

I. Background

1. Nepal: A Brief Introduction

Wedged between two giant neighbors India and China, Nepal is a heterogeneous country in terms of topography, climate, ethnicity and culture. It has a population of 23,151,423 and consists of 102 social groups and 92 languages (Census: 2001). Currently there are 3,912 VDCs and 58 municipalities, including one metropolitan and four sub-metropolitan cities. Subsistence farming is the main occupation for nearly 80% of Nepal's population. The economic condition of the country is poor, which is evidenced with lower Human Development Index, with 38% of the population under abject poverty level. In the World Poverty Index 2001, Nepal stood at 77th out of 90 developing countries. Moreover, the acute poverty takes its toll disproportionately on women and children. It has become a leading cause of women's lower life expectancy than that of men. Nepal still suffers with illiteracy (one of the 10 least female literacy rate in the world), high rate of school dropouts, acute poverty, high infant, (64.4/1000),(91.2/1000) child and maternal mortality (41.5/1000) and morbidity.

Nepal's formal education system is a five-tier system, starting with pre-primary level to the continuum of primary (class 1 to 5), lower secondary (class 6 to 8), secondary (Grades 9 and 10) and higher secondary levels (Grades 11 and 12). Vast majority of schools in Nepal are the community schools (government aided and non-aided). The number of institutional or private schools is also on the rise. Currently, there are 24,776 primary schools, 7,436 lower secondary schools, and 4,547 secondary and 775 higher secondary schools. There are 5,919 private schools that are mostly concentrated in urban cities and in some district headquarters (MOES: 2004).

The total enrolment in primary level is 3.7 million and the percentage of girl enrolment is 42.6 percent. The girls' enrolment accounts 40.9% in the lower secondary and 39.7% in the secondary level.

The Gross Enrolment Ratio (GER) for primary, lower secondary and secondary education in 2001 are 124.7 (114.7% for girls), 63.7 (54 for girls) and 43.8% (36% for girls) respectively¹. Similarly the Net Enrolment Ratio (NER) in primary, lower secondary and secondary level of education are 81.1 (75.1% for girls), 39.4 (33.3% for girls) and 25.5% (20.9% for girls) respectively.

According to the annual school based data of MOES in 2000, 19.6% of the total primary school age children are never enrolled in school, and 45.4% of the children enrolled in primary schools dropout without completing Grade Five. Dropout occurs mostly in Grade one (13.5%). Only 47.4% students of Grade One are promoted to Grade Two.

The number of out of school and illiterate children, school dropouts and class repetition rates varies by region, by gender and by social groups. There is a wide gap between rural and urban areas, males and females, and between haves and have-nots. Taking school education to the unreached section of the population in one hand and retaining the students, enhancing their learning ability and achievement on the other, is the perceived challenge facing the country now.

Similarly, lack of trained health personnel, essential drugs and facilities and lack of proper coordination are the challenges perceived by the health sector. The situation is further aggravated by lack of education and awareness, social stigma, myths and other social and economic barriers. There is still a need to give due priority to preventive and promotive

¹ Analytical Description of Educational Indicators of Nepal, 1997-2001

health components. Hence a synergic interface between the health service sector and the education sector from the central to the grassroots level is a must for promoting the people's health as well as enhance the access and quality of school level education in the country.

2. Rational of School Health and Nutrition Programme (SHNP)

About 41% of Nepal's population (45,00,000) is below the age of 16. These young people live mostly in remote rural villages. High prevalence of anemia (78% in Pre-school children and 64% in school girls of 14 years of age), Total Goiter Rate (40% in school children), helminthes infestations (66%), Vitamin A Deficiency in pre-school children with sub-clinical Vitamin A Deficiency/VAD (32%), night blindness (1.2% in school children), lack of water and sanitation facilities all indicate the poor health indicators among school children in Nepal. These poor health indicators, without any doubt, have profound, impact on the educational attainment of the school children. *(Please refer to Appendix A for the School Health and Nutrition Programme (SHNP) indicators)*. Despite such indicators, the health of school children is not yet a priority in Nepal.

In Nepal students spend about 200 days in the school in a year. Most of the time they spend (six to seven hours a day) in school. Their mental and physical health is greatly influenced by their interaction in the school environment. The school is one of the agencies that could contribute more than any other institution to promote the health of young people and school personnel. The school has a role of in lieu of parents. The school years are formative time for the children. The school setting provides an effective means of enhancing young people's health, self-esteem, life skills (abilities related to effective decision-making, communication, understanding emotions, critical thinking, coping with stress etc.) and behavior. (WHO: 1997). In schools children acquire not only life-style messages and develops attitudes and skills but also make their way into families and peers as transmitters.

Studies carried out in many developed and developing countries have shown that SHNP is crucial to address many pressing health and nutrition problems such as malnutrition, short-term hunger, helminthes infection, poor sanitation and food safety, lack of immunizations, poor oral health, infectious and endemic diseases, problems associated with lack of physical exercise, use of alcohol, tobacco and drugs, psychological problems and HIV/AIDS and sexually transmitted infections. Health is a key determinant in school enrolment as well as continued participation and educational attainment of students in school.

Though there are more schools than the health care providing institutions and more teachers than health workers, health of the school children is outside the core business, not only to the schools but also to health institutions.

The status of health and nutrition of school children in Nepal is not well understood. Health and nutrition services for the school populace do not come under the priority of the health workers. Nor the school is concerned with children's health because of their priority in academic matters. The impact of health and nutrition status to the learning achievement is getting less attention. Government organizations (GOs) and a few I/NGOs have implemented small-scale health and nutrition service programmes in some pocket areas of certain districts.

It is only through comprehensive and coordinated education and health services, which could create an enabling environment to ensure **better learning achievement and improved health of the school children**. School Health and Nutrition Programme can be the cost-effective and easiest way in improving students' health and academic performance. Not only to the students and school personnel but also to the family, community and nation, promoting health through school is financially, socially, economically and politically desirable.

Investing in school health has far reaching results and schools can serve as an entry point for health promotion. Therefore, SHNP must be a key approach to achieve the twin goals, “Education for All” and “Health for All”. Health should then be a high focus in the agenda of the education sector at all levels.

3. Global Initiatives in School Health and Nutrition Programme

The history of school health can be traced as early as 1700 AD when John Locke emphasized inculcating health rules among children. In 1832, Horac Mann advocated the need for training the teachers in health education.

The **World Health Organization’s Expert Committee on School Health Services**, around 1950s, highlighted a connection between health and education that to learn effectively children need good health (WHO, 1950). In the late 1980, definition of school health changed as societies changed. The following eight areas of SHNP were identified (Allenworth D, Kolbe L. eds, 1987):

- School health services;
- School health education;
- School health environment (physical and psychosocial);
- Health promotion for school personnel;
- School outreach programme and school-community projects;
- Nutrition and food safety;
- Physical education and recreation; and
- Mental health, counseling and social supports.

The **Ottawa Charter** for Health Promotion (1986) called attention to strategize five critical areas for action while strengthening SHNP:

- To promote public policies for school health that provides resources for and embody a commitment to enhanced health and education;
- To foster supportive environments that are the result of assessment and improvement of the physical and psychological environment of the school;
- To encourage community action that supports the process of health promotion and the linkages between the school and other relevant institutions;
- To promote personal skills development (through both curriculum and the teaching and learning process) that emphasizes specific health-related behavior, as well as the skills needed to support health throughout life; and
- To reorient health services in the school and community. So that these will:
 - Provide enhanced access to services within the school as well as referral to the external health system
 - Identify and implement specific health interventions that are best carried out through the school; and
 - Integrated creative and preventive interventions

Till 1997, there was increasing realization that health promotion through schools was possible through organized comprehensive and holistic strategies. A multi-disciplinary team convened in 1994 in the United State’s Institute of Medicine defined a comprehensive SHNP as an **integrated set of planned, sequential, school-affiliated strategies, activities and services designed to promote the optimal physical, emotional, social and educational**

development of students. This definition emphasized both the vertical coordination between central government agencies and grass root agencies, and horizontal collaboration and cooperation among various agencies, including school and community.

WHO forwarded a definition of health promoting schools in 1996². It evolved as a strategy of helping school to build and use their entire organizational capacity to improve health among the students, school personnel, families and communities (*Please see Appendix B.3 for features of health promoting school*).

The interface between health and education was well reflected in **Education for All (EFA)** goal of World Education Forum held in 2000. According to this Forum, health interacts with EFA as:

- A condition required for learning
- An outcome of education
- A sector to collaborate with in achieving EFA.

The EFA recognized that poor health and malnutrition were important underlying factors for low school enrollment, absenteeism, poor classroom performance and early school dropouts.

The **Thematic Study (1990-2000) of Education for All (EFA)** recommended that:

- Health promotion and disease prevention programmes are cost effective
- Multiple coordinated strategies produce a greater effect than individual strategies
- Health education is most effective when it uses interactive methods in a skill-based approach
- Trained teachers produce more significant student health outcomes
- Health promotion for teachers benefits their health, morale, and quality of instruction
- Health promotion for students can reduce disease in the community
- Good health is a condition required for learning and an outcome of good education.

The major six goals set by Dakar Forum for the year 2015 clearly envisaged the need for effective SHNP (*Please see Annex B.2 for the EFA Goals*)

The **EFA review in Dakar, Senegal (2000)** lunched a health partnership among UNESCO, UNICEF, WHO, World Bank, Education International and World Food Programme (WFP).

Nepal, as a signatory of the **Child Right Convention (1989)**, has committed to respect the rights of the children. It includes the right to optimum health, nutrition, and clean drinking water, (Article 24), the right to primary education (Article 28), and the right to personality development, including physical and mental development (Article 29). Based on these rights, Nepal has formulated and enforced different Regulations and Acts such as Labor Act and Children's Act.

The **Focusing Resources on Effective School Health (FRESH)** is the most recent approach of school health, hygiene and nutrition programme. It is a merger of the concept of "Child Friendly School" of UNICEF and "Health promoting school" of WHO. It realizes that health

² A health promoting school was described as a school constantly strengthening its capacity as a healthy setting for living, learning and working.

and education go hand in hand in school³: The convergence of health and education categorically represents by four core elements.

- Health-related school policies
- Healthy, safe and secure learning environments
- Life skilled-based health education
- School-based health and nutrition services

The **FRESH** approach gave an impetus to multi-sectoral approaches (e.g. education, health, sanitation and nutrition) in school settings.

The world community, including United Nations and international support agencies has appreciated the need of an effective SHNP in order to achieve all or some of the **Millennium Development Goals (MDGs)** by 2015(Refer to *Annex B.2 for the Goals*):

The EFA Goals and Millennium Development Goal for Education cannot be achieved without urgent attention to SHNP. Active coordination between health and education sector has been increasingly recognized worldwide for the purpose of protecting and promoting health of students and school personnel.

Health promotion of the school children is and should be one of the main responsibilities of the state. Hence a strategic policy regarding the SHN programme is the need of the country.

4. National Response to School Health and Nutrition: A Historical Prospective

With an intention of enhancing the educational performance of the students, the school-feeding programme, was introduced first time during the *Rana* regime. During the decades of 1950, students in need were provided free mid-day meals in the government schools of Kathmandu Valley. The Sanskrit schools have continued free education with accommodation and foods till date through for limited number of students.

Provision of physical facilities in schools such as lighting and ventilation, furniture appropriate to classroom needs, school garden, playground and sport field was clearly spelled out by the **National Education System Plan**. The plan had laid emphasis on supervising the set up of physical facilities in the school. (MOE/HMG/N, 971: Pp55).

Basic and Primary Education Programme Implementation Plan (BPEP II, 1999- 2004) focuses to improve access particularly for girls and disadvantaged children and to reduce overcrowding in Grade 1 and 2, enhance the quality of classroom space, and upgrade environmental and health situation in primary schools through strong emphasis on sanitation and water supply (HMG/MOES, BPEP II, 1999). BEPE II emphasizes creating appropriate physical learning environment in schools by supporting to construct toilets and drinking water facilities. The implementation plan also mentions the need to sensitize community members on the importance of physical facilities and health and hygiene of the school children. The strategies to create a better learning environment include increase the daily attendance, and create healthy, safe and pleasant school environment. These strategies are to be taken into account while developing School Improvement Plan (SIP), which aims at

³ A Child Friendly School is a space in which children and adolescents develop/acquire knowledge, abilities and life skills in a healthy and safe environment inclusive, protective respectful of gender differences and cultural diversity of children (UNICEF). This space creates active participation of children, adolescents, teachers, parents and the community.

remodeling 10,800 classrooms and constructing up to 8,000 drinking water and toilet facilities.

The **National Goals of School Education** stresses to nurture and develop personalities and innate abilities of each student. One of the aims is to make individuals able to lead a socially harmonious life. Primary education is meant to develop positive awareness of health issues in everyday life. The lower secondary and secondary education also attempts to make students health conscious, competent and healthy citizens.

The periodic **Development Plans** have increasingly added value to SHNP. The current Tenth Plan (2002 – 2007) has adopted a policy of increasing the access and utilization of primary health services by providing training and orientation to the schoolteachers and students (Grades 6 – 10). Similarly, reaching women through school children initiated from 1999/2000 imparts health information to students, which could be transmitted to their family and neighborhood.

The **National Health Education, Information and Communication Centre (NHEICC)** has developed separate Teacher Training Guidelines on School Health Programme for the trainers and the health institutions. The budget for the training is provided by the MOH. The role of students and teachers as disseminators of key health messages such as school sanitation, safe motherhood and family planning, reproductive health, nutrition, immunization HIV/AIDS, community health problems and health services available in the community is well recognized in the guideline. As per this mandate, each of the D/PHOs is now conducting orientation programmes to the teachers and students on SHNP. At the end of the training, an action plan is asked to develop and implement accordingly.

The **Second Long Term Health Plan (SLTHP 1997 to 2017)** mentioned School Health Services, diarrhoeal disease, helminthes, oral health, HIV, STIs, malaria, eye and hearing problems, substance abuse, and Basic trauma care as the key areas for the health interventions (MOH, Health Information Bulletin, 2001).

MOH's focus on life-cycle approach-based care and support programme, which is needed by an individual from conception to old age, is imperative in creating an enabling environment for the implementation of SHN programme.

The contributions made by the government, I/NGOs UN, multilateral and bilateral agencies and other organizations are noteworthy in school health, nutrition and sanitation programmes. However, most of their programmes are rather fragmented and based on their project requirements (*Please see Annex B.1 for the School health and nutrition related programmes of different organizations*)

Programme such as deworming, water sanitation and health check up are sporadically implemented in Nepal. A wealth of good practices and lessons has emerged from such programmes, which could be replicated in the future school health and nutrition programmes. However, due to lack of a national strategy and a clear policy, SHN implementation, coordination and networking among the key players are yet to be done. In order to implement SHNP by following standard procedures in a coordinated manner, it is imperative to develop a national school health and nutrition strategy and make it mandatory by regulations.

5. Scope of School Health and Nutrition Programme

The school health and nutrition programme encompasses school programmes jointly organized by education and health sectors to enhance health, nutrition and education status of children aged 5-17 years by improving use of school-based health and nutrition services, safe water and sanitation and skills-based health education and community support and policy environment.

According to FRESH approach, the school health and nutrition promotes following sub-areas under each core elements:

1) School-based health and nutrition services

School can effectively deliver health and nutrition services provided the services are **simple**, **safe** and **familiar**, and address problems that are **prevalent** and **recognized** as important in the community.

- Micronutrient deficiencies: Iodine, iron and Vitamin A
- Worm infestations: Round worm, hook worm and whip worm

2) Healthy, safe and secure learning environments

- Provision of safe water and sanitation
- Reinforce health and hygiene education
- Sound construction policies to address issues such as gender access and privacy

3) Skills-based health education (SBHE)

- It is an approach to health, hygiene, and nutrition education focuses on developing the knowledge, attitudes, values and life skills that young people need to make and act on the most appropriate and positive health related decision
- Beyond physical health to include psychosocial and environmental health

4) Health related school policies

- Ensure and secure physical and psychosocial environment; address issues such as:
 - Abuse of students-child labour, girls trafficking, use of children in public activities etc.
 - Sexual harassment
 - School violence and bullying
 - Guaranteeing further education of pregnant school girls and young mothers, and
 - Reinforce health education for teachers and students.
- Promote overall health, hygiene and nutrition

6. Goals and Strategic Objectives

Goal : Develop physical, mental, emotional and educational status of school children

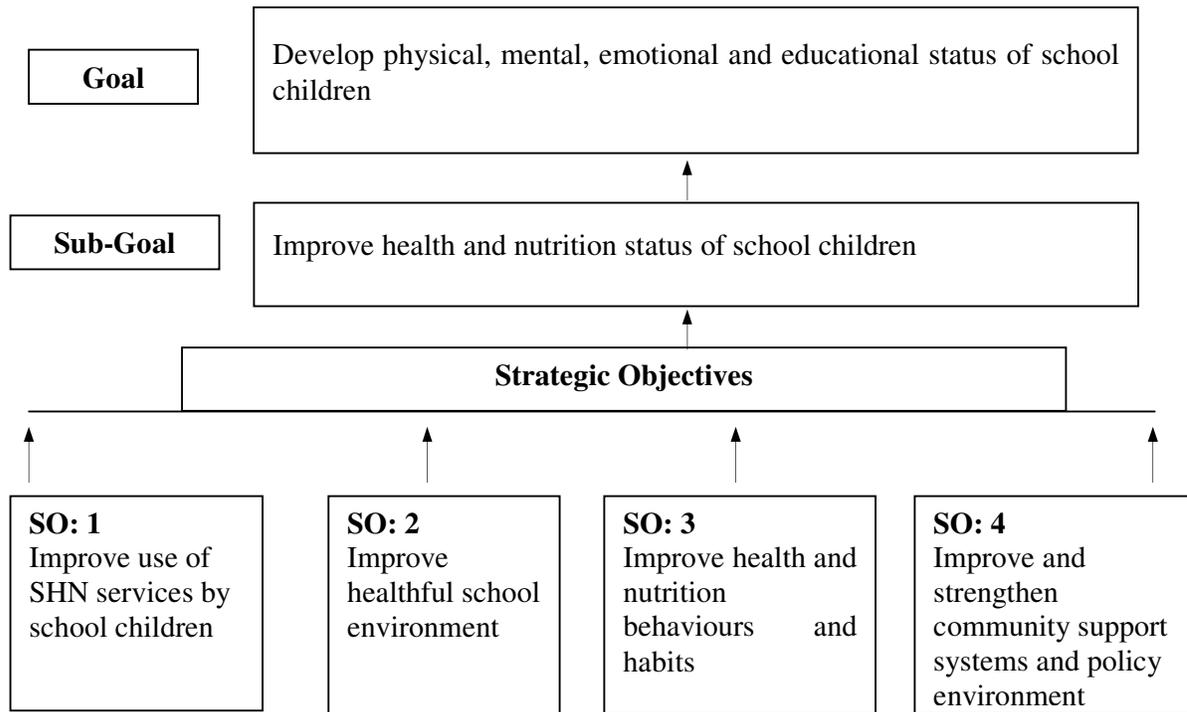
Sub-goal : Improve health and nutrition status of school children

Strategic Objectives (S.O):

The strategic objectives of School Health and Nutrition Programme will be to:

- S.O. 1: Improve use of School Health and Nutrition services by school children
- S.O. 2: Improve healthful school environment
- S.O. 3: Improve health and nutrition behaviors and habits
- S.O. 4: Improve and strengthen community support systems and policy environment.

7. Strategic Framework



8. Key Strategy

Capacity Building

Promoting health of children through schools is a new initiative for Nepal. Despite limited project specific interventions carried out by some I/NGOs, UN, multilateral and bilateral agencies in their programme areas, a need-based, holistic, organized and comprehensive SHNP is yet to implement. Multidisciplinary and multi-sectoral initiatives and collaborative efforts of all related sectors including education, health, population and environment, agriculture, women group, children and social welfare is a must for the effective implementation of SHNP. Capacity building of the workforce to be involved with the SHNP and that of related institutions at the central, district and school level should be enhanced. Teachers, Child clubs, students, SHN committee, SMCs, PTAs, VDCs, local sub/health posts, local health practitioners, SHN and Child right Committee, DEO and central level stakeholders such as representatives from MOES and MOH, require various capability building opportunities so as to acquire proper knowledge and skills for the management of SHNP effectively. A lesson from the small scale SHN pilot projects implemented in Nepal is that capacity building of the stakeholders at all policy and implementation levels contributes for a result oriented, cost effective and sustained programme.

The strategies and activities that need to be initiated for capacity development of the key players in terms of the four strategies are included under the four subsequent strategies.

8.1 School-based Health and Nutrition Services

Strategic Objective (S.O.1): To improve use of School Health and Nutrition services by school

The role of school as a “delivery site” in helminthes control and prevention, micro-nutrient supplementation, control of diarrhoeal diseases, tuberculosis, malaria, leprosy, immunizations, safe water and sanitation, reproductive health and activities or services for the prevention of HIV/AIDS and STIs has been demonstrated successfully in some parts of the country. *(Please refer Appendix ‘C’ for the programme description)*

A needs-based and effective strategy for a collaborative and sustainable school health services is increasingly realized. A policy governing SHNP and functional organizational structures with clear roles and responsibilities is critically important in protecting, maintaining and promoting the health and nutritional status of school children and that of those who come in contact with the children in school. Meeting the health and nutritional needs of the out of school children and community by linking school health with community health is equally important.

Schools can effectively deliver health and nutrition services if these services being provided are simple and safe, address problems that are prevalent and are recognized as important in and by the community. And it is cost effective as well.

Objectives:

1. Increase availability and access to SHN services (Physical check up, minor treatment and referral as per need; deworming; iron supplementation; Vitamin A as per need and screening for hearing, vision and dental),
2. Build the capacity of the different levels of key players involved in school health and nutrition services,
3. Reduce anemia and worm infestation rates among school children,
4. Increase parent, community and local health service providers’ participation in the provision of SHN services,
5. Improve prevention and control of possible communicable diseases and nutritional deficiencies,
6. Improve counseling and referral services relating to school health and nutrition,
7. Improve school attendance rate, reduce dropout rate and increase class promotion rate.

Strategic interventions and activities:

Strategy 1: Building Capacity of the key players from the DOE (MOES), CHD/Nutrition Section, NHEICC, School Management Committees, teachers, DDC, DEO, DHNCC, SHN Committee, VDCs, Child clubs and health workers

Activities:

- Mobilize local health service providers in conducting session/topics such as helminthes control, first aid, adolescent health, safe motherhood, sanitation and personal hygiene, information about existing health services and referral points, nutrition and HIV/AIDS and STIs during the period of teachers' training and students' orientations.

- Organize orientation, leadership and management training based on FRESH model to strengthen the capacity of DOE, Curriculum Development Centre, Nutrition section, Child Health Division, DEO, DHO/HP/SHP/PHCC, DDC, Regional Directorate of Education, Resource persons and supervisors, and health service providers for implementing school health and nutrition programme
- Provide training to teachers, and child clubs on basic first aid procedures, screening of vision, identifying hearing defects and anthropometric measurements, iron distribution, deworming and Vitamin A distribution.

Strategy 2: Increasing use of SHN services

Activities:

The schoolteachers, SMCs, and PTAs with the assistance from the education and health service providers and community development organizations will conduct:

- Annual physical check ups including measurement of height and weight for assessment of nutritional status, provide minor treatment and refer as per need;
- Screening for vision, hearing and oral health;
- Develop a Visual Dietary Guideline based on the local context;
- Mass deworming bi-annually;
- Mass iron tablets distribution, 1 tablet per week for 13 weeks in a year and Vitamin. 'A' supplementation, if required;
- Extend school feeding programme, wherever possible and link it with the total school programme;
- Promote school tiffin or midday meal in primary schools by increasing involvement of parents, government and other support organizations;
- Supervise/monitor the students' tiffin for quality assurance;
- Promote a system of informing parents during emergency illness and at times when students need referral and treatment from the health service providers;
- Manage first aid kits having minimum required medicines with refilling system with the support of support agencies, budget received for implement of SIP and by mobilizing local resources from VDC and municipalities;
- Keep students' health records and share with their parents for improvement;
- Conduct formative research to assess the SHN needs as well as diet diversification.

8.2 Healthful School Living

S.O. 2: Improve Healthful School Environment

School environment depends on a constellation of physical and psychosocial factors. For a safe, secure, healthful school living and joyful learning the animate and inanimate environments should be supportive to the health of the pupils and school personnel. Three elements make up the school environment: the physical surrounding, the psychosocial aspects of education and the community within which the school functions (WHO: 1997).

The condition of the physical environment includes school location, buildings, interior structure, classroom and furniture, playgrounds, cleanliness and availability of clean water for drinking and hand washing, means of waste collection and disposal, hygienic latrines, safe

food services, insect and vectors control and other minimum prerequisites for establishing and maintaining a healthful environment.

The social environment of the school also plays an important role in the psychosocial well being of the students and school personnel by promoting a positive school culture, mutual respect and dignity that is conducive to learning. It involves quality relationships among staff, among students, between staff and students, and cooperative relationship between parents, and school and community.

Objectives:

1. To increase availability of and access to safe water;
2. To increase availability of hand washing facilities, and waste disposal facilities at schools;
3. To increase access to toilet facilities for boys and girls;
4. To increase access to safe and pleasant and joyful school environment at school;
5. To increase participation of students, school personnel and community in developing and taking care of the school facilities;
6. To develop negotiation skills among students to protect themselves from abuse and harms/harassment.

Strategic interventions and activities:

Strategy 1: Provision of adequate and safe water supply and sanitary facilities

Activities:

- Analysis of water supplies for contaminants (arsenic and fecal matters) and treat as needed.
- Ensure all schools have drinking water facilities. Install drinking water facilities as per need.
- Girls, boys and teachers have access to clean and separate toilet facilities. Comply with standard student to latrine ratio. SMCs/School health and child right committees/PTA ensure maintenance and functionality of latrines.
- Establish and maintain hand-washing facilities at schools
- Establish and maintain waste disposal systems at schools.
- Organize orientations to the child clubs/School Health and child right committees; School Health Committee and PTA regarding the importance of school sanitation there by to increase demand and response, and formulate action plan at the school level.
- Students and teachers actively participate to keep their classroom and school playground clean and safe on routine basis.
- Mobilize student houses, class monitors, genitors, child clubs, School Health and Child Right Committees for this. Keep dustbins and containers as per the local needs. Observe National Sanitation and Cleanliness week (World climate Day) (World Health Day) with various awareness programmes each year.
- Conduct Fund raising activities with the involvement of students, child clubs, SMC and VDC for construction, operation and maintenance of the school facilities. Every school should raise a maintenance fund for promoting school facilities and water and sanitation

facilities. Schools should be encouraged to contribute in cash or kind for the toilet construction.

Strategy 2: Revisit, update and implement standard regulations and norms by the Ministries of Education and Health for school construction and maintenance and operation (e.g. school area, school building, classroom space, ventilation, furniture, water supply including tube wells, toilets, drainage, lighting, fencing, school remodeling, structural adjustment for inclusion of children with disabilities)

Activities:

- The MOES/DOE and MOH revisit the existing regulations and policies regarding the school building construction, furniture and blackboard, water supply, toilets, lighting and ventilation along with other requirements and promulgate a SHNP policies, which influence the school's actions and resources.
- Develop simple and adaptable tools based on evidence-based research to assess the quality of the school environment. This will indicate the minimum standard for monitoring the school environment.
- The school Supervisors and Resource Persons supervise the school's physical environment and water and sanitation facilities required by a child friendly school and submit their reports to the DEO. They should direct/feedback to the SMCs, RPs and teachers. Supervision of the SHNP should be a part of the supervisor's job description.
- Incorporate school programmes aiming to improve the physical environment including water, sanitation and hygiene, and SHN services into the School Improvement Plan (SIP).

Strategy 3: Minimizing risk environment

Activities:

- MOES formulates policies and code of conduct that prohibit smoking and substance abuse, harassment of girls, corporal punishment, discrimination against *dalits* and orphan children, people with disabilities (PWDs) and HIV/AIDS (PLWHAs). Dissemination of the policy will be held at the central, district and community levels.
- Children will be protected from conflict and abuse, and schools will be regarded as 'Zone of Peace'
- Provide safe and hygienic food service (if available)

8.3 Life skills-based and Behavior-centred Health Education

S.O 3: Improve health and nutrition behavior and habits

Each year millions of children in Nepal suffer from poor personal health, malnutrition, infectious diseases, substance abuse, injuries, violence and increasing burden of HIV/AIDS. In order to provide, inculcate and reinforce existing knowledge, positive attitudes, pro-social and healthy skills and behavior and to prevent or minimize myths and misinformation, taboos, negative attitudes and risky behaviors, children, young people and school personnel

need to be equipped with knowledge, attitudes, values and skills that will help them cope with these challenges.

The knowledge-based health (including nutrition) education improves knowledge and attitudes of student but it is correlated poorly with desirable behavioral changes. Therefore, life skills-based health education is a must for achieving and sustaining behavior change. Life skills, contexts of life skills-based health/behavior-centred education and the methods of teaching and learning are the three components of life skills-based health education.

Interpersonal communication skills, critical and creative thinking, decision-making, self-awareness and coping with emotions and stress management skills, among others, are the key life-skills needed for making responsible health-related decisions. The approach of life skills-based health education focuses upon the development of knowledge, attitudes, values and skills needed to make possible health-related decisions. The behavior-centred education enables them to practice healthful behaviors. This approach uses various participatory learning methods like demonstrations and practice, role plays, interactive sessions, group/individual projects, use of real local food stuff for nutrition classes, etc. Both the formal and informal curricular approaches are very crucial to counteract the diseases and conditions that affect health of students and school personnel such as control and prevention of diseases, malnutrition and a range of health-compromising behaviors.

Objectives:

1. To improve knowledge of/and attitude towards key behaviors related to SHN;
2. To develop life skills needed for making health and nutrition related decisions;
3. To conduct behavior-centred health education sessions on regular basis;
4. To develop negotiation skills among students to protect themselves from abuse and harms/harassment.

Strategic interventions and activities:

Strategy 1: Enhancing knowledge and skills through behavior-centred and skill-based health education

Activities:

- Train teachers as “main actors” to take lead role for conducting the life skills- based and behavior centred health education programme.
- Develop with the consultation of health service providers behavior-centred/skill-based health education curriculum incorporating developmentally appropriate learning experiences for children from the primary to the higher secondary level
- Orient DOE and CDC/MOES and DHO, DoHS/MOH in developing life skills-based/behavior centred health education curricula collaboratively.
- Conduct behavior-centred sessions at least once a week on personal hygiene, nutrition, prevention of worm infestation and anemia, proper toilet use, hand washing with soap, food handling and consumption. Interactive and participatory teaching methods will be used to develop positive knowledge, attitude and behavior among students and school personnel.
- Promote adequately iodized salt by establishing a school-based iodine monitoring system with use of rapid test kits.
- Encourage kitchen garden promotion in the school

- Carry out life skills-based health education activities with the active participation of child clubs, School Health and Child Right Committees and school personnel in the extra-curricular activities such as drama, role-play, quiz context, oratory, cultural programmes and essay writing and wall magazine.
- Organize behavior-centred health education sessions to the teachers and students annually by D/PHO and local health service providers from the sub/health post or PHC or hospital to enhance students' health-seeking behavior, knowledge values and attitudes.

Strategy 2: Introduce Child-to-Child and Child-to Parent and community approach for the acquisition of knowledge necessary for health promotion, development of attitudes, values and ideas that motivate each individual to promote health and establishment of essential health practices.

Activities:

- Develop, disseminate and use IEC materials that promote positive knowledge, attitudes, values and behaviors among students, staff and the family. I/NGOs, governments and existing community's resources will be used for developing and disseminating the IEC materials.
- Collaborate with NHEICC and Nutrition section of CHD/DoHS on skill based Health and Nutrition education.
- Organize health education and awareness campaigns such as street drama, folk songs, pasting posters, and rallies in the schools as well as in the communities.
- Form and train child clubs, SMCs, PTAs, Health Management Committees, School Health and Child Right Committees and SHN Committees on life skills-based health, sanitation and nutrition programme.
- Conduct child initiative programmes such as monitoring personal hygiene, inspecting nails, dental caries, school sanitation, extra curricular activities, management of Tin-box library or IEC corners.
- Involve students in practical activities in the community. For example, secondary level students will be made involved in immunization, promotion of iodized salt, construction of latrines etc. as the requirement for their practical work.
- Conduct researches for need assessment and impact of life-skills-based health education and develop indicators for measuring the immediate, intermediate and long-term impacts.
- Initiate child-friendly counseling and peer counseling programmes in schools.
- Develop and disseminate SHN facilitation reference manual for teachers.

8.4 Networking and Collaboration for SHNP through Partnership

S.O. 4: Improve and strengthen community support systems and policy environment

School Health and Nutrition Programme is a multidisciplinary and multi-sectoral initiative. It requires networking and collaboration through committed partnership in order to develop the technical, managerial and financial aspects of the programme. Networking and collaboration, from the ministry level to the district and VDC levels, facilitates exchange of ideas and experiences at the national, district and local levels and channelize the resources for the implementation of SHNP.

DOE under MOES, in consultation with Child Health Division and NHEICC at the central level will lead the networking and collaboration of SHNP. Linkages and networking among various stakeholders from education, health, population and environment, agriculture, and women and child development will be done while implementing SHNP. It can take many different forms and use different approaches such as consultative meetings, workshops, exchange visits, self-monitoring and partnership for health promotion, etc. Health and education professionals, administrators, policymakers, students, teachers, political leaders, parents, communities, local government and groups from the private sector (civic organizations, business and corporate groups, academic, professionals, research institutions, youth groups, etc.) should make collaborative efforts for diffusion of SHN related approaches and innovations, motivating people, sharing experiences, and enhancing technical and financial capabilities of the key actors involved in SHNP. (See section eight for institutional framework of SHN implementation). Since SHNP falls under purview of various sectors and agencies, networking and collaboration among all key actors is necessary. Coordination between MOES and MOH is a key for improving health, and nutrition status and educational outcomes of school children.

Objectives:

1. To increase inter and intra-sectoral linkages and collaboration for promotion of health and nutrition status of school children through the SHNP
2. To promote collaboration and partnering in SHNP among SMCs, PTAs, UN, multilateral and bilateral agencies, I/NGOs, GOs, private sectors and communities.
3. Create conducive policy environment related to SHNP

Strategic Interventions and activities:

Strategy 1: Strengthen the linkage and, networking between MOES and MOH and build on partnership with government line agencies, non-governmental and private sectors at the national, regional, district and school level.

Activities:

- Form a national level SHN Advisory Committee (NSHNAC).
- Assignment of a SHN Focal person at DOE, CHD/DoHS, NHEICC, DDC, DEO and D/PHO to facilitate the implementation of SHNP. In the future, a separate nurse or Health Assistant or medical officer will be given special responsibility of providing technical support to each District Education Office. The school will assign a SHNP focal teacher (preferably female) as well.
- Assign a related teacher (preferably female) with the responsibility of implementation of SHNP in each school until a post of health teacher is assigned.
- Integrate school-based health and nutrition services that contribute to the needs of students and school personnel into the existing health services in the school and in the community. Establish linkages and networking between the health service institutions, child clubs, school health and child right committees, SMC, VDCs, PTAs, women groups, local clubs, CBOs, I/NGOs, multilateral, bilateral and UN agencies and private sector to expand and improve the health and nutrition services for the school children.
- Orient the SMC, PTA, VEC, teachers, health workers, child clubs, and VDC/municipality representatives to formulate and implement school health and nutrition activities and incorporate the plan into the SIP, Village Education Plan (VEP) and Village Development Plan (VDP).

- Organize consultative meetings, workshops and orientations at the central, district and school levels to enhance their technical and human resource capacity with the participation of different sectors related to SHNP.
- Encourage public private partnerships for the promotion of health, nutrition and education status of school children. For example: hand washing with soap initiative, toothbrush promotion, HIV/AIDS etc.
- Establish a functional group mechanism for effective lines of communication coordination a partnership between the central, district and school level (VDC level) structures for implementing the SHNP effectively.

Strategy 2: Improving policy environment

Activities:

- Establish a proper network between MOES/DOE and MOH/DoHS to implement SHNP in an integrated and organized manner.
- Formulate school policy and protocols on school infrastructure, healthy food, first aid, helminthes control, health screening and physical check up, school closures during epidemic and emergencies, emergency preparedness, control of HIV/AIDS/STI and safety plan for emergencies during natural and other disasters.
- Prepare SHN programme policy, procedure implementation guideline, and legal provisions and job description of the key players.
- Develop school policies, norms and code of conduct regarding use of drug, tobacco and alcohol, disciplinary actions to teacher and students, violence and abuse of students, pregnant girls, orphans and students with disability and diseases (including HIV/AIDS).
- Sensitize policy level key actors in inter country FRESH framework, of good practices and lessons learned with reference to planning, organizing and monitoring SHNP.
- Sensitize policy makers and politicians at the national, regional district and VDC level regarding the regulations and policies, and advocate about the need for a SHNP based on FRESH approach.

9. Institutional Framework and Implementation Strategy

The institutional framework for effective implementation of SHNP will comprise various levels, from policy level national structures to the district and school-level implementing mechanisms. At the National level, the **School Health and Nutrition Steering Committee (SHNSC)** will be constituted as the over-all central policy making body for SHNP nationwide. MOES/DOE with MOH/DoHS in close coordination, collaboration and consultation with other line ministries, National Planning Commission, national and international NGOs, multilateral, bilateral and UN agencies and the private sector active in SHNP will develop and revisit the National SHN policy, strategy and guidelines. It will facilitate resource mobilization for the SHNP.

The Regional Directors of Education and Health will coordinate and monitor the district SHN programmes.

In the District level, **District School Health and Nutrition Coordination Committee (DSHNCC)** will be set up for formulating district level SHN plan and policies, programme implementation, coordination and monitoring mechanisms based on SHNSC recommendations. It will have a pivotal role in coordinating for allocation of budget to the

local bodies working in SHN programme, which are approved under the SIP, Village Development plan and District Development plans. It will avoid duplication and optimize use of resources. School Health and Nutrition Committee (SHNC), Child clubs/Student Health and child right committee/society, PTA, SMC, teachers, local VDC/municipality and DHO/PHC/sub/health post workers will work at the school and community level under the DSHNCC.

Inter and intra-sectoral coordination and collaboration will be made in all levels of implementation. Community support systems and policy environment SHN will be improved accordingly.

Institutional Provisions

Level	Organizational Structure	Lead Agency	Composition	Main Responsibility
National	National School Health and Nutrition Advisory Committee (NSHNAC)	MOES/DEO	MOES (1), MOH/DoHS (1), CHD (1), DOE (1), CDC (1), NHEICC (1), INGO (1), NGO (1), NPC (1) other Support agencies (2) e.g. WHO & UNICEF	<ul style="list-style-type: none"> Development and review of national SHN policy and guidelines Networking and resource mobilization Monitoring and supervision of district level, SHN committee
Regional	Regional SHN Committee	Regional Directorates Education and Health	Regional Director of Health (1) and Education (1), Health Education, Info and communication center (1) I/NGOs/Support agencies (2)	<ul style="list-style-type: none"> Monitor and evaluate district level SHN programmes and provide feedback
District	District School Health and Nutrition Coordination Committee (DSHNCC) District SHNP focal person	DEO/DHO	DEO (1), DEO/DHO focal person (1), DDC president (1), D/PHO (1), I/NGO (1), District Child welfare Committee (1), RP (1)	<ul style="list-style-type: none"> District level SHN planning, resource mobilization, coordination, implementation based on NSHNCC recommendations, monitoring and supervision
School	School Health and Nutrition Committee (SHNC) School Management Committee (SMCs) PTAs Child Clubs/Student Houses/Student Health and child right Society/committees Trained teachers VDC/municipality	School	SMC chairperson (1), Headmaster (1), Child club (2), HPE teacher (1), VDC Representative (1), Ward Chairperson (1), RP (1) S/HPI (1)	<ul style="list-style-type: none"> Prepare SIP incorporate SHNPs, mobilize local resources, implement and self-monitor the SHNP.

It is suffice to say that all the activities mentioned in this strategy cannot be implemented at a time. It will be implemented based on the available resources. However, following activities or programmes will accord high priority and will be made mandatory:

1. Formulation of central, district, VDC and school level organizational set up involving education, health, nutrition, sanitation and hygiene related sectors for policy-making, implementation, monitoring and evaluation of SHNP.
2. Assignment of a SHN Focal person at DOE, CHD/DoHS, NHEICC, DDC, DEO and D/PHO to facilitate the implementation of SHNP. In the future, a separate nurse or Health Assistant or medical officer will be given special responsibility of providing

technical support to each District Education Office. The school will assign a SHNP focal teacher as well.

3. Formulation and execution of SHNP policy, norms and guidelines for establishing, remodeling, operation and maintenance of schools, including code of conduct regarding alcohol and tobacco use, teacher and student behaviors.
4. Annual health check-up at the beginning of the Educational Session, anthropometric assessment and screening of vision, hearing and oral health of school children and personnel with the support from the local health service sectors.
5. Weekly iron supplementation, one tablet per week for 13 weeks in a year.
6. Vitamin A supplementation will be done as per the need.
7. Mass deworming of primary school children bi-annually.
8. Provision of mandatory school tiffin or midday meal in gradual manner by increasing involvement of parents, GOs, I/NGOs, bilateral, multilateral and UN agencies and private sectors. Improve nutritional components of the school meals, where there is a provision of tiffin.
9. Provision of separate, adequate and child friendly toilets and urinals for boys, girls and school personnel
10. Provision of safe and adequate drinking water.
11. Maintenance of first aid kits having minimum required medicines with a refilling system
12. Promotion of tin-box library/IEC corners in each school.
13. Incorporation of key health education message by making use of the empty spaces of the school textbooks for all school level in each subject.

10. Legal and Official Provisions

A supportive system, policy and legal environment are vital for implementing SHNP. The prevailing HMG/N Education Act, policies, laws and regulations will be reviewed in light of promoting health, nutrition and education status of school children. A legal framework will be developed and put into effect for implementing SHNP. National guidelines and standards in all components of SHN will be developed and implemented by the MOES. A proper network will be developed between MOES/DOE and MOH/DoHS to facilitate policy formulation, implementation, monitoring and reporting mechanism from the central to the district and school levels.

The mass media, I/NGOs, community based organizations, VDCs, DDCs, DEOs, students, teachers, parents, PTAs, social leaders and relevant SHN committees will actively participate for advocacy in relation to all policies and legislation on SHNP.

The Village Development Committees, Municipalities and DDCs will work under Local Self-governance Act and the schools will develop participatory SHNP related policies, rules and regulation for schools.

11. Monitoring, Evaluation and Reporting

Monitoring, evaluation, documentation and reporting is essential for reasons such as to ensure that sectoral policies are being implemented uniformly, evaluate implementation modalities, to measure progress made in achieving SHNP goals and objectives and impact of the programme. Monitoring, evaluation and reporting of the SHNP will be done at different tiers.

MOES/DoE and MoH/DoHS in consultation and support from I/NGOs and line ministries will develop guidelines for monitoring, evaluation and reporting on SHNP. A regular system for sharing of reporting, monitoring and evaluation outcomes will be developed in the central level.

At the district level, the DSHNCC, SHNP focal persons and RPs will make regular visits to the schools and monitor and evaluate SHNP activities. The DoE will collect and review the reports submitted by DSHNCC and SHNP focal person and provide feedback on them. Documentation and reporting forms being used by the supervisors and RPs will be submitted to the DoE to feed into the central level Education Management Information System (EMIS) database. There will be a system of report/progress sharing between DHO and DEO in the district level and DOE/MOES and MoH/CHD.

The DSHNCC and SHNP focal person will monitor the district, VDC, Municipal and school level SHN activities. DDCs, VDCs and municipalities will monitor the use of resources and effectiveness of SHNP by using self-monitoring and reporting formats. The guidelines and reporting formats developed and used in the sanitation and hygiene programme in Nepal will be used, where appropriate. Formative researches, baseline and endline surveys and feedback sessions will be carried out to monitor and evaluate the progress of the SHNP and provide feedback to proper agencies and opportunities.

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