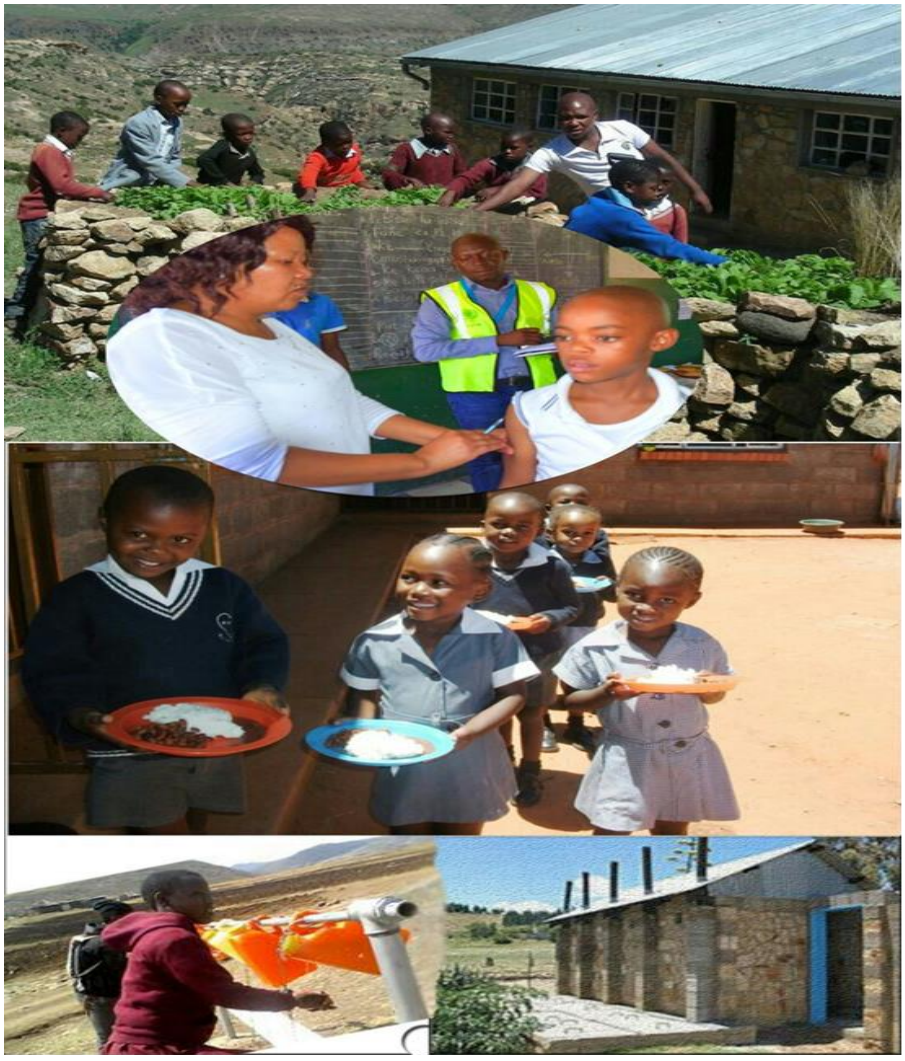
Ministry of Education and Training

Ministry of Health

Lesotho School Health and Nutrition Policy



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Foreword

The link between education and health is now well established, with research demonstrating how each can have a positive or negative impact on the other. Lesotho National Strategic Development Plan (NSDP) 2012/13 – 2017/18 places education and health at the epicentre of ensuring human capital development in order to propel economic growth as well as address poverty and unemployment. The aim of education is to enable individuals to reach their full potential, to create healthy educated individuals that can contribute to their nation's development, their communities and their own well-being. To achieve this goal and in particular Sustainable Development Goal 4, will require (amongst others) not only increased enrolment but also increased attendance and ability to learn, a decrease in drop- outs, and improvements in the quality of education.

Some health conditions such as HIV infection can have a dramatic impact on the education of those infected and affected by lowering attendance and enrolment. Early and unintended pregnancy also often leads to adolescent drop-outs from school, while child marriage – with consequent pregnancy - can be another reason for dropping out. A number of easily preventable health conditions also impact on education, for example worm infections can reduce enrolment and increase absenteeism, and hunger and anaemia can affect cognition and learning.[1]The interrelationship between education and health and thus the importance of school health and nutrition programmes has been highlighted in a number of world conferences, and in 2000 at the Dakar World Education Forum (WEF) the Framework for Action committed signatories to *inter alia*,

"Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life-skills programmes."

The Dakar WEF also saw the launch of Focussing Resources on Effective School Health (FRESH) initiative. FRESH was developed in an effort to address repetition, absenteeism and drop-out, and to improve the quality of education.

[1]The World Bank. 2012. *What Matters Most for School Health and School Feeding: A Framework Paper*. SABER Working Paper Series. Number 3 June 2012. Washington D.C., The World Bank.

The Communique from the 9th EFA High Level Meeting in Ethiopia in 2010 also stated that:

"In addition, poor health, malnutrition and diseases . . . affecting hundreds of millions of poor children . . . reduce enrolment, increase absenteeism and diminish cognitive development and learning"[2].

Thus, in an effort to improve both educational and health outcomes of learners, the government of Lesotho developed School Health and Nutrition (SHN) Policy with generous technical and financial support from, UNESCO, UNICEF, Ministry of Education and Training and Ministry of Health. This policy is a product of years of intensive engagements with relevant stakeholders to provide comprehensive and well-coordinated support to learners from pre-primary through to Grade twelve (12). It promotes complementarity and harnesses synergies and linkages among different role players in school health and nutrition.

The Ministry of Education and Training calls on all role players to come to the fore and marshal their resources to support children through variety of measurers and activities outlined in this document. The destiny of Lesotho lies, to a considerable extent, at the level at which we invest in our youth so that they can confidently take the baton of development agenda forward. All the costs, financial and non-financial, incurred towards implementation of this policy should be understood as our social responsibility towards education of Basotho children.

Prof Ntoi Rapapa
Minister of Education and Training-Kingdom of Lesotho

Acknowledgements

The Lesotho School Health and Nutrition Policy was supported by UNESCO and UNICEF. The Ministry of Education and Training would like to thank our colleagues from Line Ministries who provided insight and expertise that greatly assisted the development of this policy; their technical assistance that greatly improved the policy. We are also immensely grateful to the individuals, Organisations and Institutions they represented for sharing their pearls of wisdom with us during the development, validation and finalization of the Lesotho School Health and Nutrition Policy, although any errors are our own and should not tarnish the reputations of these esteemed persons

The promotion of the health of learners in schools is a critical step towards quality achievement in education. Therefore, implementation of the School Health Programme is core to the realization of the goals of the National Policy on Education

Thabiso Lebese (Ph.D)

Principal Secretary-Ministry of Education and Training-Kingdom of Lesotho.

Executive Summary

The Ministry of Education and Training (MoET) and The Ministry of Health (MoH), will work in partnership to create a conducive, safe and learning environment for children and learners. Ensuring that learners are healthy and able to learn is an essential component of an effective education system. However, the most vulnerable and disadvantaged learners are often the least healthy and most malnourished, who have the most to gain educationally from improved Health and Nutrition.

Good Health and Nutrition are not only essential inputs but also important outcomes of quality basic education. On one hand, learners must be healthy and well-nourished in order to fully participate in education and gain its maximum benefits. Thus, the SHN program which improves Health and Nutrition can enhance the learning and educational outcomes of learners. On the other hand, quality education, including Education about Health, can lead to better health and nutrition outcomes for learners and, especially through the education of both boys and girls, for the next generation. The SHN Programme, supported by policy and strategies, is critical in improving not only the Health and Nutrition of learners, but also enhancing academic achievements and acquisition of life skills.

The key objective of the School Health and Nutrition Policy is to guide, protect, and promote healthy measures for all learners in schools.

The policy will address these key areas;

- 🕮 Effective collaboration and partnership between MoET, MoH and other stakeholders.
- 🕮 Promoting School Health Education programs, health promoting schools and providing Friendly Health Services.
- 🕮 Proper Nutrition for school aged children.
- 🕮 Sexual and Reproductive Health (SRH) Education and Comprehensive Sexuality Education (CSE) for all learners in schools.
- 🕮 Ensuring all schools are Drug, Substance, Alcohol and Tobacco free.
- 🕮 Provision of First Aid training programs for all schools.
- 🕮 Ensure all schools have clean safe drinking water and proper sanitation facilities.
- 🕮 Providing equal opportunity for vulnerable and marginalised children.

The main Ministries to implement this policy are the Ministry of Education and Training (MoET) and Ministry of Health (MoH). This policy will require the support and involvement of Line Ministries, NGO's and Stakeholders. To sustain the School Health and Nutrition Program, Line Ministries and all stakeholders offering services to children and adolescents need to plan their implementation activities through their respective Strategic Implementation Plans and Annual Implementation Planning (AIP) and Budgeting processes for over five years' period to drive this policy.

1: Background

Lesotho Population is at 2,007,201 million[1] with 34.2% of the population living in urban areas. The four largest districts, Maseru, Leribe, Berea and Mafeteng account for 64.6% of the population. Females account for 51.1% of the population and males 48.9%. Lesotho has a very young population, 31.8% are under the age of 15, 10% are under five years old, and only 6.1% are aged 65 years and above. It is estimated that 31.1% of Lesotho's population are adolescents.

1.1:National Context

The challenges that children, adolescents and young people face as they go to school are many and varied and have not been attended to for many years. The school Curriculum and Assessment does not adequately address the quality and relevance of Health and Nutrition issues for learner behaviour formation and change. Poor Health and Nutrition have a negative impact on the physical, psychological, and social development of learners. As children grow, they develop physical, psychological and social needs that need to be addressed. The transition from childhood to adolescence and adulthood is one such problem.

As traditional to modern cultural Norms and behaviours have given rise to new patterns of sexual behaviour among young people, leading to risk-taking on the basis of insufficient and incorrect information on Sexual and Reproductive Health issues. As a result, they are prone to STIs/ HIV and AIDS, unintended pregnancies, drug, substance and alcohol abuse, Gender Based Violence and child marriage and these are more likely to jeopardize learners' potential careers. Parents and the schooling system are ill equipped to handle these transitional changes. Adolescents are therefore more prone to physical, social and psychological Health and Nutrition challenges.The health system is not specific in the provision of adolescent friendly health services. Besides, there are more schools that are far away from health facilities.

In view of the above it is imperative that a SHN programme be put in place to commit Government especially the *Ministry of Education and Training*, *Ministry of Health*, *Ministry of Agriculture and Food Security*, *Ministry of Social Development* and other stakeholders that provide services to children and Adolescents to undertake activities that would assist improve the Health and Nutrition

[1] Lesotho Vulnerability Assessment Committee (LVAC) 2016

status of the school-age children (including under-fives) and adolescents (10 to 24years old) who constitute 15% and 35% respectively of the total population (CSA, 2008), thereby improving on enrolment, retention and learning achievements. The intent of this policy is to provide better co-ordination, protection and promotion of quality Health care and Nutrition for all children and adolescents in school.

1.2:Education

1.2.1.:School Proprietorship

Lesotho's Education System follows a 1-7-5 system, which means One year of preschool, Seven years of Primary Education and Five years of Secondary Education. Non Formal Education is provided as an alternative pathway Certification at Primary and Secondary Education. There are 2,208 ECCD centres, 1,483 Primary schools and 347 Secondary schools in 2018.[2] Lesotho's Education System is characterised by varying ownership of schools. Eighty-Three percent (83%) of primary schools were owned by the churches, 11% by government and 4% by the Community. Thirty-four (34%) percent of the church owned registered Primary schools belonged to the Roman Catholic Mission (RCM) and 32% to the Lesotho Evangelical Church (LEC) ACL 12% AME 1% Private 2% Other Churches 4%. At Secondary level, a total number of registered Secondary schools was 347 of which 26% were owned by Government, 26% by RCM and 24% by LEC, ACL 11%, Community 4% Private 4% Other Churches 4% AME 1% with a total enrolment of 138,894.
In 2018, 17,981 learners (5.3%) registered in primary schools had a Special Educational Needs or disability. Of these, (53.2%) had an intellectual disability such as learning difficulty, epilepsy or mental retardation. (21.3%) had a visual impairment. 21.5% (73,046) primary school learners were orphans in 2018, of which 16.9% were double orphans (12,349). At Secondary level, of the total enrolled, 8,493 (6.1%) had a disability, with visual impairment accounting for 47.2%, intellectual disability 20% and physical disability 6.3% and theses conditions hinder the performance of such learners. In 2018, 35.8% (49,698) of learners enrolled in secondary school were orphans; paternal orphans accounted for 56.4% (28,010) while 24.6% (12,209) were double orphans.

[2]Unless otherwise stated education data for this section is taken from the Lesotho Government's *Education Statistics Bulletin 2013*. Statistics Office. Education Planning Unit. Ministry of Education and Training.

1.2.2.:Enrolment

The enrolment at ECCD 50,056, Primary 340,421 and Secondary 138,894. The Free Primary Education (FPE) which started in 2000 in Lesotho, reached its peak in 2003. In 2013 there were just under 370,000 learners enrolled in primary schools. More boys than girls were enrolled in standard 1 to 4, but from standard Five on, the opposite becomes true. An estimated 14% of Primary school learners repeated their year, with the highest number in standard 1 and decreasing with progression. The highest rate of repetition is within the first four years and has stagnated around 20% since 2008. Until grade 7, more boys than girls repeat. In 2012 the average primary school dropout rate was 3.2% with 13.2% dropping out in Standard 1.

1.3:Health

A large part of the burden of disease for adolescents in Lesotho falls under Sexual and Reproductive Health (SRH) issues, and include amongst others HIV and other STIs, Early and Unintended Pregnancy (EUP) and childbirth, abortion complications, access to contraception, safe sex, impact of traditional practices, and adolescent marriage.

Life expectancy in Lesotho has improved from 47 years in 2008 to 50.5 years in 2017[3] predominantly due to the HIV and AIDS epidemic. The leading cause of death in Lesotho is AIDS, followed by Pulmonary Tuberculosis (TB), Meningitis, Pneumonia and other Acute Respiratory Infections (ARI), violence, diarrheal diseases, cancer, anaemia, stroke, diabetes, neonatal disorders and ischemic heart disease, amongst others.

While HIV represents the highest burden of disease, a number of Non-Communicable Diseases (NCDs) are increasingly affecting the burden of disease. The STEPS survey[4]of 2012 highlighted that 31% of the participants had raised blood pressure (higher among women 35.6% than men 26.3%). The prevalence of smoking was also quite high at 48.7% among males (0.7% among women). Alcohol consumption not only has an impact on chronic disease but also acts as a contributing factor to injuries, road traffic accidents and violence. Of increasing concern is the percentage of people who are overweight (58.2% of female respondents and 24.8% of males) and obese (31.9% of females and 7.9% of males) as this will impact on a number of NCDs including diabetes. Mental Health is another NCD that is contributing to the country's burden of disease, with

[3] http://worldpopulationreview.com/countries/lesotho-population/ downloaded on 25 September 2017

[4]Ministry of Health. 2013. Lesotho STEPS Survey 2012: fact sheet. Maseru: Ministry of Health

the top two mental disorders reported as epilepsy and schizophrenia. Thus NCDs are becoming a major public health problem in Lesotho.

1.3.1.:Children and Young People'sBurden of Disease

According to the last Population and Housing Census in 2016, Lesotho has a population of 2,007,201 million people and most of the population (69.9 percent) is below the age of Thirty-Five and half of the population within school age. The youthfulness of the population coupled with high unemployment levels puts the youthful population and school age children including adolescents at a predisposition for risky behaviors and vulnerable to preventable diseases and also be affected by a wide range of socio-cultural problems that constrain their ability to thrive and benefit from education. These include some aspects of traditional practices, child labor, Psychosocial and substance use, teenage pregnancies, Transactional sex and early marriages.[5] Orphans and Vulnerable Children (OVC) are at the highest risk as poverty and food insecurity that leads them to child labor, use of sex for food, being susceptible to violence, as well as rape. Health related challenges include HIV and AIDS, TB, childhood illnesses, disabilities, injuries, poor water supply and sanitation, and unsafe school environment. Some of the common nutrition-related problems being inadequate food consumption and poverty.

A 2011 situational analysis which assessed 1,072,974 children found that 363,526 (34%) were orphans. The study also estimated that 10% of Basotho were vulnerable, and around 3% were most vulnerable.[6] Burden of disease is not only impacted by socio-economic level but also by culture, as pointed out in the draft National Health Strategy for Adolescents and Young People 2015-2020: The prevailing patriarchal system in Lesotho, which is evidenced under both customary and civil law which regards a married women as a minor under the care and control of her husband, has health and educational implications. Gender inequality is a major contributor to burden of disease regardless of age, but young people, lower socio-economic groups, and those with low levels of educational attainment are most affected.

[5]Ministry of Health, Kingdom of Lesotho. 10 April 2015. National Health strategy for Adolescents and Young People 2015-2020. Final Draft.

[6] Ministry of Health, Kingdom of Lesotho. 2015. Global AIDS Response Progress Report 2015. Lesotho Country Report. Reporting Period: January – December 2014. http://www.unaids.org/sites/default/files/country/documents/LSO_narrative_report_2015.pdf (accessed 23 September 2015).

1.3.2.:Sexual and Reproductive Health

While not necessarily a burden of disease, puberty is a very important period which occurs in school-going age groups, the Developmental phase experienced by every human being."[7] UNESCO further points out that by facing this pivotal phase of life unprepared, learners are left confused and unsupported, which in turn affects the quality of their education, and in some cases it may directly affect school attendance, especially for girls.

Sexual activity starts as early as 12 for males and 14 for females, and by the age of seventeen, 50% have initiated sexual relations.[8]Inter-generational sex, sexual intercourse with older partners who are often at higher risk of having an STI or be HIV positive, is common.

A 1999 study[9]highlighted that a large number of adolescents reported being cheated into or coerced into sexual relations. A very small qualitative study[10] showed that the main reason adolescent mothers reported becoming pregnant was 1) poverty, 2) lack of knowledge and services on pregnancy and its prevention, 3) Poor parent-child communication on issues of sex and sexuality, including pregnancy 4) inability to resist peer pressure, including media influence, 5) lack of protection for orphaned and vulnerable girls and 6) alcohol and drug abuse. Consequences of Early and Unintended Pregnancies (EUP) are unsafe abortions, using dangerous methods to terminate pregnancies, stigma and discrimination, difficult relations with family members and ill health for both teenage mother and baby. Early and Unintended Pregnancies can lead to early/forced marriage and school drop-out.

1.3.3.:HIV and AIDS

HIV and AIDS add to the complexity of health issues in education. Although the rate of HIV and AIDS among learners and adolescents is low compared to those of adults, girls suffer disproportionately as victims. The impact of HIV and AIDS is devastating to learners and teachers

[7] UNESCO. 2014. *Good Policy and Practice in Health Education. Booklet 9. Puberty Education and Menstrual Hygiene Management*. Paris, UNESCO.
[8]Ministry of Health, Government of the Kingdom of Lesotho. 2006. *National Adolescent Health Policy.* Maseru, MOH.
[9]Motlomelo, ST & Sebatane, EM 1999: A study of adolescents' health problems in Leribe, Maseru and Mafeteng districts of Lesotho. Institute of Education, National University of Lesotho.
[10]Yako, EM and Yako, JM. A descriptive study of the reasons and consequences of pregnancy among single adolescent mothers in Lesotho. Curationis 30(3): x-y.

as it touches all aspects of their lives. Numerous risky behaviours and practices such as multiple concurrent sex partners, inter-generational sex, transactional sex, unprotected sex, substance abuse, early marriage, initiation, extra-marital relationships, polygamy etc. are detrimental to the health of adolescents and young people.[11] They help to explain why Lesotho has one of the highest rates of infection in the world, currently estimated at 23.4%[12] (which translates to 310,000 people living with HIV). It is also estimated that there are 74,000 orphans due to AIDS. Prevalence among adolescent girls aged 15-19 is estimated at 4.1% and for boys 15-19 at 2.9%.[13] This means that about 2000 new HIV infections occur annually among adolescents aged 15-19. Given the high prevalence rate it is worrying that the 2014 LDHS found that only **37.6%** of 15-24 year old women and **30.9%** of males had knowledge about HIV prevention (i.e. consistent use of condoms during sexual intercourse, having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about transmission or prevention of HIV ,that HIV can be transmitted by mosquito bites and by sharing food with a person who has HIV). The LDHS does also point out that comprehensive knowledge generally increases with age, educational attainment, and wealth and that urban young people are more likely than rural young people to have knowledge of HIV prevention.

One policy to address the high prevalence rate has been the establishment in 2012 by the MoH of a Voluntary Male Medical Circumcision (VMMC) programme. The goal of this programme was to rapidly scale up VMMC in order to reach 80 percent coverage by 2017. The 2014 LDHS shows that while 72.1% have been circumcised nearly 50% were only traditionally circumcised, and that traditional methods leave half of the men with a portion or all of the foreskin, thereby negating the positive benefits of circumcision. Given that young men are being accessed through schools, it will be important not only to coordinate these activities, but ensure that young men and their parents fully understand what the programme entails.

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[11] Kimane, I. March 2015. *Updated Situation Analysis (Sitan) for Adolescents and Young People's Health in Lesotho*. Ministry of Health Kingdom of Lesotho, WHO.

[12] UNAIDS. http://www.unaids.org/en/regionscountries/countries/lesotho (Accessed 23 September 2015).

[13] Ministry of Health Lesotho. 2015. Global AIDS Response Progress Report 2015. Lesotho Country Report. Reporting Period: January – December 2014. http://www.unaids.org/sites/default/files/country/documents/LSO_narrative_report_2015.pdf (accessed 23 September 2015).

1.3.4.:Mental health

There is no available data on the mental health of 5-24 year olds, however it is likely that given the number of OVCs, the levels of violence, early and unintended pregnancy and substance use that exist, there is an unfulfilled need.

1.3.5.:Oral Health

There is no baseline data on oral diseases / conditions for 5-24 year olds in the country. Annually there is a significant number of new oral health cases seen in dental clinics. Dental caries (tooth decay) remains the highest of all reported cases in these clinics, followed by periodontal diseases. The facility based oral health data from the Annual Joint Review report shows that dental caries constituted about 78% of all cases seen in 2015 and of this 88% were presented by the age group of 12 years and above[14]**.** Data from a study conducted in 2012 which assessed dental caries experience among 12-year-old school children revealed the caries index, expressed as the Decayed, Missing, and Filled Teeth (DMFT), of 0.4. Although the index falls within the 0.0-1.1 WHO classification range which, indicates a very low DMFT, the decayed component of the DMFT contributed the most in this index at 97.2%[15].

1.3.6.:Road accidents and injuries

There is very little data disaggregated by age on injuries among children and young people. However, in-patient hospital records indicate that trauma and respiratory diseases are common among the 5-14 year age group, and that one of the common causes of hospital admission, for those between 15 and 24 years, is trauma, which is more prevalent among males.[16] Road accidents, predominantly in urban developed areas, are likely to increase over time with an increase in the number of cars on the roads.

[14] The Lesotho health sector Annual Joint Review Report 2015-2016 FY

[15] Ministry of Health and Social Welfare. (2010). Dental caries sentinel surveillance in 12 year olds primary school children.[Unpublished]

[16] Ministry of Health. Government of the Kingdom of Lesotho. November 2006. *National Adolescent Health Policy*. Maseru, MOH.

1.3.7.:Substance Use

Lesotho Demographic and Health Survey (LDHS) 2014[17] shows the vast majority of women who use tobacco products use snuff while nearly all men who use tobacco products smoke cigarettes. Among men who smoke cigarettes, 16% reported smoking 10 or more cigarettes in the 24 hours prior to the interview. This LDHS also observes that tobacco use among men has increased since 2009, from 35% to 42% while it has remained stable among women. Cigarette smoking rises sharply with age among men, from a low of 19% for those age 15-19 to a high of 53% for those age 25-29. After age 30, tobacco use is relatively stable.

The survey also notes differences by residence in tobacco use with 43% of men in rural areas smoking cigarettes versus 38% in urban areas. According to the LDHS 2014, tobacco use is also correlated with education level with the results showing that the higher one is educated, the less likely they are to use tobacco. For example, only 34% of men with no education do not use tobacco compared with 76% of men with more than secondary education. Likewise, 73% of women with no education do not use tobacco compared with 99% with more than secondary education. Snuff use among women inversely correlates with education and wealth.

The National Adolescent Health Policy 2006 points out substance use starts very early in Lesotho as a result of boredom, peer pressure and stress. In 2002 a study in selected districts showed that 12.5% of children aged less than 10 years smoked cigarettes, 5.7% were using alcohol, 6.7% marijuana and that 11.2% sniffed glue. These figures rose in the 10-14 years age-group with 46.6% smoking cigarettes, alcohol being consumed by 46.9%, marijuana by 31.7%, and glue by 64.3%. The percentages in the 15-19 years' age-group were cigarettes 39.6%; alcohol 47%; dagga 60.7%; and glue 21.3%. Of particular concern is the higher proportion of 10-14 year olds compared to 15-19 year olds.[18]The figures imply an increasing problem of substance use among young people, which need to be addressed through education, prevention and mitigation within a SHN programme.

[17] Ministry of Health. Demographic and Health Survey 2014.

[18]Ministry of Health. Government of the Kingdom of Lesotho. November 2006. *National Adolescent Health Policy*. Maseru, MOH.

This survey, coupled with the health indicators for this age group, shows that the majority of young people and adolescents are not health literate[19] and are not receiving sufficient Skills-Based Health and Nutrition Education to enable them to make healthy choices.

1.4:Use of Health Services

A 2015 survey[20] of 177 adolescents' utilization of health services showed that more girls than boys seek services, that 49% of 20-24 year olds used services, 35% of 15-19 and only 16% of 10-14 year olds. This indicates that younger adolescents either feel they don't need health services, or don't know how to/fear accessing services. The reasons for accessing services were predominantly SRH issues, which for girls included: pregnancy issues, sexual issues, HIV & TB, sexual and physical abuse, and menstruation. For boys it was predominantly sexual issues and substance use.

The implication from all these studies is the need to improve not only knowledge, but also the skills needed to enable healthy Sexual and Reproductive Health decision making. Thus a SHN programme responses will need to address both the educational and physical needs (e.g. menstrual hygiene management) and also go beyond prevention and medical mitigation and include policies to ensure re-integration into the school system.

2:Violence

Violence against children and young people manifests itself in a number of different ways. It can be Gender-Based, it can be physical, mental or sexual, occurs among peers or inflicted by adults, within marriage, the family unit or schools. Schools can often be unsafe from a physical and psychosocial point of view with bullying, harassment, sexual abuse and Corporal punishment occurring. Gender inequality, patriarchal values and traditional practices can promote male domination and lead to Gender-Based Violence.

[19]Health Literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health Literacy goes beyond a narrow concept of health education and individual behaviour-oriented communication, and addresses the environmental, political and social factors that determine health. http://www.who.int/healthpromotion/conferences/7gchp/track2/en/

[20]Kimane, I. March 2015. *Updated Situation Analysis (Sitan) for Adolescents and Young People's Health in Lesotho*. Ministry of Health Kingdom of Lesotho, WHO.

While there is little peer reviewed evidence on violence against children in Lesotho, anecdotal evidence suggests high levels of sexual violence and exploitation of children.[21]The Lesotho Health Sector Strategic Plan 2012/13-2016/17 refers to one study that states that rape is quite common among adolescents and which showed that 53% of all inpatients attended were adolescents who had been raped. One cross-sectional study[22] found that 22.6% of male and 21.5% of female 11-16 year old respondent self-reported experience of being forced or coerced into sex. The 2011 Children's Protection and Welfare Act[23] points out that a 2011 study showed that 5.8% of all households with children had at least one child who had been subjected to violence in the year preceding the survey, 4.6% experienced physical violence, 1.1% sexual violence, and 0.1% both physical and sexual violence. In addition, 9.7% of respondents stated that they were personally aware of situations of sexual abuse in their immediate neighbourhoods, with figures especially high in urban areas. Thus it is estimated that there were 10,000 cases of child sexual abuse, which represents 2 to 3% households.

Evidence of violence at school also tends to be anecdotal. A research report on out-of-school children identified corporal punishment as one of the reasons why learners drop-out of school.[24]A small study,[25] found that only 36.40% of the respondents had *never* seen incidences of physical violence between learners, that only 46.32% of the respondents had *never* witnessed and 55.14% had *never* experienced threatening behaviour by their educators. In addition, 10.66% of respondents reported that some learners at their respective schools raped fellow learners.

Although the evidence tends to be anecdotal, it shows the need to address prevailing gender inequalities, the need to create safe physical and psychosocial environments for both learners and education staff, and the need to equip learners with the knowledge attitudes and skills that promote respect, empathy and healthy behaviours.

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[21] Weber, Stephanie. 2013. *National Response Efforts to Address Sexual Violence and Exploitation Against Children in Lesotho: A Desktop Study*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

[22] Andersson N, Paredes-Solıs S, Milne D, et al. 2012. "Prevalence and risk factors for forced or coerced sex among school-going youth: national cross-sectional studies in 10 southern African countries in 2003 and 2007." *BMJ Open*.

[23]Government of Lesotho. 2011. Childrens' Protection and Welfare Act, 2011. Maseru: Government Printers. Quoted in Weber, Stephanie. 2013. *National Response Efforts to Address Sexual Violence and Exploitation Against Children in Lesotho: A Desktop Study*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

[24]Lefoka, P.J., Motlomelo, S.T. and Nyabanyaba, T. MOET & UNICEF. June 2012. *Out-of-School Children Research Project.*

[25] De Wet, C. 2007. School Violence in Lesotho: the perceptions, experiences and observations of a group of learners. *South Africa Journal of Education*. Vol 27: 673-689.

3:Nutrition

Lesotho Vulnerability Assessment Committee (LVAC) report of 2016 estimated low levels of Global Acute Malnutrition (GAM) at 2.7% among children aged 6 -59 months and severe acute malnutrition (SAM) at 1.4% among children of the same age. Moderate acute malnutrition was however above the global threshold for emergency response for severe acute malnutrition at 2.3% in children aged 6-17 months. The Report also estimates underweight national prevalence at 12.2% whilst moderate underweight was 10.3%. Obesity was also estimated at 8.8% among children aged 6-59 months old. Stunting or chronic malnutrition was estimated to be very high, based on WHO classification, at 42.9%, while severe stunting was estimated at 17.3% with boys recording the highest prevalence of 21.3%. The Report also observes age disparities in stunting prevalence with severe stunting being most prevalent in children aged 18-29 months (25.9%) whilst moderate stunting was high in children aged 30-41 months (29.9%). Acute and chronic malnutrition stunting was highest in Mokhotlong at 51%. The 2014 LDHS shows that 33% of children under the age of five are stunted and 11% severely stunted, these figures rise to 47.7% and 18.9% respectively in Mokhotlong (stunting is inversely correlated to wealth quintile).

In addition, 10% of children are underweight, 2% severely underweight and 51% have some degree of anaemia. The situation has been aggravated by the fact that Lesotho has been food insecure for a number of years, with only 30% of food needs covered by domestic production and the rest dependent on imports and food aid.

Early nutritional deficiencies can continue to have an impact on later life, and it is likely, given the socio-economic situation of many young people (including high unemployment rates in the country), that nutrition continues to be an issue throughout adolescence and beyond. This is backed by data from the 2014 LDHS which points out that the anaemia prevalence observed among men and women is serious (26% of women and 12 % of men aged 15-49 had some level of anemia, rising to 14% for adolescents aged 15-19) and that the prevalence among children is critical, which implies a generalised dietary deficiency. As nutrition can have a cognitive impact and decreases ability to concentrate, it should be addressed within a SHN programme both from an educational and service provision point of view. In addition, the growing obesity rates mentioned earlier also point to the need to address nutrition and the need for physical activity at an early age to ensure that healthy habits become ingrained.

School feeding is currently the largest social safety net in place in Lesotho. An estimated 390,000 primary school children and 50,000 ECCD and reception class children benefit from school feeding. The School Feeding Policy sets out the conditions and systems for the implementation of an extended programme. The Food and Nutrition Coordinating Office (FNCO) in the Prime Minister's Office which is in charge of coordinating all nutrition services has led the process of developing National Food and Nutrition Policy which was launched in 2016 and is currently leading the process of developing National Food and Nutrition Strategy and Action Plan (2018-2023).

4:ىegislative and Regulatory Framework (including Obligations)

Existing and current legislative and regulatory frameworks underpin the importance of providing protection and welfare for all children, that they should have the right to education, adequate diet, clothing, shelter, protection, medical attention, social services and any other service required for the child's development, without *discrimination or exclusion on any basis* and the right of every child to express his/her opinion freely and to have that opinion taken into account in any matter affecting the child. However, there are limitations to these Acts and policies. They do not address SHN issues adequately. the socio-economic challenges largely affect learners in schools as indicated by the deteriorating health status, increasing levels of poverty, malnutrition and disease burden. The combined effects of these challenges lead to reduction in learners' capacity and motivation to learn, delayed enrolments, absenteeism, high repetition, dropout and push out rates.

It is within this context, that the country has enacted pieces of legislation and put in place policies and strategic frameworks that are relevant to Education, Protection, Health and delivery of Friendly Health services for children and adolescents in Lesotho. The Government of Lesotho (GOL), through Government Gazettes, policy documents and position papers on national development issues such as Vision 2020 has clearly expressed its desire to efficiently use the available limited resources to address the various national competing needs including those of young people. Over the years, the GOL has developed various Policies and Legislative Frameworks that seek to promote, protect and support the welfare of children and young people.

The Government of Lesotho has also ratified a number of international and regional conventions that identify the rights of children and young people, and guide programming for both Education

and Health. All of these documents provide a conducive environment for the development of the School Health and Nutrition Policy and programmes as well as their implementation.

5:Coordination of Subsectors

One of the key partnerships for effective implementation of the School Health programme is between the MoET and the MoH and Prime Minister's Office, with each having a specific role to play. Generally, Ministry of Health is responsible for providing friendly-Health Services in schools while MoET is responsible for creating an enabling environment for the provision of these Health services, the creation of safe physical and psychosocial environments, as well as for ensuring the integration into the curriculum and provision of, Skills-Based Health and Nutrition Education.

Each ministry shall be responsible for the financial implications of the SHN policy according to their role and responsibilities. Specific roles and functions of each Ministry are outlined below.

1. **Ministry of Education and Training (MoET)** shall; Ensure inclusion of Skills-Based Health Education in the curriculum and its implementation in schools. Provide Guidelines to schools on Community and parental involvement. Strategically lead in the coordination and management of School Health and Nutrition at the national, regional and district level.

The Ministry of Education and Training (MoET) shall establish ***Learner Care and Welfare Support Unit (LCWSU)*** as proposed in the new structure and this Unit will be responsible for coordination of implementation of SHN Policy and for providing support to the districts for the implementation of the policy.

The ***LCWSU*** will have the following functions and responsibilities:

- Provide guidelines and advice to MoET on implementation of the policy,
- Coordinate MoET and stakeholders,
- Ensure monitoring and evaluation of the School Health and Nutrition Policy and programme and report back on progress in implementing the SHN policy.
- Act as the Secretariat for the ***School Health and Nutrition Technical Working Group*** (SHNTWG)

2. **Ministry of Health (MoH);** shall support MoET by;

Providing technical assistance and advice on medical issues and coordinate with MoET on Health and Nutrition Education. Including School Health and Nutrition Services in the District Medical Teams' Responsibilities. Offering Child and Adolescent friendly-health services for all learners.

3. **Ministry of Social Development (MoSD);** shall support the MoET in providing support and also managing the welfare of vulnerable learners**.**

4. **Ministry of Agriculture and Food Security (MoAFS);** shall support MoET by training teachers and learners on Good Nutrition and Health and provide technical assistance on effective agriculture to improve output and quality to better manage climate change challenges.
5. **Food and Nutrition Coordinating Office-(FNCO**); shall support MoET by Developing, coordinating and monitoring the implementation of National Nutrition Policies including nutrition component of School Health.

6. **Ministry of Police and Public Safety/ Child and Gender Protection Unit(CGPU);** shall support MoET by Enforcing children's protection Acts, legislation and Regulations and also disseminating information and Education in schools on Procedures to report abuse, Road Safety and traffic control around schools and Alcohol use and abuse, Drug and Substance use and abuse issues.

7. **Ministry of Justice, Human Rights and Correctional Services;** shall support MoET in implementing SHN in probation schools and managing the welfare of child-learner offenders.
8. **Ministry of Finance;** shall provide resources and budgetary allocation to support The School Health and Nutrition Policy implementation across all relevant Ministries**.**

9. **Ministry of Gender, Youth, Sports and Recreation;** shall support MoET by Constructing and improving recreational and sports facilities in schools. Design and Implement a child and adolescent specific program for schools to use physical activity and sports to reduce obesity and gender inequality. Provide technical assistance and capacity building for sports teachers; - Sensitize learners and youth and the school community on the importance of sports; - Organizes anti-drug abuse campaigns.

10. **Ministry of Local Government and Chieftainship**; shall support MoET in Identifying safe locations for new schools and ensure protection of learners in those schools through awareness campaigns on SHN issues with community councillors.

11. **Ministry of Water;** in coordination with MoET and MoH, ensure clean water supply in schools and adequate sanitation for all learners.

12. **Development Partners:** Development Assistant Financial Team (DFAT)**,** United Nation Fund for Population Activities(UNFPA)**,** United Nation International Children Emergency Funds(UNICEF)**,** World Health Organization (WHO) shall, in collaboration with government provide financial and technical assistance in support of the design, implementation, monitoring and evaluation of the School Health and Nutrition Program; especially in the areas of Education, Health, Water Supply, Sanitation and Agriculture to promote the health of the school community.

13. **Non-governmental Organisations;** This group includes Parent-Teacher Association (PTA), Community Based Organizations (CBOs), Faith-Based Organizations (FBOs) Non-Governmental Organizations (NGOs), Professional Organization (PO) and School-Based Management Committees (SBMC). Civil Society Organisations (CSOs) shall in agreement with the school authority contribute to the improvement of the Health of the school community. These organisations shall adhere to government priorities and procedures and support MoET in advocating for SHN and Provide services, technical assistance and skills on SHN and child protection.

14. **Professional Organisations** (POs) support government efforts through provision of standards and technical assistance for effective implementation of School Health and Nutrition Programme.
15. **School proprietors;** shall support MoET by creating a safe and conducive learning environment in and around schools while implementing the SHN policy in schools
16. **The Community;** The success of the School Health and Nutrition Programme depends on the extent to which the community members are aware of, and willing to support Health and Nutrition promotion efforts. The communities shall work in close collaboration with the school authorities to identify areas of Health and Nutrition needs that require interventions. Consequently, the community shall: Participate actively in the management of their neighbourhood schools. Mobilize local human and material resources to support the School Health and Nutrition program. The Community Shall Organize communal efforts and participate in School Health and Nutrition activities including infrastructure development and maintenance, financial and technical support, and enforcement of regulations against any behaviour likely to disrupt the learning environment e. g., crime, sexual violence, discipline, absenteeism, etc.

6:Problem Statement and Analysis

HIV continues to represent the highest burden of disease in the country and to break the vicious cycle will require accessing young people before they become sexually active and providing them with the knowledge, skills and attitudes they need to protect themselves[26]. A number of easily preventable health conditions also impact on education, for example worm infections can reduce enrolment and increase absenteeism, and hunger and anaemia can affect cognition and learning.[27]

Learners that are beginning and continuing in school come from different backgrounds. Socialization and interaction with other children is promoted in schools to support their personal development. Adapting to the new environment is a common situation for most learners and many

[26] Report on the Mapping of Neglected Tropical Diseases: Schistosomiasis and Soil Transmitted Helminthiasis in Lesotho, July 2015

[27] The World Bank. 2012. *What Matters Most for School Health and School Feeding: A Framework Paper*. SABER Working Paper Series. Number 3 June 2012. Washington D.C., The World Bank.

take time to adapt, while being affected by bullying and behavioural issues. These issues affect their mental health and consequently learners' ability to learn. Teachers have been trained on Transitions issues and basic Counselling skills to provide support services for learners. However, most schools do not provide counselling services.

There have been two different school feeding Schemes in Lesotho; a government programme covering 1,044 schools with 330,000 learners in the lowlands and foothills.; and World Food Program(WFP) covering 429 schools with 80,000 learners in the highlands. However, both models share a number of disadvantages; the existence of these two school feeding models inherently lead to inefficiencies. Secondly, school meal menus are not adapted to local preferences or capacities, which limit the potential for communities to provide the required commodities

Little attention is paid to Physical Education yet it is crucial for learners' wellbeing. 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 do not involve all the learners 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 behaviour.

Life Skills Based Sexuality Education (LBSE) is taught through the Curriculum at upper primary and secondary schools. Teachers are pre-trained and in-service trained to teach *Knowing One Self and living with Others,Human Rights and Child protection,Gender Norms and Equality,Sexual and Reproductive Health, Drug, Alcohol and Substance Use* and *HIV and AIDS and STIs*. However, the curriculum does not cover Sexual and Reproductive Health in depth and teachers are not sensitised adequately to teach it.

Inclusive Education is not practical; learners living with disability do not get equal opportunity to education and access to Friendly Health Services. They suffer many times from stigma, exclusion and marginalization in school and society in general. Special schools are minimally not supported

by government health services but are rather left to families and non-government entities to care for.

All children are encouraged to receive all their vaccines from birth to school entry and exit. Currently not all children are immunised at birth and at school age due to a lack of information and knowledge amongst caregivers and parents.

Most schools do not have a school clinic or sick bay to cater for learners except some private schools which are very few. Learners who are sick during school days are sent home or referred to the nearest health centre.

There is an increasing trend of Substance and Drug use and abuse and alcohol consumption among young people. Learners, teachers and the school community are directly affected by the practice of alcohol and substance abuse (EUP situational Analysis; 2018). Smoking causes many health problems, including cancer, heart attacks, and liver and kidney diseases. It reduces physical performance and can distract young people from their learning opportunities. Cigarettes and tobacco products are easily accessible to learners through informal markets and due to poor enforcement of smoking regulations. Learners begin smoking due to peer pressure, stress and bad role models. The combination with alcohol increases the risk of acquiring other illnesses.

Many schools lack adequate safe water and proper sanitation facilities. Waste disposal facilities that are present are often in bad condition which leads to contamination of the environment. Schools and the surrounding environment can create a high risk area for disease outbreaks due to the lack of sanitation facilities and poor water facilities among other issues. The response to disease outbreaks in schools is addressed reactively. The preparedness of the School community for outbreaks in schools has not been properly established

6.1.:Analysis of issues

6.1.1.:School Health Data in the Ministry of Education

The format used by the EMIS needs to be reviewed to include other activities that are being implemented in the school Health program. This will enable implementers to report on the actual activities performed during the school visits.

6.1.2.:Alcohol and Substance Use and Abuse

Most adolescents abuse substances like alcohol, tobacco, marijuana and other drugs of dependence. However, only extreme cases are brought to the attention of the class teacher and Principal. This kind of scenario poses a great risk for learners who are not yet substance dependent. The early use of alcohol and illicit drugs can have harmful effects on the health and well-being of learners and adolescents. The consumption of drugs and alcohol can lead to; increased risky behaviour such as absenteeism, vandalism, violence, poor concentration and dropping out of school. learners turn to alcohol and drugs due to peer pressure, depression and bad role models Substance abuse also leads to physiological and psychological illnesses such as cancer, high blood pressure, liver and mental problems. Moreover, appropriate counselling services are often lacking and most teachers do not have skills on how to recognize early signs of substance abuse problems.

Schools must reinforce that they are drug and alcohol free and promote better health practices. Any injuries related to drug and alcohol abuse in schools should be properly treated and referred according to its severity. Harm reduction activities must be promoted to effectively deter students from drug and alcohol abuse

6.1.3.:Mental Health

A sound mind is essential for proper growth and development of the learner. Fear of failing, bullying physical and mental abuse, body and hormonal changes and coping with

school requirements are major problems faced by the children and adolescents. Better counselling services and curriculum are essential for children and adolescents' learning.

6.1.4.:Children with Disability

Many schools do not provide enabling environment for learners with disabilities. Learners with Disabilities are often ignored, disrespected, uncared for and often left to cope by themselves.

6.1.5.:Sexual and Reproductive Health Education

Early and Unintended Pregnancy (EUP-Situational Analysis-2018) shows that many adolescents lack basic knowledge and information on Sexual and Reproductive Health. Evidence shows that adolescents engage in risky and unprotected sexual behaviours as early as 14 years. Unwanted or Early Pregnancies STI cases, including HIV and AIDS amongst young school aged children are on the rise. Many young children leave school due to unwanted pregnancies.

6.1.6.:School Health and Nutrition Services

School-Based Health and Nutrition programmes were fragmented and uncoordinated due to lack of support, resources and coordination between Ministry of Education and Training and Ministry of Health. Implementation of Health related interventions by different stakeholders, led to inefficient and ineffective programme delivery as well as poor results. Services need to be revived to utilise One Health and Nutrition Day quarterly every year for each school.

6.1.7.:Health Promoting schools

Effective delivery of interventions reaching school children with information and knowledge needs to be strengthened in Schools. Health promoting schools need to be revived and supported to raise awareness on Health and Nutrition messages among learners in all schools.

6.1.8.:Nutrition in Schools

School feeding is currently the largest social safety net especially in ECCD and primary education in place in Lesotho. An estimated 390,000 primary school children and 50,000 Early Childhood Care and Development (ECCD) and reception class children benefit from school feeding[28].

However, in scome schools Vendors providing food to school children are convenient and allowed as part of the informal sector. The regulations are available but are not effective to monitor food that is sold outside of the school gates which the learners are accessing. School canteens continue

[28] Lesotho National School Feeding Policy 2014

to sell less nutritious foods as they are affordable and easy to store for learners. Better awareness on nutritional food, food safety and other issues is needed to improve the nutritional status of learners in all schools.

6.1.9.:Partnerships

Partnership with line Ministries and other stakeholders lacks coordination. Coordinated engagement of partners in School Health and Nutrition activities is needed to improve partnership and avoid duplication of efforts and interventions. Encouragement of effective partnerships will enable the development of better Skills Based Health and Nutrition curriculum and program for schools.

6.1.10.:Coordination

Poor coordination of the School Health and Nutrition Program (SHNP) has resulted in it being poorly managed between the Ministry of Education and Training, Ministry of Health and Stakeholders without any clear ownership. Thus ensuring the effective management of the program and monitoring of its progress.

7:Current state of School Health and Nutrition

Currently health services in schools are being provided on an ad hoc basis depending on national priorities and campaigns, such as; deworming-dispensing of albendazole to school children and the Human Papilloma Virus (HPV) vaccination campaign or on the priorities of the District Health Management Teams. There is no clarity as to what or when certain services will be provided, or agreement on what services should be provided for each age group.

Besides, various stakeholders including the Ministry of Health, a number of Organisations, both governmental and non-governmental are working in schools, providing Health and Nutrition Education activities and some of these visit schools without knowledge and approval of MoET at National level. There is therefore, little or no quality control of the Health related interventions implemented in schools. Materials and tools used for Health and Nutrition Education by these organisations may or may not be in line with MoET's curriculum for that age group. It is also possible that certain schools are receiving similar services by different partners, while other schools

underserviced. This has therefore meant there was little or no coordination, reporting and accountability on School Health and Nutrition activities and services provided to learners.

There are large disparities with regards to physical infrastructure and safety in schools. In most schools, limited resources impact negatively on hygiene and sanitation standards. In addition, routes to schools and the immediate surrounding area have a number of hazards such as river crossing, closeness to major roads, and lack of safety from physical harm. Very little is currently being done to address these dangers although the Child Friendly Schools Standards provide guidance to principals and the school community on how to tackle these issues.

Monitoring and evaluation of School Health and Nutrition activities is currently limited to a small number of indicators in the Education Monitoring and Information System (EMIS) and the Child Friendly Schools Standards that are not yet widely used for Health and Nutrition activities.

Skills-Based Health Education is a major pillar of any School Health and Nutrition Programme, and Lesotho is implementing Life Skills-Based Sexuality Education (LBSE). LBSE curriculum is integrated in the Learning Area *Personal, Spiritual and Social* (PSS) for learners in grades 4, 5 and 6 and offered as stand-alone from Grade 7 to Grade 10. Curriculum packages for Grades 8-10 are yet to be implemented. It is compulsory and assessed associated assessment packages are also being developed for all the relevant grades. The main thematic areas of LBSE covered are: *Knowing One's self and living with Others*,*Human Rights and Child protection, Gender Norms and Equality, Sexual and Reprodutctive Health(SRH) HIV and AIDS incuding Sexually Transmitted Infections(STI's)* and *Drug,Alcohol and Substance* use. PSS also contains elements on Physical activity, Nutrition, Religion etc.

8:The Policy Development Process

A first draft of a School Health Policy was developed in 2005 in consultation with major stakeholders. It was however never finalised. The process of finalising the policy was resuscitated in 2015. This resuscitation included conducting a situational analysis of the School Health and Nutrition Programme to assess what was currently taking place in schools and to identify needs and

priorities. This was followed by a two-day workshop with stakeholders from government, Civil Society Organisations, Faith-Based Organisations, multi-laterals, academia, etc., to reach a consensus on needs and priorities, coordination and implementation mechanisms, as well as monitoring and evaluation and accountability requirements. The findings of the workshop were used to develop this policy which was then widely circulated for comments to stakeholders.

The policy was later validated in 2016 with a wide representation of relevant stakeholders. It was also presented to the Senior Management of the Ministry of Education and Training. Inputs from these various stakeholders were then consolidated to finalise this policy.

9:Beneficiaries

9.1.:Primary beneficiaries: of SHN activities are all learners at all levels of the education system, including those with special needs, from ECCD till the end of secondary school. However, this policy will specifically focus on learners in primary and secondary since Health and Nutrition priority areas for ECCD are identified and laid-out in the 2013 National Policy for Integrated Early Childhood Care and Development.[29] The policy also does not cover tertiary education, as the needs of learners at the tertiary level are very different to those at primary and secondary levels.

9.1.2.:Secondary beneficiaries of the SHN policy will be the whole school community including teachers, principals, school management boards, parents and the community, as Health and Nutrition information and Education is passed on, Health and Nutrition Services provided, referrals systems set up, and discussion between the schools and the communities initiated on creating a healthy and safe route to school.

While Initiation Schools do not fall under the scope of this policy, it is assumed that they will comply with the SHN policy, provide awareness and education, and will coordinate with schools to ensure learners do not leave school at critical moments such as examination time.

[29]Ministry of Education and Training, Kingdom of Lesotho. 2013. *National Policy for Integrated Early Childhood Care and Development*. Maseru, MOET.

9.2.:Guiding Principles

Lesotho School Health and Nutrition Policy will be implemented within the context of relevant laws and policies of Lesotho. Focus on achievement of Health and Educational outcomes, its implementation will be guided by the following principles:

- ***Access***- All individuals covered by this policy will have access to Skills-Based Health and Nutrition information and promotion as well as learner-friendly Health and Nutrition Services, support and or referrals;
- ***Adherence to principles of social justice and Universal Human Rights and Children's Rights***- Implementation of this policy will be guided by principles of social justice and will be rights-based ensuring that the basic Human Rights are observed and where learners are concerned, services and interventions are in the best interest of the child.
- ***Equity***- Ensuring full coverage of all learners starting in the most disadvantaged schools and taking into account quality and equitable distribution of resources;
- ***Inclusivity***- Implementation of this policy will address and respond to the diversity of Health and Nutrition needs of all learners without any discrimination
- ***Protection from Stigma and Discrimination***- Implementation of this policy will ensure that nobody is stigmatised and or discriminated against with regard to school health and nutrition programme.
- ***Privacy and confidentiality***- Implementation will ensure Health and Nutrition status of those covered by this policy remains private and confidential.
- ***Gender responsive and sensitive***- Application of all aspects of this policy will be sensitive and responsive to the different needs of boys and girls, men and women and interventions will recognise the special social and physiological needs of vulnerable groups based on gender.
- ***Adherence to relevant Professional Standards of Practice and Ethics***- All those involved in the implementation of this policy including those offering Health and Nutrition information, Education and services within the provisions of this policy are required to remain professional and ethical.

10:School Health and Nutrition Policy

10.1.:Vision

To promote and provide quality and cost effective Health and Nutrition Services to all learners for them to achieve their full potential through provision of quality education, in a safe and healthy environment, free from disease, prejudice and violence.

10.2.:Mission Statement

Our mission is to ensure all learners have access to friendly Health and Nutrition Service within the School Health program. A conducive and safe learning environment for their personal growth and social and economic development is paramount.

10.3.:Goal

To contribute to improvements in the Health of learners by providing them with the knowledge, Attitudes and Skills for healthy decision-making, access to quality Health and Nutrition Services, and a safe and healthy learning environment for all and thereby improve education outcomes by decreasing drop-outs, increasing enrolment and attendance, and enhancing the quality of education.

10.4.:Strategic Objectives

The strategic objectives of the School Health and Nutrition Policy are to:

1. Promote and support provision of Skills-Based Health and Nutrition Education, Friendly Health and Nutrition Services, sustain a safe and healthy physical and psychosocial environment in both formal and non-formal education settings in order to improve education outcomes.

2. Promote and maintain the health status of learners through the initiation of effective health promoting activities in order to enhance and sustain their physical, social and mental well-being.

3. Ensure capacity building among stakeholders and improve collaboration among line ministries in planning and implementation of SHN interventions. Focus will be on Strengthening multi-sectoral coordination, linkages and partnerships, joint planning, implementation among relevant ministries, communities and other stakeholders for School Health and Nutrition and referrals.

4. Facilitate effective monitoring and evaluation of the School Health and Nutrition programme by establishing accountability and monitoring & evaluation (M&E) mechanisms.

5. Strengthening school and community based Health and Nutrition activities. Enable participation of parents, guardians and the community in promoting, supporting and protecting the Health, Nutrition and general welfare of children and young people in both formal and non-formal education settings.

11:Policy statements

1.Skills-Based Health and Nutrition Education

1. Advocate and provide schools with Health and Nutrition Information and Knowledge in the curriculum.
2. Develop and disseminate user friendly IEC materials on key health messages for health promoting schools to use.
3. Encourage school community involvement and partnerships in health promoting schools.
4. Teachers are trained and supported to teach a more user friendly and comprehensive curriculum on Sexual Reproductive Health Education.
5. Sensitize parents to compliment the school curriculum on Health and Nutrition Education for their children.
6. Develop guidelines for schools and train teachers to identify, assess and respond to disease outbreaks in both standard and emergency situations in a safe and timely manner.

7. Any research, surveys or data collection conducted by non-governmental organizations and private individuals regarding school health services must follow the standard procedures set out in the National Health Research Policy.

2.Safe Physical and Psychosocial Environment

1. Strengthen and support activities and policies to ban alcohol, drug and substance use and abuse in all schools, and disseminate user friendly IEC materials to schools on the harmful effects of alcohol, drug and substance abuse.
2. Educate and encourage the school community on the importance of being good healthy role models for learners.
3. Advocate and educate the school community on the Rights and needs of learners with disabilities to have access to Friendly Health and Nutrition Services.
4. Develop Standard guidelines for the school community on how to provide Education with care and understanding to learners with disabilities.
5. All schools should have sick bays or at least have First Aid kits or similar supplies within their sick bay as first point of care.
6. All schools should establish adequate referral systems for learners to access Friendly Health Services in health facilities.
7. Schools water and sanitation inspections must be carried out annually during school visits.
8. Educate the school community on the importance of safe water and sanitation practices and proper disposal of waste and waste management through user friendly IEC materials.

3.Services and Referrals-Health

1. General physical examinations should be done for school entry, exiting, learners that may be involved in competitive sports and the learners that teachers are concerned of.
2. Psychosocial Support and Counselling services shall be provided to all learners and proper referrals will be facilitated.
3. Teachers shall be trained on Basic counselling skills to provide Psychosocial Support services and also identify learners that need health related interventions.
4. Encourage partnerships with stakeholders to support Health Promoting schools.

5. Educate the school community on Healthy lifestyle, the importance of vaccinations and future emerging diseases.all eligible learners should be immunized;

4:Nutrition:

Parents, vendors and the School Community must be educated to provide safe and nutritious food for learners in schools. In order to improve nutrition levels, the Government shall ensure that:

1. The school community and vendors are educated on food handling practices and the provision of a variety of nutritious foods in schools to support Health and Nutritional needs of all learners.
2. School canteens and vendors shall be monitored by School and Health authorities to provide safe and nutritious food and drinks for learners.
3. Parents are educated on the importance of proper nutrition for the development of their children.

12:Factors Critical For Successful Policy Implementation

The provision of Health and Nutrition interventions shall be implemented jointly with other line ministries, organisations and agencies with MoET leading the programme

- ***Leadership, Political will and Commitment at all levels***: Implementation of this policy will need strong and committed leadership from the highest levels of relevant government sectors especially Ministries of Education and Training and Ministry of Health. It will also require commitment of parliamentarians, parents, religious and community leaders to ensure that learners live in healthy environments, access necessary learner-friendly services as well as Skills-Based Health and Nutrition Education.
- ***Coordination:*** An SHN programme requires multi-sectoral collaboration, and in particular strong coordination between the Health and Education sectors. Thus Capacity and relationship building will need to occur at all levels, national, district and community.
- ***Human & financial resources***: Implementation of the SHN Policy has human and financial resource implications. Teachers will need to be trained in Skills-Based Health and Nutrition Education including counselling, classroom management, student-centred learning methodologies, conflict resolution and how to create a safe learning environment. Principals and school boards will also require support and/or training to enable them to develop and implement a SHN programme. The provision of health services including

screenings will need availability of health service providers. In addition to human resources, transport, equipment, supervision and other costs will need to be integrated into budgets, and funds made available at the district and community levels.

- ***Referrals for Health and Nutrition or specialised education services***: For this policy to be well implemented, there is a need to first Develop guidelines and implement SHN programme accordingly; there must be clear and well-functioning referral structures, system and services known by all concerned stakeholders. These referral system and services must also be user-friendly.
- ***Participation***: Done through the establishment of committees at all levels; Learner, parent and community participation are essential, requiring the school to forge strong linkages with the community and ensure they participate in the development and implementation of a school SHN programme.
- ***Consideration of culture and local context***: Implementation of this policy will require that implementers from various sectors take into account the local context of schools, learners, teachers and communities within which the schools are. Learners from different cultures and contexts will face different health and education challenges and it is for the implementers of this policy to prioritise interventions according to these contexts. For example, the issue of early child marriage may need to be prioritised in the rural areas of Lesotho than it may be the case in the urban areas
- ***Monitoring & Evaluation***: Progress in the implementation of this policy will need to be ascertained through a monitoring and evaluation framework with clear indicators. All partners working in School Health and Nutrition must adhere to this framework and findings from it must be used to influence prioritisation, the continuation, modification, expansion, replication or termination of specific activities, as well as enable the identification of gaps and barriers to implementation of the SHN policy.

12.1.:School Health and Nutrition Activities and Services[30]

In addition to the development of an equitable policy at national and school-level, there are ***Four*** main aspects to implementing the SHN programme in schools: ***Skills-Based Health and Nutrition, A Safe Physical and Psychosocial Environment, Services and Referrals*** and ***Nutrition***. The following lay-out the basic content for these ***Four*** aspects that should be provided in every school:

12.1.1.:Skills-Based Health and Nutrition Education

Skills-Based Health and Nutrition Education will be planned and sequenced from ECCD to Senior Secondary Education level. Concepts presented at ECCD and the lower education levels shall focus primarily on the individual and family, and expand by end of Senior Secondary to include community, national and global health and social issues. It shall provide opportunities for learners to develop and demonstrate health-related knowledge, attitudes, practices and skills as well as integration of the physical, mental, emotional, social and spiritual dimensions.

Skills-Based Health and Nutrition Education will be offered to all learners within the education system from ECCD to Grade 12.

12.1.2.:A Safe Physical and Psychosocial Environment

The school environment refers to aspects of the school or learning space that affect both the physical and psychosocial well-being of learners, teachers and other school staff.

12.1.3.:Services and Referrals-Health

A number of Health and Nutrition Services will be provided in school settings. When this is not possible, referrals systems shall be established to ensure learners have access to the Health, Nutrition and Psychosocial Support services they require.

12.1.4.:Nutrition

School feeding shall be provided to all learners in Lesotho primary schools in line with the guidelines and procedures set out in the National School Feeding Policy. Schools shall ensure

[30] This section refers specifically to activities and services to be provided from primary till the end of secondary school, for all ECCD level activities and services please refer to the 2013 *National Policy for Integrated Early Childhood Care and Development*.

promotion of healthy lifestyles and good nutrition within and around their settings including the sale and promotion of foods that only consists of maximum and moderate nutritional value.

13:Management of Sensitive and Controversial Issues

- The Ministry of Education and Training shall establish a set of national guidelines for managing sensitive and controversial issues in line with its regulations and other relevant national legal and policy frameworks.
- Sexually active learners below the "legal age of consent" shall receive voluntary child and youth-friendly professional counselling and advice.
- In the event of pregnancy or a sexual or criminal offence, the school authorities shall engage the parent or guardian or the Children's Court in all the deliberations in accordance with the established guidelines.
- Schools shall follow the national established guidelines for the re-integration of girls into the education system, following childbirth.
- In the case of sexual violence including rape or defilement, school authorities shall report the case to the relevant authorities and make a written report without delay.

Sensitive and controversial health topics such as sexuality will be taught following guidance provided by Ministry of Education and Training.

14:Policy Support and Coordination

In order to implement a successful SHN Programme that promotes, protects and supports the Health, Nutrition and Welfare of the school age population in Lesotho, a multi-sectoral approach shall be adopted and shall involve all relevant line Ministries, Non-Governmental Organizations, Faith-Based Organizations, School Proprietors, institutions of higher learning, intended beneficiaries (learners, teachers and the community), and international development partners including the UN agencies.

14.1.:National Level:

14.1.1.:*School Health and Nutrition Technical Working Group*

There shall be established at national level, a School Health and Nutrition Technical Working Group (SHNTWG) as a multi-sectoral coordination mechanism to ensure effective implementation of School Health and Nutrition Policy.

- The SHNTWG will comprise representatives from relevant departments of Ministry of Education and Training (MoET), relevant ministries, FNCO, NAC, UN agencies, training institutions/academia, school proprietors and Civil Society Organisations.
- It will be chaired by the relevant officer of MoET assigned by Principal Secretary of Education and Training
- It shall *inter alia*, be responsible for providing guidance and technical expertise to MoET and all relevant stakeholders on SHN issues, development of standard M&E guidelines/tools for implementers, and regularly review the package of services and suggest amendments.
- SHN monitoring and evaluating systems are established; and utilized;
- Partnerships with all stakeholders in SHN activities are strengthened;
- SHN is institutionalised at all levels of the Education system;
- Networking and sharing information between learning institutions and districts is initiated and strengthened at all levels;

14.1.2.:Legal Framework

The Ministry of Education and Training, Ministry of Health and Stakeholders shall ensure that:

(a) SHN activities are implemented as provided for within the existing pieces of legislation.

(b) United Nations and the African Union Children's Charters and any other relevant Charters are incorporated into SHN activities.

14.2.:District level

Roles and responsibilities at the district level are similar to that at the national level, e.g. Ministry of Social Welfare is responsible for financial and psychosocial support to OVCs, etc. Close collaboration between the district education and Health and Nutrition teams will occur through the development of a coordination mechanism at the district level, chaired by the MoET.

- The District Education Manager (DEM) shall either use an existing coordination structure such as the Child Protection Team or establish a District School Health and Nutrition Technical Working Group (DSHNTWG).
- The coordination mechanism shall be composed of key staff from the different relevant ministries and local government representatives, and any district level staff from the following organisations: UN agencies, training institutions/academia, school proprietors and civil society.
- The district coordination mechanism shall be responsible for ensuring that:
  - Roles and responsibilities of the different partners are understood.
  - A costed SHN implementation plan is developed and integrated into district Education, Health, Nutrition and other relevant plans.
  - Activities and services are coordinated to ensure there are no duplications or gaps.
  - The most disadvantaged schools (which should be targeted during the early phases of implementation) are identified and prioritised.
  - Appropriate referral processes are in place and schools are aware of the closest facilities and how learners can access them.
  - An audit of training needs is conducted and appropriate and adequate training programmes for new and existing staff are put in place.
  - The procedures for working in schools are adapted to the district context, disseminated to implementers and adhered to.
  - There is monitoring & evaluation.
- The District Education Manager (DEM) will also be responsible for ensuring that SHN forms a regular part of the Heads of Programmes meeting agenda.
- Oversight of all SHN programmes at district level shall ultimately rest with the District Education Manager (DEM).

14.3.:Community level

Partners at the community level include the School Board, (the Principal, the Chief, the Councillor, Parents, School Proprietor representative, Teachers), learners, the Health Centre Committee and other education sector staff, CBOs, NGOs, the School Feeding Committee, the School Feeding Managing agent, the Water Committee, and influential members of community.

- The principal shall use either an existing mechanism such as the School Board or the School Feeding Committee, or develop a new SHN coordination mechanism.
- The coordination mechanism shall include the principal, a teacher, a learner, a peer educator (if a programme exists in the school), a parent representative, a school board member, any CBOs/NGOs working within the school, a representative of the school proprietor, a member of a relevant committee e.g. school feeding.
- To ensure understanding and buy-in to the SHN programme, the MoET shall integrate SHN issues into School Board trainings.
- Chiefs, Community Councillors, school proprietors, other members of the school management systems, and influential community members shall advocate for and support the principal in the development and implementation of a school SHN programme.
- Village Health Workers and Health Centre Committees will also support implementation of an SHN programme and create linkages between schools and the community.
- Parents shall also play an integral part by ensuring school attendance, support the development and implementation of a SHN programme, and contribute to activities. They shall also be expected to assist in improving children's' behaviour at school, contribute to safety both on the road to and within the school, and advocate for and contribute to infrastructure development.
- Each principal, supported by the district, will be accountable for developing, implementing and reporting on a SHN programme for the school based interventions on the national SHN Policy. The programme will at a minimum provide the package of services listed above, as well as any context-specific additional needs.

- Implementation will require ensuring the provision of Skills-Based Health and Nutrition Education, creating a safe physical and psychosocial environment, and the provision of health services in coordination with the District Medical Team.

- Each teacher will be accountable for the provision of Skills-Based Health and Nutrition Education within their allocated subject matter, as well as the creation of a safe environment through *inter alia*, supervision of children and zero tolerance for bullying and abuse. Meaningful participation of learners shall be integrated into the programme.

- School level SHN programme shall make a concerted effort to expand availability and accessibility of education and prevention services at family and community levels in order to detect and remediate health problems at home and in the community that can negatively affect learning, as well as to ensure a continuity of health messaging and thus a reinforcement of the health education provided in schools.

- SHN programme shall mobilize the community, and the public and private sectors including Faith-Based groups to participate in School Health and Nutrition activities including infrastructure development and maintenance, financial and technical support, and enforcement of regulations against any behaviour likely to disrupt the learning environment e. g., crime, sexual violence, discipline, absenteeism, etc.

- The school level SHN programme shall take into account emerging family unit structure and the special needs of the child-headed families, children living with grandparents, step-parents or living in institutions as orphans.

14.4.:Partnership And Coordination

Effective partnerships between stakeholders in School Health will be encouraged at all levels to better coordinate and implement School Health programs.

Strategies

1. Establish a Joint Department Committee between the Ministry of Education and Training and Ministry of Health to oversee School Health Program.
2. Develop Memorandum of Agreement between the Ministry of Education and Training and Ministry of Health on School Health Program.
3. Encourage free dissemination of information by all stakeholders to support the School Health Program.
4. Identify and engage existing and new partners and promote collaboration between all stakeholders to support the School Health Program.
5. Ministry of Education and Training and Ministry of Health will support schools in the districts to conduct, monitor and review implementation of the School Health Program.

15:Monitoring & Evaluation

Monitoring and Evaluation of the School Health and Nutrition Program must be integrated with the existing Health Information Systems. It should also interface with the Education Information System. Monitoring and evaluation will focus on the following:

- The SHNTWG shall establish mechanisms for monitoring and evaluating the SHN policy. the extent of co-ordination within the health sector as well as between the Health and Education sectors
- Strengthening of existing services
- Data must be monitored for quality by the School Health Program Coordinator.
- Monitoring and evaluation shall focus on, inter alia, coverage and quality of services and the impact of the service on Health, Nutrition and Education indicators (e.g. access to schooling, retention and achievement of learners).
- Evaluation of SHN involves teachers, school learners, parents, health and allied Health and Nutrition personnel, administrators, school boards, evaluation specialists or officials from the MoET and other line ministries.
- Learners, teachers, supervisors, health and nutrition personnel and education administrators, parents, the community, civic organizations, the curriculum, and textbooks shall be evaluated.
- Reporting, monitoring and evaluation of the SHN policy shall be integrated as far as possible within the existing Education Information Systems (EMIS).
- Existing EMIS SHN indicators will be reviewed to ensure they cover needs and are easily understood by data collectors.
- SHNTWG shall develop and adopt a national research agenda and action plan relevant to the formal and non-formal education sector in Lesotho.
- All research shall observe strict ethical and professional standards including safeguards for protecting the rights of minors such as confidentiality, anonymity, right to choose to participate or not, and risk from injury.
- Unlinked anonymous testing among selected sentinel groups for surveillance purposes shall be encouraged to determine epidemiological trends of HIV and STIs, teen pregnancies, nutritional status or drug use/abuse among other diseases and social issues.

- Evaluation of SHN shall also include values, needs and interests, societal health problems, content, objectives, teaching strategies and techniques, curriculum development process and structure, the school environment and the evaluative process.
- All partners wishing to implement SHN activities in schools will be responsible for using the M&E framework developed by the SHNTWG to ensure comparability and national aggregation.
- All partners wishing to implement School Health and Nutrition activities shall get approval from the MoET and provide reports of their interventions to MoET
- Any research, surveys or data collection conducted by non-governmental organizations and private individuals regarding School Health Services must follow the standard procedures set out in the National Health Research Policy. M&E of SHN shall be conducted before, during and after implementation as findings influence the continuation, modification, expansion, replication or termination of SHN activities or its components.

16:Appendices

Appendix 1:Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
CGPU	Child and Gender Protection Unit
CPR	Contraceptive Prevalence Rate
DEM	District Education Manager
DEO	District Education Officer
DHMT	District Health Management Team
DHSL	Demographic Health Survey
DP	Development Partners
ECCD	Early Childhood Care and Development
EAC	Education Advisory Council
EMIS	Education Management Information System
EFA	Education for All
ESA	Eastern and Southern Africa
EUP	Early and Unintended Pregnancy
FNCO	Food and Nutrition Coordinating Office
FPE	Free primary education
FRESH	Focusing Resources on Effective School Health
GAM	Global Acute Malnutrition
GOL	Government of Lesotho
HIV	Human immunodeficiency virus
HPS	Health Promoting School
HPV	Human Papilloma virus
HTS	HIV testing Services
ICPD	International Conference on Population and Development
IEC	Information Education Communication
LDHS	Lesotho Demographic and Health Survey
LEC	Lesotho Evangelical Church
LCWU	Learner Care and Welfare Unit

LVAC	Lesotho Vulnerability Assessment Committee
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
M&E	Monitoring and Evaluation
MoET	Ministry of Education and Training
MoH	Ministry of Health
MMR	Maternal Mortality Rate
NAC	National AIDS Commission
NCD	Non-communicable Diseases
NCDC	National Curriculum Development Centre
NFE	Non Formal Education
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother To Child Transmission
PSS	Personal, Spiritual and Social (curriculum learning area)
RCM	Roman Catholic Mission
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SADC	Southern African Development Community
SAM	Severe Acute Malnutrition
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SHN	School Health and Nutrition
SHNIP	School Health and Nutrition Policy Implementation Plan
SDGs	Sustainable Development Goals
TB	Tuberculosis
TFR	Total Fertility Rate
T.O.T	Training of Trainers
TVET	Technical Vocational Education and Training
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Fund for Population Activities

UNESCO	United Nations Educational, Scientific and Cultural Organization
VHW	Village Health Worker
VMMC	Voluntary Medical Male Circumcision
WEF	World Education Forum
WFP	United Nations World Food Programme
WHO	World Health Organisation
YFS	Youth Friendly Services

Appendix 2:Glossary

Adolescent	Any person between 10 to 24 years of age
Bullying	A person who use strength or influence to harm or intimidate those who are weaker to force them to do some things.
Child	Any person less than 18 years of age.
Children	Persons between birth and full growth; a young boy or girl. Children of school going age which is generally between of age of 6 and 18
Disability	A physical or mental condition that limits a person's movements, senses, or activities; disadvantage or handicap
Disease Outbreak	An occurrence of disease greater than would otherwise be expected at a particular time and place. It may affect a small and localized group or impact upon thousands of people across an entire continent.
Health	A state of complete physical, mental and social well-being and not merelythe absence of disease or infirmity.
Health Education	Any combination of experiences and information designed for learners, individuals and communities to improve their health, by increasing their knowledge or positively influencing their attitudes.
Health Promoting School	A school where all members of the community work together to provide integrated and positive learning experience and an environment that promote and protect their health
Learners	Persons enrolled in a formal education system(public or private) beginning with Early Childhood Care and Development (ECCD) to Senior Secondaryand those enrolled in a non-formal education systemincluding learning posts and learning centers
Sensitize	The process of making someone aware of something. Train the school community and school teacher to teach Health and Nutrition issues in the curriculum to make a difference in school health promotion
School	An institution for educating learners. In the context of this policy, it includes Early Child-Care Centres (ECCC), Primary and Secondary Schools, and Non-Formal Education Centres (NFE).
School-age children	Children attending schools at all levels in the country.
School community	The entire community involved both directly or indirectly with a learning site or school setting: learners, parents/caregivers, educators, school management members which includes the principal and members of the school Board, administrative and other auxiliary staff schools attending learning sites (as defined above), regardless of age
School feeding program	A social safety net instrument that targets children in chronically food insecure areas and protects them against the worst consequences of household food insecurity and contributes to better learning and educational outcomes as well as to better nutrition

School Health Services	School Health Services are services from medical, teaching and other professionals applied in or out of schools to improve the health and well-being of children and in some cases whole families
School Health and Nutrition	An integrated set of planned school-based strategies, activities and services designed to promote the optimal physical, mental, social, spiritual and educational development of learners and to improve the health of the surrounding community.
School Health Programme	in the context of this policy, is a series of harmonized projects / activities in the school environment for the promotion of the health and development of the school community
School Health Day	shall refer to a day set aside annually to create awareness on Health and Nutrition related issues in the schools.
Service	is a system or arrangement that supplies public needs. It could be organized by an individual, group or the government.
Sick Bay	An area or room where sick or injured person is treated in institution
Stakeholder	An individual or organization that partners and collaborates in School Health and Nutrition interventions
Target group	The main beneficiaries of this policy. In this instance it refers to all children

Appendix 3:Skills-Based Health and Nutrition Education and its situation in Lesotho

Skills-Based Health and Nutrition Education is a critical component of any SHN programme. It seeks to impart knowledge, skills and attitudes to enable learners and education sector staff to adopt healthy behaviours, optimize their wellbeing and quality of life, and help them to become health literate. The body of knowledge in SHN is drawn from public health, nutrition, medicine, physical, biological and social sciences. The framework and methodology of delivery is derived from pedagogical sciences, educational psychology, the performing arts, communication and the behavioural sciences and requires participatory and student-centred methodologies.

The knowledge to be imparted is context and age-specific, and can change if the burden of disease changes. The skills to be developed include cognitive skills such as problem-solving, creative and critical thinking, and decision-making; personal skills such as self-awareness, anger management and emotional coping; and interpersonal skills such as communication, cooperation and negotiation. As decision-making and other skills are dependent on attitudes which are influenced, *inter alia,* by values, beliefs, social norms, rights, intentions and motivations, these need to be discussed and analysed to ensure learners are able to develop positive attitudes, including empathy and respect for others.

In Lesotho, National Curriculum Development Centre (NCDC) is responsible for the development of curriculum that responds to the learners' and the country's needs. The NCDC works through national subject panels comprising representatives of teachers, teacher-training institutions, Inspectorate, teacher associations and subject specialists. The Education Advisory Council (EAC), upon recommendation from the NCDC, advises the Minister of Education and Training on all school curriculum matters. The EAC is a widely representative statutory body including senior government officials, representatives of tertiary institutions, teacher associations, school proprietors and the business sector. All curriculum materials intended for use in the schools must be approved

by the government on the advice of the EAC. Instructional materials are prescribed or recommended by the MOET and provided to schools.

Life Skills-Based Sexuality Education (LBSE) which includes Skills-Based Health and Nutrition Education is integrated in *Personal, Spiritual and Social* (PSS) and *Scientific and Technological (ST)* Learning Areas from Grades 4 to 6. It is compulsory and assessed. LBSE emerges at as a stand-alone subject from Grade 7 to 10. This curriculum is currently taught from Grade 4 to 7 and piloted in Grade 8. Syllabus packages are also being developed for Grade 9 and 10. Its goal is to equip learners with knowledge, skills, and values to enable them to exercise their human rights, adopt healthy lifestyles, make responsible choices, and become forces for positive change. The learning outcomes of the LBSE Curriculum address transmission of knowledge and critical thinking; development of life skills; and values, attitudes and behaviour change through content that is organised around six interrelated themes:

- *Knowing oneself and caring for others*
- *Human rights and child protection*
- *Gender norms and gender equality*
- *Sexual and reproductive health*
- *HIV and AIDS and STIs*
- *Drug, alcohol, and substance abuse*

National Curriculum Development Centre (NCDC) bears the primary responsibility for implementation of LBSE curriculum. Apart from ensuring that good quality LBSE curriculum is in place, NCDC works in collaboration with other departments of MoET such as Teaching Service Departments (TSD), Inspectorate, School Self-Reliance and Feeding Unit (SSRFU) and Early Childhood Care and Development (ECCD) to coordinate in-service training in the subject. It has developed a Framework/Guideline for In-service Training of Teachers in LBSE in collaboration with other stakeholders. This Framework/Guideline outlines the content to be covered in LBSE training of in-service teachers, methodologies that teachers need to be skilled in, values, attitudes and behaviours that the LBSE Curriculum must address, as well as the minimum duration of LBSE training of teachers. Efforts are also being made to strengthen provision of LBSE at pre-service teacher education institutions.

Appendix 4:Government Legislations and Policies

Legal and Protective Acts:

- ✓ Constitution of Lesotho (1993)
- ✓ Criminal Procedures and Evidence Act (1981)
- ✓ Sexual Offences Special Provisions Act (1998)
- ✓ Sexual Offences Act, Vol. XL VIII (2003)
- ✓ The Legal Capacity of Married Persons Act (2006)
- ✓ Lesotho Education Act (2010)
- ✓ Anti-trafficking in Persons Act (2011)
- ✓ Children's Protection and Welfare Act (2011)

Education Policies and Frameworks:

- ✓ Education Sector Plan 2016-2026
- ✓ Curriculum and Assessment Policy- Education for Individual and Social Development (2008)
- ✓ Child-Friendly School Standards-Lesotho (2012)
- ✓ Lesotho Education Sector HIV and AIDS Policy (2011)
- ✓ National Policy for Integrated Early Childhood Care and Development (2013)
- ✓ National School Feeding Policy (2015)

Health and Sexual and Reproductive Health Policies and frameworks:

- ✓ Mental Health Law (1965)
- ✓ Expanded Programme on Immunization Policy
- ✓ National Health Policy (2011)
- ✓ Sexual and Reproductive Health Policy (2010)
- ✓ National Adolescent Health Policy (2012)
- ✓ National Minimum Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services (2013).

- ✓ National Health Strategy for Adolescents and Young People (2015-2020)

HIV and AIDS Policies and Frameworks:

- ✓ National Policy Framework on HIV and AIDS: Prevention, Control and Management (2002)
- ✓ Policy on HIV Testing and Counselling (2009)
- ✓ National HIV and AIDS Policy (2006)
- ✓ National HIV and AIDS Strategic Plan 2011/12-2015/16

Development and Social Welfare Policies and Frameworks:

- ✓ Lesotho Gender and Development Policy (2018-2030)
- ✓ Social Welfare Policy (2003)
- ✓ National Policy for Orphans & Vulnerable Children (OVC) (2006)
- ✓ Children's Protection and Welfare Act (2011)
- ✓ National Multi sectoral Child Protection Strategy 2014/5-2018/9
- ✓ National Standards and Guidelines for Care for Vulnerable Children (2014)
- ✓ Lesotho National Youth Policy (NYP) (2017-2030)

Appendix 5:International and Regional Conventions

- The Convention on the Rights of the Child
- World Summit for Children (1990)
- The World Conference on Education for All (1990)
- The Dakar Declaration on Education for All (EFA) Goals (2000)
- UN General Assembly Special Session on HIV and AIDS (2001)
- The Convention on the Elimination of Child Labor
- Africa Charter on Child Rights and Welfare

- The UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW)
- The Organization of African Unity Charter on the Right and Welfare of the Child
- Ouagadougou Conference on the Education of Women and Girls (1993)
- The Fourth World Conference on Women UN 1995 Platform for Action and Beijing Declaration
- The SADC Protocol Article 17 on Child and Adolescent Health
- The SADC Minimum Package of Services for Orphans, Vulnerable Children and Youth (2011)
- The SADC Regional Conceptual Framework for Psychosocial Support for Orphans and Other Vulnerable Children (2010)
- SADC Policy Framework on Care and Support for Teaching and Learning (CSTL) (2015)
- The Eastern and Southern African (ESA) Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for adolescents and young people (2013)

Appendix 6:Topics to include in School Health and Nutrition Programme

Skills-Based Health and Nutrition Education

The main topics to be covered in a ***SHN Skills-Based Health and Nutrition Education*** programme include:

- Nutrition, physical education and recreation
- Personal and environmental hygiene
- Knowing your body (including body image and body privacy)
- Menstruation & menstrual hygiene management
- Sexually Transmitted Infections (STIs) including HIV
- Sexual and Reproductive Health (including contraception, early and unintended pregnancy, PMTCT, VMMC etc.)
- Chronic illnesses (including HIV and TB)
- Violence (sexual, physical and emotional abuse, including bullying)
- HIV Testing and Services (HTS) Package, stigma and discrimination mitigation
- Mental Health issues including alcohol use, drugs and substance abuse, depression, anxiety and suicide
- Gender issues
- Gender-Based Violence (sexual, physical, emotional, including bullying and disability)
- Being responsible and safe, Rights and Responsibilities
- Safe environment, risk assessment injury prevention etc.
- Accessing and using Child and Adolescent-Friendly Health Services
- "Cyber savviness" (internet & social media)

Sensitive and controversial health topics such as sexuality will be taught following guidance provided by Ministry of Education and Training.

- The content and skills imparted will be based on needs of learners, societal expectations, research, current and emerging health concepts or social issues. In addition, the content taught and the methodology used shall be adapted to meet the needs of the learner including language, culture, religious views and developmental characteristics.

- Content and skills taught under School Health and Nutrition shall be reinforced across the entire school curriculum in science, social subjects and arts among others.
- Schools shall provide curriculum that includes activities that provide learners with knowledge, attitudes and skills to make positive healthy food choices and food safety and learn about the variety of foods available for good health
- Schools shall display Health and Nutrition Information and promotion materials about healthy eating for school communities.
- As much as possible, Health and Nutrition Information and Education Services will be extended to the family and community in order to fully exploit the potential of Skills-Based Health and Nutrition Education to produce behaviour change among learners and employees.
- Skills-Based Health and Nutrition Education shall be delivered by teachers, facilitators and peer educators who are well-trained in health and nutrition.
- Skills-Based Health and Nutrition Education shall be supplemented by co-curricular activities and education within the school setting. These will include creation of School Health and Nutrition clubs or peer education programmes, and they will address among many issues, gender inequality, Sexual and Reproductive Health and alcohol use, drug and substance abuse.

A Safe Physical and Psychosocial Environment

- Schools will ensure that all individuals are free from violence and danger, disease, physical harm or injury;
- Schools will develop, disseminate and enforce codes against misconduct, bullying, exploitation, abuse, stigma and discrimination, violence including Gender-Based Violence and understood by the whole school community. These Codes will be developed in line with *Child-Friendly School Standards-Lesotho (2012)*.

- Enforcement of the Codes as well as enforcement of other policies and rules to create a safe environment shall be the primary responsibility of the principal working together with the school community (teachers, school board, parents and learners).
- Each school shall develop reporting and complaints mechanisms and ensure that they are disseminated and understood by the whole school community.
- Schools will ensure sufficient safe water and gender segregated and age appropriate sanitation facilities are provided; and physical structures (buildings, paths and latrines) are sound, accessible and secure. Efforts will be made to ensure that sanitary facilities are in an appropriate ratio to the number of children as recommended by Education Facilities Unit (EFU) and maintained in good working order by learners and staff.
- New schools will be constructed where they are accessible (e.g. learners do not have to cross a river to get it or there is a bridge, disability-friendly), where they pose no hazards to the learners (e.g. not close to the major road, places which serve alcohol), and where a safe environment can be created.
- Efforts will be made to ensure that soap and janitorial cleaning supplies are available in all schools.
- Schools will ensure that buildings/classrooms space-per-child ratio and class size are suitably maintained as per EFU recommendation as well as maintain appropriate furniture.
- Schools will ensure that facilities (classrooms and sanitary facilities) as well as playgrounds are disability-friendly.
- Schools shall prohibit sale and consumption of tobacco, alcohol and illicit substances (including by staff) on school grounds.
- Emergency/evacuation drills shall be practised on regular basis according to the evacuation plan developed by each school.
- Every learner shall take part in Physical Education and Recreation activities in order to enhance their health.
- Learners with disabilities will be provided with appropriate physical activities under supervision.

- Safety of playgrounds and equipment shall be regularly ensured, and learners will be supervised when on the playground.
- Coaches and physical educators shall be trained in the management of sports injuries and administration of First Aid.
- Physical Education and Recreation activities implemented in schools shall focus on the physical and the development of attitudes and values such as team work etc.

Services and Referrals

- A regular physical examination, treatment and referral systems in all learning institution are re-established and sustained;
- All eligible learners are immunized;
- Most of the health services will be provided under the supervision of the District Health Management Team (DHMT).
- Medical and nutrition staff providing services in schools shall be trained in providing child and adolescent friendly services.
- Psychosocial Support and Counselling services are strengthened;
- Appropriate facilities for learners with Special Education Needs (SEN) are provided;
- Physical Education in all learning institutions is strengthened;
- Adequate clean and safe water is available;
- Regular personal hygiene inspections on learners are carried out;
- Appropriate and adequate sanitary facilities are available;
- The school environment and structures are safe, clean and maintained;
- Initiatives aimed at controlling, preventing and mitigating the spread and impact of STIs/HIV AND AIDS on the school community are established and strengthened;
- Preventive and control measures against communicable and no- communicable diseases are instituted;
- School based anti-substance abuse programmes in all schools are intensified; and o) collaboration and partnership with relevant stakeholders are promoted and strengthened;

Nutrition

- School feeding shall be provided to all learners in Lesotho primary schools in line with the guidelines and procedures set out in the National School Feeding Policy.
- Health and Nutrition Education is institutionalised at all levels of the school system;
- Eligible learners receive micronutrient supplements; and a school de-worming programme is strengthened;
- Food production units are revitalised in all learning institutions;
- Schools shall ensure promotion of healthy lifestyles and good nutrition within and around their settings including the sale and promotion of foods that only consists of maximum and moderate nutritional value.
- Where schools provide meals for learners, they shall review their existing school feeding initiatives to ensure that they provide adequately nutritious meals
- Where and when schools provide food during school events and activities, they shall ensure healthy food supply for such activities and events.
- The school shall ensure healthy food and drinks choices that promote culturally sensitive and inclusive healthy eating habits, including regular drinking of clean water throughout the day, and ensure opportunities for learners to experiment new nutritious foods.
- Schools shall provide positive, supervised appropriate social environment for learners to eat with staff who model healthy eating behaviours.
- Schools shall provide scheduled break times for healthy and nutritious meals and snacks.
- Schools will make efforts to ensure at least one balanced meal per day before and/or during lunch time especially for children from under- privileged families.

Appendix 7:Services offered in Schools

- There will be Health and Nutrition Screening and Assessment Services provided to learners in schools at least ***four*** times a year and in line with *School Health and Nutrition Policy* and *National Minimum Standards and Implementation Guide for Provision of Adolescent-Friendly Health Services*.
- At the primary level, all screenings will be placed on vision, hearing, speech, oral health, gross and fine motor skills, and mental health/psychosocial needs.
    - ✓ Vaccination – only during National Health campaigns
    - ✓ Oral Health: screening, Atraumatic Restorative Treatment and fissure sealants
    - ✓ Nutrition-assessment, counselling and provision of meals and referrals, deworming and supplementation interventions according to ministerial protocols
    - ✓ First Aid services for minor ailments
    - ✓ Information, counselling and referrals to SRH services
    - ✓ Vision screening
    - ✓ Hearing screening
    - ✓ Speech screening
    - ✓ Physical assessment (gross and fine motor skills)
    - ✓ Mental Health screening & psychosocial support services
    - ✓ Chronic illness screening and referrals for both communicable (e.g. TB) and non-communicable diseases
- At secondary level the package will be the same as above and emphasis will be on SRH and Mental Health services (see below for a break down by age groups).
- All learners will be assessed at each of the five main phases (see stages in the package of services below) of their education.
- Individual assessment of learners will be recommended where such a learner continuously repeats a grade or where possible Health and Nutrition problems have been identified by the school.

School Health and Nutrition Package of Health Services

Skills-based Health Education	**Health Screening**	**On-site services**	**Safe environment**(all age groups and schools)
6 years and below- See IECCD Policy-			**Physical environment**
6-9 years old – Reception to Grade 4			
Hand Washing (e.g. before and after meals, after using the toilet) Personal and Environmental hygiene (e.g. open defecation, running water, menstrual hygiene management and oral hygiene) Nutrition (nutritional value of food, the three types of food, with a special emphasis on Vitamins and iodized salt) Chronic Diseases (diabetes, HIV and AIDS, TB, etc.) Road Safety (incl. for children with special needs) Poisoning Know your body (SRH incl. puberty, touch continuum-bodily privacy) Abuse and bullying (sexual, physical and emotional; reporting abuse) Stigma and Discrimination (especially re. chronic illness, children with special needs) Disease prevention (e g. EPI, VMMC etc.)	Nutritional assessment Oral health Vision Hearing Speech Physical assessment (gross and fine motor skills) Mental health Chronic illness Tuberculosis	Vaccination Nutritional supplements (Iron) School feeding Oral health-Atraumatic Restorative Treatment and fissure sealant Basic first aid SRH counselling Nutrition counselling Psychosocial support Deworming (where appropriate) Referrals to appropriate health and psychosocial support services	Conduct an environmental safety assessment Latrines are in sufficient numbers, are gender segregated, lockable, in a safe location, with handwashing facilities and kept clean Buildings are in line with recommendations School is fenced Develop a “Clean School Plan” (incl. routine for cleaning classrooms & latrines and availability of soap etc.) Daily hand-washing before meals Proper waste disposal systems in place First aid kit Safe drinking water available on-site Evacuation/emergency plans & drills in place School gardens (where possible) Prohibit the sale and consumption of alcohol, tobacco and any other illicit substance on

Drug and substance use Basic first aid (bleeding wounds, bleeding nose) Disaster risk protection, prevention & response and basic survival skills (river crossings, lightening, herding, snow, fire, avoiding heat strokes) Physical Education "Cyber savviness" including internet and social media			school grounds Analyse risks on 'road to school' and establish mitigation strategies
9-12 years old –Grade 4 to Grade 7			**Psychosocial environment**
Ibid plus the following Traditional and voluntary medical male circumcision HIV testing services(HTS) Protective tools against HIV and Pregnancy Early and unintended pregnancy Child marriage and labour (child rights) Self-examination (e.g. for breast cancer, symptoms of STIs &urinary tract Infections, etc.)	Nutritional assessment Oral health Vision Hearing Speech Physical assessment (gross and fine motor skills) Mental health Chronic illness	Vaccination (e.g. HPV) Nutritional supplements (Iron) School feeding Oral health-Atraumatic Restorative Treatment and fissure sealant Basic first aid Strengthened SRH	School rules are developed, disseminated to learners, teachers and parents, and enforced Codes of conduct and school rules are disseminated and enforced Zero tolerance for bullying& abuse Reporting mechanisms for bullying & abuse in place Referrals system in place with CGPU and other service providers

Suicide Psychosocial wellbeing (e.g. emotional wellbeing, self-esteem, spiritual etc.) Child trafficking	Tuberculosis	counselling & referrals to services Nutrition counselling Psychosocial support Referrals to appropriate health and psychosocial support services	Learners are supervised at all times Staff trained in classroom management, conflict resolution and addressing bullying Increase awareness of teacher At risk learners are identified for psychosocial support
12-15 years old – Grade 7 to Grade 15			
All the topics mentioned in the first two year groups A particular emphasis on SRH, STIs, HTS, and early and unintended pregnancy Referral systems for SRH, HTS, and early and unintended pregnancy PMTCT	Nutritional assessment Oral health Vision Hearing Speech Physical assessment (gross and fine motor skills) Mental health Chronic illness Tuberculosis Counselling regarding SRH (if indicated), and provision	Vaccination (e.g. HPV) Nutritional supplements (Iron) School feeding Oral health-Atraumatic Restorative Treatment and fissure sealant Basic first aid Strengthened SRH counselling & referrals to services Nutrition counselling	

	of and referral for services as needed	Psychosocial support Referrals to appropriate health and psychosocial support services	
15 and above –Grade10 and above			
All the topics mentioned in the first two year groups A particular emphasis on SRH, STIs, HTS, and early and unintended pregnancy Referral systems for SRH, HTS, and early and unintended pregnancy PMTCT	Oral health Vision Hearing Speech Physical assessment (gross and fine motor skills) Mental health Chronic illness Tuberculosis Counselling regarding SRH (if indicated), and provision of and referral for services as needed	Vaccination (e.g. HPV) Nutritional supplements (Iron) School feeding School gardens (where possible) Oral health-Atraumatic Restorative Treatment and fissure sealant Basic first aid Strengthened SRH counselling & referrals to services Nutrition counselling Psychosocial support	

		Referrals to appropriate health and psychosocial support services	
All schools			
- School Health and Nutrition Plan (sensitive to HIV, culture and gender), including rules on re-entry after early and unintended pregnancy, developed and implemented - School HIV and AIDS Action Plan developed (or included in SHN Plan) and implemented - Referrals systems for learners with disabilities/learning challenges and for psychosocial support established either within the education system or through partners - School Boards, parent associations, & community included in development of SHN Plan and participate in activities - School meetings (e.g. open days, parent teacher meetings etc.) used to address issues relevant to SHN and rights of children on a regular basis - Physical education and recreation - Establishment of HIV and AIDS or health clubs (where appropriate) - Disciplinary measures are dealt with privately (not in public) and with respect - Establish a physical space with privacy for the provision of on-site services and psychosocial support (where possible) - M&E of SHN			

Appendix 8:Roles of Stakeholders

The relevant Ministries, agencies and parastatals of government (at all levels) whose traditional functions have great implication for ensuring a learner-friendly environment for the implementation of The School Health and Nutrition Programme include but not limited to Ministries of ***Education and Training***, ***Health, Water***, ***Agriculture and Food Security, Finance***, ***Gender, Youth ,Sports and Recreation***, ***Local Government and Chieftainship***, ***Public works and Transport***, ***Social Development***, ***Police and Public Safety***, ***Justice and Judiciary*** and other line ministries and the National Planning Commission. these line Ministries and their counterparts have parallel roles in line with their mandate. In line with implementing the SHN programme, their specific role has been detailed below.

Line Ministries

Ministry of Education	**Ministry of Health**	**Ministry of Agriculture and Food Security**	**Ministry of Gender, Youth, Sports and Recreation**	**Ministry of Water**	**Ministry of Local Government & Chieftainship**
Revise the curricula of Schools to encourage the teaching of Values, Attitudes, Life Skills, Comprehensive Sexuality Education and Skill-based Health Education and Prevention of Gender Based Violence as compulsory subjects at all levels	Ensure adequate provision of Friendly Health services and personnel to promote the health of the school community	Promote agricultural practices in schools	Create awareness on contemporary health issues	Ensure provisions for schools with clean drinking water supply intervention programmes	Advocate and Raise awareness of SHN policy with Community councillors

•Develop age-appropriate, gender and culturally sensitive teaching and learning materials for skill-based health education	Ensure Health Care providers are trained in the provision of adolescent Friendly Services for the delivery of health services in school	•Facilitate the services of Agriculture Extension Staff to schools	•Employ sports to handle remediable problems of school children	•Support water and sanitation activities in schools including sewerage and quality control of water supply sources in collaboration with the concerned ministry	Identify safe locations for new schools and ensure protection of the environment surrounding those schools to maintain a safe learning environment for the whole school community
•Encourage the formation of health/sanitation promotion clubs in schools	•Facilitate Referral services between the school and health facilities in the community	•Encourage the formation and operation of Young Farmers' Clubs in schools	•Mobilize schools to use sports as a channel to divert them from unwholesome practices	Establish environmental sanitation and solid wastes management standards in schools.	Sensitize parents and guardians on the importance of the School Health and Nutrition Programme
•Collaborate with other stakeholders in the capacity building of personnel for the Programme	•Conduct routine health screening and assessment of learners and other School Health and Nutrition Services and facilitate Referrals while maintaining	•Supply improved farm inputs for crop and animal farming in schools	•Mobilize school children to overcome academic stress through sports	•Promote environmental sanitation and hygiene in schools through provision of waste disposal facilities and other activities	Advocate for equitable access to School Health Programme for boys and girls

	routine health records of learners				
Provide Data on Children with disability and special needs in schools to improve rehabilitation services.					
• Coordinate and Oversee regular school inspection to enforce implementation of standards of sanitation and develop a database on school health linked to NEMIS	•Ensure that information for the prevention of communicable and Non Communicable diseases including immunization services are extended to schools in the context of Primary Health Care (PHC)	•Develop suitable standards and cost effective meal plans for schools in different communities in collaboration with the Ministry of Health	• Design sporting activities and Build capacity of personnel to supervise these activities in schools	Ensure compliance with minimum sanitation standards in schools through routine school inspection	Ensure that School Health and Nutrition Programme is integrated into Local Government Plans of action
•Train teachers and the school community on basic counselling skills, psychosocial	Provide First Aid management Training for teachers as part of	Provide assistance in schools on effective agriculture to improve output and quality of	• Construct and improve sport facilities in schools to promote healthy living for learners.		Mobilize local resources for the implementation of the SHN Programme

support to strengthen the referral linkages between the Ministry of Health and other Health service providers.	the implementation of the SHN programme	their produce			
•Ensure regular inspection of ECCD and NFE centres on school health Programme Conduct and publish research on School Health	Provide technical assistance and advice on medical issues and Coordinate with MoET on Health and Nutrition Education		Implement Child protection and Gender issues	•Establish standards for food sanitation in schools	•Provide direct assistance and supervision to schools in the implementation of the SHN programme
•Formulate and review the implementation guidelines for the School Health and Nutrition policy	Disseminate information and education on alcohol use and abuse, Drug and substance abuse in schools		Mainstream Gender issues across other sectors and its programmes with focus being the learner in school Design sporting activities		Encourage utilization of community recreation facilities / play ground by learners
To build the capacity of the school Community and other	To build the capacity of the Health Care		Advocate for Reduction of Gender Based Violence(GBV) in schools		Build capacity of care givers in ECCD for School Health Programme

key stakeholders on Gender Needs, priorities and concerns in schools.	Providers and other key stakeholders on Gender Needs, priorities and concerns in schools.				
Education Facilities Unit-MoET					Assist in the management and protection of facilities provided for the School Health and Nutrition Programme by government and other stakeholders in the school
Ensure that schools are planned to meet approved standard specifications for Health					•Mobilize local human and material resources to support the School Health
•Ensure that school buildings comply with approved standards of sanitation					School Health Programme in schools
•Ensure that school					•Organize communal efforts

buildings meet with approved safety standards and are sensitive to the needs of physically challenged learners					especially in NFE, ECCC and Schools, for the provision of toilets, fencing, access roads and the clearing of bushes to ensure a safe learning environment

Ministry of Police and Public Safety	**Ministry of Public works and Transport**	**Ministry of Social Development**	**Justice and Judiciary**	**Ministry of Finance**	**Ministry of Communications**
Implement Child protection and Gender issues	Ensure the provision and maintenance of access roads to schools	Coordinate OVC services including Child Grants and implementation of the National Child Protection Strategy and the OVC policy and Acton Plan	Disseminate Information and Education on young people and children's Rights	Ensure sufficient budgetary allocation for SHN activities across all relevant Ministries	Design, produce and disseminate information, education and communication (IEC) materials on School Health through various media channels
Implement sensitive effective and rapid handling of cases of abuse	•Design internal roads in schools with adequate drainage system	Ensure provision of therapeutic food for OVCs	Ensure probation schools implement SHN Policy	Provide guidance on alternative funding sources	•Conduct public enlightenment campaigns on SHNP in the communities

Disseminate information and education in schools on Rights and procedures to report abuse	•Construct speed breakers at 1km interval within 5km radius to schools and and zebra crossing in front of the school entrances.		Enforce Children's Rights at all levels(by all sectors) to implement the SHN programme	Mobilize funds for School Health Programme from government and Donors	•Support the celebration of school health days
Disseminate information and education on Road safety in schools and control traffic around schools	Disseminate information and education on Road safety in schools			•Ensure effective coordination, monitoring and evaluation of the School Health and Nutrition Programe	
Disseminate information and education on alcohol use and abuse, Drug and substance abuse in schools					

Appendix 9:Statistical Tables

9.1:Enrolment

Enrolment	2014	2015	2016	2017	2018
ECCD	6178	53,530	53,793	53,803	50,056
Primary	369,469	361,637	360,756	354,847	340,421
Secondary	128,473	128,701	128,780	129,192	138,894

9.2:Net Enrolment Rate (NER) and Gross Enrolment Ratio (GER)

Level of Education	2016		2017		2018	
	NER	GER	NER	GER	NER	GER
ECCD	29.5	42.2	29.7	41.6	27.5	38.2
Primary	89.4	116	87	112.7	85.2	106.7
Secondary	43.1	61.1	43.3	60.4	46.8	64.1

9.3:Orphans

ECCD Orphans by Type, Age and Sex, 2018											
Orphan Type	**Age<3**		**Age 3**		**Age 4**		**Age 5**		**Age>5**		**Total**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
Paternal	39	68	83	94	153	170	249	229	162	173	1420
Maternal	21	21	32	32	46	45	76	85	60	52	470
Double	8	11	9	14	24	19	52	44	26	40	247
Total	**68**	**100**	**124**	**140**	**223**	**234**	**377**	**358**	**248**	**265**	**2137**

9.4:Orphans in Registed Primary schools

Enrolment of Orphans in Registered Primary Schools by Type, grade and Sex, 2018															
Type	**GRADE 1**		**GRADE 2**		**GRADE 3**		**GRADE 4**		**GRADE 5**		**GRADE 6**		**GRADE 7**		**Total**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
Paternal	2682	2201	2502	2297	3072	2469	3322	3000	3603	3476	3774	3801	3992	4470	44661
Maternal	827	733	822	831	1053	913	1175	1161	1310	1302	1433	1441	1457	1578	16036
Double	515	415	514	363	648	572	906	781	1085	943	1279	1192	1499	1637	12349
Total	**4024**	**3349**	**3838**	**3491**	**4773**	**3954**	**5403**	**4942**	**5998**	**5721**	**6486**	**6434**	**6948**	**7685**	**73046**

9.5:Orphans in Secondary and High Schools

Orphan Type	FORM A		FORM B		FORM C		FORM D		FORM E		Total
	M	F	M	F	M	F	M	F	M	F	
Paternal	3967	4706	2967	4005	2059	2918	1681	2498	1326	1883	28010
Maternal	1294	1571	1002	1298	699	960	670	858	482	645	9479
Double	1536	1922	1190	1732	900	1358	792	1153	686	940	12209
Total	**6797**	**8199**	**5159**	**7035**	**3658**	**5236**	**3143**	**4509**	**2494**	**3468**	**49698**

9.6:Learners with Special Educational Needs

ECCD Enrolment of Children with Special Education by Type of Disability, Age and Sex, 2018											
DISABILITY TYPE	**AGE<3**		**AGE 3**		**AGE 4**		**AGE 5**		**AGE>5**		**Total**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
Physical Disability	7	11	18	11	20	21	18	17	24	12	159
Visual Impairment	2	5	6	3	15	11	23	17	10	9	101
Hearing Impairment	3	1	4	11	6	9	11	14	7	9	75
Intellectual Disability	8	8	13	17	27	11	30	21	26	14	175
OTHER	6	2	12	14	22	25	36	20	27	12	176
Total	**26**	**27**	**53**	**56**	**90**	**77**	**118**	**89**	**94**	**56**	**686**

9.7:Enrolment of Pupils with Special Educational Needs

Enrolment of Pupils with Special Educational Needs in registered Primary by type of disability, Grade, 2018															
Disability Type	**Grade 1**		**Grade 2**		**Grade 3**		**Grade 4**		**Grade 5**		**Grade 6**		**Grade 7**		**Total**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
Physical Disability	134	83	92	60	69	64	97	67	78	81	69	59	82	71	1106
Visual Impairment	206	142	264	157	239	171	337	255	353	282	338	336	382	368	3830
Hearing Impairment	108	89	96	77	104	116	154	165	179	221	179	221	184	157	2050
Intellectual Disability	550	344	619	314	783	423	1024	546	1126	626	1087	608	920	598	9568
Other	176	99	115	64	135	85	121	61	118	73	148	83	102	47	1427
Total	**1174**	**757**	**1186**	**672**	**1330**	**859**	**1733**	**1094**	**1854**	**1283**	**1821**	**1307**	**1670**	**1241**	**17981**

9.8:Registerd Secondary Schools

Number of Students with Special Education in Registered Secondary Schools by Disability Type, Level of Education and Sex, 2018												
Disability Type	**FORM A**		**FORM B**		**FORM C**		**FORM D**		**FORM E**		**Total**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**		
Physical Disability	99	107	47	59	34	44	47	63	19	18	537	
Visual Impairment	486	589	329	639	266	511	219	429	203	334	4005	
Hearing Impairment	144	228	126	215	101	187	59	159	57	128	1404	
Intellectual Disability	277	287	190	247	137	133	95	124	87	120	1697	
Other	116	108	87	102	77	102	67	108	24	59	850	
Total	**1122**	**1319**	**779**	**1262**	**615**	**977**	**487**	**883**	**390**	**659**	**8493**	

9.9:Primary Schools Dropout Rates by Sex, 2017

Dropout Rate		
Male	**Female**	**Total**
14,4	10,1	12,3
1,7	0,9	1,3
2,0	1,1	1,5
3,9	1,1	2,5
8,8	3,2	6,1
11,8	6,1	8,9
18,5	13,6	15,9
4,1	4,1	4,1

In Secondary Schools, Dropout Rates is not calculated. (This is according to MoET Statistics Office).

Appendix 10: Multi Sectoral Working Group for School Health and Nutrition Policy:

Mpheng Molapo- HIV and AIDS Coordination Unit

`Makhotso Lecheko- HIV and AIDS Coordination Unit

Santi Mofoka-Legal-MoET

Leseme Moreke-TSD

Motsamai Motsamai-Government Schools

Motšoanyane Maruping- LDTC

Lineo `Malesaoana Molapo- NCDC

`Matšepang Mosae- NCDC

Sibongile Molapo-Special Education Unit

Jubilee Ntloana- SSRFU

Teboho Moahloli- Planning-MoET

Retšelisitsoe Koloti-Planning-MoET

`Manamolo Kobong- Planning-MoET

Reabetsoe Ntho- Planning-MoET

`Mamonyane Mongope-Planning-MoET

Hlaoli Ramahapu- Planning-MoET

`Mahlompho Nkunyane- St Catherine High School

Ntsoaki Pakela- Lesotho High School

`Matšenase Tšenase- DCD-MoH

Dr Lieketseng Petlane-Oral Health-MoH

Mary Mahloane- Sports Coordinator-MoGYSR

Mohau Tšilo- Coordinator NVC-MoGYSR

Thabo Lebaka-MoSD

`Mantsane Tšoloane- Bolepo- WHO

Makhetha Moshabesha-UNICEF

Lethola Mafisa-UNESCO

`Maseretse Ratia- UNFPA

`Mampeoane Kholumo-World Vision

Ntsoaki Ramokhele-World Vision

Polo Motšoari-JHPIEGO

Joel Seeiso Pii- Baylor Clinic

Marorisang Mphaki- Baylor Clinic

Tlali Matela-L.P.P.A

Ntsoaki Roelane-Sentebale

Phomolo Mohapeloa-REPSSI

Thabo Mokhutšoane-LTTU

`Matšiame Mafa-PALT

Lebohang Mosaku-LIRAC

Tlalane Panyane-HED-MoH

Dr Navoneiwa Linjewile Marealle-Oral Health-MoH

Konosoang Nkuatsana- Family Health Division-MoH

`Mampesi Lekoekoe-RCC Schools

Audrey Hettaney- Consultant

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