strengthening school and community actions, and (v) carrying out advocacy to increase investment in school health. A broad based, package of comprehensive interventions and supporting guidelines on key operational concepts, methods and implementation of comprehensive, integrated interventions shall be designed
- (3) The package of interventions shall be developed with reference to relevant policy and legal instruments and with the involvement of key national programme of the Health and Education sectors
- (4) The interventions shall include a special component for reaching out of school age children.

### **6.3. Programme management**

Effective management of the NSHP is essential for achievement of programme objectives.

### ***Key issues***

- i). The NSHP does not have program standards
- ii). There is inadequate capacity to manage NSHP implementation
- iii). NSHP funds are usually budgeted but not necessarily availed as needed
- iv). The role of teachers and health workers in the NSHP is not clear
- v). There is limited community involvement and participation in NSHP

### ***Policy statements***

- (1) NSHP program standards shall be established
- (2) A national plan for capacitating NSHP coordinators and other implementers shall be developed and implemented on a priority basis starting with poor and needy areas
- (3) Modalities shall be put in place to ensure allocation of the budget for NSHP
- (4) The roles and responsibilities of teachers and health workers in NSHP shall be clarified and on the job training provided as appropriate. School health shall be included in pre-service training for teachers and health workers at the community level

- (5) A guideline for supporting community involvement in NSHP shall be developed and used for strengthening community participation.

#### **6.4. Programme coordination, collaboration and partnerships**

Globally, evidence demonstrate that implementation of successful school health programmes depends on strong partnerships among education and health sectors, teachers and health workers, schools and surrounding community (groups) and learners and persons responsible for school health programmes (programme officers). The establishment of effective partnerships between stakeholders is critical to assist the formulation, implementation, monitoring and evaluation of priority areas for school health programme. Provision of forums coupled with scheduled meetings shall ensure that the thrust required for effective collaboration in the implementation is maintained at all levels.

The health sector has many school health actors; the same applies to education sector. Such actors include government departments, MDAs, development partners, NGOs, companies, private providers, faith-based organizations, CBOs and significant others. These players do what they know best using their own approaches and methods and in many cases their interventions are not evaluated. There is also overlap in some cases, leading to wastage and inefficient use of resources.

#### **6.5. Community Participation**

Community structures play an important role in improving health of learners in schools. In many cases actions or

interventions carried out at surrounding community directly impact schools, so do the interventions at schools. Community mobilization shall be conducted to create awareness for people to take positive action towards improving health of learners in schools. Active involvement of the school governing bodies, community leaders (such as traditional leaders, faith-based leaders and ward counsellors) is required. A buy in of the entire school community for the success of the programme is also required. Nearby health facility is part of the community so is required to be linked to the programme in order to provide comprehensive health services and health education.

### **6.6. Learners Participation**

The participation of learners through government and other organizations such as school clubs, boys' and girls' scouts, and learners with special needs will further ensure successful implementation of the SHP. Learners need to be consulted and encouraged to support the implementation of the programme through platforms created at school and community level.

#### ***Key issues***

- i). Overlap and competition among NSHP players
- ii). Weak learners' involvement and participation
- iii). Coordination framework not clearly defined
- iv). Sustainability is not guaranteed due to ad-hoc approach
- v). Best practices and lesson learned for future interventions are not comprehended; and roles

and responsibilities of each stakeholder as well as coordination mechanism are not stipulated

### ***Policy Statements***

- (1) Mechanisms shall be put in place to ensure that operational relationships within the health sector (intra-sectoral) and with other sectors and stakeholders (inter-sectoral) such as MDAs, donors, academia, communities and others are optimally functional and well-coordinated
- (2) Key school health intervention areas shall be stipulated to direct all stakeholders and optimize use of resources. These thematic areas shall be used to leverage coordination and optimize synergy and complementarily. Modalities shall be designed to ensure synchronized priority setting, planning, implementation and evaluation of program activities
- (3) Guidelines and tools for supporting collaborations, alliances, and partnership shall be developed



## CHAPTER SEVEN

### 7.0. POLICY GUIDELINES ON INTERVENTIONS

#### 7.1. Defining a package of interventions

Implementation of the NSHP is limited in scope and school coverage. Issues addressed are usually very specific health service delivery such as de-worming. Other health services such as health education and promotion are narrowly defined. Key issues identified in this package include:

##### ***Key Issues***

- i). Not all schools implement comprehensive school health
- ii). Intervention frameworks which have proved to be effective are not mainstreamed in the NSHP implementation in all schools
- iii). Activities are not integrated in terms of issues and underlying causes
- iv). Currently most NSHP activities focus on specific diseases with little attention paid to underlying determinants of health such as behaviours and knowledge and the environments that help support health improvement.

##### ***Policy Statements***

- (1) The NSHP shall be mandatory in all schools (nursery- to secondary school), with a special component for same age out of school children

- (2) Activities carried out shall be comprehensively planned and integrated. The activities shall encompass all the elements of a health promoting school initiative basically on Curricula and non-curricula based activities and health education/promotion:
- (3) School based health services (de-worming, first aid, immunization, dental/eye sight/hearing screening, body mass index, referral to health facility etc.), provision of safe, secure, physical environments, water sanitation and hygiene, value and life skills, child protection, rights and gender issues, adolescent reproductive health, physical activity, school nutrition, counselling psychosocial support and social services, behaviour change communication, and community/parent participation.
- (4) Linkages between school community and nearby health facility for referral purposes on communicable as well as NCDs, emerging diseases, emergencies and disasters, and neglected tropical diseases (NTD)
- (5) Intervention framework which has proved to be effective elsewhere such as Health Promoting School (HPS), Focus Resource on Effective School Health (FRESH) and Comprehensive School Health Programme (CSHP) shall be mainstreamed in the program implementation.

## **7.2. Provision of physical environments that support health**

Provision of physical environment that support health schools embraces the health and safety of learners and other members of the school community. It is an essential factor in achieving the overall goals of the School Health Programme because it has implications for all areas of school health. It attends to the physical and aesthetic surroundings, psychosocial climate and culture of the school community. Factors that influence the physical environment include the school building and all the areas surrounding it including biological or chemical agents, the weather and other forms of pollution that affect learners and staff of the school community. Such agents include, insects, pest and vectors, temperature and humidity, noise and lighting, etc. The psychosocial environment includes the interrelated physical, emotional and social conditions that affect the well - being and productivity of learners and staff of the school community.

### ***Key issues***

- i). Not all schools have physical infrastructure to support effective learning
- ii). Lighting, ventilation, temperature, humidity is not considered taking into account the size of the structure and number of the learners using the structure i.e. class or dormitory.
- iii). Poor site selection for constructing the school that may affect school community such as dampness, noise, pest and vermin infestation

- iv). Some parts of the school environment are not safe for children
- v). Poor environment that does not support hygiene and sanitation practices

### ***Policy Statements***

- (1) The school buildings must meet architectural standards and be learner and gender friendly. It shall be well lit and ventilated. It shall also put into consideration the physically challenged learners
- (2) Materials used for the construction of the building shall meet approved standard
- (3) Number of learners in a classroom shall be in line with the Education Policy and guidelines
- (4) Appropriate desks and chairs shall be provided and spaced in the classroom in line with the education guidelines
- (5) Separate rooms for specific functions such as counselling, first aid, menstrual hygiene shall be provided
- (6) Each school shall periodically carry out an assessment of its physical environment with regard to the status of water, sanitation, security and safety facilities

- (7) Each school shall ensure there is clean safe water, safe and secure grounds, solid waste disposal facilities, enough toilet facilities for boys and girls and learners with disabilities and fire-fighting equipment and training
- (8) Each school shall have a policy on safety, security, and health of the physical environment with information and warning signs displayed appropriately
- (9) The school shall obtain and enforce national laws, standards and regulations on sanitation, safety and security
- (10) Curricular based activities on knowledge, behaviour and attitudes relating to the physical environment shall be strengthened
- (11) Facilities, equipment and assistance for children with special needs shall be available in schools

### **7.3. Provision of Health Services**

School Health services as an essential component of effective school health program ensure that children are healthy, developed and able to learn at all times. It is an essential component for achieving universal education, taking into account of children with special needs. School Health Services cater for both preventive and curative services provided for the learners and staff within the school setting. The purpose of the School Health Services is to help children at school to achieve the maximum health possible for them to obtain full benefit from their education.

School health services are provided by the health workers, teachers at schools and other appropriate personnel to appraise, protect and promote the health of members of the school community. School health services include: Health screening and referral; administering medications and treatments; provision of first Aids; vaccines; health education, health counselling education and support student to acquire self- management skills.

### ***Key Issues***

- i). Low vaccination coverage leads to some learners become not fully immunized as per the national guidelines. Some school children are faced with stunting due to medical problems such as anaemia, and worm infections which negatively impact health and education outcomes
- ii). Early detection of conditions and diagnosis of diseases and its management can significantly improve health of student and subsequent adulthood health
- iii). School children are vulnerable to injuries and accidents at school which require prompt treatment or management
- iv). Learners, staff, disabled and people with any form of denial are long time victims of incurable diseases and conditions, hence, they require counselling.
- v). Learners have no defined scheme of health care hence they cannot be referred for treatment after diagnosed through health screening

- vi). School health cards which monitor student health records have not been fully utilized.

### ***Policy Statements***

- (1) Arrangement in collaboration with various stakeholders should be made for regular school health screening. Results of the screening shall be recorded
- (2) Every school shall designate nearby health facility to facilitate, health screening, education, early treatment and referral
- (3) Every learner shall be covered with appropriate health care insurance scheme to allow access to medical care at any time. Schools shall work with parents, community and council to ensure compliance and regulation
- (4) Each school shall ensure that there are FIRST AID guidelines and Kits in working order and appropriately stored. Teachers and learners be trained on proper use of kits and guidelines. Linkages shall be established with health facilities to enable referral and for follow-up.

### **7.4. Integrated Vector Management (IVM)**

Vector-borne diseases are among diseases that contribute to medical problem and school absenteeism. Integrated vector management at school is geared to manage disease vectors and reduce reliance on chemical controls. Sustainable, long-term IVM approaches will ultimately improve living conditions of school learners and surrounding

community. School based integrated vector management will take a holistic approach such as ecological strategies that benefit the environment and working with local communities to deliver information, training and support to effectively reduce the vector density.

### ***Policy Statements***

- (1) Schools shall take necessary measures to protect, prevent and control all types of vectors borne diseases at school environment and vicinity and shall undertake all measures to minimize or eradicate vector habitats as well as to destroy common breeding sites
- (2) IVM shall also promote the use of other vector protective methods such as use of insecticide treated nets (ITN)
- (3) Knowledge and other control measures against neglected tropical vector borne diseases shall be promoted through schools.

### **7.5. School Health Record Card**

It is a condition or a must that a child is provided with a health record card from his/her initial enrolment. The card will record essential health information supplied by parents/guardian or primary health care giver must be recorded and kept at school. Information from parents on the health status during childhood (0-5 years) must also be retrieved and recorded.

A health record card should be provided for each learner when he/she enters school for the first time (primary or



secondary school). The health information goes with the learner from class to class. If the learner transfers to another school, the original should go with him/her and the duplicate should be retained by the original school. The health record should contain personal and family history; history of past illnesses/hospitalization with relevant information on treatment received and whether follow-up is necessary and being carried out.

The health records will also contain information related to:

- (a) Immunization
- (b) Results of screening tests
- (c) Records of heights and weights taking at regular intervals. This will help in the appraisal rate of physical development of every child
- (d) Results of teacher's routine observations

It is imperative to make sure that records contain sufficient information to justify the diagnosis and treatment and accurately document all health assessments and services provided to the student. Each entry into the student's record must be dated and authenticated by the staff member making the entry indicating name and title.

### ***Key Issues***

- i). Schools lack record keeping system for recording, keeping and retrieving information about their children
- ii). Schools lack health information record card for their children, hence they get difficulties to obtain them when needed especially when a child is transferred to another school

- iii). Schools lack comparisons among growth, development and education advancement of their children when monitoring effectiveness of NSHP implementation

### ***Policy Statements***

- (1) A record keeping system provides consistency, confidentiality and security of records. Schools shall take necessary measures to initiate record keeping system in documenting significant health information and the delivery of health care services
- (2) Schools shall appropriately enter into school health record card all required information of a learner on first enrolment or transfer in from another school. This act shall keep track the learner on route education advancement
- (3) Schools shall be provided with school health record cards and their storages prepared by SNHP or respective ministries
- (4) School staff, parents/community shall be responsible in providing information about the learner and ensure that they are properly entered into the card

## **7.6. Life Skills Education and Values**

### **7.6.1. Life Skills**

School-age years are critical formative years for the development of behaviour and skills in an individual. Life Skills Education enables an individual develop adaptive and positive behaviour so as to effectively deal with

challenges and demands of everyday life. The main goals of the Life Skills Education approach at school is to enhance learners' ability to take responsibility for making choices, resisting negative pressure and avoiding risky behaviour. It has been proven that when life skills education is well developed and practiced, it enhances the wellbeing of a society and promotes positive outlook and healthy behaviour. Life skills Education are classified into three broad categories;

- (a) Skills of knowing and living with oneself
- (b) Skills of knowing and living with others
- (c) Skills of effective decision making

### **7.6.2. Values**

Values are beliefs, principles and ideas that are of worth to individuals and their communities. They help to define people who are and the factors that guide their behaviour and lives. People obtain values from families, friends/peers, media, technology, traditions, culture, norms, school environment, political influences, life experiences, religious teaching and economic experiences. Our values shape our behaviour and a world view. For school health programme to positively become effective it has to envisage schools to use education and health services to ensure that children are taught and supported to acquire positive values.

#### ***Key issues***

- i). Learners in nursery school, primary and secondary school, face varied challenges, which are compounded by various factors including intra & interpersonal conflicts, lack of positive role models, negative media influence (social media, internet) and inadequate and unreliable sources of information especially on human sexuality.

- ii). Traditional education which was applied to instil values through informal education system, but due to historical reasons, traditional family and educational ties have largely broken down thereby leaving children and adolescents vulnerable, hence the need to optimize schools as potential avenue to develop positive values, attitudes, skills and healthy behaviour in order to help them effectively deal with the challenges of everyday life
- iii). Inadequate knowledge on values and life skills for teachers (pre-service and in service)
- iv). Indulgence in risky behaviour and negative peer pressure
- v). Inadequate communication skills
- vi). Lack of capacity, information and role models
- vii). Dysfunction families due to divorce, acute poverty etc.

### ***Policy statements***

- (1) Curriculum for values and life skills shall be reviewed, strengthened or developed for teachers, staff and surrounding community
- (2) Values, attitudes and skills of learners shall be enhanced through school settings

## 7.7. School Feeding Services

School Feeding services or Food and Nutrition Services in Schools aims at providing an adequate meal a day to all children enrolled in schools nationwide. Currently malnutrition (under and over), exists in schools. Correct knowledge on healthy eating is limited, and many learners engage in unhealthy eating habits. Poor quality foods from vendors (sweets, sugary drinks) are available in the vicinity of schools.

The objectives of the School Feeding Service include; to:

- (a) Reduce hunger among school children;
- (b) Increase school enrolment, attendance, and retention and completion rates particularly among children from poor communities in both rural and urban.
- (c) Improve the nutritional status of school children
- (d) Enhance the comprehension and learning abilities of learners

### **Key issues**

- i). Some kids have no meals during school
- ii). Provision of unbalanced meals where provided
- iii). Negative impact of commercial sources of food
- iv). Inadequate hygiene practices among food handlers at school vicinity including medical examination.

### **Policy Statements**

- (1) Schools shall be provided with proper food storage facilities depending on the nature of food
- (2) School feeding guidelines on nutrition shall be established depending on the local food available

- (3) Food saved for both day and boarding schools shall possess required nutritional value
- (4) Food fortification and supplementation shall be planned and implemented as per guideline
- (5) Parents/community shall be responsible in providing food to warrant availability of school meal
- (6) Schools shall be provided by the local health authority supportive skills on food hygiene practices

### **7.8. Water, Sanitation and Hygiene**

Water, sanitation and hygiene are critical towards creating an improved learning environment. Improving water, sanitation and hygiene in our learning institutions generates considerable benefits in terms of improved child-health, attendance, retention, performance, and transition of all learners including children with special needs. The aim for improving school Water, Sanitation and Hygiene (SWASH) is to reduce water-borne and sanitation-related diseases such as cholera and other diarrheal diseases, worm infestation, water washed diseases like skin infections, etc. Learners are positive change agents within their communities, and instilling habits early is the most effective way to change current practices. Therefore, the multiplier effect of appropriate and positive messages on hygiene promotion will influence the larger communities. This influence will translate in reduced ill health and ignorance and will ultimately result in a well-informed society.

### ***Key issues***

- i). Water, sanitation and hygiene related diseases and conditions are common among school children
- ii). Improper sanitation and hygiene infrastructure do not provide supportive environment for student to learn
- iii). Many schools do not possess standard and sufficient latrine
- iv). Many schools have no access to reliable source of sufficient clean and safe water
- v). The conditions of water supply provide risk for contamination before or during usage.

### ***Policy statements***

- (1) Guidelines provided under SWASH programme shall form the bases for water, sanitation and hygiene interventions at school settings.

## **7.9. Provision of supportive psychosocial environments**

To ensure Child Protection and safeguard against gender-based violence and ensure provision of basic health services provision of supportive psychosocial environment for learners in schools is mandatory

### ***Key issues***

- i). There is exposure of children to abuse, bullying, harassment and violence in and out of school. Most of these abuses are not reported and sometimes are regarded as normal

- ii). Some of the learners have not benefited from fundamental health services such as immunization. However, issues of linkage to child protection and gender-based violence is one of the major attributes to mental health and hence a potential public health problem.

### ***Policy Statements***

- (1) Schools shall have regulations to enable prevention of harassment, abuse and bullying according to national policies. The regulations shall be based on national policies, laws, protocols, conventions and guidelines/ standards
- (2) Provision of supportive psychosocial environment for learners in schools shall be made for free and confidential reporting of all forms of harassment or abuse
- (3) Schools shall refer affected children to appropriate services and or agencies
- (4) Each learner shall have a health card to be checked on entry and used according to IVD policy.

### **7.10. Prevention of injury and substance abuse**

Abuse of tobacco, alcohol and other substances is reported from school health surveys. Injury and even death can occur from falls and motor traffic accidents to learners engaged in smoking tobacco, and taking alcohol and other substances. Motorcycle traffic accidents have become rampant.



### ***Key issues***

- i). Knowledge about the damage caused by various substances and especially alcohol is not provided to school children
- ii). Some cultures encourage on use of alcohol and other substances
- iii). Vendors of such substances willingly sell the substances to children for profit
- iv). Knowledge for preventing accidents and related injuries are not routinely taught.

### ***Policy Statement***

- (1) School shall collaborate with partners from the community to initiate or strengthen activities aimed at substance abuse and injury prevention
- (2) Schools in collaboration with SNHP partners shall organize sessions on skill building interventions against alcohol and substance use for learners, teachers and parents
- (3) School shall establish framework for gathering and sharing best practices with other schools
- (4) Regulations on substance abuse and injury prevention shall be enforced in every school

## 7.11. Specific diseases and conditions

### 7.13.1 Prevention of Non-Communicable Diseases

NSHP shall address NCDs as an essential element of the program. These may include: Diabetes, Cancer, Cardio-Vascular Diseases (CVDs), Asthma, Sickle Cell Disease (SCDs), Stroke, Eye diseases, Oral diseases, Ear Nose and Throat (ENT)

The underlying determinants of most NCDs include behaviours whose uptake occurs during school age. These include diet, physical activity/inactivity, stress, tobacco, alcohol and other substances.

#### ***Key Issues***

- i). NCDs are relatively less understood than other diseases
- ii). Most school children as well as teachers are unaware of the relationship between NCDs and behaviours such as use of tobacco, alcohol and other drug substances; physical inactivity, poor diet rich in sugar, fat and salt
- iii). Usually unknowingly, learners are introduced to tobacco, alcohol and foods rich in sugar, fat and salt
- iv). Few learners are informed about the benefits of physical activity, fruits and vegetables

## ***Policy Statements***

- (1) All schools shall have school coordinated NCDs prevention and control guidelines and activities whose focus shall be on education on supportive behaviours, protection and reducing access to harmful substances and reducing negative behaviours
- (2) Linkages shall be made with families, communities and service providers to support children already abusing substances or behaviours that contribute to NCDs
- (3) Major and commonly occurring NCDs need to be included in the curriculum
- (4) Eye diseases and vision problems shall be given special attention

### **7.12. Eye Care**

Poor eye health impacts learners learning capabilities negatively. Most learners live with vision problems without knowing that they are affected due to lack of services. Contagion is a factor in spread of eye infections.

#### ***Key Issues***

- i). There are inadequate school health and education programme focused on eye care
- ii). Most school children with irreversible visual impairment and blindness, lack assistive devices
- iii). Teachers lack eye screening education and abilities to identify child with eye and vision problems

- iv). Schools lack availability and accessibility of tools on vision testing and specialist's recommendations as a base for learning

### ***Policy Statements***

- (1) Eye care shall be part of the school health and education programme
- (2) Teacher assisted, Self-screening of vision through a well prepared self-explanatory 'vision corridor', availability of tools on vision testing and follow specialist doctor recommendations as a base for learning and teaching method for children believed to have vision disabilities
- (3) Eye screening shall be undertaken once per year for every child and recorded in school health card
- (4) School shall support children with irreversible Visual impairment and blindness, and with provision of assistive devices
- (5) School environment shall be friendly to children with Visual Impairment and blindness e.g. Sitting at the front or middle of the class, enough light, ramps entrance to all areas, protected public spaces for all children with disabilities
- (6) Schools shall have First Aid guidelines and kit that shall include 'Eye First Aid'

### **7.13. Prevention of communicable diseases**

Key communicable diseases include: STIs/HIV, Tuberculosis, Malaria, Cholera, Hepatitis, Skin diseases/ infections (jiggers, fungal infection, ringworm, lice), emerging and neglected diseases all of which are preventable, though their methods differ from one disease to another.

#### ***Key issues***

- i). Knowledge and behaviours relating to prevention and control of CDs are limited in the school setting
- ii). There are many myths and misconceptions of disease in many schools and communities, leading to delayed use of available facilities.

#### ***Policy Statements***

- (1) Using national guidelines, schools shall promote and implement vaccinations, de-worming, use of mosquito nets and promote other actions that contribute to prevention of communicable diseases
- (2) Each school shall establish linkages with health facilities for treatment, referrals, screening and counselling
- (3) Curriculum activities on communicable diseases are to be intensified
- (4) Link with community health workers for supporting prevention at home.

#### **7.14. Disaster and Climate change management**

Many disasters/emergencies can affect school and or surroundings These include earthquakes, floods, attacks by terrorists or intrusion by robbers, fire outbreaks and other situations that can disrupt normal school activities. Climate change can agitate weather change leading to weather related disasters.

##### ***Key issues***

- i). Many schools are not prepared for disaster/emergencies management or mitigation.

##### ***Policy Statements***

- (1) Each school shall have an emergency preparedness plan
- (2) Focal points for disaster/emergency response shall be determined and the school community notified and updated continuously
- (3) Drills or exercises shall be carried out to test the preparedness plan
- (4) Measures to mitigate climate change shall be implemented at all schools.

#### **7.15. Control of Neglected Tropical Diseases**

Control of Neglected Tropical Diseases (NTDs) is among the country's priority. There are many NTDs of Public Health importance in Tanzania which affects a significant population including children. Children are vulnerable to NTDs due to various factors such as biological factors, environmental factors and ecological factors. For example,

children get exposed to soil transmitted helminthiasis through play, work, and substandard living conditions. These children are more vulnerable to environmental exposures and developmental stresses than adults, because their immune systems are not fully developed, and their developing bodies are biologically more susceptible to the effects of environmental assaults. Although many NTDs are not directly cause of mortality but are known to cause immense suffering and more often life-long disability. In Tanzania NTDs lead to anaemia and micronutrients deficiency, hence, are great causes of stunting to school children. Despite of much information has been gathered on NTDs in Tanzania yet more information on the impact and magnitude of the problem on school-age children need to be generated. This is because health problems affecting children are not diagnosed and reported promptly and timely.

### ***Key issues***

- i). School environmental exposes children to STDs and risks them to develop stresses
- ii). Many schools do not mechanism for controlling NTDs
- iii). There is limited health and education capacity building mechanisms in controlling NTDs
- iv). Schools lack monitoring and evaluation mechanisms linked to the health monitoring system (HIMS)

### ***Policy Statements***

- (1) Mechanism including rapid assessment and periodic assessment to generate more information on the magnitude of the NTDs on school age children shall be designed and implemented to inform the intervention at school setting
- (2) Strategy for NTDs control at schools shall be develop to describe different control methods for school children
- (3) NTDs educational and information tailored to their prevalence and vulnerability shall be integrated into school health package
- (4) NTDs monitoring and evaluation mechanism shall be developed at school setting and be linked to the health monitoring system (HIMS).



## CHAPTER EIGHT

### 8.0. RESOURCES FOR NSHP

NSHP is not self-sufficient without resources. Since the focus of SNHP is on mainly behavioural cognitive and physical determinants of health that do not touch directly on health, it is difficult to get allocation and disbursement of funds. The NSHP relies on teachers together with a few coordinators at national, regional and district levels for implementation. However, it has been observed that facilities, materials and equipment for NSHP in the school setting are very limited.

#### ***Key issues***

- i). Lack of coordinated resource mobilization to support government budget
- ii). There are problems of accessing budgeted funds
- iii). Technical capacity to mobilize resources are inadequate
- iv). Inadequate finances, facilities, materials and equipment
- v). Inadequacy of governance for school health programme

#### ***Policy Statements***

- (1) Ministry of health with PO-RALG and MDAs shall ensure coordinated mobilization, allocation and use of resources. This includes both internal and external resources that shall be mobilized and allocated in a complimentary manner

- (2) To ensure proper resource management there shall be improved governance and guidelines for NSHP resources mobilization and utilization.
- (3) Good monitoring and evaluation mechanisms shall serve to attract resources
- (4) A capacity building plan shall be put in place to enable implementers acquire the skills and knowledge for effective management of NSHP
- (5) The role of communities and CBOs in resource mobilization, management and accountability shall be ensured through agreements and contracts
- (6) An advocacy plan for NSHP shall be developed

## CHAPTER NINE

### 9.0. RESEARCH, MONITORING EVALUATION AND KNOWLEDGE MANGEMENT

It is important to have operational research to inform program planning and implementation, and also facilitate knowledge management.

#### ***Key issues***

- i). Operational research is not systematically incorporated in implementation school health initiatives
- ii). Tools for monitoring and evaluation need to be strengthened and applied
- iii). Comprehensive knowledge management mechanism inadequate

#### ***Policy Statements***

- (1) All NSHP activities shall have an inbuilt operational research component
- (2) Period surveys shall be conducted to assess progress
- (3) A robust Monitoring and Evaluation plan shall be put in place
- (4) monitoring and evaluation framework shall be established
- (5) Establish monitoring and evaluation calendar shall be established

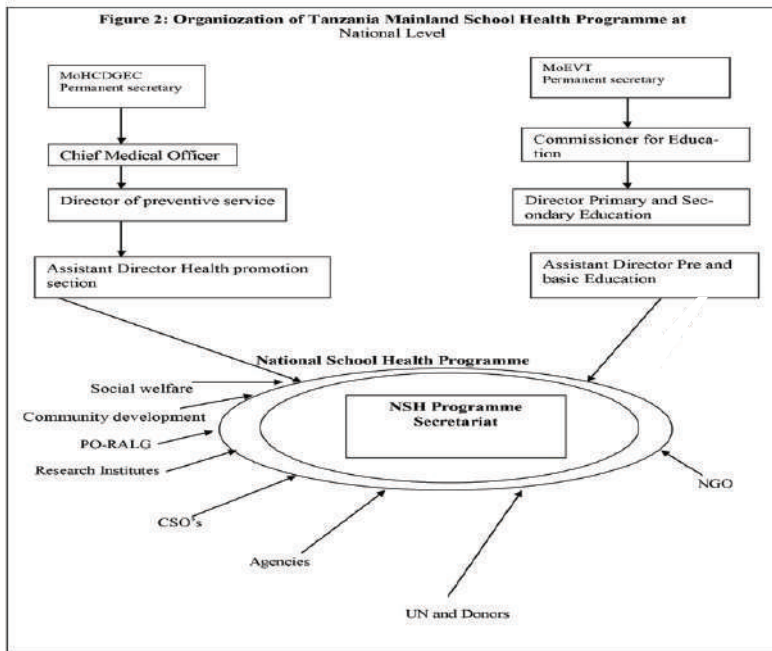
- (6) A comprehensive knowledge management mechanism shall be developed.

## CHAPTER TEN

### 10.0. INSTITUTIONAL FRAMEWORK

There are three key Ministries involved in the NSHP; Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), Ministry of Education, Science and Technology (MoEST) and President Office Regional Administration and Government (PO-RALG). For effective implementation, therefore, the NSHP shall be integrated into the Existing structures of Health and Education sectors as well as Local Government authorities.

**Figure 2: The Organogram of the NSHP in Mainland Tanzania.**



## **10.1. At National Level**

### **10.1.1. Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC)**

The MoHCDGEC shall have the following roles: -

- i). Take the lead role in all issues pertaining to provision of school health interventions and relationship between schools and local health services. The NSHP shall be responsible for the overall management of the program
- ii). Coordinating strategic development and implementation of programme
- iii). Reviewing and or developing policy guidelines, standards, materials and other tools for the Program
- iv). Provide overall technical direction supporting capacity building and supportive supervision for regional and District implementers
- v). Secretariat to the technical advisory committee
- vi). Coordinating and facilitating operational research, monitoring and evaluation and knowledge management
- vii). Mobilizing resources
- viii). Prepare coordination meeting (TAC, inter-ministerial, intra-sectoral, steering committees)

### **10.1.2. The Ministry of Education, Science and Technology**

The MOEST shall be responsible for: -

- i). School curriculum development for health, instruction and educational Materials
- ii). Set standards and guidelines for school
- iii). Capacity building for teachers and other instructors or facilitators
- iv). Monitoring and evaluation
- v). Quality assurance of learning
- vi). To inform the on school-based research questions

### **10.1.3. President Office: Regional Administration and Local Government**

The PO-RALG shall be responsible for:

- i). Coordinate the implementation of the policy guideline at local authority levels
- ii). Participate in the inter-ministerial Technical working committee (TWC)
- iii). To monitor and provide supportive supervision to the Council
- iv). Management teams in relation to policy guidelines implementation

- v). Collaborate with the Sector Ministries to maintain standards and quality of program implementation.
- vi). Advocate for inclusion of the interventions tailored to guidelines in the council comprehensive health plans (CCHP)

## **10.2. Coordination mechanism at the national Level**

### **10.2.1. The Technical Advisory Committee (TAC)**

The TAC will constitute membership from various Ministries, Departments, Agencies, Development and Implementing Partners, NGOs, Religious organization, Private Sector and CSOs.

The TAC will be chaired by the Director of Preventive Services after being appointed by the Permanent Secretary. TAC will meet quarterly every year and will have the following roles:

- i). Identify capacity and budget for the resources necessary for implementing the SHP such as human, financial and other (equipment, materials and supplies) resources.
- ii). Monitor and evaluate the implementation and impact of the (NSHP)
- iii). Review the policy and package of services at appropriate intervals.
- iv). Review and identify research priorities for school health.
- v). Mobilize resources



- vi). Review the strategic and implementation plan.

### **10.3. Health sector technical sub-committee for school health program**

The health sector technical sub-committee shall bring together various health sector stakeholders for school health. The aim is to formulate the common vision and agree on how to deliver health interventions comprehensively.

#### **10.3.1. Roles of the health sector technical sub-committee**

- i). Provide technical input for school health programme
- ii). Review all interventions and strategies aiming to be delivered through school health program
- iii). Formulate a common vision and strategic planning for health sector
- iv). Agree on the comprehensive approach for the health sector interventions
- v). Review and endorse a 5 years' strategic plan and priorities for school health interventions.

### **10.4. Education sector technical sub-committee**

The education sector technical sub-committee aims to bring together various education actors who have stake on school health initiatives at school setting. The technical sub-committee will formulate a forum for the stakeholder to discuss and agree on the common vision and standards. The role of the education sector technical committee is:

- i). Provide the technical input for program implementation

- ii). Review and agree on the standard linked to learning materials, infrastructure and conducive learning environment
- iii). Discuss and agree the common education vision for the program implementation
- iv). Review and endorse the 5-year strategic plan and priority
- v). Ensure accessibility to educational related infrastructure and materials.

### **10.5. Inter-Ministerial task force for school health**

The national level will provide technical support to regions in development, monitoring and Implementation of the SHP. This shall be done through inter-Ministerial task force. Member of this task force will come from the three ministries, Health, Education and Regional Administration and Local Authority. Other members shall be from the development partners and MDAs who have stake in school health.

#### **10.5.1. Roles of the Inter-Ministerial Task Force committee**

- i). Review and endorse a 5 years' strategic plan for school health to be submitted to the Technical advisory committee
- ii). Provide recommendation for coordination for implementation of programme activities between ministries and school-based health projects

- iii). Prepare and review quarterly and annual project plans and variations
- iv). Provide support and review technical subcommittee inputs to the school health program
- v). Present their institutions/organization's views on policies, resources, plans etc. in order to promote school health program implementations
- vi). Ensure school health and its issues are covered to appropriate parties within their Institutions/organization for implementation
- vii). Mobilize resources and support regarding the content of the programme, as well as strategic direction with regard to its implementation
- viii). Meet quarterly to deliberate the intended goals
- ix). Develop standardized guidelines for implementation and service provision with corresponding training packages
- x). Develop appropriate norms and standards for all aspects of the SHP

### **10.6. School Health Ambassador/Champion**

The programme in collaboration with stakeholders shall appoint ambassador or champion. The aim of the school health ambassador/champion is to allow dignitaries and celebrities with a demonstrable interest on improving learners' health use their fame to raise the profile of school

health programme as an important platform to achieve the twin goals of improving health and educational outcomes of school age children.

### **10.7. Coordination at Regional level**

Regional task teams with representatives from Health, Education and local government sectors, key actors need to be established. The regional SHP Team is responsible for ensuring that school health services and interventions reach all learners.

#### **10.7.1. Roles of Regional Task Force**

- i). Developing a five-year implementation plan for the SHP in the region, as well as detailed implementation plan for the first year
- ii). Mobilize the required resources (financial, material and human) through local partners
- iii). Identifying and prioritizing the most disadvantaged schools which should be targeted during the early phases of implementation
- iv). Ensuring that an appropriate and adequate capacity building for new and existing staff is in place
- v). Monitoring implementation of the NSHP in the region
- vi). Advocacy and promotion of school health related initiatives and activities
- vii). Linking with MDAs, NGOs and other sectors/ players in the Region to promote NSHP

- viii). Receive, compile and share progress reports
- ix). Provide to the district technical support and capacity building at Local Government levels
- x). Design, implement, monitor and follow-up district plans for school health. Operational roles shall be spelt out in detail in NSHP strategic Plan.

The coordination mechanism at this level is comprises of regional school health coordinator for both health and education sectors.

### **10.8. District level**

District is a hub for School Health Programme implementation with accompanying responsibility to ensure that the programme is implemented in all sub-districts and reaches all targeted schools and learners. Each district should establish a Task Force team that shall be responsible for overseeing school health services. The team shall develop an implementation plan with clear objectives and indicators which forms part of the district health plan. The team is jointly responsible for overseeing and coordinating the SHP within the district. This includes ensuring progressive coverage of all schools and learners (starting with the most disadvantaged schools); co-ordination of other partners who provide components of the school health package; and reporting on school health activities to both the Health and Education sectors as per hierarchy i.e. regional level.

## **10.9. Coordination at District Level**

At the district level coordination is accomplished by district school health coordinators (Health and Education) and the District Task Force

### **10.9.1. Roles of district Task force team**

- i). Ensure that the SHP plan is developed and integrated into the district/council Comprehensive health plan (CCHP) or other relevant plans
- ii). Allocate a person to oversee and manage the SHP (District School Health coordinator for both health and education sector
- iii). Conduct an audit of existing capacity for the delivery of the SHP
- iv). Appoint School Health Teams who are responsible for providing and coordinating provision of the school health package to all targeted learners.
- v). Strengthen existing systems for communication, transport, equipment and referral
- vi). Monitor implementation of the SHP as outlined in the SHP monitoring and evaluation frame-work
- vii). Conduct capacity building of both health professionals and educators at lower level (sub-district).

### **10.10. Ward Level**

Wards have a key role to play in ensuring that all schools are reached. The Ward Health Officer, Ward Executive Officer and the Ward Education Officers will formulate the ward task force team which shall be based at the ward level. The head of the nearby Health Facility will be part of the task force as well as a representative(s) of any local CBO, FBO or any community organization involved in implementing school health initiatives.

### **10.11. Roles of ward school health Task Force team**

- i). Ensuring of the implementation of the annual and five years' work plan or strategy
- ii). Supervise the implementation at school level
- iii). Present the school health programme agenda to the ward executive development committee meetings
- iv). Monitoring and evaluating the implementation at school level

### **10.12. Coordination at school and community level**

The heart of the NSHP is the level of the school and community. Participation by learners, parents, teachers and community is essential to the success of the programme. Community-based health programmes can contribute to schools in their community. School-based activities can contribute to the health of their communities. The NSHP should therefore be seen as part of the Community Based Health Programme.

At the school, there is school committee or school board under the chairmanship of Head of the school/head teacher. In addition, there are school health teachers for each school collaboration with the classroom teachers and all school staff. Shall directly be involved on all daily matters related to health and education in schools.

### **10.13. Roles and Responsibilities of Stakeholders**

Mainly the roles of various stakeholders are stipulated to achieve the following objectives:

- i). Strengthen collaboration and coordination
- ii). Enhance sharing of information, best practices and lesson learned.
- iii). Enhance effective monitoring and knowledge management
- iv). Promote advocacy and dissemination of the revised guidelines and strategy
- v). Maximize resource mobilization and utilization as well as technical support.
- vi). Adhere with procedures and standards.

Despite the fact that the health sector is responsible for provision of the package of school health services, the Education sector plays a key role in creating an infrastructure for the provision of the SHP. This includes planning, managing and monitoring of the programme, facilitating access to schools and services, and liaising with other role-players at all levels of the system.



#### **10.14. Role of parents, families and Community**

- i). Guide and protect children as well as provide life-skills and basic needs and appropriate moral support without gender discrimination
  
- ii). Provide security and enabling environment for optimum growth, development and proper upbringing of children through responsible parenthood
  
- iii). Provide role modelling for respect, love and cooperation

#### **10.15. Role of Development Partners and Private Sectors**

Provide resources and technical support to strengthen NSH

#### **10.16. Role of Training and research Institutions**

Provide evidence for improving program performance and produce competent teachers who could oversee welfare of the school children in schools.

