

Republic of Rwanda



MINISTRY OF EDUCATION

NATIONAL SCHOOL HEALTH POLICY

Kigali 2014

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FOREWORD

The Government of Rwanda has felt the need to develop a comprehensive national school health policy as an integrated set of planned and sequential efforts designed to promote the students' physical, social, psychological and educational development. The policy should provide training skills, knowledge and services to teachers and students in the following areas: health, hygiene, disability and special needs, environment, physical education, nutrition, sex education, measures to prevent chronic diseases including HIV and AIDS. The required services include guidance and counseling, psychosocial support, prevention of drug abuse and other unhealthy habits. Systematic and effective SH programs should be carried out to provide the institutional framework to support all these efforts. The development of this document is an effort in this direction.

To ensure the health and good academic performance of children, the institutions must be engaged in coordinated activities which involve parents and community members. These activities will promote youth development and risk prevention.

A child-friendly school environment and healthy school community are essential prerequisites for the achievement of Rwanda's national goals, as highlighted in the Education Sector Policy 2003, Education Sector Strategic Plan 2013-2018, Vision 2020, and international commitments such as MDGs and EFA. The efficiency of the education system has to be improved by reducing drop out and repetition rates, increasing completion rates, ensuring that students are able to respond to the demands of the job market.

The SH policy requires a strong inter-sector coordination led by the Ministry of Education in collaboration with the Ministries of Health, Agriculture, Infrastructure, Gender and Family Promotion, Sports and Culture, Local Administration, Youth, as well as other governmental and non-governmental stakeholders. The success of the implementation of this policy depends on the cooperation of all partners and stakeholders.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
BCC	Behavior Change Communication
CDC	Center for Disease Control
CEDAW	Convention on Elimination of all Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRS	Congenital Rubella Syndrome
DHS	Demography and Health Survey
ECD	Early Child Development
EDPRS	Economic Development and Poverty Reduction Strategy
EFA	Education For All
ESSP	Education Sector Strategic Plan
FAO	Food and Agriculture Organization
GBV	Gender-Based Violence
HC	Health Center
HGSFP	Home Grown School Feeding Program
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma Virus
HSSP III	Health Sector Strategic Plan III
IEC	Information Education and Communication
MDGs	Millennium Development Goals
MHM	Menstrual Hygiene Management
MIGEPROF	Ministry of Gender and Family Promotion
MINAGRI	Ministry of Agriculture and Livestock
MINALOC	Ministry of Local Government
MINEDUC	Ministry of Education
MINECOFIN	Ministry of Finance and Economic Planning
MINISANTE	Ministry of Health
MIFOTRA	Ministry of Public Service and Labor
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NISR	National Institute of Statistic in Rwanda
NTDs	Neglected Tropical Diseases
OVCs	Orphans and Vulnerable Children
PE	Physical Education
PMI	President's Malaria Initiative
PTAs/PTCs	Parents and Teachers Associations/ Parents and Teachers Committee
PTSD	Post Traumatic Stress Disorders
RBC	Rwanda Bio-Medical Center
SEN	Special Educational Needs
SGBV	Sexual and Gender Based Violence
SH	School Health
SHE	Sustainable Health Enterprises
SHP	School Health Programme/Policy
SRHR	Sexual and Reproductive Health and Rights
SH	School Health
STIs	Sexually Transmitted Infections

TB	Tuberculosis
TRAC	Treatment and Research AIDS Centre
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSO	Voluntary Service Overseas
WFP	World Food Program
WHO	World Health Organization

EXECUTIVE SUMMARY

School-age children in Rwanda face many challenges related to poor health and poverty such as: environmental hazards including inadequate water, sanitation facilities and school infrastructure, communicable and non-communicable diseases and gender-based violence. These factors influence the learners' attendance and ability to concentrate on lessons.

In order to improve this learning environment, the Government of Rwanda developed a comprehensive School Health Policy and Strategic Plan with recommended policy actions in eight key areas: (1) health promotion and disease prevention and control; (2) HIV, AIDS and other STIs; (3) sexual and reproductive health and rights; (4) environmental health; (5) school nutrition; (6) physical education; (7) mental health; (8) gender and GBV issues.

Efforts to implement school health actions are strongly aligned to Rwanda's international and national commitments and development goals. The policy recommendations contribute to the achievement of MDGs goals, EFA, commitments in the Convention of the Rights of the Child, as well as national plans and strategies such as the EDPRS II, Vision 2020, National Investment Strategy and Education Sector Strategic Plan.

The vision of this policy is as follows: "all Rwandan school children shall achieve their full development potential, by studying in a healthy environment in child-friendly schools, free from disease, prejudice and violence". In order to achieve this vision, the policy recommends a minimum school health package, including health promotion and education, referral and follow-up of minor health issues, safe water and sanitation provision, deworming, school nutrition, and other health interventions.

Other important health factors which influence students' development are: sexual and reproductive health, HIV and AIDS prevention, trauma and violence, substance abuse and mental health problems. Such factors should be addressed through health promotion and health education activities and need to be incorporated into the curriculum.

The effective implementation of this policy requires strong institutional structures and coordination among different ministries and stakeholders. In particular, a crucial role must be played by the Ministries of Health, Agriculture, Local Government, Infrastructure, Gender and Family Promotion. The implementation framework details the roles and responsibilities of all government stakeholders, including centralized and decentralized levels.

Monitoring and evaluation strategy focuses on strengthening the data collection of school health indicators. This data will allow MINEDUC to monitor the implementation of school health services and education, as well as measure its impact on the progress of learners. A set of indicators has been identified and suggested to measure and monitor the implementation of activities.

1. ISSUE

School Health issues are among the priorities of the Government of Rwanda and are addressed in various sectors and strategic plans. The ESSP 2013/14-2017/18 calls upon an adoption of a holistic approach to SH, covering issues related to HIV and AIDS, multiple acute and chronic health conditions, disabilities and special educational needs, sexual and reproductive health, hygiene, school feeding, school environment, mental health, trauma and sports. Poor hygiene in schools and lack of community ownership in SH activities are challenges to be addressed.

The effective implementation of this SH policy will facilitate in the following:

- Enabling school environment;
- Improving academic outcomes for all students;
- Combating HIV and AIDS, malaria and other acute and chronic health conditions;
- Addressing hunger and malnutrition;
- Reducing child mortality;
- Improving maternal health.

Students are the most important link between schools and the community. Their Behavioral changes, stemming from the knowledge of health, hygiene, nutrition, prevention of diseases and physical exercise, lead to spill-over effects in communities surrounding schools. The involvement of PTAs/PTCs, leading to a strong relationship between schools and communities, plays an important role in this policy.

The value of SH policy stems from the importance of promoting the health of students and the effects on wellbeing and learning outcomes. The learning capability of many children is reduced due to situations and behaviors which jeopardize their physical, mental and emotional status. This SH policy aims to identify and mainstream the key health interventions for improved school health, nutrition and education. The policy comprises eight thematic areas:

- Health promotion, disease prevention and control
- HIV, AIDS and other STIs
- Sexual and reproductive health and rights
- Environmental health
- School nutrition
- Physical education
- Mental health
- Gender and GBV issues

The main beneficiaries of the SH policy are learners in pre-primary, primary and secondary education, and equally importantly teachers, managers, and to some extent to their households, and the communities. *(The word community has been used quite often in this document to mean all the residents of the area in the neighborhood of the school).*

1.1. Definition of SH

Health as defined by WHO and UNICEF in the declaration of ALMA ATA is “a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity and is a fundamental human right”¹. WHO defines a school health program as a combination of services ensuring the physical, mental and social well-being of learners so as to maximize their learning capabilities (Medical Dictionary).

The WHO Expert Committee on School Health argue that school health programs can advance public health, education, social and economic development, and that the global expansion of school health programs attests to the value placed on such programs². SH policy will focus on quality of life of the child in terms of healthy environment to take advantage of opportunities to thrive, so schools and communities can ensure that their teaching programs and school facilities are exploited to their maximal potential.

1.2. Importance of SH policy

Most children spend up to 15 of their formative years (from early childhood to young adulthood) in a classroom environment. This provides an ideal opportunity for health education and interventions which address the many health and socio-economic factors affecting children in Rwanda. As these children are agents of change, once educated, they will potentially become influential sources of health information and models of healthy behavior for their families and the broader communities. In this way, the health system would be able to reach far beyond the walls of health institutions.

SH services also have the potential to provide a safety net for children who do not access preventive health services during their pre-school years. They are also able to identify avoidable health problems that may constitute barriers to learning.

1.3. SH principles

The SH policy is part of education and health policies which operates within the EDPRS II Framework and will:

- Focus on achievement of health and educational outcomes;
- Be implemented within a child’s rights approach. This means that children should not be passive recipients, but must be empowered as actors in their own development and in the development of the community;
- Ensure full coverage of all learners;
- Ensure that appropriate assessment, treatment, care and support services are available and accessible to all learners who are identified as requiring them;
- Be informed by local priorities;
- Be based on local needs of the target groups (Need for local/grass root consultations);
- Equip students with the knowledge, skills and values to achieve their full development potential;

¹ The status of school health (WHO, 1996)

² WHO (1996) Recommendations of the WHO Expert Committee on Comprehensive School Health Education and Promotion

- Take into account quality and equitable distribution of resources;
- Be implemented as a partnership between the Ministry of Health (MoH), Ministry of Education (MINEDUC) and all other relevant stakeholders and role- players.

1.4. Target groups

The target groups are students in pre-primary, primary and secondary schools. The SH policy aims to facilitate the optimum development of learners by developing schools as environment conducive to health and addressing barriers to learning that will hinder the learners' benefit from education.

2. CONTEXT

School health lies within the scope of policy options and international, regional and national strategies. It refers to statements from various summits, protocols and recommendations of international institutions as well as to the laws, policies and sectoral strategies in Rwanda.

2.1. International

Millennium Development Goals (MDGs)

SH is critical for the achievement of the MDGs, being directly relevant to seven out of eight of them. It will help to decrease the prevalence of underweight children under five years, responding to MDG 1, of eradicating extreme poverty and hunger. While the readiness for timely enrolment in primary school is part of achieving the MDG 2, achieving the universal primary education. Furthermore, the ratio of girls to boys in primary education school contributes to the achievement of the MDG 3, to promote gender equality, empower women. Furthermore, decreasing under-five and infant mortality by immunizing them against measles assists in the reduction of child mortality as the MDG 4. Effective SH education and the birth spacing will lead to decreased maternal death and increased mothers' socio-economic development, contributing to MDG 5 and 3. Prevention activities of HIV and AIDS, and malaria contribute to achievement of MDG 6. When increasing the proportion of population with sustainable access to improved water sources and improved sanitation contributes to MDG 7, of ensuring environmental sustainability.

Education for All (EFA)

By 2015 ensuring that all children including girls, most vulnerable and disadvantaged children have access to free and compulsory quality primary education. Rwanda is committed to fight against all socio-cultural factors hindering children learning process, such as illnesses (HIV and AIDS, malnutrition, neglected tropical diseases, etc) and harmful cultural beliefs³.

A joint strategy session at the World Education Forum held in Dakar in 2000 made a strong statement “...that provision of effective school health services is an important strategy for achieving Education for All”. Provision of school health services not only responds to a need, but also increases the efficacy of other investments in child development, ensures better educational outcomes, achieves greater social equity and is a highly cost effective strategy⁴. The forum further recommended that the following basic components of a school health program should be provided in all schools:

- Health-related school policies,
- Ensuring physical learning environment, emphasizing on safe water and gender-sensitive sanitation facilities,
- Health Skills and hygiene education,
- School-based health services.

³ FRESH, UNESCO, UNICEF, WHO, World Bank and International Education, 2002

⁴ UNESCO, UNICEF, WHO and World Bank (2000) Focusing Resources on Effective School Health: a FRESH Start to Enhancing the Quality and Equity of Education. Downloaded from <http://www.freshschools.org>

The study of 2002 on school health showed that hygiene and nutrition are effective in improving academic performance. The same study shows that these programs are of benefit to students, school staff, and families as well as to the community⁵.

Convention on the Rights of the Child (1989)

In 1989, the Convention on the Rights of the Child became the first legally binding international convention to affirm human rights for all children. It codifies principles that Member States of the United Nations agreed to be universal - for all children, in all countries and cultures, at all times and without exception, simply through the fact of their being born into the human family. As signatory of this convention, the Government of Rwanda is committed to improve the rights of Rwandese children. Specifically, this SH policy contributes to achieve: article 3, concerning the best interests of the child; article 23, referring to the right to benefit from special care and education for disabled children; article 24, providing access to preventive and curative health care services; article 28, improving the right to free primary education, with availability of vocational education, and implementation of measures to reduce drop-out rates.

2.2. National context

Vision 2020

This policy clearly supports the ambitious goals set up by Vision 2020, particularly in pillar 2, human resource development and a knowledge based economy, with improvements in health and education services used to build a productive and efficient workforce. The GoR is emphasizing on reduction of infant mortality (from 107 to 50 per 1000) and maternal mortality (from 1070 to 200 per 100,000 live births); and increasing, in the long run, life expectancy from 49 to 55 years. Much more emphasis is on controlling malaria and other epidemics; reducing the prevalence of HIV and AIDS; increasing access to potable water (from 52% to 100%); improving the proper disposal of waste and sewage and hygiene measures at all levels and then attaining the goal of education for all⁶.

EDPRS II

In the EDPRS II, the main health objectives are related to prevention of diseases particularly malaria and HIV and AIDS; facilitating access to basic health care, the provision of health information at the community level; ensuring quality improvement of health services; and improving the educational environment for girls by providing the necessary facilities such as dormitories and toilets.

National Investment Strategy

The national investment strategy aims at providing accessibility to primary health care; developing the health insurance scheme; eradicating of malaria; controlling HIV prevalence; controlling tuberculosis and promoting reproductive health⁷.

⁵ FRESH, a holistic approach to school health for the prevention of HIV and AIDS and improve learning outcomes, 2002, ED-2002/WS/8

⁶ Rwanda Vision 2020, MINECOFIN, Kigali, July 2000.

⁷ National Investment strategy, 2003

The Seven Year Government programme

MINEDUC is committed to enhance quality Education at all teaching levels and to streamline implementation of the Nine year basic Education with emphasis on upgrading to 12 year basic education by focusing on technical and vocational schools.

Education Sector Strategic Plan (2013/14 - 2017/18)

The present SH policy is comprehensively aligned to the priorities established in the Education Sector Strategic Plan, addressing barriers of access to education for vulnerable children, including adolescent girls, children with disabilities, children living with HIV and children from poorer backgrounds.

MINEDUC is committed to strengthen school health nutrition actions. Furthermore, the Government aims at strengthening school nutrition programmes, drawing upon community participation, creating a national home-grown school feeding programme. ESSP focuses on sexual and reproductive health and rights, providing information about HIV and other STIs, prevention, care and treatment of affected students and teachers. It also supports the role of sports and physical education to promote healthy bodies and minds, promoting the construction of playgrounds and sports fields; and provision of special counseling, care and support to children with special needs.

Key sector policies related to SH Policy:

1. Education Sector Policy, 2003.
2. Health Sector Policy, 2005.
3. Special Needs Education Policy, 2007.
4. Agriculture Sector Policy, 2008.
5. Mutual Health Insurance Policy in Rwanda, 2006.
6. Gender Policy, 2010.
7. National Youth Policy, s/d.
8. National Social Protection Strategy, 2011.
9. National Policy & Strategy Water Supply and Sanitation, 2010.
10. Rwanda National Strategic Plan on HIV and AIDS, 2009-2012.
11. ECD Policy, 2011.
12. Girls' Education Policy, 2008.

3. SH VISION AND OBJECTIVES

3.1. Vision

“All Rwandan school children shall achieve their full development potential, by studying in a healthy environment in child-friendly schools, free from disease, prejudice and violence”.

3.2. Objectives

3.2.1. Short-term

- To provide preventive and curative services that address needs of school children;
- To ensure provision of safe water and adequate sanitation facilities in schools;
- To improve and enhance knowledge of students and teachers about SH, including sexual and reproductive health and GBV, prevention of HIV and AIDS and other diseases, management of disabilities and special learning needs, hygiene, nutrition, physical education and mental health.

3.2.2. Medium-term

- To improve attendance and completion rates, due to better health status of children;
- To increase access to education, especially for girls, OVC’s and other disadvantaged children;
- To create a healthy, safer and hygienic environment for the school community, so as to ensure effective teaching and learning for both teachers and students.

3.2.2. Long-term

- To improve secondary graduation rates of students;
- To improve preparedness of students for tertiary opportunities;
- To have a healthier and better qualified workforce, and responsible parents for the next generations;
- To decrease medical health care costs, due to prevention and early detection of diseases in school children;
- To improve equality, equity and reconciliation.

4. ANALYSIS

The major constraints to learning for children in Rwanda are poor health, poverty, environmental factors such as inadequate water and sanitation facilities, adequate school infrastructure, communicable and non-communicable diseases and gender based violence. These factors impact on attendance at schools and on learners' ability to concentrate on lessons.

4.1. Health promotion, disease prevention and control

Preventable diseases, such as malaria, diarrhea, worm infections, pulmonary infections and HIV⁸, are the main causes of morbidity and mortality among Rwandans (MoH, 2012). HSSP III clearly states that Neglected Tropical Diseases (NTDs) may have an enormous impact on the productivity of communities, including “preventing children from attending school”. In addition, chronic health concerns, including epilepsy, physical and mental disabilities, and special educational needs, contribute to under-enrollment and low academic achievement of affected children. In this context, schools have potential to promote health education, identify chronic health conditions, and partner with health specialists and parents to develop appropriate plans for the management of chronic conditions, assist in the referral of children to health centers when necessary with school-based deworming, immunization campaigns.

4.1.1 *Worm infections*

Worm infections affect 65% of the population in Rwanda, and school-aged children typically have the highest intensity of worm infection of any age group (Global Network for Neglected Tropical Diseases, 2008). They are the second-highest cause of all health clinic visits in Rwanda, and may cause serious blood loss leading to iron-deficiency anemia, malnutrition, mental and physical disabilities in millions of children. However, much of this morbidity can be rapidly reversed by treatment (deworming), which can be delivered in a very cost-effective way through schools.

4.1.2 *Malaria*

Regarding malaria prevention and control, Rwanda has made significant progress in scaling up interventions, and MoH statistics show declines in malaria cases since 2005. In 2010, 663,785 malaria cases were reported, 96 percent of which were laboratory confirmed. Malaria-attributed morbidity (fever cases with laboratory confirmation of malaria) decreased from 16 percent in 2009 to about 8 percent in 2010 (PMI, 2012). In order to maintain this decreasing trend, it is important to keep adopting preventive measures in schools, such as promoting the use of mosquito nets in boarding schools, in-door spraying and elimination of breeding places of mosquitoes.

⁸ Although HIV, AIDS and other STIs belong to the key area of “disease prevention and control”, they were analyzed as a separate topic, due to its importance.

4.1.3 Tuberculosis

TB is a preventable and curable infectious disease, but it has a negative effect on HIV-infected people. In Rwanda, the number of people affected by TB has been decreasing over the last five years. The figures decreased from 7,800 people in 2008 to about 6,200 in 2012 (RBC, 2013). According to CDC, some of the common symptoms of the disease in children include cough, feelings of sickness or weakness, lethargy, weight loss, fever and night sweats. Since it is a contagious disease, spread from person to person through the air, it is very important to have trained teachers who are aware of the symptoms, and able to report any suspicious case. In the absence of the above symptoms, like cases of latent TB, only a skin or blood test may confirm the disease.

4.1.4 Measles and Rubella

Measles is a highly-contagious virus, spread by contact with an infected person through coughing and sneezing. When one person has measles, 90 percent of the people who come into contact with that person will become infected, if they are not immunized. The symptoms include high fever, severe skin rash and cough. Measles does not cause death directly, but it weakens the immune system and opens the door to secondary health problems, such as pneumonia, blindness, diarrhea and encephalitis. Poor children are more likely to be malnourished and have severe complications from measles. Even if a child recovers, he or she can be left with permanent disabilities.

Rubella is another disease, which is mild, but can have serious consequences for pregnant women and their children. If infected with rubella in the first term, women have a very high risk of giving birth to a child with Congenital Rubella Syndrome (CRS). CRS often presents multiple birth defects, including heart problems, deafness and blindness. Like measles, rubella can be prevented with a safe, effective and inexpensive vaccine.

In March 2013, Rwanda became the first country in Africa to roll out the measles and rubella (MR) vaccine nationwide. As a school-based immunization, the combined vaccines were administered to about five million children between the ages of 9 months and 14 years. Rwanda has been vaccinating all infants with one dose of measles vaccine for many years, and experts have estimated that measles deaths in Rwanda declined from 670 in 2000 to 3 in 2010. This SH policy supports this initiative and calls upon a systematization of such essential immunization campaigns, carried out at school level.

4.1.5 Skin diseases

Skin diseases affect around 25.7 percent of school children in Rwanda, according to a cross-sectional study (Hogewonig A, Amoah, et al, 2013). In children with skin diseases, skin infections represented the greatest proportion of disease, accounting for 22.7%. Diseases with the highest prevalence were *tinea capitis* and bacterial skin infections, especially in rural areas and in schools serving children living at lower socioeconomic levels. In most of the cases, skin diseases are visible conditions, and children with such conditions might be referred to health facilities by trained teachers, or nurses.

4.1.6 Epilepsy and other chronic health conditions

Results from the 2005 study countrywide showed that the prevalence rate of epilepsy is 49 per thousand inhabitants. The generalized crises represent 90% of the cases against 10% of partial crises. The crises most often are released for the first time by the emotion to 28% the

luminous stimulation to 28%. The family antecedents of crises exist in 53% of the cases. The infectious factors are represented by 38%, the antecedents of cranial traumatism represent 50%, because of the 1994 genocide against Tutsi.

4.1.7 Disability and special learning needs

The World Bank estimates that approximately 20% of the population in developing countries lives with some form of disability. In Rwanda, the large majority of children with disabilities and Special Learning Needs (SLNs) remain outside the school system, and the educational attainment of those that do enroll remains far below average. Disabilities involving visual, auditory, mental or multiple impairments remain particularly underserved. The Special Needs Education Policy (2007) promotes inclusive education and the mainstreaming of children with physical and mental disabilities at schools within their communities.

The ESSP (2013/14-2017/18) further highlights the need to increase services to students with disabilities and SLNs such as general learning disability, dyslexia, aphasia, dyscalculia and attention deficit disorder. This mandate necessitates increased capacity at the school level for early identification, integration and support to children with disabilities or SLNs, as well as deliberate action to overcome the prevalent stigma that inhibits effective response and support for these learners, and the referral of children to specialized schools or health facilities as needed. Early detection and appropriate accommodation and management will maximize positive outcomes for these children, both in their academic pursuits and their later success as autonomous and productive adult members of society.

4.2. HIV, AIDS and other STIs

4.2.1. HIV and AIDS

According to TRAC Plus (2010), the number of children (0-14) who are HIV positive is 22,794, and only 75 percent of these children are receiving ART. DHS (2010) reveals that HIV prevalence in Rwanda population (15-49) is at 3%, i.e., the same as it was in 2005. HIV prevention knowledge gap is the greatest bottleneck for an effective and sustainable behavior change among adolescent.

Prevention of HIV and AIDS is a priority in the ESSP, which fully supports initiatives of protecting school children against HIV, at primary and secondary levels. It also states that *“the education sector also has a central role in the multi-sectoral response to HIV and AIDS prevention through increasing awareness and enabling a positive attitude to HIV and AIDS in the workplace environment. This can be done through the curriculum, teacher training, peer education, debating and life skills clubs.”* In an effort to improve the knowledge about HIV, MINEDUC has set up focal points; trained trainers in the fight against HIV and AIDS; created anti-AIDS clubs; promoted girls' education to fight ignorance, the source vulnerability to HIV and AIDS, improved HIV component in the school curricula.

4.2.2. Other STIs

Human papillomavirus (HPV) is a sexually transmitted virus, found in virtually all cases of cervical cancer, which is a common cancer amongst women in Rwanda. In 2010, 986 cases of cervical cancer were diagnosed in the country and 678 women died from the disease. In the same year, Rwanda evaluated options for HPV vaccination rollout and decided to pursue a partnership with Merck to offer Rwanda's young girls the opportunity to receive a life-saving

vaccine (Binagwaho et al, 2012). In 2011, Rwanda’s HPV vaccination achieved 93 percent coverage after the first three-dose course of vaccination among girls in grade six. This was made possible through school-based vaccination and community involvement in identifying girls absent from or not enrolled in school. A nationwide sensitization campaign preceded delivery of the first dose (WHO, 2012).

Table 1: Cumulative HPV vaccination coverage, by vaccination round

Coverage	Round 1	Round 2	Round 3
Girls vaccinated in school	91.752	89.704	88.927
Girls vaccinated outside school	2.136	3.066	3.180
Total no. of girls vaccinated	93.888	92.770	92.107
Cumulative coverage (%)	95	93	93

Source: Binagwaho A, et al (2012)

Other major STIs present in the country are gonorrhea, syphilis, chancroid, genital warts, herpes, hepatitis, trichomoniasis and chlamydia. Adopting preventive measures can considerably reduce the risk of infection and, therefore, it is crucial to raise awareness among students about these infections. The transmission of some of these infections are not limited to sexual relationship, but may also occur due to lack of hygiene from an infected individual to a healthy one⁹.

4.3. Sexual and reproductive health, and rights

4.3.1 Access to information about contraception, safer sex, STIs

Sexuality Education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one’s own values and attitudes and to build decision making, communication and risk reduction skills about many aspects of sexuality. Sexuality education tends to lead to later and more responsible sexual behavior.

Adolescent girls and young women suffer disproportionately from negative sexual and reproductive health outcomes. They suffer from social and economic barriers in accessing sexual and reproductive health information and services, which is evidenced by persistently high levels of unmet need for contraception, maternal mortality, and HIV incidence. Young women aged 15 to 19 are twice as likely to die in childbirth as adult women, and half of all new HIV infections occur in young people between the ages of 15 to 24 (YHCR, 2011). Such negative sexual and reproductive health outcomes have economic, social and health consequences that affect young people throughout their lives, as well as their families, communities and the whole country.

Many young people approach adulthood faced with conflicting and confusing messages about sexuality. Schools can become trusted community centers that provide necessary links to other resources, such as services for sexual and reproductive health, substance abuse, gender-based violence and domestic crisis. This link between the school and community is

⁹ DHS 2010

particularly important in terms of child protection, since some groups of children and young people are particularly vulnerable. These include those who are married, displaced, disabled, orphaned, or living with HIV. They need relevant information and skills to protect themselves, together with access to community services to help protect them from violence, exploitation and abuse.¹⁰

According to a rapid assessment of adolescent reproductive health programs in Rwanda (MoH, 2010), 92 percent of interviewed adolescents self-reported being sexually active, with an estimated age of sex debut of 12 for girls and 15 for boys. Taking into account this situation, schools can play a very important role as a place to provide sexual information to young men and women about family planning services, safer sex and STIs. Breaking taboos about sexual health and stimulating an intergenerational dialogue, involving students, parents and teachers, is both a challenge and an opportunity to improve knowledge about SRH&R.

4.4. Gender and GBV issues

4.4.1. School-related gender-based violence (GBV)

In Rwanda, according to the GBV Law, gender based violence is defined as any act that results in a bodily, psychological, sexual and economic harm to somebody just because they are female or male.¹¹ The 2010 DHS showed that, 23.9% of children aged (15-19) experienced some form of violence, while age at first experience of sexual violence is between 10-14 years for 41.2% of children.

Whereas schools are important places that should be safe enough to enable pupils/students to acquire knowledge, it has emerged that a range of GBV incidences take place there. These incidences may include sexual, physical, economical and emotional/psychological abuse. When these incidences take place in and around the school environment, then they are termed as school-related gender-based violence.

4.4.2. Adolescent pregnancy

According to the research carried out in schools [MINEDUC 2006] on gender-based violence in schools, many students claimed that they give in to sexual abuse when they are promised money to meet their needs or wants they can't get from their parents or guardians. Neglected by parents/guardians, peer pressure and poor discipline were also among the major causes of sexual crimes which lead to unwanted pregnancies.

There were 522 unwanted pregnancies among girls between 10-18 years registered in 2012 in several schools countrywide, a Gender Based Violence (GBV) in Schools report indicated that most of the cases were in Karongi (58), Kayonza (53), Gatsibo (52) and Gasabo (50). The biggest perpetrators of sexual violence which leads to unwanted pregnancies are older men, commonly referred to as sugar daddies, fellow students, teachers, and motorcyclists.¹²

In 2011, the Ministry of Education discovered that there is a high dropout rate due to early pregnancies in schools and called upon teenagers faced with sexual violence in their communities, whether at school or home, to always report these cases. Much more, "Children need proper parenting in order for them to make the right decisions. Everyone in community

¹⁰ International Technical Guidance on Sexuality Education

¹¹ Article 2 (1) Law No. 59/2008 of 10/09/2008; on Prevention and Punishment of Gender Based Violence

¹² <http://allafrica.com/stories/201305030087.html>

should play a role of proper parenting and not leave it to teachers or biological parents. Perpetrators of the different forms of GBV should also be punished."¹³

Early 2013, in a Rwamagana based school, 26 students were found to be carrying unwanted pregnancies. Currently, there are no administrative records on unwanted pregnancies in schools. Therefore, MINEDUC urges to compel schools to keep records and follow-up on pregnant girls to return to school. It also proposes communication between parents and children on reproductive health by using existing channels like parents' meetings locally called "*umugoroba w'ababyeyi*".¹⁴ The biggest perpetrators of sexual violence which leads to unwanted pregnancies are older men, commonly referred to as "sugar daddies", fellow students, teachers and motorcyclists.

4.4.3. Gender inequalities

MINEDUC has prioritized education of girls and gender development and is recognized as a key component in improving economic and social wellbeing. The Government is fully aware that investing in girls' education contributes to the achievement of critical social objectives like decreased fertility and infant mortality, increased child health and improved productivity. Among the missing 25% of children in education, an estimated 400,000 children, who are yet to enroll or have dropped out of primary school, are mostly boys. In addition, in almost all primary schools in Rwanda, orphans and vulnerable children represent a large portion of the school population and they are probably the first to drop out due to problems faced in foster families, orphanages or account of their being heads of households. These children require more than formal classrooms, as their special circumstances of life will not permit them to enroll, stay in school and do well in it like every other child. The main challenge remains in the reduction of disparities in terms of gender, geographic location and social economic groups.

4.5. Environmental health

Lack of adequate water and sanitation facilities in schools is a major health issue for school children. Common water and sanitation related diseases in Rwanda are diarrhea, which is among the top three main causes of morbidity in the country (DHS 2010, MoH 2012), worm infections and typhoid (reported outbreak in 2004).

4.5.1. Water

Contaminated water is one of the major causes of illness, which may lead to death. The Government is striving to increase safe water access in schools, with coverage of over 50% of rain water harvesting system, and more than 30% with tap water, in primary and secondary schools. Pre-primary schools have only 14% of coverage in both water tanks and tap water, as seen in Table 2.

¹³ <http://allafrica.com/stories/201305030087.html>

¹⁴ <http://allafrica.com/stories/201305030087.html>

Table 2: Water access in schools

	Water tank	Tap water
Pre-primary	14%	14%
Primary	58%	34%
Secondary	67%	45%

Source: Education Statistics (2012)

As much as it is important to ensure water access, it is also crucial to ensure there is safe drinking and cooking water in schools. It is recommended that schools treat drinking and cooking water, by using filters, chlorine, boiling or any other available treatment.

4.5.2. Sanitation

Currently, the ratio of toilets in Rwanda is of 1 per 75 students at primary schools, and 1 per 23 students at secondary schools [norm: 1 per 30]. The Government should continue the efforts to decrease the ratio of students per latrine, for both boys and girls. Table 3 provides detailed information about

Table 3: Number and ration of toilets in schools

	Toilets for students	Toilets for staff	Total
Primary	31.818 (1:75)	2.963 (1:14)	34.781 (1:70)
Secondary	23.754 (1:23)	2.283 (1:10)	25.857 (1:22)

Source: Education statistics (2012). Ratio latrine: students/staff is in parenthesis.

In addition to the efforts of expanding the number of latrines construction at schools in Rwanda, the Government aims at increasing the access to gender-sensitive sanitation facilities, with toilets for boys and girls. As stated in ESSP 2013/14-2017/18: “*In attempt to overcome specific problems related to girls absenteeism and poor performance, a ‘special girls’ room’ is now included in every newly constructed schools to provide additional sanitation and hygiene facilities for girls*”. So far 1,705 “girls’ rooms” have been built in primary schools, and 723 rooms in secondary schools. Furthermore, knowledge and services for menstruation management shall be provided, in an effort to reduce girls’ absenteeism, estimated to be at 50 days/year/girl: “*Support will be given to girls in obtaining sanitary towels and special facilities for girls will be established to reduce absenteeism and poor performance in order to ensure adequate water, cleansing and washing materials and private spaces for managing menstrual flows hygienically and privately, and with dignity, in the home and in school spaces.*” (WSSCC, n/d)

4.5.3. Hygiene

Cleanliness of school facilities, including classrooms, toilets, kitchens (in schools with school feeding programs), is essential to prevent children from becoming sick. In the past years, hygiene campaigns in schools have been carried out in some regions of the country, but no systematic nationwide campaign of hygiene in schools has been launched. Raising awareness and knowledge of school community about hygiene, hand-washing, cleanliness and menstrual hygiene management is crucial to ensure a healthy school environment. On the other hand, it is also important for schools to have the means to meet hygiene standards, such as having adequate access to water and soap, gender-sensitive sanitation facilities, hand-washing points, cleaning materials, and menstrual care products.

4.5.4. Environmental protection

Other environmental protection actions include the use of alternative sources of energy, such as solar power and biogas, whenever is possible. It is also recommended to increase greening and beautification initiatives, such as school gardens and tree planting because it gives a beautiful scenery, provides fresh air, shed/shelter, controls soil erosion, and so on. Table 4 provides an overview of the current situation in schools:

Table 4: Energy sources and trees

	Electricity	Solar power	Biogas	Trees
Pre-primary	12%	1%	0%	n/d
Primary	25%	9%	0%	92%
Secondary	44%	14%	5%	89%

Source: Education statistics (2012)

4.6. School nutrition

Nationally, chronic malnutrition rates among under five in Rwanda are 44 percent, but in the poorest *ubudehe* classification, it is 60 percent. Food insecurity and chronic malnutrition in Rwanda have a main underlying cause in common: poverty.

Currently there are three school feeding programs operating in the country, two of which are government-funded and -operated programs.

Table 5: Coverage of school feeding programs

	Number of students	Percentage of coverage
One Cup of Milk	75,000	2.4%
Boarding Schools	104,722	3.4%
WFP	82,000	1.2%

Source: Ministry of Agriculture, Ministry of Education, WFP (2013).

The three programs combined respond to 10% of all students in pre-primary, primary and secondary schools in Rwanda.

Apart from giving meals at school the nutrition education is also done at school level where

nutrition is included in the curriculum and there is message sent to all schools (primary and secondary schools) aimed at educating children about the balanced diet. School gardens are also done at school level with nutrition education purpose.

4.7. Physical education

In Rwanda, little attention is paid to physical education yet it is crucial for students' well-being. This is illustrated by the fact that physical education is not allocated its own time schedule on the school time table since it usually combined with other subjects like Music, poetry, drama hence making it an optional subject. More so, it is usually confused with sports competitions yet these are carried out seasonally, and worse still they don't involve all the students but specific participants. In addition, there is hardly provision of recreational facilities in most schools.

Physical Education should be visional for future skills and values development. The main goal of the life skills approach is to enhance young people's ability to take responsibility for making choices, resisting negative pressure and avoiding risky behavior. Where life skills education is well developed and practiced, it enhances the wellbeing of a society and promotes positive outlook and healthy behavior. Life skills are classified into three broad categories:

- Skills of knowing and living with oneself (self-respect)
- Skills of knowing and living with others (cooperation, respect of rules and authority, fair play, communication skills, team work)
- Skills of effective decision making values (problem-solving skills, discipline)

These attitudes and values learnt from games are conserved during the whole life. Sports have also a very significant impact on the psychological health of children, as stated in the ESSP: *"The importance of sports or games in building healthy bodies and intelligent minds is also under-emphasized in many schools"*.

4.8. Mental health and related needs

4.8.1. Trauma

Results from the Posttraumatic Stress Disorder (PTSD) survey carried out in Rwanda in 2009 showed that 79% of the sample met a traumatic life event. The prevalence of PTSD was 28% in general adult population. Significant statistical differences were found concerning provinces, sex and age etc. Among people suffering from PTSD, depression as the first co-morbid disorder has been found with a prevalence of 53%. Among people with PTSD, 10% were already addicted to alcohol and 7% to drugs. While assessing quality of life, it was found that the mental health component was more affected than others.

4.8.2. Drug abuse

According to a study carried out on substance abuse in youth in Rwanda in 2012, overall, the past-30 day prevalence (whether the youth has used the drug within last month) was 34% for alcohol, 8.5% for tobacco smoking, 2.7% for cannabis, 0.2% for glue and 0.1% for medicines like diazepam. Due to regular substance use, One youth in thirteen (7.46%) is alcohol dependent, one youth in twenty (4.88%) had problem of being dependent on nicotine and one youth in forty (2.54%) were found to be dependent on cannabis¹⁵.

¹⁵ M. Kanyoni, D. Gishoma, V.Ndahindwa (November 2011): Prevalence of psychoactive substance use among youth in Rwanda, school of Public Health, Kigali/Rwanda.

5. RECOMMENDED POLICY ACTIONS

5.1. Health promotion, disease prevention and control

1. Prevention and early detection of diseases and chronic health conditions: It is recommended to continue deworming of all school children, as well as HPV, measles and rubella vaccination campaigns. In malaria prevention, boarding school students should be provided with mosquito nets, and schools should carry out in-door spraying regularly and eliminate breeding places of mosquitoes. Finally, a health examination should be done by nurses from neighboring health centers every term, to screen children for diseases (dental, vision, etc), and chronic health conditions such as epilepsy. The nurse, teacher and school leadership should work in partnership with the parent to develop an appropriate course of action, to include referring children to health facilities as needed.

2. Early identification and management of disabilities and special learning needs: Health examinations should be done by nurses from neighboring health centers on an annual basis at early childhood care and development (ECCD) centers and primary schools to screen and identify children with special learning needs and disabilities. The nurse, teacher and school leadership should work together with parents to develop an individualized and adapted course of action for each child with special learning needs or disabilities to ensure their particular needs are met to maximize their success at school, whether through mainstreaming or enrolling in specialized learning centers, and including the referral of identified children to relevant health facilities as necessary.

3. First aid kit at school level: Schools shall have a first aid kit available for emergency cases.

5.2. HIV, AIDS and other STIs

1. Prevention of HIV and other STIs: The curriculum about HIV, AIDS and STIs should be reviewed and updated and framed within a SRH & R; youth should also be educated about prevention methods (condoms, abstinence, blood transmission), and about HIV testing. School health clubs will include this topic in the discussions, and IEC/BCC materials about HIV should also be produced and disseminated. The school management will be encouraged to support health clubs to address these issues and to ensure that these health clubs are fully operational.

2. Creation of supportive environment for HIV-positive students and teachers: It is important to train peer educators and carry out sensitization campaigns to reduce stigma and discrimination of HIV positive students and teachers, and inform HIV-positive about the treatment and availability of drugs for free in health centers.

3. Reinforcement of monitoring and mitigating mechanisms: HIV and AIDS should be included in the SH M&E system, in order to review progress on prevention, care and impact mitigation.

5.3. Sexual, reproductive health and rights

1. Inter-generational communication between parents, teachers and school children: Use of existing channels like parents' meetings (*akagoroba k'ababyeyi*), to discuss about sexual and reproductive health and rights, including early pregnancy, STIs and SRGBV. Also

encouraging children to discuss certain issues related to sexuality with parents or other trusted adults might help to increase parent-children-teacher communication.¹⁶

2. *Promotion of education on sexual and reproductive health:* A specific curriculum for SRH&R should be established and teachers trained, in order to strengthen knowledge and build skills of young adolescents, and the module on sexual and reproductive health developed by the MoH should be used. Topics to be covered include: sexual health and well-being require human rights; gender; sexuality, interpersonal relationships, communication and decision-making skills; body, puberty and; sexual and reproductive health.

5.4. Gender and GBV issues

1. *School related gender based violence (SRGBV):* Capacity building of teachers, students and school community about SRGBV, through trainings, discussions in health clubs, education and sensitization campaigns, involvement of PTAs, information about use of GBV kit in health centers (PEP, EC, STI prophylaxis). A SRGBV victim referral system should also be designed and implemented, as well as responding to GBV cases with adequate law enforcement and counselling.

2. *Early pregnancies:* Sensitization of youth about early pregnancy and reproduction health choices; referral of pregnant girls to adequate health facilities, for medical checks, and in cases of post abortion. A follow-up system should also be established, to ensure that young women who dropped out of school due to pregnancy return to complete their studies.

3. *Gender inequalities:* Efforts to include out of school children (which are boys in the majority of cases) to go back to school.

5.5. Environmental health

1. *Strengthening the provision of safe water to the children and staff in the schools:* Construction and maintenance of rain water harvesting systems and provision of tap water should be continued. Ensure water quality and adequate treatment of drinking and cooking water is also crucial.

2. *Strengthening the provision of adequate sanitation facilities in schools:* Gender-based sanitation facilities, hand-washing points, clean sanitation on a daily basis and sanitary inspections each term are actions recommended to ensure adequate sanitation facilities. As it pertains to menstrual hygiene management, “identify simple design innovations to efficiently and effectively enhance MHM facilities in schools for girls and female teachers. These designs may include privacy screens, full-length mirrors, and dustbins for disposal, incinerators, and buckets of water inside latrines or toilet stalls, and doors with locks on stalls.

3. *Improvement of general hygiene, including menstrual hygiene management:* Education of school children on general hygiene practices and oral health that includes menstrual hygiene management. Hygiene promotion campaigns in schools about the importance of cleanliness of the school environment that includes MHM topics. Every school should have sanitary pads available for emergency situations and every new school should have girls’

¹⁶ Research has shown that one of the most effective ways to increase parent-to-child communication about sexuality is to provide student homework assignments to discuss selected topics with parents or other trusted adults. If teachers and parents support each other in implementing a guided and structured teaching/learning process, the chances of personal growth for children and young people are likely to be much better.

rooms.

4. Operationalization of solid waste management systems in schools: Whenever is possible, schools should set up waste management systems, e.g. eco-san toilets, Flexi biogas (fertilizer and source of energy), with the involvement of the community could also be involved (making briquette from the waste). Training and supervising teachers and learners on solid waste management in schools are also recommended especially as it pertains to disposal of menstrual waste products.

5. Protection of school environment: Healthy learning environment (well ventilated class rooms, adequate number of students per class, special infrastructure for children with physical disabilities), tree planting and gardening are recommended.

5.6. School nutrition and Nutrition education

The implementation of this component will be highlighted in the National Food Security and Nutrition policy under the Ministry of Health.

The Ministry of Education will work together with the concerned institutions on the nutrition education component by reviewing and updating curriculum about nutrition education; and involvement of school children in gardening activities, balanced diet preparation for skills development.

5.7. Physical education

1. Strengthening of physical education and sports in schools: Review and re-orientation of physical education curriculum to life skills development; training of physical education teachers in life skills; ensuring the implementation of physical education curriculum and involvement of PTAs/local communities in the implementation of the PE/Sport curriculum.

2. Sports facilities and equipment: Provide adequate sports facilities and equipment to schools and ensure good management and maintenance of sports facilities. If land is a limitation, schools may adopt collective or central facilities, or focus on activities that do not require large space.

5.8. Mental health and related needs

1. Enhancing basic psychosocial care by trained teachers: Students dealing with mental health issues and any other health needs with potential effects on mental health and wellbeing, such as trauma or HIV, GBV and MHM harassment/teasing, are assisted by trained teachers and peer educators.

2. Operational referral systems: Operational referral systems between schools and health facilities should be established to assist on mental health issues.

3. Prevention and control of alcohol, tobacco and other drug abuse: Raise awareness to prevent drug abuse, monitor addicted children, to help them in their rehabilitation process.

5.9. Cross-cutting issues

1. Enabling policy and financial framework for SH: SH should be integrated into national policies and related sector strategic plans, in education, health, agriculture, youth, gender.

Furthermore, it is important to consolidate budget lines in all sectors of development (including the private sector and CSOs), to support schools in implementation of SH actions.

2. Capacity building of teachers and students on SH: Teachers should be trained on school health, using an updated version of the school health teachers' training material that emphasizing participatory pedagogical methods. Students/peer educators should also be trained and sensitized on SH that is grounded in a SRH & R framework, and use after-school health clubs in schools to disseminate their knowledge.

3. Operational M&E system on SH: The effective implementation will be monitored by updating the health indicators of the current MINEDUC's statistical data collection.

6. STAKEHOLDERS' VIEW

In order to develop and harmonize the SH policy and strategic plan, the Ministry of Education organized two workshops that were conducted in May 2013, to consult governmental and non-governmental stakeholders. Besides representatives of the Ministry of Education, the consultation also included participants from the Ministry of Health, Agriculture, Gender and Family Promotion, Youth and ICT, Sports and Culture, and Local Government. UN agencies, namely UNICEF, WFP, UNFPA and WHO, and civil society organizations, SNV, Plan Rwanda, SHE, Right to Play and VSO, also participated in the discussions and recommendations of this policy.

The main recommendations of the groups were to: (1) maintain the seven key areas of priority interventions: health promotion and disease prevention and control; HIV, AIDS and other STIs; sexual and reproductive health and rights; environmental health; school nutrition; physical education and sports; mental health and psychosocial care; (2) add "gender and GBV issues" as priorities; (3) creation of a high-level SH steering committee.

The overall objective of the consultation was to have an updated, reviewed and technically validated document, which encompasses the delivery of a school health package of services, contributing to the physical and mental development and wellbeing of school children. The draft policy and strategic plan have been widely distributed for comments and inputs among all stakeholders.

7. IMPLEMENTATION PLAN

The SH policy implementation will require a solid implementation effort from all involved parties, representing a diversity of organizations. Significant inputs in terms of financial and human resources will be required to support SH interventions in each of the eight health priority areas. It is therefore important to put in place a solid governance structure to enable smooth and effective implementation under the coordination of MINEDUC

Governance means “the effective presence of strategic policy frameworks that are combined with effective oversight, coalition building, regulation, attention to system-design and accountability and the provision of appropriate regulation and incentives”. WHO distinguishes five objectives of a proper governance system¹⁷:

- Regulation, legal frameworks;
- Standard and quality assurance;
- Internal and external coordination;
- Voice and Participation;
- Efficiency and effectiveness.

7.1. Institutional framework

The successful implementation of school health programs depends on strong partnerships between education and health sectors, teachers and health workers, schools and community groups and learners and persons responsible for school health programs

7.1.1. National level

SH Steering Committee

The SH Policy and the implementation of its Strategic Plan will be governed by both political and operational structures. At the political level, a Steering Committee composed of a core group of decision makers in key ministries and partners will meet upon request to provide overall leadership and guidance on the implementation of the Strategic Plan and the achievement of the SH policy actions. SH in Rwanda is the responsibility of the Ministry of Education along with the support of line ministries, different governmental and non-governmental agencies including local and international organizations, UN agencies [WFP, UNICEF, UNFPA, WHO, FAO], USAID projects, the private sector and other health and education sector implementing partners. Collaboration among all stakeholders is key for the successful implementation of SH strategies and activities at national, district and community levels.

SH Technical Working Group

The work of the Steering Committee will be supported by an SH Technical Working Group, chaired by MINEDUC and composed of technical staff from key Ministries/institutions, UN agencies, and NGO's. The TWG will meet on a regular basis to agree upon specific actions and to report to the Steering Committee on progress and plans. Ministry of Education will provide instructions to all schools to guide the implementation of the policy. The unit in charge of cross-cutting programs in MINEDUC will be

¹⁷ HSSP III

responsible for implementing SH program activities.

Cross-Cutting Program Unit

Under the Technical Working Group we have the cross-cutting program unit, which will be responsible for the implementation of the SH program activities. The unit is responsible for the school health program activities and will coordinate the implementation phase; carry out M&E activities; provide guidelines and advice on how to implement SH activities at district, sector, cell and school level; provide regular feedback to the SH technical working group; advise on capacity building issues.

7.1.2. Decentralized levels

District Level

SH activities will be coordinated by the District SH Committee composed of vice mayor in charge of social affairs, district education officer, district health officer, agriculture officer, school feeding officer, faith-based organisations' representative, private sector federation representative. The committee will be led by vice mayor in charge of social affairs, and will have the following responsibilities: to mobilize resources from community and development partners at district level, for SH activities; carry out joint action planning, implementation and M&E of SH activities, in collaboration with all levels; prepare the procurement process to supply food and other health goods to schools; provide periodical reporting on the progress of implementation to the national level.

Sector and Cell Levels

At sector and cell levels, coordination will be led by the unit in charge of social affairs. Key responsibilities delegated to the sector and cell levels for the implementation of the SH strategic plan include advocating and sensitizing the community about SH; carrying out joint action planning of decentralized levels and assisting in the implementation of M&E activities.

School Level

At the school level, there will be a committee responsible for school health activities. The school health committee will be composed of the head teacher (head master/mistress), the teacher in charge of the school health club, a representative from students, a representative from PTA, a store manager and one nurse from the nearest health facility. The school will have the responsibility of appointing one focal point teacher (in charge of school health); integrate SH activities into the school action plan; prepare food storage facilities; coordinate and implement all activities of SH programs.

7.2. Roles and responsibilities

Ministry of Education (MINEDUC)

- Provides policy and strategic and minimum guidelines;
- Capacity building and training of SH personnel;
- Provides guidelines for the community involvement in SH programs
- Specifies the roles and responsibilities of the different actors at school, cell, sector, district, provincial and national levels in the implementation plan of the SH policy;
- Advocacy and resources mobilization;

- Conducts research in school health domain.

Ministry of Health (MINISANTE)

- Includes school health activities among other public health responsibilities of health centres in its catchment area at district level. HCs are called to provide technical support to schools in planning, implementing and follow up SH activities;
- Provides school based health services;
- Provides SRH &R content for curricula;
- Provides health kit;
- Provision of MHM health kits;
- Carries out capacity-building on health issues at all levels;
- Community mobilization on SH issues;
- Mobilization of resources;
- Conducts operational research on school health domain.

Ministry of Agriculture (MINAGRI)

- Encourages and provides technical support in school gardening;
- Supports school feeding programs;
- Assists livestock resources extension;
- Provides capacity building on agricultural extension;
- Supports small farmers to increase production.

Rwanda Education Board (REB)

- Reviews standards of school infrastructures that guaranties inclusiveness characteristics (taking in account gender and disabled children special needs);
- Construction of gender-sensitive latrines;
- Provide gender-sensitive sanitation facilities from user to waste disposal;
- Construction of adequate classrooms (well ventilated);
- Capacity building of SH personnel;
- Avail SH materials.

Ministry of Infrastructure (MININFRA)

- Enhancing the provision of clean running water in schools;
- Enhancing the provision of electricity in schools;
- Enhancing the provision of flexi biogas systems as to replace the firewood;
- Technical support in setting up flexi biogas systems in schools.

Ministry of Gender and Family Promotion (MIGEPROF)

- Support and protect vulnerable children in foster families against any form of abuse;
- Sensitization in promoting children rights to health services;
- Overseeing gender mainstreaming in school health services;
- Identifying minimum packages of OVC;
- Empower teachers & students on school related gender based violence and rights.

Ministry of Finance and Economic Planning (MINECOFIN)

- Ensures sufficient budgetary allocation for SH;

- Facilitates the mobilization of local and international resources to support SH;
- Provides funds across the ministries for school based health interventions programs;
- Provides guidance in the creation of alternative funding strategies.

Ministry of Local Government (MINALOC)

- Oversees the implementation of SH policy at decentralized entities;
- Ensures that SH issues are integrated in performance contracts at all local levels;
- Sensitises the community and local leaders to combat drug abuse in and around schools.

Ministry of Sports and Culture (MIJESPOC)

- Ensures that recreational and sports infrastructures are in place;
- Provides technical assistance and capacity building of sport managers;
- Sensitize youth and school community on the impact of sports;
- Organizes anti-drug abuse campaigns.

7.3. Monitoring and evaluation

The SH TWG must establish mechanisms for monitoring and evaluating the SH policy. Reporting, monitoring and evaluation of the SHP must be integrated within the existing education information systems. Monitoring and evaluation need to focus on:

- Coverage and quality of services;
- The impact of the service on the health of learners and on access to schooling, retention and achievement of learners;
- Sustainability of school health services in all districts;
- The M&E framework must propose a set of national indicators and timeframe that will be used to monitor the SHP.

Some illustrative indicators for SH are presented in annex III.

8. FINANCIAL IMPLICATIONS

The Ministry of Education has been tasked with providing leadership for SHP, though all concerned Ministries will contribute through their own budgets.

8.1. Financial plan

Currently, funding for school health, HIV&AIDS and healthy environment mainly comes from development partners. Government support will include a commitment to expand current budgets in all relevant ministries for integrated initiatives on comprehensive school health components outlined in the SH policy and Strategic Plan.

8.2. Human resources development plan

The School Health Team will be assisted by a nurse from a neighboring health center, who may also work with a community health worker. She/he will visit schools every term to ensure referral and follow-up of learners when required.

The health education and promotion components of the SHP should ideally be delivered by focal point teachers - which are members of the School Health Team. Complementary Health education and promotion activities may also be provided by other cadres (such as Community Health Workers) and by non-government or community-based organizations.

Employing additional staff: where districts assess that current staff capacity is not sufficient to deliver the SH package, districts will have to employ additional staff to perform this function. District and national budgets must take this possible requirement into account and support these districts by giving priority to school health budgets.

Training requirements: training and re-orientation is required for all categories of staff who will be implementing the SHP.

Categories of staff that will require training/re-orientation

- MINEDUC and MoH officials and managers will require orientation and training on the SHP
- School health teacher focal points will require training in all aspects of the SH policy.
- Teachers/head teachers (directors) who have to implement the SH policy will need training.

Particular attention will need to be paid to ensuring that teachers and focal point teachers are comfortable in dealing with issues related to adolescent sexual and reproductive health & rights as well as menstrual hygiene management, and that services are provided in an adolescent-friendly manner. Experienced staff might also need training on how to fulfill a mentoring role to new staff that is inexperienced in delivering the school health package.

9. LEGAL IMPLICATIONS

It is not envisaged that the adoption of this policy will result in any new legal commitment or obligations for the Government of Rwanda. The SH policy provides direction to the Government of Rwanda and all stakeholders on how best to fulfill already existing legal obligations and commitments to children such as:

- Convention on the Rights of the Child (CRC), its Optional Protocols;
- African Charter on the Rights and Welfare of the Child, 1999,
- Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), 1981,
- Convention on the Rights of Persons with Disabilities, 2006, along with its Optional Protocol, 2008.

Although there is no legal commitment needed to implement this policy, it is recommended that a “school feeding law” could be adopted after the initial pilot phase of the HGSP program. This will provide sustainability to the program, and will also demonstrate a high level of political commitment.

10. IMPACT ON BUSINESS

It is expected that the implementation of the recommended SH policy actions will result in a healthier and better educated workforce, providing a large and talented human resource pool, equipped with critical thinking and entrepreneurial skills which will strengthen Rwanda’s economy in the coming years.

As well as these positive results, the economy will also benefit from reductions in other costs:

- Reduced health care costs (hospital and clinic costs for young children and adolescents);
- Increased safety & learning opportunities for children;
- Improved education outcomes & increased internal efficiency of education system (lower costs due to reductions in repetition and drop out, and to higher achievement and primary school completion);
- Reduced juvenile delinquency & justice system costs for youth;

All of the above contribute to higher national productivity. There are also several business opportunities related to the implementation of the SH Policy. As the demand for SH services grows, there will be greater returns on private investment in SH services. As the provision of SH services is professionalized, and as communities and government invest more in such services, there will be a demand for materials which will be produced locally, all of which will have a positive impact on economic output. Finally, in the nutrition component, with the implementation of the HGSP program, an impact on smallholders’ production and income is expected, due to the links with school feeding and local food procurement.

11. IMPACT ON EQUALITY, UNITY AND RECONCILIATION

The SH policy promotes an equity-based approach for providing healthy environments for children. This is in recognition of the fact that socially disadvantaged children are vulnerable to poor development but that they stand to gain the most from quality SH programs. Poor and otherwise disadvantaged children are less likely to enroll in school at the right age. They are also more likely to attain lower achievement levels or grades for their age and to have poorer cognitive ability.¹⁸

Some evaluations suggest that at school entry, children from disadvantaged backgrounds could already be years behind their more economically advantaged peers (Brooks-Gunn, Britto and Brady 1999). Interventions in the early years have the potential to offset these

¹⁸ Vegas and Santibáñez 2010

negative trends and to provide young children with more opportunities and better outcomes in terms of access to education, quality of learning, physical growth and health, and, eventually, productivity. These interventions are among the most cost-effective investments a country can make in the human development and capital formation of its people (Heckman 2008) and the impact in poorer communities can be quite stark. In short, expansion of SH services throughout Rwanda has the potential to break the cycle of poverty and to act as a great social and economic equalizer.

12. HANDLING PLAN/COMMUNICATION STRATEGY

A communications strategy will be developed and implemented to raise awareness of the importance of SH among the general population and to disseminate key documents and instructions to SH stakeholders at all levels. The SH Strategic Plan envisages the organization of regular sensitization campaigns and seminars as well as the use of media to increase awareness on SH as well as to educate parents and the community on how to participate actively in the SH policy implementation.

13. CONCLUSION

The SH policy has the potential to contribute substantially to improving health and learning outcomes for school-going children. Successful implementation of the SHP will depend on a number of critical factors which are outlined below:

Coordination: A need to strengthen co-ordination between this service and other programs to ensure that school health services are delivered in the most efficient and effective way. Therefore, joint steering by the Ministry of Health, MINEDUC and the providers of the service at the local level is important.

Resource availability: Implementation of the SHP has substantial resource implications with regard to staffing, transport, equipment and medication. Successful implementation will only be possible if these resources are made available at national, district and sector level.

Adequate referral and follow-up of learners who are identified as having health or other problems: in some areas this will require development and strengthening of services in order to ensure that learners have access to the services which they require.

Advocacy, communication and social mobilization: these elements should be conducted in collaboration with essential role-players at national and district levels. These include all government departments, other health programs, UN agencies, government donors and NGOs rendering health services to the school community, PTAs/PCAs, parents and learners.

Prioritization: Priorities for the SHP should be based on the understanding of the integral link between health and education and its impact on learners' successful development and educational outcomes.

Effective capacity building depends upon:

- The involvement of key ministries, schools, health facilities, parents and others in the development and delivery of the SHP;
- Re-orientation and training of teachers and health facility personnel to assist and support the delivery of the school health service within the SH policy;
- The development of the capacity of school communities to take responsibility for their health needs through informed interaction with the MoH and MINEDUC, district and sector levels.

Effective Monitoring and Evaluation depends upon:

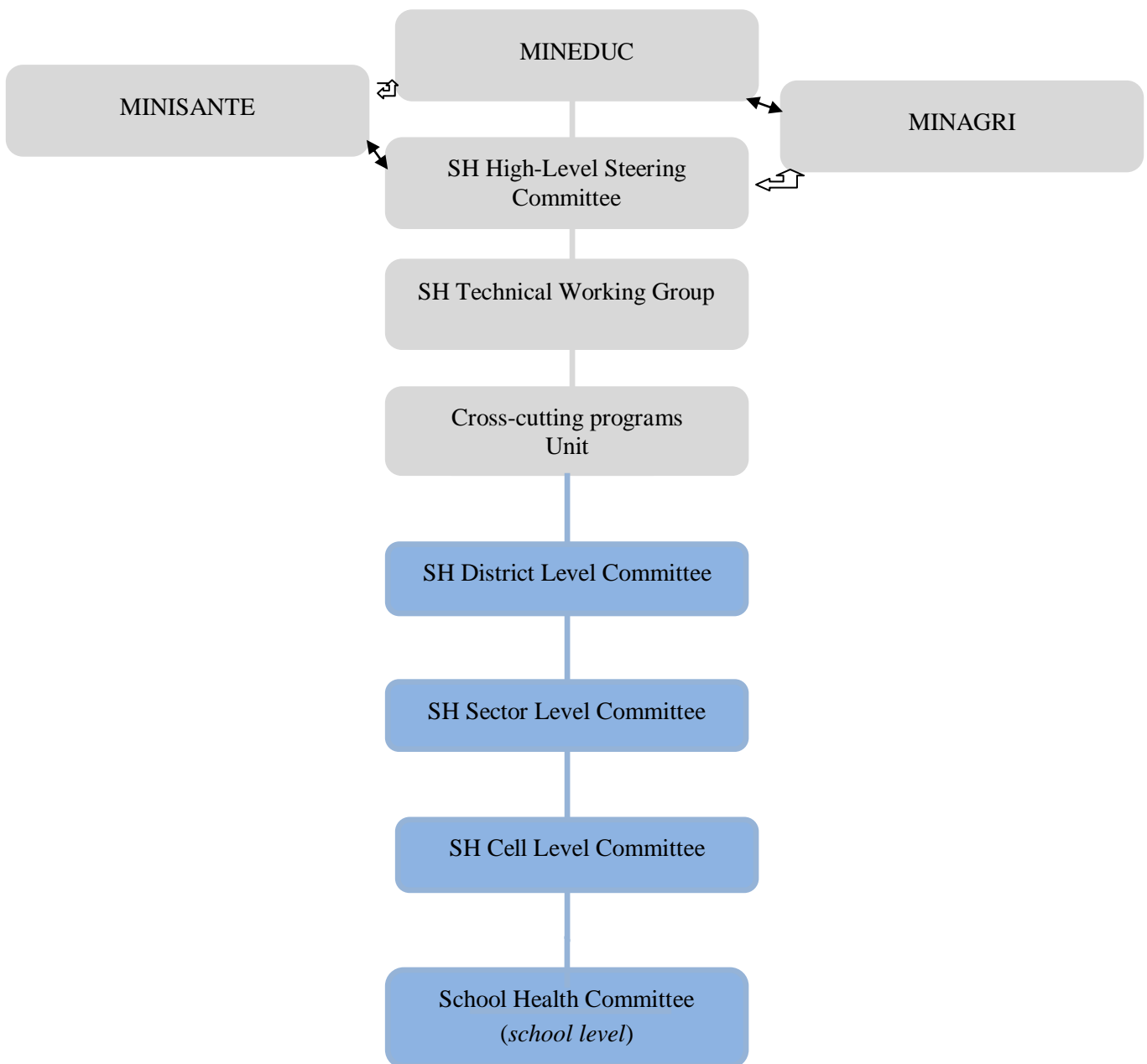
- The development of a strong and comprehensive M&E framework;
- Active monitoring and reporting;
- M&E of the program to ensure learner coverage and quality and identify gaps and barriers to implementation.

Identification of research priorities in SH policy would also assist with policy review, program planning and implementation at all levels.

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ANNEX I: SH COORDINATION CHART



ANNEX II: SCHOOL HEALTH INDICATORS (WHO, 2011)

Indicators
Extent of integration of health education across the curriculum
Classroom time devoted to each topic area and its distribution across years
Availability of prevention intervention such as Mosquitoes nets supplied and their use encouraged
Availability of protective equipment for sports and physical education
Increased availability and promotion of healthy foods
Clean and well maintained buildings and ground, free of dangerous materials
Adequate light and ventilation in the classrooms and dormitories
Facilities for social interactions and quiet work
Availability and accessibility of safe drinking water
Clean, functioning and adequate toilets/latrines for both boys and girls. Availability of hand washing facilities
School facilities catering for the needs of pupil with physical disabilities
Extent and nature of student involvement in decision making
Proactive programs to reduce bullying and violence
Proactive programs to enhance a positive psycho-social school environment
Peer support programs
Nature and extent of parental involvement encouraged by the school
Frequency and nature of health promotion programs for school staff
Involvement with local community leaders in promoting health (for example, preventing cigarette sales to minors)
Frequency and nature of involvement of government, non-government, community and commercial agencies with school
Frequency of teacher-parent meetings and health issues discussed at those meetings
First aid and other support for those with chronic disease (for example asthma)
Screening according to MoH Health guidelines
Referral for those with complicated illness (including those with a drug addiction, mental health problem, social adjustment difficulties)
Counseling and conflict resolution for staff-staff, staff-student and student- student problems

ANNEX IV: SCHOOL HEALTH MINIMUM PACKAGE

1. INTRODUCTION

A comprehensive, holistic approach encourages each school to look at its whole school community and develop an environment and culture that promote healthy ways of living. A Comprehensive School Health framework combines four main elements: Health Education, Health and Support Services, Social Support and the Physical Environment. It involves the active participation of all members of the school community in creating action plans that make their school a healthier place.

The school health minimum package provides the context for effective implementation of access to health services within school health programmes. School-based health services, such as micronutrient supplementation and deworming, are likely to be most effective where they are supported by other strategies such as safe and secure environment, provision of safe water and sanitation, effective referral to external health service providers and links with the community.

These core components of the school health minimum package require school-community partnerships as the supporting strategies for the success of school health programmes. These include effective partnerships between the health and education sectors, teachers, parents and health workers, schools and community groups and between the pupils and those responsible for implementing school health programmes.

2. TYPES OF SCHOOLS

2.1. Boarding schools

Boarding schools cater for children who, for various reasons, are unable to return home each day. In boarding schools, all means, sleeping accommodation and washing facilities are provided. It is therefore of critical importance that water, sanitation and hygiene enabling facilities are adequate. Risks of transmission of communicable diseases are raised because of the communal eating, sleeping, and sanitation and hygiene arrangements in boarding schools. Nevertheless, it is possible to provide adequate water, sanitation and hygiene conditions for all children.

2.2. Day schools

Day schools catering for children of ages 6 to 16 provide academic and, in many cases, recreational activities for children who return home every day, but who may often eat at or near the school. Problems faced by schoolchildren and teachers in this kind of school often include lack of basic water supplies, sanitation and hygiene-enabling facilities; inadequate or hazardous outdoor space; and overcrowded classrooms where there is noise, poor lighting, poor seating, excessive heat or cold, damp and poor indoor-air quality. Funding for improved conditions in schools may be lacking, but there may also be a strong desire and capacity for change among staff, schoolchildren and parents.

3. TARGET

These guidelines are written for use by education managers and planners, architects, urban planners, water and sanitation technicians, teaching staff, school board, village education

committees, local authorities and similar bodies. These groups are encouraged to work together to set relevant, achievable and sustainable targets for water, sanitation and hygiene in schools.

3. AIM

This school health minimum package document offers a guide for creating the minimum conditions required for providing schooling in a healthy environment for schoolchildren, teachers and other staff.

In the area of school health programs, it should be used to:

- develop specific national standards that are relevant to various types of school in different contexts;
- support national standards for SH&N and set specific targets at local level;
- plan and carry out any improvements required;
- ensure that the construction of new schools is of acceptable quality; and
- prepare and implement comprehensive and realistic action plans, so that acceptable conditions are maintained

4. OBJECTIVE

To promote SH programmes and services at school level.

5. BENEFITS OF THE MINIMUM PACKAGE

5.1. Highly cost effective

The package helps link the resources of the health, education, nutrition, and sanitation sectors in an existing infrastructure, the school. The school system coverage is generally superior to health systems and there is an extensive skilled workforce (teachers and administrators) that already works with the local community.

5.2. Increases the efficacy of other investments in child development

The package is the essential extension and complement to early child care and development programmes. Continuing good health at school age is essential if children are to sustain the advantages of a healthy early childhood and take full advantage of what may be their only opportunity for formal learning.

5.3. Ensures better educational outcomes

Ensuring good health at school age can boost school enrollment and attendance, reduce the need for repetition, and increase educational attainment. Good health practices can promote responsible behavior that enhances sexual and reproductive health and help avoid HIV and AIDS infections. It is estimated that the burden of disease for school-age children 5 to 14 years old is 11% of the total global burden of disease.

5.4. Improvement of social equity

As a result of universal basic education strategies, some of the most disadvantaged children - girls, poor rural children and children with disabilities - have access to school for the first

time. But their ability to attend school and to learn whilst there is compromised by poor health. These are the children who will benefit most from health interventions, since they are likely to show the greatest improvements in attendance and learning.

6. THE PACKAGE

The school health minimum package is divided in four main areas: (1) Health education; (2) Health and support services; (3) Social support; (4) Physical environment.

Areas	Interventions	Details
<i>Health Education</i>	Capacity building	At least two teachers per school are trained in school health, with the following modules: <ul style="list-style-type: none"> - Causes and prevention of common diseases - HIV, AIDS and other STIs - Sexual and Reproductive Health and Rights - School health and hygiene - Nutrition and school gardening - Physical education - Psychosocial care and counseling
	Health clubs	School health clubs will have the following content: <ul style="list-style-type: none"> - Environmental health and hygiene; - Gender-based violence; - Sexual and Reproductive Health and Rights; - Nutrition; - Malaria; - Tuberculosis; - Mental health; - Non-communicable diseases; - Children under five; - Immunization and VPD surveillance; - HIV, STIs and blood borne infections; - Other communicable diseases [infectious diseases]
	IEC/BCC material	IEC/BCC materials will be disseminated in schools: <ul style="list-style-type: none"> - HIV, AIDS and other STIs; - Sexual and Reproductive Health and Rights; - Alcohol and tobacco abuse (substance abuse)
	Intergenerational dialogue	Sexuality, STIs, pregnancies, GBV should be discussed in existing channels such as parents meetings
<i>Health and Support Services</i>		
	GBV referral system	Every school shall have a GBV referral system, with support to victims, fast referral to health centers (for HIV and STIs prophylaxis and psychosocial care), record of cases, and inclusion of GBV in teachers' code of conduct.

Areas	Interventions	Details
	First aid kit	A first aid kit should be available in all schools
<i>Social Support</i>	Counseling	Trained teachers and peer educators providing counseling services and psychosocial care
	OVCs, Pregnancy and GBV	Data collection about OVCs , pregnancies and GBV
	Follow-up	Follow-up if above mentioned girls are coming back to school.
<i>Physical Environment</i>	Water	Safe drinking water Rain harvesting
	Sanitation	Separate toilets for girls and boys Separate toilets for female and male staff Girls' rooms (sanitary pads, water, soap)
	Hygiene	Hand-washing points Minimum cleaning materials (detergent, soap, broom, etc.) Elimination of breeding places of mosquitoes
	Physical Education	Playground Sports facilities (Toys,...)
	Environment	Compost system Trees Greening Mosquito nets for boarding schools
	Infrastructure	Well-ventilated classrooms Structure for disabled children
	School nutrition ¹⁹	Kitchens Store rooms Improved stoves School gardens Fruit trees Kitchen items (pots, pans, plates, etc.)
	Alternative energy ²⁰	Eco-toilets Biogas Solar energy

¹⁹ In all schools with operational school feeding programmes.

²⁰ These interventions are highly recommended, but are not mandatory, since they depend on the availability of resources.

7. RECOMMENDED ITEMS IN THE FIRST AID KIT

Every school should have a first-aid kit, with the following recommended items:

1. Eosine %
2. Dakin
3. 2 Thermometers
4. Paracetamol syrup
5. Paracetamol tablets
6. Acetyl salicylic acid tablets
7. Cotromoxazole syrop and tablets for throat irritation
8. Some sterile gauzes
9. Lots of non-sterile gauzes
10. 5 cotton and stretch bandages
11. 5 Adhesive tapes or safety pins
12. 5 adhesive plasters, different sizes
13. 5 adhesive plasters, small
14. 5 triangular bandages
15. 5 soap
16. Re-usable or disposable gloves
17. Scissors
18. Matches, candles
19. Torch with battery cells
20. A small container
21. Pen, paper, and notebook
22. 50 ORS packets
23. Sanitation pads
24. Small disposal towels