

Republic of Namibia

Training of Trainers Manual on School Health





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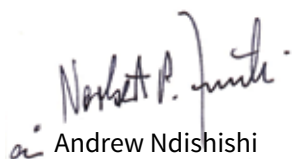
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Preface and Acknowledgement

After the family, schools are the most important places of learning for children: they occupy a central place in the community. Schools are a stimulating learning environment for children and stimulate or initiate change. This Training of Trainers Manual on School Health is meant to assist the stakeholders of School Health in facilitating efforts to implement the school health programme. It provides them with tools and ideas on how to work with trainees from diverse professional and cultural backgrounds. By focusing on school going children and turning schools into centres of health and cleanliness, future generations will be better prepared to care for their families, health of communities and clean environment.

Ministry of Health and Social Services and Ministry of Education, Arts and Culture both wish to acknowledge the assistance of the project partner National Institute for Health and Welfare (THL) Finland, and particularly the Finnish Ministry for Foreign Affairs for funding the “Strengthening the School Health Programme in Namibia” (2012-2015). This project has provided extensive capacity building to staff members from our two Ministries. The two Ministries would furthermore like to acknowledge, with sincere appreciation, the substantial commitment of all stakeholders involved in the development of this School Health Training Manual. These include staff from various Directorates within both Ministries, in particular the Primary Health Care Services, and Special Programmes Directorate from the Ministry of Health and Social Services and Programme Quality Assurance within the Ministry of Education, Arts and Culture, the University of Namibia, the MoHSS National Health Training Centre, the Directorate of Water Supply and Sanitation Coordination within the Ministry of Agriculture, Water and Forestry. The invaluable support from the UN family in Namibia cannot be over-emphasized. UNESCO, UNFPA, UNICEF, WFP and WHO provided continuous financial and technical support throughout the drafting and finalization of the training manual.



Andrew Ndishishi
Permanent Secretary
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Foreword

Good health is a prerequisite for national development. In our quest for the achievement of Vision 2030, health and education are fundamental. In this regard, it has to be appreciated that effective learning and engaged participation in important school activities depends on the good health of every school going Namibian. According to the 15-School Day Report 2015, there are 1,779 schools in Namibia with 697,620 enrolled learners. As spaces where a majority of Namibian children and young people spend the better part of their year, schools create a unique opportunity to improve both the education and health status of learners throughout the nation.

The School Health Programme is a joint collaborative programme between the Ministry of Health and Social Services (MoHSS) and the Ministry of Education, Arts and Culture (MoEAC). Namibia adopted the World Health Organization's Health Promoting School Initiative (HPSI) as a key strategy to deliver on the Vision 2030 goal of ensuring equity and access to quality education for all Namibians, especially young people. Namibia's School Health Programme furthermore complements the Eastern and Southern African (ESA) Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health and Rights. This initiative, which was signed in 2013 by the Ministers of Health and Education of the 21 countries in Eastern and Southern Africa, including Namibia, strives for improved access to quality sexuality education and reproductive health services for all young people. Under the slogan, "Young People Today - Time to Act now", it reminds us that we need to lay the foundations for a better today for our young people now by reviewing young people's education and sexual and reproductive health needs and concerns.

This Training Manual on School Health is targeting both Education and Health implementers and is envisaged to facilitate an integrated approach to health programming and more effective learning at the school level. This manual has been pilot-tested in October 2014 followed by the first training workshop held in March 2015. We are convinced that this Training of Trainers Manual will assist greatly in the implementation of the school health programme and will go a long way towards promoting the realisation of the rights of the child to education and health.

It is often assumed that government alone should provide a healthy school environment. However, quality education remains the task of all of us. It is therefore vital that learners, teachers, health workers, parents and communities are jointly engaged to bring about an improvement of the overall situation of learning and education at every school. Through better health promotion, strengthened prevention, and appropriate curative and rehabilitative measures, the many health barriers experienced by our Namibian learners can be greatly reduced. This will ensure greater quality education for all children in Namibia. We therefore encourage all stakeholders involved in our national School Health Programme to utilise this new Manual extensively and to work tirelessly to ensure its success. Make this Manual your desktop resource and use it every day as an expression of your commitment to a healthy and educated Namibia! The time to act is now!



Hon. Dr. Bernard S. Haufiku, MP.
Minister of Health and Social Services



Hon. Katrina Hanse-Himarwa, MP.
Minister of Education, Arts and Culture

List of abbreviations

ADL's	Activities of Daily Living
AFHS	Adolescent Friendly Health Services
ASRH	Adolescent Sexual and Reproductive Health
BCG	Bacille Calmette Guerin
BMI	Body Mass Index
COC	Combined Oral Contraception
CVD	Cardiovascular Disease
EC	Emergency Contraception
ECP's	Emergency Contraception Pills
ENT	Ear, Nose and Throat
HAMU	HIV/AIDS Management Unit
HIV	Human Immunodeficiency Virus A
HPS	Health Promoting School
HPSI	Health Promoting School Initiative
IADL's	Instrumental Activities of Daily Living
IDS	Acquired Immunodeficiency Syndrome
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
MDG	Millennium Development Goals
MGCW	Ministry of Gender and Child Welfare
MoEAC	Ministry of Education, Arts and Culture
MoHSS	Ministry of Health and Social Services
MoU	Memorandum of Understanding
NAMPOL	Namibian Police
NCD	Non-communicable disease
NCDC	Non-Communicable Disease and Condition
NCDRD	Non-Communicable Disease Related Diet
NGO	Non-Government Organisation
NHTC	National Health Training Centre
PMDRC	Policy Management, Development and Review Committee
POP	Progestin Only Oral Contraceptives
PWID	People who inject drugs
SHP	School Health Programme
STIs	Sexually Transmitted Infections
UNAM	University of Namibia
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
WACPU's	Women and Children Protection Units
WCBA	Women of Childbearing Age
WHO	World Health Organization

Introduction to the Training of Trainers Manual on School Health

As a national or a regional facilitator your role is crucial to the success of the implementation of the Integrated School Health Programme in schools. It is therefore important that you familiarise yourself with the content of the Training Manual. A truly participant-centred training must start with the experiences and needs of the participants. We've therefore made every effort to ensure that the content of the manual is fit for a non-expert reader. The information is provided in a way that our target audience, which includes health workers, teachers, regional school counsellors, social workers and school administrators as well as community members who are keen on advancing the cause of school health, can fully understand the manual regardless of their previous training. You are encouraged to apply the concepts of school health in practice. It is moreover important that you as a facilitator further tailor the information to the particular context in which you will conduct your training and ensure it reaches your audience.

Once the training has taken place, teachers should be better equipped to identify school health issues and refer learners. If they have also been given first aid training, they could give learners support for minor ailments. In addition, the training of school nurses should give them more confidence to diagnose possible medical conditions and treat or refer the learners. The wider school health community also have important roles to play. Hostel matrons would also benefit from experiencing this training to allow them to act in the same way as teachers. Kitchen staff and cleaners would benefit from having training on modules that relate to their responsibilities at school. In addition, school principals would also benefit from being exposed to the key school health information contained in this manual in order for them to ensure that the implementation of their school health policy is always given high priority. Finally, parents and guardians of learners must also be informed about their important roles in bringing the integrated school health programme into effect. In some cases, like the hostel matrons, only they can ensure that certain components of a learner's health and development challenges are supported in the right way.

It is only with a holistic approach by all key role players that the benefits of this new, integrated approach to school health are likely to be fully realised.

Structure of the Manual

This manual is made up of 7 modules; every module is further divided into units dealing with a specific topic. The purpose of this structure is to help organise the content in a logical manner and make it easier to access information on a particular topic.



Overview of the Training of Trainers Manual



Training Facilitator's Notes

Present an overview of the manual and contents of the workshop.

- Module 1 Comprehensive School Health Programme
- Module 2 Nutrition and Healthy Lifestyle
- Module 3 Mental Health and Psychosocial Well-being
- Module 4 Sexual and Reproductive Health and Rights
- Module 5 WASH - Water, Sanitation and Hygiene
- Module 6 Learners with Diverse Needs
- Module 7 Violence Against Children

Icons used in the Training Facilitator's Guide

Icons used in the Facilitator's Guide are meant to assist you in facilitating the content of the workshops on school health:



Indicates notes for the facilitator: theoretical overview of the relevant content focusing on information relevant for the Namibian context.



Key notes: a recap featuring key information and is usually found at the end of a module or a unit.



Indicates an activity: features an explanation of a practical/fun activity to help build an understanding of the concept. The time for each activity is a recommendation; facilitators will decide on the time together with the participants who will work at their own pace for each workshop.



**Training of Trainers Manual
on School Health**



HOW TO INTRODUCE THE WORKSHOP

START THE PROGRAMME

Objectives

By the end of this session, participants will have:

- been introduced to the workshop participants and developed a productive group dynamic
- examined individual expectations and available resources in the group
- reviewed the programme objectives in relation to the expectations and needs



Facilitator's Notes

1. Introduce the facilitator and welcome participants.
2. Workshop Introduction – 30 minutes



activity

Workshop Introduction – 30 minutes

Ask participants to form pairs. Each person must introduce him/herself, state what he/she is doing and tell his or her other partner something about him or herself that the other person may not know. (5 minutes)

Participants return to their seats.

Each person now needs to give feedback to all the other participants stating his/her partner's name, designation and what the partner told him/her. (25 minutes)

MODULE 1: COMPREHENSIVE SCHOOL HEALTH PROGRAMME

Overall Objective

To help the trainer understand the components of a comprehensive school health programme, specifically the health promoting school initiative in Namibia and clarify the roles of health workers, school staff, learners, community members and other stakeholders in creating and maintaining a healthy school environment.

Module summary table

Unit	Content	Time	Activity	Materials
1	Overview of the School Health Programme (SHP): Components of a comprehensive SHP	45 min	Presentation	Policy Documents and Guideline Screening equipment
2	Health Promoting School Initiative: What is a health promoting school? How can my school become a health promoting school?	2 hours	Presentation, demonstration and case study	PowerPoint presentation, tools, awards and First Aid Kits, promotional materials
3	School Health Services Package: On-site health services to children in Namibian schools Health equipment for school-based screening and referral	3 hours	Presentation, role play, demonstration, practical session and group work	Handouts, PowerPoint presentation, tooth brush, tooth paste, posters, videos and models
4	School-based screening for the most important diseases affecting Namibian children Mandatory screening for vision and hearing Oral hygiene Personal hygiene (nails, etc.) Tuberculosis Vector-borne diseases (malaria, bilharzia, STH) Skin infections (scabies) Rheumatic Fever/Rheumatoid Heart Disease Non Communicable Diseases: Hypertension, Obesity, Type 2 Diabetes, Allergies, Immunisation	4 hours	Presentation, and role play	PowerPoint presentation, videos and posters

Glossary:

Bilharzia: A parasitic disease caused by the larvae of one or more types of worms known as schistosomes (The Free Dictionary, n.d.)

Communicable disease: Spreads from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid.

Comprehensive: A term that means complete or including all or nearly all elements or all aspects of something.

Decay: Is a process which involves rotting or slow destruction (decomposition) of natural material with the assistance of bacteria or fungi

Disease: A term that describes a condition when the body is ill or not healthy. The body presents with certain characteristics symptoms or signs typical of the disease,

Gum disease: Occurs as a result of inflammation to the gums. This is often accompanied by pain, reddish and bleeding gums.

Health promoting school: A term used to describe a school that aims to maximise the learner's ability to learn by involving all persons in the holistic learning process.

Hearing loss: A term that refers to any degree of impairment to the ear and/or auditory pathway that affects the ability to apprehend sound correctly (The free dictionary, n.d.)

Hygiene: Conditions or practices that encourage cleanliness and thereby promote healthy living and bodies.

Immunisation: The use of vaccines to protect people from disease (Namibian College of Open Learning, 2012)

Non-communicable disease: A slow progressing and long enduring (chronic) disease that is not contagious or passed from one individual to another (WHO, 2015)

Nutrition: The process of taking in nutrients from food substances for growth, repair and maintenance of the body. Good nutrition can help prevent disease and promote health (Namibian College of Open Learning, 2012)

Obesity: The condition of being grossly fat or weighing more than one's normal weight (overweight).

Parental consent: A type of form that is filled in by parents/caregivers as proof that they give permission for some action/treatment to be carried out on their child. It suggests that the parent/caregiver is knowledgeable of what the action/procedure/treatment entails and how it can affect the child. (US Legal, 2015)

Referral: The act of sending a learner to a professional or expert for consultation, review and further management or action. (Oxford Dictionaries, 2015)

Scabies: A contagious skin disease marked by itching and raised red spots caused by the itch mite.

School Health Policies: Refer to a set of guidelines and rules that promote a healthy, safe and secure school environment, which guarantee equal rights and opportunities and regulate the provision of health education and health services to improve education outcomes.

Screening: A short evaluation that is conducted to determine whether a specific medical condition is present or absent. (The Free Dictionary, 2015)

TB: A bacterial infection which is commonly spread through the air when an infected person coughs, sneezes or spits.

Vector-borne disease: An illness caused by an infectious micro organism that is transmitted to people by blood-sucking insects or spiders. (Virginia Department of Health, 2015)

Visual impairment: Refers to a reduction in vision, which if not corrected with glasses or contact lenses, reduces the learner's ability to function (US Legal, 2015)

Unit 1: Overview of the School Health Programme (SHP)

Specific Objectives

At the end of this unit, the trainers will have:

1. Gained insight into the history and current challenges of school health service in Namibia; and
2. Understood the components of a comprehensive school health programme and its importance for positive outcomes in education.

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart and markers

1.1. Introduction: overview of school health service in Namibia

In 1990, Namibia established a School Health Programme (SHP) in order to promote the health of school going children and ensure that Namibian learners have optimal conditions to grow, develop and learn. School Health then formed a core component of the country's Primary Health Care strategy. In 1998, Namibia adopted the World Health Organisation (WHO) Health Promoting Schools Initiative (HPSI) to promote and strengthen school health. The goal of this initiative was to provide health services for all school-going children. In 2008, Namibia launched a National School Health policy whose aim is to ensure all school children in Namibia acquire the knowledge and skills they need to make informed decisions about their health and well-being and to improve their quality of life. It is beyond doubt that only healthy learners can do well in school. Therefore ensuring learners' well-being is a prerequisite of favourable outcomes in education. The purpose of this training manual is to offer guidance as to what a community of stakeholders interested in education can collectively do to support the school and assure that the conditions in which our learners live and study are healthy and stimulating for them to reach their full potential.

Despite the well-established policy framework, Namibia faces several challenges related to implementation. The School Health Programme staff struggles with a shortage of trained school health care workers, insufficient health education materials, equipment for health check-ups and underdeveloped information systems. Long distances make transportation a challenge thus hampering the implementation of school health plans. Public rural schools face difficulties in ensuring access to water, electricity, sanitary facilities as well as supply of teaching and learning materials.

Within the Namibian Government, different line Ministries assume responsibilities in accordance with their mandate to carry out various aspects of school health policy. For example, the Ministry of Health and Social Services (MoHSS) is responsible for providing health services, e.g. immunisation, providing learners with information regarding sex related issues and screening of learners to detect diseases and other impairments. The Ministry of Education, Arts and Culture (MoEAC) is responsible for the implementation of School Health Education to learners from pre-primary up to grade 12 learners. The MoEAC

also has to ensure that learners have a healthy school environment, e.g. proper sanitation, clean water, playground, comfortable and sufficient chairs and desks and adequate classrooms, as well as that a feeding programme is in place.

Finally, the Ministry of Gender Equality and Child Welfare (MoGECW) has the mandate to conceptualise and oversee the implementation of the Early Childhood Development (ECD) programme which encompasses all children under the age of 4 and is seen as the most important developmental stage in an individual's lifespan, thus critical for later success in education and life.

Such a division of responsibilities, even though in accordance with the law, often leads to a lack of coordination between different stakeholders and as a result, suboptimal service delivery to Namibian school-going children. For example, health workers concentrate mainly on inspection of the school environment and immunisation against childhood diseases for primary learners while secondary schools tend to focus on sex-related issues. At the same time, inadequate training may have contributed to some teachers and health workers not addressing sexual and reproductive health issues in the best interest of the learners due to cultural constraints or personal beliefs.

Therefore, it is important that all stakeholders assume responsibility for the welfare of the Namibian child and work together to ensure their well-being, from the moment they are conceived until they successfully graduate from Grade 12 as healthy, as well as cognitively and physically empowered young individuals. A Memorandum of Understanding between the MoHSS and the MoEAC is being drafted and prepared for submission to the Cabinet, the aim of which is to obtain Government approval to revitalise the school health in Namibia and to strengthen the collaboration through shared responsibility of the two Ministries in promoting school health services across the country.

Figure 1.1: A Healthy School in Namibia



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To ensure Namibian children grow and develop in an optimal learning environment, the following core components must be in place to guide the implementation of the School Health Programme:

1. School health policies

Health policies in schools, mandating a healthy, safe and secure school environment, guaranteeing equal rights and opportunities and regulating the provision of health education and health services, to improve education outcomes.

2. Water, sanitation, infrastructure and the environment

Safe water and appropriate sanitation facilities are basic first steps towards a healthy, safe and secure learning environment. Moreover, the condition of the school building and the surrounding areas, the presence of any biological or chemical agents that are detrimental to health, conditions such as undesirable temperatures, noise and lighting, are some of the factors that can adversely affect health in a school environment and therefore must be kept in check.

3. Skills-based health education

This includes a planned sequential course of instructions to address the physical, mental, emotional and social dimensions of health throughout the school, with the aim to influence learner's understanding, attitudes and behaviours concerning health practices. It includes topics such as personal hygiene, environmental health, sexual education, injury prevention and safety, nutrition, prevention and control of diseases, substance abuse, etc.

4. Health risks to young people

These services are designed to promote access to primary healthcare through early identification and detection and timely referral mechanisms. They also include nutrition, prevention and treatment of common conditions such as communicable diseases, mental health problems and barriers to learning, checkups, monitoring of outbreaks and vaccination. Importantly, school feeding programmes are of great importance for assessing and managing the nutritional needs of learners and relieving short-term hunger.

5. School-based health services

Health risks to young people can be minimised by creating a safe healthy environment in schools and at home. For example, it is important to stress that personal and oral hygiene is more likely to be managed in the home, teachers and health workers should strive to convey this message to both learners and their parents. All schools must have a system in place that minimises the spread of infectious disease so that teachers can spot symptoms.

A clean school environment must include hostels, kitchens, classrooms and play areas. Access to water for hand washing should be available to learners near classrooms, to kitchen and hostel staff where food is prepared and to everyone using toilets. For example, a simple way to create awareness about a clean school environment is to have signage put up around the school that underpins hand washing practices.

Unit 2: Health Promoting School Initiative

Specific Objectives

At the end of this unit, the trainers will have:

1. Understood what is a health promoting school initiative; and
2. What are the 10 practical steps one can take to help turn her/his school into a health promoting school.

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart and markers

2.1. Introduction: Health Promoting School Initiative in Namibia

In 1995 the WHO in collaboration with other international agencies (UNESCO, UNICEF) introduced the Global School Health Initiative (GSHI). The Health Promoting School Initiative (HPSI) originates from the GSHI and focuses on mobilising, strengthening and complimenting the School Health Programme. In 1998, Namibia adopted the Health Promoting School Initiative and it is currently the responsibility of the Ministry of Education, Arts and Culture and the Ministry of Health and Social Services to coordinate the training of various health and education officials and jointly coordinate the implementation of HPSI. The initiative has been successfully introduced in four regions, namely Khomas, Erongo, Omaheke and Otjozondjupa. It involves the development of participating schools into health promoting schools and the presentation of an award that recognises the efforts of all the partners who have made the development possible.

2.2. What is a health promoting school?

A health promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working (WHO, 1976).

A health promoting school engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place striving to provide:

I. A healthy school environment comprising:

- Safe and clean drinking water
- Gender appropriate sanitation/toilet facilities
- Comfortable seating arrangements
- Safe playgrounds
- Learner friendly environment
- Access for physically challenged learners

Figure 1.2: Elements of a comprehensive school health programme



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II. Education on health and hygiene issues including:

- A focus on cleanliness, personal hygiene and sanitation
- Preventative information against various non-communicable diseases
- Prevention against communicable diseases
- Comprehensive sexuality education, including HIV and AIDS prevention, care and psycho-social support services
- Environmental education
- Life skills based education
- Orientation of teachers and parent-teachers' forums to abolish corporal punishment in schools and come up with alternatives to violence
- Establishment of health clubs
- Providing school-based health and nutrition services

This manual has been developed to assist YOU in bringing HPSI to your school. Our goal is to increase the number of schools in Namibia that can truly be called health-promoting schools. With your help, we can achieve this goal sooner rather than later.



activity

Activity: Health-promoting school – 30 minutes

Divide the participants into four groups, each consisting of five members. Provide each group with flipchart paper and markers. Groups have to determine what a health promoting school will look like. Each group provides feedback to the plenary.

Health Promoting School (HPS)



Facilitator's Notes

Now that we have determined what the participants think a health promoting school should look like, let us have a look at what should be in place in an ideal Health Promoting School (HPS). The following 10 steps will lead you to a health promoting school:

1. Leadership

Leadership at all levels (national, regional, community, school) is critical. In a Health Promoting School, continuous involvement of the principal, superintendent, school board, teachers, learners and parents drives the creation of a healthy school environment.

2. Establishment of the school health committee

The function of the school health committee is to:

- Help gather information about local needs and resources;
- Participate in the analysis of the needs and resources;
- Develop a school health plan in conjunction with school officials;
- Provide a forum for students, parents, and the broader community to address school health-related concerns;
- Facilitate linkages between the school and the community;
- Act as an advocate for the HPS programme and its participants;
- Facilitate communication with groups interested in school health (e.g. WHO, UNICEF, UNESCO, WFP, civil society etc.);
- Help to mobilise resources to advance school health and
- Assist in programme evaluation.

3. School policy

One way of ensuring that current policies are available to school staff, board members, students, and families is to develop and distribute a manual that consolidates school policies and procedures related to all aspects of a school health programme. We hope that this manual may be useful in this regard.

4. Mapping of existing resources

Resource mapping is a technique that schools can use to depict what is currently in place in a school/community. After the mapping exercise, the school board can then help to identify duplications and gaps and decide on a course of action to close the gaps and utilise existing resources rationally.

5. Mapping of needs

The purpose of this exercise is to assess all existing programmes in schools using data from the Global School-Based Student Health Survey as well as school-based health screening tests. One has to take special heed of the following information: learners' blood pressure, vision and hearing, pregnancy rates, incidence of sexually transmitted diseases, tobacco use, unhealthy dietary habits, inadequate physical activity; alcohol and substance abuse, incidence of learner pregnancies and behaviors that may result in intentional injuries (violence and suicide) and unintentional injuries (motor vehicle crashes).

6. Programmatic needs

Once the resource mapping has been conducted and the different needs assessed to identify gaps in the school's health programme, decisions are to be taken about how to strengthen or modify existing health-related efforts.

Programmatic needs ought to be prioritised based on factors such as:

- Importance for academic achievement;
- Resources required (professional development, funding, time requirements);
- Number of students, family members, or staff that will benefit;
- Readiness of the school community.

7. Existing and potential sources of funding

Funding is a huge but not insurmountable challenge. The community has potential resources that the School Board Health School Committee ought to identify. Moreover, there exist school district, circuit level or regional plans for both Education and Health Ministries related to health programmes and every school ought to assess how to tap into those.

8. Plan development

Development of a single plan or shared vision, focusing primarily on outcomes which reduces duplication and increases programme effectiveness is the right way to go. Plans based on identified prioritized needs and available resources are usually more successful.

Effective plans include:

- Outcomes-based planning (what are the concrete goals for school health we want to achieve in our school?);
- Strategies or activities for accomplishing objectives;
- Clear timelines for implementation and assigning responsibilities;
- Individuals involved: is there a need for human resource training?
- Identify material resources.

9. Ongoing monitoring and evaluation (M&E)

M&E should be concerned with both quantitative information (how much) and qualitative information (how well) and capture the following aspects of implementing a HPSI:

- Daily activities;
- Management strategies;
- Learning experiences and community involvement (process evaluation);
- Health knowledge, skills and behaviors of children and youth (impact evaluation) and
- Longitudinal changes in health status indicators (outcome evaluation).

10. Local and International Support

Local and international support must be solicited in order to enhance the ability of schools, regions and local communities to promote school health and education.

2.3 Criteria for HPSI levels

For a school to qualify as health promoting, it needs to fulfill a number of criteria upon which the school then becomes HPS at different levels: Bronze, Silver and Gold.

Bronze Level

The Bronze level entrance is based on the following criteria:

1. Availability of safe drinking water
2. Sanitation Facilities:
 - Toilet facilities should be maintained in good working order and hygienic conditions
 - Separate toilets available for use by teachers, boys and girls
 - Toilets with a wash hand basin, running water, soap and a hygienic
 - Method of hand drying available (such as paper towels, etc)
3. Access to health services and school feeding/food and nutrition services (when possible)
4. Skills-based health education for pupils
5. Health-related school policies
6. Development of the school health charter
7. Display health messages in classrooms, toilets and notice boards
8. A safe and clean school environment
9. Establish school health clubs, and create a Health Corner in each classroom, library or any place that is accessible to all the learners, teachers and school personnel

10. School canteens to provide safe nutritious food
11. School nutrition programme
12. Oral Health programme

Silver Level

In addition to the criteria for the bronze award the silver level entrance is based on the following criteria:

1. An appropriate learner/toilet facility ratio of 1 properly working and hygienically maintained toilet per 50 pupils; availability of hand washing facilities with soap and drying facilities. (Girls: 1 toilet cubicle for 25 girls and boys 1 cubicle toilet for 100 boys and 1 urinal for 40 - 60 boys according to Policy Framework (2005)(WHO)
2. Building/improving water fountains/water bags or increasing number of tap water on the school grounds according to the school size
3. Creativity in the approach of a specific health promotion project or intervention; this can be in a form of a drama group, involvement in a community project, etc.
4. Participation in the National/Regional Science Fair with at least one health related project
5. Continuation of the School-based Health Clubs/ projects
6. Continuation of the School-based Health Clubs, HIV/AIDS projects
7. Provide a sick bay for learners to use when not feeling well
8. Started process of implementing the school-based oral health programme
9. School canteens to provide safe nutritious food
10. Mobilize for school nutrition programme

Gold Level

In addition to the criteria for bronze and silver awards the gold level entrance is based on the following criteria:

1. Help at least one school in the country to move toward the Silver level of HPSI implementation(sisters school)
2. Participate in National/Regional Science Fair with a least one health related project
3. Creativity in the approach of local health problems and intervention or health promotion e.g. Participate in community projects, do survey/research in local community on any health issue
4. Continue with the school-based Health Clubs/ Projects
5. Continue with the school-based Health Clubs/ HIV/AIDS Projects
6. Full implementation of the school-based oral health programme
7. School canteens to provide safe nutritious food
8. Mobilize for School Nutrition programme



Facilitator's Notes

Once the school has committed to becoming a Health Promoting School, a number of assessments need to be carried out both by the school (internal assessments) and by the MoHSS and MoEAC officials (external assessment) to confirm that the school has qualified as a HPS. This Training Manual provides you with a comprehensive toolkit to help you prepare your school for HPSI. Below is a list of the most important forms that are part of the assessment toolkit. The samples of the forms are attached at the end of the manual as annexes.

- Internal assessments check list for Health Promoting Schools form (Annex 1A)
- External assessment check list for Health Promoting School form (Annex 1B)
- Parental Consent form (Annex 2)
- Referral Form (Annex 3)
- Health Screening & Physical Examination form (Annex 4)
- Class lists (Annex 5)
- Summary Forms (Annex 6)
- School-based inspection and examination report (Annex 7)
- The Reporting format (Annex 8)
- Annual School Health Plan (Annex 9)
- Immunisation Timetable (Annex 10)
- Ten steps to School Health (Annex 11)

Article 24: Every child has the right to good quality health care, clean water, nutritious food and a clean environment

UN Convention on the Rights of the Child



3

Unit 3: School Health Services Package

Specific Objectives

At the end of this unit, the trainers will have:

1. Understood what is a total package for health services for school going population under HPS; and
2. What is the equipment every school must have in order to deliver on-site health services in schools?

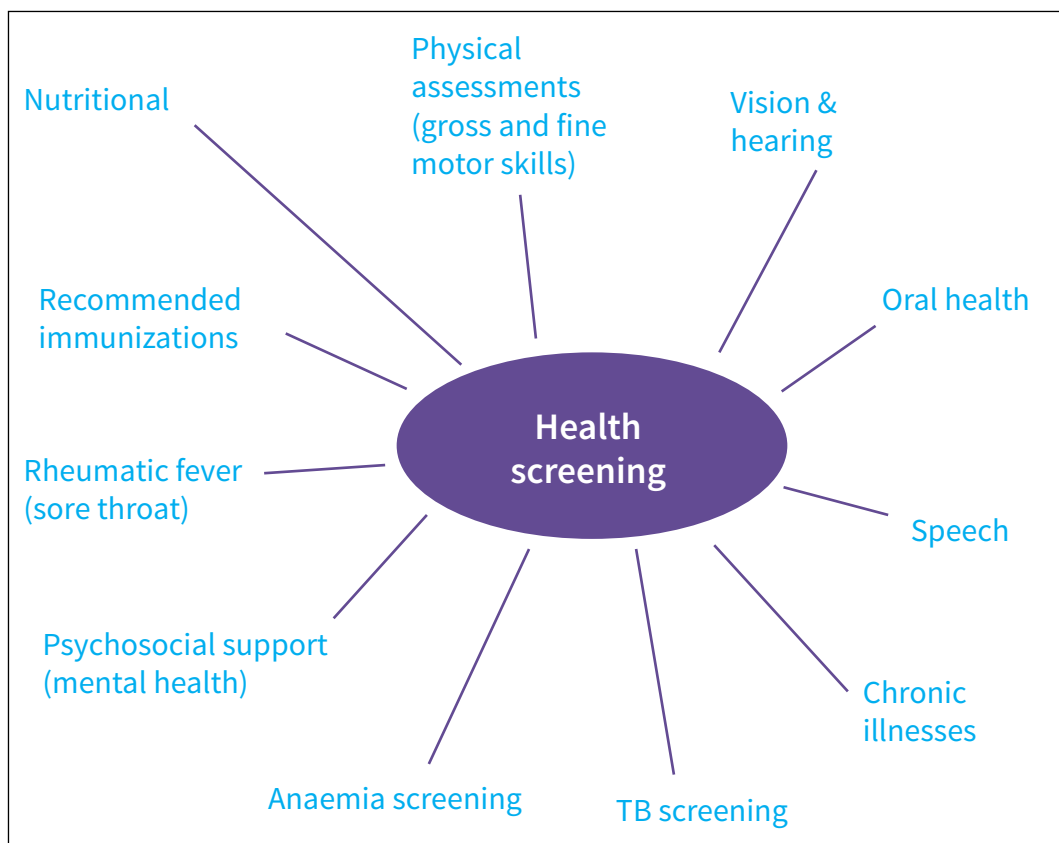
Methodology: PowerPoint presentation, information sharing

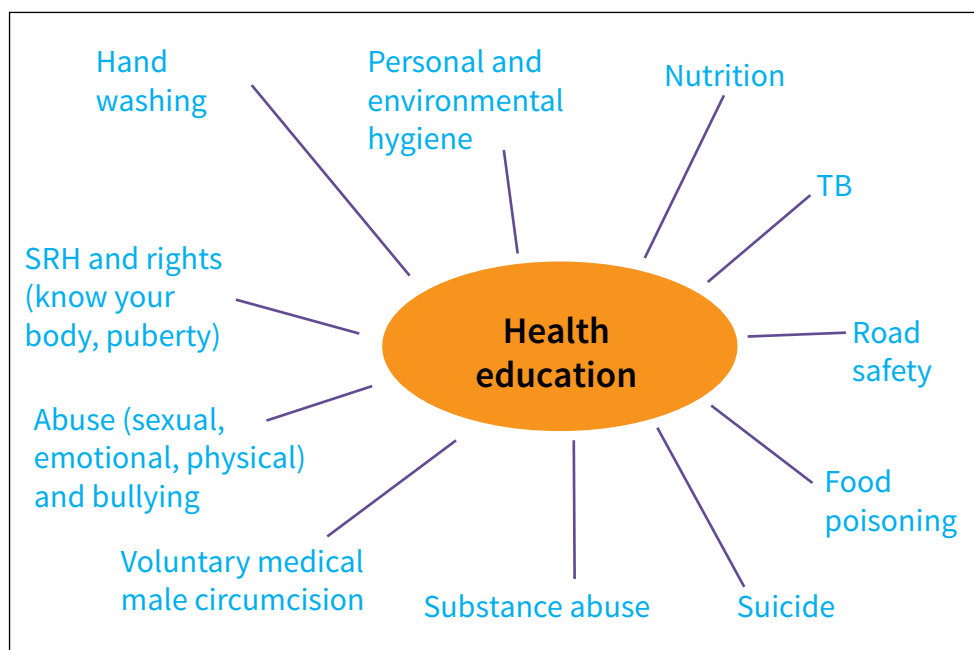
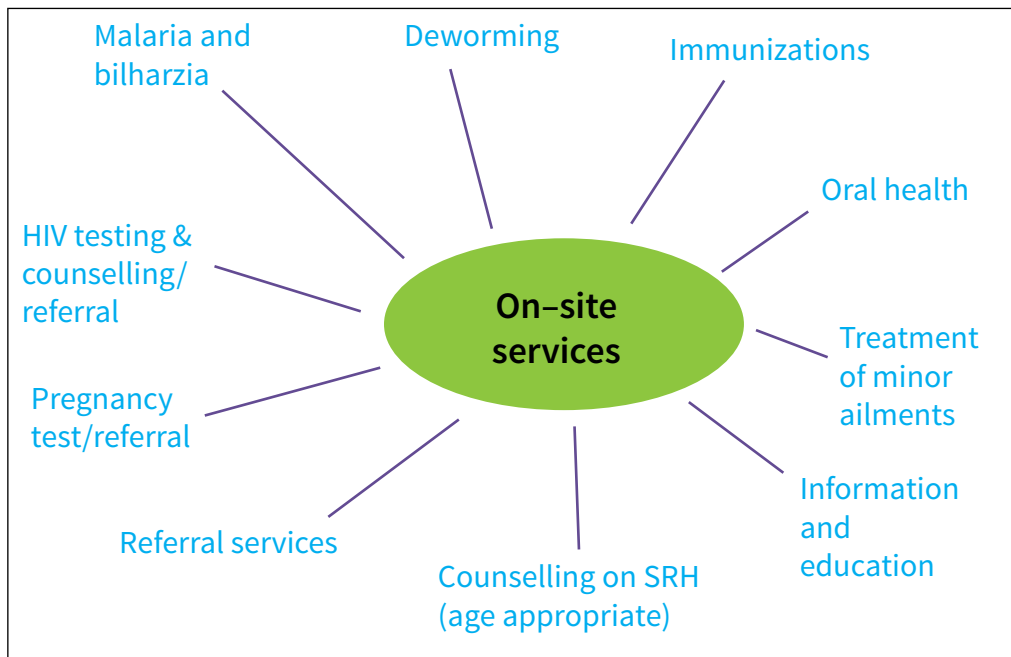
Materials: Flipchart paper, markers, equipment for assessment of trainers

3.1 School Health Services Package

We will now look at an overview of a total package for health services to school-going children under the Health Promoting Schools. The HPSI intends to increase the on-site services to schools. School Health Nurses (SHN) will be increasingly required to screen, prescribe and disperse medication to learners. The goal of HSPI is to improve access to appropriate treatment for learners and at the same time to ensure that regulations regarding prescribing and dispensing are followed and that issues related to safety are addressed.

The following charts are an indication of services that ought to be rendered available for learners in pre-primary to grade 12.





activity

Activity: School health services – 20 minutes

Divide the participants into four groups, each consisting of five members. Provide each group with flipchart paper and markers. Groups have to look at the school health package and determine who is responsible for each service. Each group provides feedback to the plenary.

3.2 School health screening equipment

For a school to optimally carry out a school health programme, it must have adequate equipment. Table below lists the necessary equipment for the most important health screens that can be done as an on-site service in schools.

Table 1.1. School health screening equipment

Service	Equipment & Other Supplies	Responsible Person
Anaemia screen (Haemoglobin test)	Haemoglobin meter	Nurse
Anthropometric measurement	<ul style="list-style-type: none"> Digital weighing scale Calculator Stadiometer MUAC tapes WHO standard reference charts for girls and boys: BMI for age, height for age, weight for age standard charts 	Nurse/Teacher
Long term health conditions	No additional equipment	Nurse
De-worming	Medicine	Nurse/Teachers
Gross and fine motor skills	No additional equipment	Nurse/Teacher
Hearing and external ear examination	Screening Audiometer Otoscope/ENT set (+ ear pieces with different sizes)	Nurse/Audiologist/ Medical Rehabilitation Worker
Immunisation	Emergency tray	Nurse
Oral health	Torch, Mouth mirror	Nurse/Teacher
Psychosocial screening	No additional equipment	Nurse/Teacher
Sexual and reproductive health	No additional equipment	Nurse/Teacher
Speech	No additional equipment	Nurse/Teacher/ Speech Therapist
TB screen	Stethoscope	Nurse
Vision and external eye examination	<ul style="list-style-type: none"> Snellen Chart: Alphabet/E chart Penlight with a +10.00D lens or ENT set with torch Reading card Occluder (eye cover) 	Nurse/Teacher/ Optometrist



activity

Activity: Equipment – 45 minutes

Divide into four groups. Provide different equipment on four tables. Allocate a table to each group. Allow groups to use the equipment on each other to become familiar with it. (10 minutes)

Groups move to the next table to familiarise themselves with the use of the equipment. (10 minutes)

Groups move to the next table. When all four groups have visited all four tables. Groups need to take their seats.

Ask participants how they felt when using the equipment. Ask whether they will be able to use it when assessing learners.

4

Unit 4: School-based screening for the most important conditions affecting Namibian children

Specific objectives

At the end of this unit, the trainers will have:

1. What are the most common diseases which impede the education process of Namibian children?
2. How to recognise common signs and symptoms?
3. How to refer the affected learners to appropriate health services? and
4. What is the importance of immunisation in children?

N.B. Please note that the list of conditions/diseases affecting covered in this Unit is not exhaustive: some important diseases which also affect Namibian learners are covered in the respective modules: mental health problems and substance abuse (Module 3) and Sexually Transmitted Diseases (Module 4).

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, markers, equipment for assessment of trainers



Facilitator's Notes

4.1. Mandatory screening for vision and hearing

4.1.1 Vision

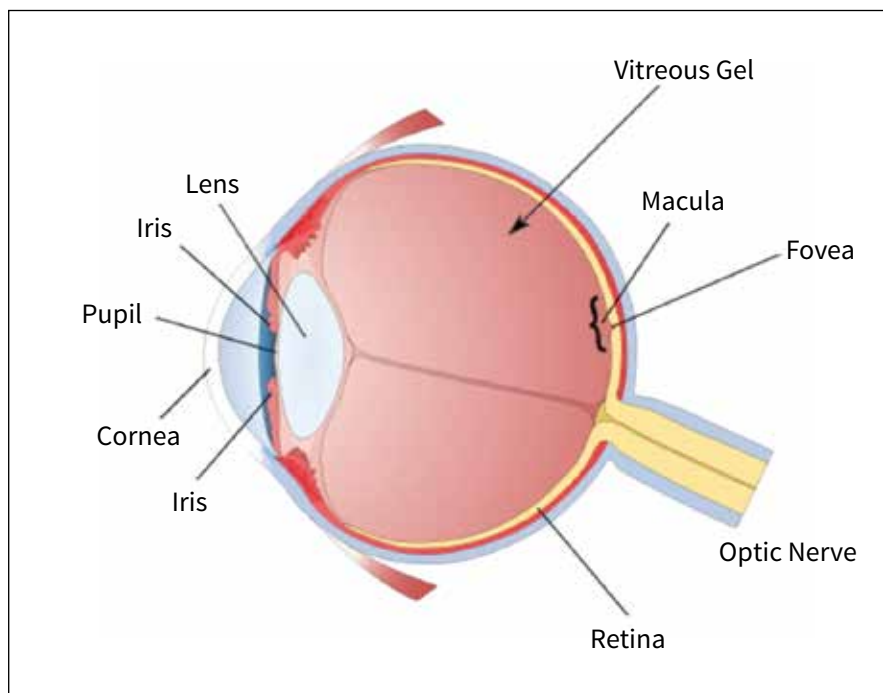
Background on people with visual impairment in Namibia

The Namibian Federation of the Visually Impaired is an umbrella body organisation of the regional associations and leagues for the visually impaired in Namibia. It is a non-governmental organisation registered with the Ministry of Health and Social Services and currently the organisation has approximately 7000 registered members.

How the eye works

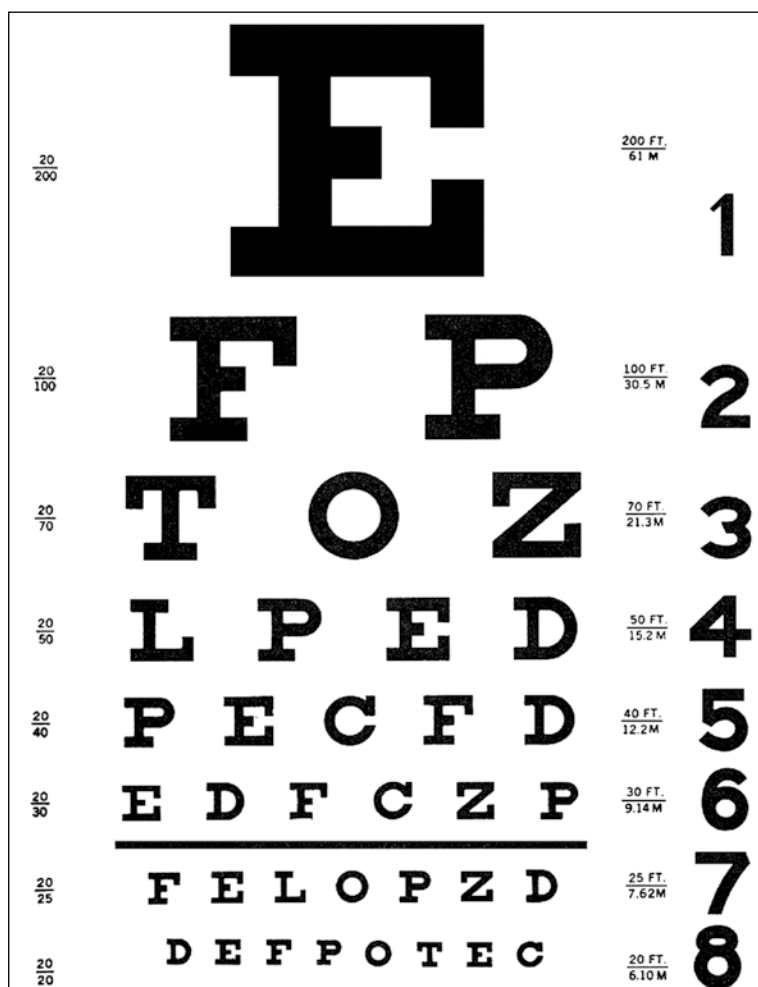
The human eye can be compared to a camera which gathers, focuses, and transmits light through a lens to create an image of the environment. In a camera, the image is created on film; in the eye, the image is created on the retina, a thin layer of light sensitive cells at the back of the eye. The lens of the eye refracts (or bends) light that enters the eye. The cornea, which is a clear, transparent covering in the front portion of the eye also contributes to focusing light on the retina. Nerve fibers extending back from the retina's nerve cells come together behind the retina to form the optic nerve, a "cable" of nerve fibers connecting the eye with the brain. The optic nerve transmits messages about what we see from the eye to the brain. Like a camera, the human eye controls the amount of light that enters the eye through the lens under various lighting conditions.

Figure 1.3: Diagram of basic eye anatomy



Source: 2013 Diagram Resources

Figure 1.4: Snellen Chart



Definition of visual impairment. Screening for visual impairment

Visual impairment is a term used to describe any kind of visual loss, whether the person cannot see at all or just has partial visual loss. In the case of young children or any person who cannot read letters, a tumbling “E” chart is used. The examiner asks the person to use their left or right hand to show in which direction the “fingers” of letter E on the chart are pointing: right, left, up or down.

The main tool used for vision screening in school is the Snellen chart (see Figure 4). It has several row of letters: the ones on top are largest, and the letters on bottom are the smallest. The child stands at 6 a meters distance from the chart covering one eye. The child is supposed to read from the top down to test what is the smallest row of letters the child can see on the chart.

- 6/6 vision (6/6/ visual acuity) is considered “normal” vision. If the child has 6/6 vision, this means that the child can read a letter at 6 meters that most human beings should be able to read at a distance of 6 meters.
- If the child can only read the big E on the top of the chart, her/his vision is considered 6/60. This means that the child can read a letter at 6m what a people with “normal” vision can read at 60m. In other words, the 6/60 visual acuity is very poor.

Table 1.2. Classification of vision based on Snellen chart performance

Visual impairment	Visual acuity based on Snellen chart performance (in the better eye with best available correction)
Normal vision	6/6 to less than 6/18
Moderate visual impairment	Less than 6/18 but better than 6/60
Severe visual impairment	Less than 6/60 but better than 3/60
Blindness	Less than 3/60 but no light perception (NLP)

Signs of visual impairments

A child with poor vision may show or express the following:

- Closes or cover one eye
- Squints (narrow the eyes) or frowns when reading or copying from the board
- Has one eye that turns in or out, especially when tired
- Complains of double vision
- Avoids reading, writing or drawing, or has short attention span in reading writing drawing or copying
- Complaining that things are blurry or hard to see (e.g. can't see what is written on the board)
- Has trouble reading or doing other close-up work or hold objects close to eyes in order to see
- Copies from a peer's book instead of the board
- Writes up or down hill on paper and/ or has excessively sloppy handwriting which becomes smaller, crowded or inconsistent in size

- Blinks more than usual or seems irritable or frustrated when doing close-up work (such as looking at books)
- Complains of eyes burning or itching after reading or writing
- Frequently rubs the eye
- Has excessively teary eyes
- Has unexplained headaches
- Leans on or feels walls to guide him/herself

School vision screenings are important and can help to detect eye conditions that are defined as “commonly occurring,” meaning that they occur in more than 1% of the school-going population. Early detection of vision problems has a demonstrated impact on quality of life for students. Traditional school vision screenings have focused on myopia (nearsightedness), children need to receive an eye exam by an eye doctor in a clinical setting that can detect issues with distance vision, close vision, color detection, and binocular vision.

Management

If the child / learner is experiencing any of the above signs and symptoms, it is an indication of not seeing well, and medical help is necessary. He/ she may need glasses, other low vision aid, or other medical intervention.

NB: Most visual problems can be managed with eye glasses or medicine, but in some cases surgery may be required for conditions such as cataracts.

Preventive Measures

- Regular check ups
- Detect early visual defects and refer for appropriate services
- Protect eyes from dangerous objects
- Protect eyes from sharp/strong sunlight and any other harmful light by using sunglasses or other protective glasses
- Avoid any irritant or toxic substances in the eyes
- Provide health education on prevention of eye diseases and proper care of the eyes in order to ensure better and lasting eye-sight.
-

4.1.2 Hearing Screening - The Ear (Hearing Loss)

Background on People with Hearing Impairment in Namibia

In Namibia out of 98,413 people who are estimated to have a disability, 6.4% are categorised as Deaf and 9.6% are reported to have hearing difficulties (Namibia Statistics Agency, 2011). While this number of individuals with hearing difficulties may seem meagre in relation to the general population in the country, it will not represent the effect of hearing loss on the individual person (adult or child) and his/her life. Hearing is critical to speech and language development, communication and learning and absence of this ability can affect the child in the following manner:

1. It causes delay in the development of receptive and expressive communication skills (understanding and producing speech and language).
2. The language deficit causes learning problems that result in reduced academic achievement.
3. Communication difficulties often lead to social isolation and poor self-concept.
4. It may have an impact on vocational choices.

How the ear works

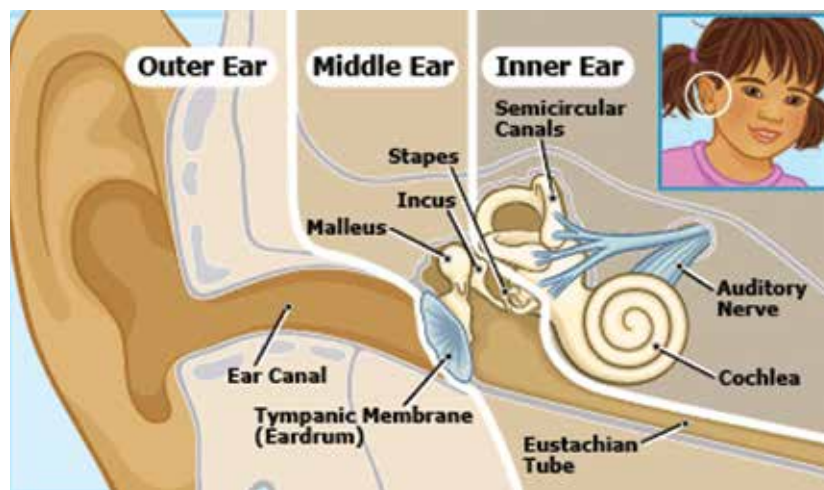
The ear comprises of three main parts i.e. the outer, middle and inner ear.

Sound travels through the air (via vibration) and is caught by the outer ear. The sound then travels through the external meatus (ear canal) and hits the tympanic membrane (eardrum). The ear drum passes the vibrations on to the middle ear, which contains the three smallest bones in the body (malleus, incus and stapes). These little bones begin to move when the eardrum is pushing against them and pass on the vibrations further. Through this movement the sound is transferred to the inner ear.

The inner ear (cochlea) has the shape of a snail. It is filled with fluid and contains many little nerve cells, called hair cells. When these hair cells are moved by the vibration, i.e. waves of the liquid, they send the sound message through the auditory nerve (cochlear nerve) to the brain, where it is processed so that we understand what was heard.

A child with hearing impairment has damage to one or more parts of the ear (somewhere along the auditory pathway).

Figure 1.5: Basic anatomy of the ear



Source: The Nemours Foundation

Types of hearing loss

There are three main types of hearing loss, namely:

- **Conductive hearing loss** - an interference in the transmission of sound to the inner ear. In other words, the breakdown in sound transmission occurs in the outer ear and/or middle ear. Infants and young children frequently develop conductive hearing loss due to ear infections. This loss is usually temporary and treatable with medicine or surgery.
- **Sensorineural hearing loss** - malformation, dysfunction, or damage of the inner ear (cochlea). The most common type is cochlear hearing loss which can be hereditary or arise as a result of medical problems before, during or after birth. Children with this type of hearing loss can often be helped with hearing aids, except in cases of profound deafness.
- **Mixed hearing loss** - when there is a combination of a conductive and sensorineural hearing loss. This means that the breakdown in sound transmission occurs in the outer and/or middle ear as well as the inner ear. These cases are managed by first treating the cause of the conductive hearing loss (e.g. ear infection) and then addressing the sensorineural hearing loss, if possible by fitting a hearing aid.

The severity of hearing loss

The measurement of hearing involves two parameters: the frequency or pitch of the sound (low vs high) and the intensity or loudness of the sound (soft vs loud). The device used to measure a person's responses to sound is called audiometer. The responses to the different sounds are marked on a graph called audiogram. An audiogram plots how soft a person can hear when the hearing levels are measured.

The numbers across the top indicate the frequencies (pitch). They are measured in Hertz (Hz). Although the range of hearing in the human ear is from 20Hz to 20 000Hz, the audiogram shows the frequencies that are essential for human speech, i.e. from 250Hz to 8000Hz. The numbers from the top to the bottom measure intensity. Intensity is measured in decibels (dB) and often ranges from -10dB to 110dB. As the number increases, the intensity or loudness of the sound increases at each individual frequency. Similarly, as the number decreases, the loudness of the sound decreases at each frequency.

The responses charted on the audiogram define the levels of hearing in each ear at each frequency. They are classified into the following categories:

Table 1.3. Categories of hearing (loss)

Range	Category of hearing (loss)
-10dB to 25dB	Normal hearing levels
25dB to 40dB	Mild hearing loss
40dB to 55dB	Moderate hearing loss
55dB to 70dB	Moderate/severe
70dB to 90dB	Severe hearing loss
>90dB	Profound hearing loss

In order to formally determine whether a hearing loss is present, hearing levels in both ears should be screened at 20dB at 500Hz, 1000Hz, 2000Hz and 4000Hz. A person who is able to hear at 20dB or softer in either ear, has normal hearing levels in both ears.

Screening for hearing loss

School-age hearing screenings are an important tool in identifying children with hearing loss who were not identified at birth or who developed hearing loss later in their lifetime. Efforts to provide consistent protocols, screener training and follow-up through school-age will help ensure that children with hearing loss are identified and managed in a timely manner. This in turn can minimize negative personal, social and academic consequences.

The school or community health nurse should coordinate a school-based hearing screening programme. The planning for a hearing screening programme should include school management and where possible, other health professionals employed in education.

4.2 Oral Health

Specific Objectives

By the end of the Unit, participants would understand the basics of:

- oral anatomy
- the most common dental diseases /conditions and prevention
- the most common soft tissue conditions/diseases of the oral cavity
- harmful practices on oral health and how to manage them

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, markers



Facilitator's Notes

Oral hygiene in schools

Many school-going children suffer from oral diseases. This contributes to learners not attending school and receiving poor academic results.

The rapidly growing burden of oral diseases are closely linked to unhealthy environments and to lifestyles that include diets rich in sugars, widespread use of tobacco and excessive consumption of alcohol. Most oral diseases are also dependent on clean water, adequate sanitation, proper oral hygiene and appropriate exposure to fluorides. Oral disease control and public health need to take integrated approaches to health promotion and disease prevention based on common risk factors.

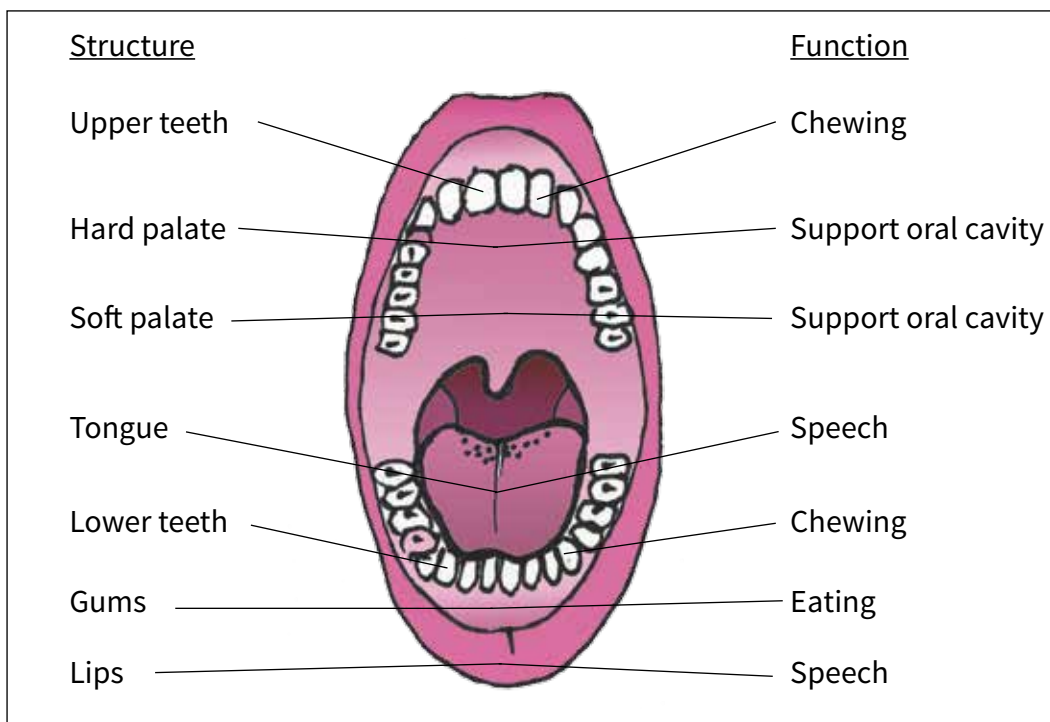
National programmes which include training of teachers and learners on health promotion and primary prevention of oral diseases are important and should include:

- effective use of fluorides for prevention of dental caries: the goal is to implement appropriate means of maintaining a level of fluoride through fluoridated drinking-water, salt, milk or affordable toothpaste
- oral health and prevention of oral disease through a healthy diet, i.e. education and advocacy for reduced consumption of sugars and increased intake of fruits and vegetables
- control of tobacco-related oral disease by involving oral health professionals in tobacco cessation and preventing children and youth from adopting the tobacco habit
- oral health through health-promoting schools
- development of oral health systems and orientation of services towards prevention and health promotion
- advocate for oral hygiene habits

Basic oral anatomy

Knowledge of the structures of the mouth, their locations, and naming is important in helping children maintain good oral health. Figure 4. shows major structures and organs in the mouth.

Figure 1.6: Major structures and organs in the mouth



activity

Activity: Equipment – 15 minutes

Divide into groups and identify the different parts of the mouth (internal and external). List them on the flipchart provided. List the function of each part.

Common dental diseases

1) Tooth decay

Definition

Tooth Decay is the formation of holes or cavities on the tooth as a result of acid produced by the bacteria found in plaque.

2) Gum diseases

Definition

Gum disease refers to inflammation of the gums presenting with painful, reddish swelling and bleeding easily.

Table 1.3: Cause, signs and symptoms and treatment of tooth decay and gum disease

	Causes	Signs & Symptoms	Treatment
Tooth Decay	<ul style="list-style-type: none">• High consumption of foods with high sugar content• NB: frequency is more important than the quantity of sugar (eg. eating one bar of chocolate once a day is not as harmful as eating smaller quantities more frequently)• Poor oral hygiene	<ul style="list-style-type: none">• Tooth may change from white to dark or yellow colour/pain/sensitivity when chewing or drinking sweet, hot or cold fluids• Swelling due to dental abscess	<ul style="list-style-type: none">• A dentist will restore teeth by using a filling or crown replacement. If the tooth is beyond repair it may be extracted.
Gum Diseases	<ul style="list-style-type: none">• Accumulation of plaque and calculus around the gums caused by poor oral hygiene which attracts bacteria.	<ul style="list-style-type: none">• Swollen reddish gums, bleeding easily• Gums may separate from teeth• Teeth become loose• Unpleasant smell in the mouth.	<ul style="list-style-type: none">• Professional oral hygiene by scaling and root planing (cleaning between the gums and the teeth down to the roots)• Surgery• Mouth wash and antibiotics• The dentist may need to use a local anesthetic to numb the gums and the roots of the teeth

Prevention

Tooth Decay

- Reduce sugary food intake
- Eat more fruits
- Brush teeth twice a day using fluoridated tooth paste
- Visit the dentist at least twice a year for a routine dental checkup.

Gum Diseases

- Brush teeth thoroughly with a proper technique, toothpaste and toothbrush at least twice a day
- Rinse mouth thoroughly after every meal
- Floss teeth every day
- Brush tongue
- Visit the dentist at least twice a year for a dental check-up

Proper tooth brushing technique

Toothbrush

- Use a toothbrush with medium end-rounded bristles
- Choose the correct size in accordance to the size of your oral cavity
- Change toothbrush every 3 months or when the bristles are bent or after an infectious disease such as TB or strep throat has been diagnosed
- Use chewing stick if there is no toothbrush

Toothpaste

- Use fluoridated tooth paste

Technique

- Brush all surfaces of the teeth (buccal, lingual, proximal and occlusal)
- Brush teeth systematically starting from one side of the jaw to the other and cover only a few teeth at a time. Brush top and bottom teeth with slow circular movements.
- Hold toothbrush at an angle of 45 degrees toward the gums
- Remember to brush the tongue
- Use clean water for rinsing
- Store tooth brush in an upright, covered position to keep germs away
- NB: Do not leave toothbrush in the toilet
- Chewing sticks can be used when toothbrush and/or toothpaste is not available



Activity: Oral health – 30 minutes

Divide into four groups. Each group should have a toothbrush, toothpaste and dental floss. One group member should demonstrate how to brush teeth and floss. The other members should comment on whether the teeth were brushed and flossed correctly or not.

4.3. Personal hygiene

Specific objectives: Connecting the notion of personal health to maintenance of personal hygiene and identifying ways of preventing diseases through maintenance of personal hygiene

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, markers



Facilitator's Notes

Personal health is the state of physical and mental fitness which enables the person to carry out various daily activities in order to fully realise one's potential as a human being. The most important precondition and at the same time the simplest way to achieve this result is to take care of one's personal hygiene. Hygiene plays an important role in preventing many bodily diseases. Prevention is achieved by maintaining personal hygiene of those parts of the human body that require special care and attention:

- The human skin, as the prime focus of hygienic cleaning;
- The apertures and holes that are exposed more to dirt – the eyes, ears, urinals and anus;
- Areas that are not exposed to sunlight and air such as the arm pits and pubic areas;
- Teeth and mouth.

4.3.1. How to maintain personal hygiene and personal health

The following skills must be practised regularly in order to maintain personal health and reduce the chance of diseases:

1. **Bathing:** washing all parts of the body with clean warm water and soap. Bathing cleanses the skin from excess secretion, perspiration, cumulative dirt and germs which produce bad odours. Since the skin is the body's first line of defence in its fight against germs, hygiene supports skin health. Other advantages of bathing include activating the blood circulation, relaxation and feeling refreshed.

2. **Hair washing:** As one of the skin's outgrowths, hair gets its nutrition from the hair roots. Upon washing and cleaning or combing one's hair, blood circulation in hair roots is activated by rubbing and massaging the scalp with the tips of one's fingers.
3. **Oral and dental care:** covered in 4.2 above.
4. **Eyes, ears and nose care:** Senses have an important role in effective communication, keeping the body and environment safe and avoiding the risks to human life and health. Eyes ought to be washed daily and their inner corners (that are close to the nose) are wiped with a cotton pad or soft handkerchief towards the outer corners in order to remove eye secretion and dust and prevent them from entering to the nasal tear canal. As for the ears, they are to be wiped (after bathing) with a smooth towel or cotton swab, which should not be pushed into the ear canal because that would cause the earwax to clog the canal and weaken hearing. The best way for nose care is to gently wipe it with a handkerchief and cleanse the area around nostrils with lukewarm water and soap.
5. **Manicure:** Nails are clipped and filed in an oval way; one should avoid over-clipping the nails in order not to infect or injure the surrounding skin.
6. **Pedicure:** Foot care takes place during bathing as the feet are rubbed and massaged with lukewarm water and soap. Longer toe nails are then clipped in a straight shape, and if available, a moisturizing cream is applied to prevent the toe nails from cracking. Another requirement for foot care is selecting/using proper and comfortable shoes.
7. **Genitalia care:** This area needs special care for healthy and sick males and females alike. Hence, it should be washed and cleaned numerous times a day with soap and water to remove dirt caused by various types of body secretions like sweat, urine, faeces, vaginal discharges and odours. Women have to have special care for these body parts particularly during menstruation; the pads should be constantly changed. They are usually placed starting from front to back; the area is also cleaned in the same direction (from front to back). Unlike what is wrongly and commonly believed, it is preferable to take daily showers during menstruation.

Remember: Excessive use of cosmetics can do more harm than good to your skin and health.

4.3.2. Common diseases caused by poor personal hygiene: lice and scabies

Lice (Phthiriasis) can infect hair, pubic and arm-pit areas and skin. Based on the place where it exists on the human body. Phthiriasis is transmitted from one person to another upon rubbing or touching the infected body parts and using the infected person's tools and clothes.

It is therefore very common in pre-primary care and primary level schools. Its symptoms include severe itching of the head and body. It is very difficult to remove even when washed. Lice has to be treated, usually with Gamma Benzene Hexchloride, and combing the hair thoroughly until all nits have been removed. The procedure must be repeated after a week. The combs and brushes must also be kept cleaned at all times.

Figure 1.7: Proper handwashing technique



Source: World Health Organisation



activity

Activity: Personal hygiene techniques – 40 minutes

The trainers are divided into four groups and asked to:

1. Explain the importance of personal hygiene for personal health;
2. List the most important techniques for maintaining personal hygiene.
3. List the most important situations in daily life when it is essential to wash hands.

It is very important to use the personal hygiene techniques properly. The example of hand washing is then used as an illustration. The trainers are asked to perform hand washing exercise in order to ensure that every learner in school can also wash hands adequately. Group members then evaluate each other and share best practice so as to ensure the golden standard of hand washing:

1. Use of bar soap/liquid soap
2. Use of lukewarm running water
3. Thorough rubbing of all surface areas of the hand and the root of the hand.

Skin infection due to Scabies

Scabies is caused by small insects which spread through touching, infected skin or clothes.

Scabies make tunnels under the skin and cause little itchy bumps in the body. They frequently nest in warm places on the human body such as: areas between fingers, on the wrists, around the waist, on the genitals, and from there they easily spread to other parts of the body.

Scabies itch especially during the night and cause the person to scratch which cause further skin infections and inflammation resulting in pus. The resulting skin infection can lead to fever.

Figure 1.8: (clockwise) a. and b. Skin infected with scabies; c. Nits; d. Head lice

A



B



C



D



Source: Ministry of Health and Social Services, Republic of Namibia

Management of Scabies

- Smear Benzyl Benzoate (BBE) lotion all over the body from the neck down (the HEW or caregiver can buy BBE in the pharmacy or get it at the health facility)
- Leave the lotion on the body overnight; do not wash it off; it will kill the scabies insects
- The next night, put lotion on again, over the child's whole body, and leave for another night
- Then do it again for a third night; the 3 day treatment will kill scabies insects and their eggs
- To keep from getting scabies again, take out all of the clothes and sleeping bedding and wash it with soap and hot water, and then put it in the full sun to dry
- You need to treat the whole family and all of their clothes and sleeping bedding; if one person has scabies, everyone else will get infected.

Educate the learners on the prevention of scabies, lice and worms:

- Bathe daily with soap and clean water and change clothes daily to prevent scabies and lice
- Always hang the bedding and clothes in the sun to prevent scabies
- Wash the your hair regularly with shampoo to prevent lice
- Avoid sharing combs to prevent lice

4.4. Tuberculosis (TB)

Specific Objective: To provide knowledge on basic information on TB infection, risk factors, mode of transmission, sign and symptoms and prevention.

TB is a disease which commonly affects lung and is caused by bacteria called *Mycobacterium tuberculosis*. When it affects the lungs, the disease is referred to as pulmonary TB. However, the TB bacteria can also affect other parts of the body e.g. brain, kidneys etc. This type of TB is called extra-pulmonary TB, in other words, it affects organs other than the lungs.

Figure 1.9: Mode of transmission of TB

1 TB is spread when a person with TB disease coughs, sings, or speaks and you breathe the air contaminated with TB germs.

2 The germs reach your lungs. From there, they can go to other parts of your body.

3 Your body fights the TB germs.

4 If your body controls the germs, you have **LATENT TB INFECTION**. When this happens,

- You may have a positive TB skin test or TB blood test.
- You don't feel sick.
- You don't have TB symptoms.
- You can't give TB germs to others.
- You have a normal chest x-ray.

5 Taking your TB medicine is very important. You need to take the medicine to help get better and to prevent the spread of TB germs to others.

6 You get TB DISEASE when the TB germs multiply and attack your lungs or other parts of your body. When this happens,

- You have a positive TB skin test or TB blood test.
- You feel sick with cough, fever, weight loss, chest pain, or sweating at night.
- You have active TB germs in your body.
- You may give TB germs to others.
- You may have an abnormal chest x-ray.

7 TB is spread when a person with TB disease coughs, sings, or speaks and you breathe the air contaminated with TB germs.

STOP TB

LATENT TB INFECTION and prevent getting TB DISEASE.

Source: Center for Disease Control

4.4.1. Mode of transmission and risk factors for transmission of TB

TB is spread when someone with TB of the lungs coughs and releases TB bacteria in the air. If someone breathes in these TB bacteria, they can get infected as well.

Risk factors that increase the likelihood of TB transmission:

- Overcrowding: sharing the same breathing space with someone with TB in an over-crowded and poorly ventilated place;
- Poverty;
- Poor nutrition – causes weak body defenses;
- Excessive alcohol consumption;
- Smoking;
- Diseases that weaken the defense system for example, HIV, diabetes, dancer etc.
- Prolonged exposure to a person with untreated or poorly treated with TB of the lungs;
- People with weak defense system, like malnourished children, elderly etc.

4.4.2. Signs and symptoms of TB

TB	- Current cough of more than 2 weeks duration - Blood in sputum
signs	- Chest pain - Night sweat - Fever
symptoms	- Loss of appetite - Weight loss

Other signs and symptoms may include enlarged lymph nodes as well as breathlessness and fatigue, depending on the site affected by the bacteria.

4.4.3. Treatment of TB

Treatment of tuberculosis (TB) takes six to nine months and sometimes longer. It is possible to cure TB by taking the medications, most importantly antibiotics, exactly as prescribed by a qualified doctor for the full course of treatment (at least six months). Treatment of TB is more challenging in cases of children who are under-nourished and/or are HIV+. Special efforts must be made to ensure additional support and care is provided to such children.

4.4.4. Prevention of TB

- Go early for diagnosis and treatment if you have signs and symptoms of TB
- Ensure that those with TB take their treatment and get cured
- All people should cover their mouth and nose when coughing and sneezing
- Make sure that all people who have spent time with TB patients (especially children and adults with a persistent cough) get tested for TB
- Promote good air circulation and lighting in homes, transport and other public places
- Trace all school-going children on TB medicines who have not adhered to treatment and ensure they comply with the treatment

4.5.2. Signs and symptoms of malaria

Malaria	- Fever - Headache
signs	- Muscle ache - Chills
symptoms	- Fatigue - Vomitting

In cases of severe Malaria the following can be observed: confusion, seizures, anemia, respiratory failure, kidney failure, coma and shock. If not treated immediately, malaria can lead to death. Therefore, school communities are advised to visit the nearest health facility for early treatment as soon as symptoms are recognized.

4.5.3. Control and prevention of malaria

- Indoor residual spraying of houses with insecticides;
- Long lasting Insecticidal nets in malaria prone areas to control adult mosquitos;
- Winter larviciding in selected water bodies to control mosquito larvae;
- Prophylaxis when traveling to areas where malaria is endemic.

Other important interventions include use of mosquito repellants and traditional herbs to repel mosquitoes and also wearing long sleeve clothes at night when outdoors as well as community mobilization and advocacy on malaria prevention.

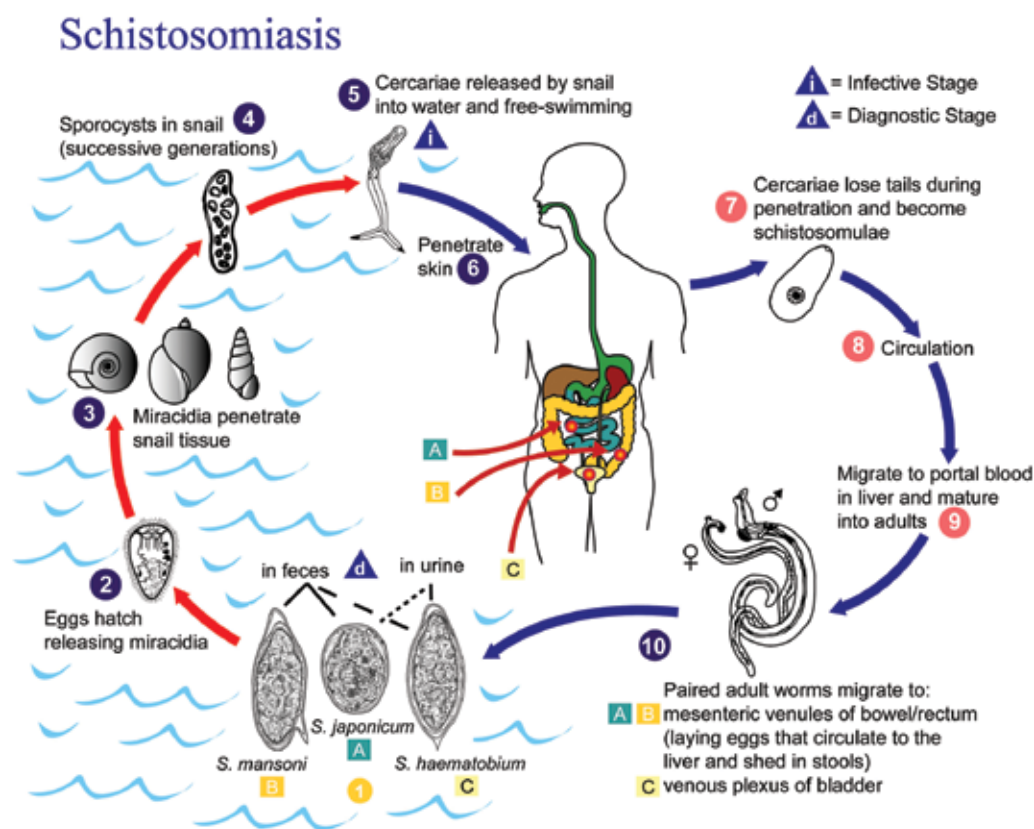
4.6. Bilharzia (Schistosomiasis)

Bilharzia is a chronic, parasitic disease caused by blood flukes (trematode worms) of the genus *Schistosoma*. Bilharzia is prevalent in Zambezi, Kavango and Omusati regions and the most common types found in these regions are *S. hematobium* which affects the urogenital organs and *S. mansoni* which affects the intestines.

4.6.1. Mode of Transmission of bilharzia

People become infected when larval forms of the parasite – released by freshwater snails – penetrate the human skin during contact with infested water. (Lifecycle of Bilharzia)

Figure 1.11: Life cycle of Bilharzia parasite



Source: Wikimedia.org

4.6.2. Signs and symptoms of bilharzia

Symptoms of bilharzia are caused by the body's reaction to the worms' eggs, not by the worms themselves.

As noted before, the symptoms of bilharzia infection are grouped based on the organ system they affect:

1. Intestinal bilharzia is suspected when the person complains of:

- Stomach pain;
- Diarrhea;
- Blood in the stool;
- Liver enlargement in advanced cases and often leads to accumulation of fluid in the peritoneal cavity (gap between the walls of the abdomen) and high blood pressure in the abdominal blood vessels.

2. Urogenital bilharzia is manifested with:

- Blood in urine;
- Fibrosis of the bladder and ureter;
- Kidney damage in advanced cases;
- Bladder cancer is another possible late-stage complication
- In women, bilharzia can damage the genitals and cause vaginal bleeding and pain during sexual intercourse.
- In men, bilharzia can damage seminal vesicles, prostate and other organs.

4.6.3. Control and prevention of bilharzia

The control of bilharzia is based on large-scale treatment of at-risk population groups, access to safe water, improved sanitation, hygiene education and snail control. Bilharzia control focuses on reducing disease through periodic, targeted treatment with the drug Praziquantel of the following at-risk groups:

- School-aged children in endemic areas;
- Adults considered to be at risk in endemic areas, people with occupations involving contact with infested water – such as fishermen, farmers, irrigation workers – and women whose domestic tasks bring them into contact with infested water;
- Entire communities living in highly endemic areas.

The frequency of treatment is determined by the prevalence of infection in school-age children. In high transmission areas, treatment may have to be repeated every year for a number of years. Monitoring is essential to determine the impact of control interventions.

4.7. Soil Transmitted Helminthes (STH) (Worms)

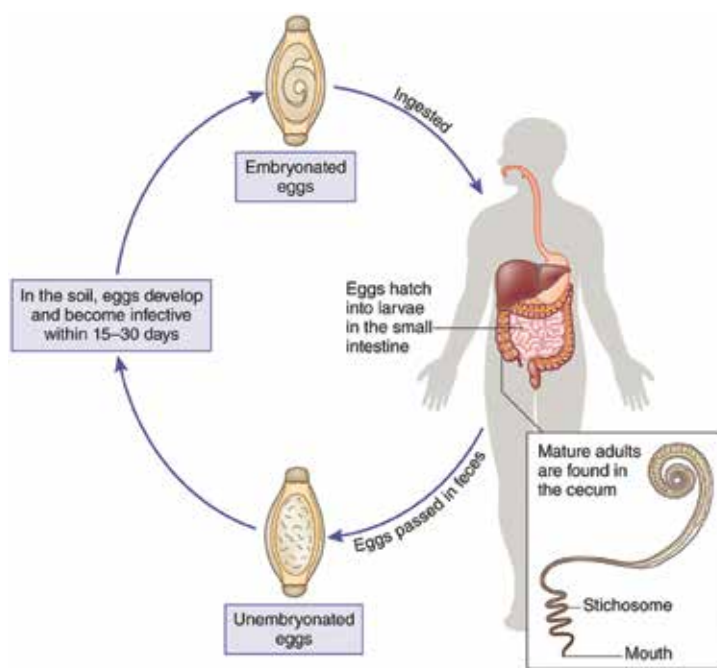
Soil-transmitted helminthes infections are among the most common infections worldwide and affect the poorest and most deprived communities.

4.7.1. Mode of transmission of STH and risk factors

The worms are transmitted by eggs present in human faeces which in turn contaminate soil in areas where sanitation is poor. The main species that infect people are the:

1. Roundworms;
2. Whipworms; and the
3. Hookworms.

Figure 1.12: Life cycle of soil parasite



Source: *Nature Genetics* 46. 661-663 (2014)

Risk factors that increase the likelihood of children getting infected with worms:

- Walking barefoot on soil that may be contaminated with sewage, where human feces may have been used as fertilizer, or where people may have defecated.
- Contaminated food or hands.

4.8.2. Signs and symptoms of STH

Most infections show no obvious signs especially when few worms are present. A small percentage of humans experience lung problems when roundworm larvae pass through the lungs.

Round-worms	- Discomfort and blockage of intestines - Weight loss
Hook-worms	- Anemia - Blood and protein loss
Whip-worms	- Dysentery - Rectal prolapse (a condition where part of the rectal wall sides out of the anus)

Importantly, all soil-transmitted helminthes impair the nutritional status of infected children sometimes causing death through:

- Intestinal bleeding, loss of appetite, diarrhea or dysentery, and reducing absorption of micronutrients;
- Complications that require surgical intervention (in cases of intestinal obstruction and rectal prolapse).

4.7.3. Control and prevention of STH

Control interventions are based on the periodic administration of anthelmintic to groups of people at risk, supported by the need for improvement in sanitation and health education.

WHO recommends annual treatment in areas where prevalence rate of soil-transmitted helminthiases is between 20% and 50%, and, a bi-annual treatment in areas with prevalence rates of over 50%.

4.8. Rheumatoid fever (RF)/Rheumatic heart disease (RHD)

Rheumatic fever starts with a sore throat that is known as ‘strep throat’ – a throat infection caused by a bacteria called Group A Streptococcus. Most sore throats get better on their own, but if sore throat is not treated with antibiotics it can cause rheumatic fever in at-risk children. RF is principally a disease of childhood (5-15 years) though it can develop in adults, both sexes are equally affected and can affect the heart, joints, skin, and brain.

The school occupies a unique position in relation to rheumatic fever control. A first attack usually occurs in children at the age when they are in the first or second grade and recurrences are most common up to the age when children are leaving high school. Teachers and others in daily contact with school children should be aware of early signs and symptoms which may mean acute rheumatic fever.

Risk factors for RF

The two most important factors in the epidemiology of rheumatic fever in Namibia are poverty and overcrowding. Furthermore, barriers to primary healthcare access and the subsequent higher burden of untreated strep sore throat infections are important factors leading to higher rates of rheumatic fever among Namibian children.

Signs and symptoms

- Fever;
- Painful/tender joints in the ankles, knees, elbows, and wrists;
- Pain in one joint that moves to another joint;
- Red, hot, swollen joints;
- Small nodules (bumps) under the skin that don't hurt;
- Chest pain;
- Rapid fluttering or pounding chest palpitations;
- Fatigue.

Figure 1.13: Most common symptoms of Rheumatic Fever



Source: Adapted from World Heart Federation Community Poster

Progression to Rheumatic Heart Disease

If unrecognised and untreated, rheumatic fever can cause permanent damage to the heart, including damaged heart valves and heart failure. Recurrences of rheumatic fever are likely in the absence of preventive measures which can further damage the heart, specifically the valves in the left heart. This condition is then referred to as the rheumatic heart disease (RHD). Because of its high prevalence in developing countries, RHD is the most common form of paediatric heart disease in the world. In many countries, it is the most common cause of cardiac mortality in children and adults aged less than 40 years.

Prevention

Almost all cases of RHD and associated deaths are preventable. The prevention of disease may be undertaken at a number of different levels. First line of prevention (primordial and primary prevention) aims to stop a disease occurring in the first place, while secondary and tertiary prevention aim to limit the progression and reduce the consequences of established disease. The following is an outline of preventative measures at these different levels:

1. **Primordial prevention:** broad social, economic and environmental initiatives undertaken to prevent or limit the impact of the throat (streptococcal A) infection in a population;
2. **Primary prevention:** reducing streptococcal A transmission and acquisition and treating the throat infection effectively;
3. **Secondary prevention:** administering regular antibiotics to children who have already had an episode of RF to prevent the development of RHD;
4. **Tertiary prevention:** intervention in individuals with RHD to reduce symptoms and disability, and prevent premature death.

5.0. Non-communicable diseases (NCD)

Specific Objectives: To provide knowledge and basic understanding of major non-communicable diseases important for the Namibian child: hypertension, type 2 diabetes, obesity and asthma, focusing on causes risk factors and prevention.

N.B. Allergies are explained in Module 2 (Nutrition)

Non-communicable diseases are illnesses caused by genetic factors, improper diet, inadequate physical activity, smoking, alcohol and substance abuse etc. They are called non-communicable because they cannot be passed from person to person. They are usually chronic which means the condition gets worse over a long period of time.

As NCDs are typically associated with poor diet and lack of physical activity, it is very important to encourage a healthy lifestyle of learners as these are the cornerstones of prevention and good quality of life.

5.1. Hypertension: high blood pressure

High blood pressure over an extended period of time results in hypertension. Although hypertension is mainly diagnosed in adults, it can occur in young people. High blood pressure is diagnosed when the blood pressure (BP) is consistently 140/90 mm Hg (millimeters of mercury) or above.

Measuring BP. Blood pressure should always be measured at least 5 - 10 minutes after rest, using appropriate cuff size, monitoring the device cuff and taken with the cuff positioned at the level of the heart.

Normal blood pressure in adults should be less than 120/80 mmHg. The higher, or top, number — in this example it's 120 — is called systolic pressure and represents the pressure at the peak of each heartbeat. The lower, or bottom, number (80 in this example) is called diastolic and represents the pressure when the heart is resting between beats.

Risk factors for hypertension:

1. Getting little or no exercise
2. Obesity
3. Poor food choices or poor diet
4. Genetic make-up
5. Old age
6. High salt intake for those who are susceptible.
7. Excessive alcohol consumption.
8. Pregnancy, especially during the last few months
9. Smoking
10. Coronary Heart Disease
11. Kidney inflammation
12. Use of contraceptive pills
13. High Blood lipids
14. Diabetes

Signs and symptoms of hypertension

An individual with hypertension may not know they have the condition until it begins to cause trouble to the heart, brain and kidneys. Therefore be on the lookout for some of the following signs and symptoms may be indicators for hypertension:

- Irregular heart beat
- Frequent and severe headache
- Fatigue or confusion
- Vision problems
- Weakness and dizziness
- Pounding of the heart and shortness of breath

Prevention and management of hypertension

- Healthy diet and regular exercise
- Reduce the intake of saturated fats and animal fat e.g. fat cakes.
- Limit consumption of caffeine beverages (caffeine is found in tea, coffee and some soft drinks).
- Reduce the intake of simple sugars e.g. table sugar, fizzy drinks etc.
- Take complex carbohydrates such as whole grain meal like mahangu and brown bread.
- Reduce or remove alcohol intake from your diet
- Reduce body weight by engaging in regular physical exercise and reduce the portion size of food during meal times.
- If overweight reduce the intake of foods such as refined carbohydrates and fatty foods.
- Increase the intake of fruits and vegetables in your diet especially fresh produce.
- Include nuts, seeds, or legumes (dried beans or peas) daily.
- Maintain a normal Body Mass Index (please refer to page, Module 2 Unit 4 of this TM) manual) of 18.5 to 24.9 which is within the recommended range.
- Manage stress by giving yourself time to meditate
- Avoid or quit smoking of any type
- Monitor or have your blood pressure checked regularly
- Develop the habit of using low salt diet through the use of garlic, tasty spices, tomato, and ginger when preparing meals.
- Avoid using cooking methods that retain a lot of fats and oils in the food such as frying.

5.2. Diabetes

Diabetes Mellitus is a chronic disorder of metabolism in which blood sugar levels are raised due to the deficiency or diminished effectiveness of a hormone called insulin. Insulin controls the movement of sugar (glucose) from blood into the body cells.

There are two types of diabetes:

Type 1

**Insulin
dependent
diabetes mellitus**

Type 2

**Non-insulin
dependent
diabetes mellitus**

Signs and symptoms of diabetes

- Excessive thirst especially at night
- Excessive urine production
- Unexplained tiredness
- Numbness (lack of feeling) due to nerve damage
- Elevated blood sugar level because of insufficient or ineffective insulin
- Low blood sugar (glucose)
- Excessive feeling of hunger despite eating
- Recurring itchy skin, skin infections, gum and bladder infections.
- Blurred vision
- Poor concentration
- Sudden weight loss

Management and prevention of diabetes

Management of diabetes should strictly follow doctor's prescription. Here are a few general advices that should be observed in cases learners suffer from diabetes.

- A well-defined, timely and regular pattern for eating, working, recreation, exercise and sleep.
- Where dietary management is inadequate, administer medicines to treat and prevent complications of diabetes
- Reduce obesity by reducing body weight because obesity makes diabetes worse.
- Follow recommendations for a healthy lifestyle and a balanced diet as given in Module 2.
- Eat more of boiled or roasted foods rather than fried foods.
- Use less gravy and fats since these contribute to obesity, which is a risk factor for diabetes mellitus.
- Eat frequently in small or modest amounts.
- Avoid eating too much in one sitting and going for longer periods without eating.
- Avoid alcohol intake.
- Go to the hospital regularly for check up
- Restrict your salt intake. Try to limit intake to less than 1 teaspoon of salt a day.

5.3. Obesity

The body requires different nutrients for its normal functions, survival, growth, development and activity. The nutrients are required in specific amounts and proportions.

The body's nutrient requirements are expressed on a daily basis and adequate nutrition is achieved when there is a balance between the amount of nutrients taken by the body and the body requirements or expenditure. When there is such a balance, a person is likely to have normal weight for height expressed as Body Mass Index (BMI) ranging between 18.5 and 24.9.

When an individual takes more calories than what the body needs it creates an imbalance which results in over-nutrition. This means that the body is taking more energy than it is able to spend during physical activity thus leading to excessive weight gain. In such circumstances a person is likely to become overweight. An overweight adult person will have BMI ranging between 25.0 and 29.9.

Obesity is a condition that develops due to prolonged imbalance between energy intake and energy expenditure. A person is said to be obese when the BMI is equal to or greater than thirty (≥ 30). Just like with being overweight, obesity occurs when the dietary intake of energy and other nutrients is higher than what the body uses for physical activity, work and body processes leading to an increased amount of stored energy mainly in form of fat. A person becomes obese as a result of the excessive accumulation of body fat.

Risk factors for obesity:

1. **Genetic make-up:** Naturally some people are more likely to gain weight than others on comparable energy intake. The genetic make-up may also influence the way the body utilises energy in different processes.
2. **Food choices:** A person is likely to become overweight when he or she eats too much starchy foods such as mahangu porridge, cassava, rice and potatoes; foods with too much fat (especially saturated fats) such as margarine, butter, cheese, fatty milk; and junk foods like chips, fizzy drinks, sweets. Too much intake of refined carbohydrates such as sugar, sweets, honey, jam, white bread, instant pasta (e.g. 2- minute noodles), cake, tart, pastries, puddings and rich pudding sauces may increase your chance to be overweight.
3. **Cooking methods:** Methods of cooking that require a lot of fats like deep frying; stewing of fatty meat or stewing by adding excess oil (using a lot of fat) may also increase the risk of becoming overweight.
4. **Lack of physical activity:** Physical activities such as walking, jogging, running, cycling and manual work make the body use more energy. When a person is not physically active and is taking more foods that are rich in energy, he or she is more likely to become overweight.
5. **Malnutrition in early stage of life:** If a person was malnourished in early childhood, he or she is more likely to become overweight. Children who are stunted (too short for their age) have a much greater risk of becoming overweight and developing chronic disease as adults.

Prevention of obesity

For tips on healthy lifestyle and a balanced diet please refer to Module 2 (Units 1 to 4) of this Training Manual.



activity

Activity: Revision of Unit 4 – 30 minutes

Questions for students:

What are communicable diseases?

What are non-communicable diseases?

Name major ways of transmitting: TB, malaria and STH?

What kind of support must be provided to HIV+ children suffering from TB?

What are the main risk factors for hypertension, diabetes and obesity?

How can a healthy lifestyle help in managing diabetes and obesity?

6.0 Immunisation

Overall objective:

To equip learners, teachers and the school community with basic information about vaccine preventable diseases.

Specific objectives of this section are to:

- Define immunization;
- Explain the importance of immunization;
- List the vaccine preventable disease for which children and women are vaccinated against;
- Provide an overview of the National Immunization Schedule in Namibia.

Definition of Immunization

Immunization is a process whereby a person is made immune or resistant to an infectious disease, by the administration of an antigen.

Importance of Immunization:

- Immunization builds and strengthens the body's immunity against diseases
- All vaccines used are WHO pre-qualified with no significant side-effects, making them safe and effective
- Fully immunized children and women are protected from diseases and cannot infect others, saving time and money
- Immunization reduces and in some cases completely eliminates some diseases thereby protecting future generations.
- A fully immunized population is a healthy and productive nation.

Demonstration:

- Display a copy of an immunization health passport
- Indicate the different antigens and explain the interval at which each antigen should be administered.
- Demonstrate where and how all immunizations are recorded on the child's health passport.
- Identify the follow up dates for the next immunization.

Diseases targeted for immunization:

6. Vaccine Preventable Diseases

6.1. Diphtheria:

What is Diphtheria?

Diphtheria is caused by the gram positive bacterium *Corynebacterium diphtheria*.

This germ produces a toxin that can harm or destroy body tissues or organs. One type of diphtheria affects the throat and sometimes the tonsils. Another type more common in the tropics causes ulcers on the skin. Diphtheria affects people of all ages, but most often it strikes un-immunized children.

How is Diphtheria spread?

Diphtheria is spread from person to person through close physical and respiratory contact. It can cause infection of the nasal-pharynx, which may lead to breathing difficulties and death.

What are the signs and symptoms of diphtheria?

When diphtheria affects the throat and tonsils the early symptoms are **sore throat, loss of appetite, and slight fever**. Within two or three days a **greyish white membrane forms in the throat and tonsils**. This membrane sticks to the soft palate of the and may bleed. If there is bleeding the membrane may become greyish-green or black. **The patient may either recover at this point or develop sever weakness and die within 6 or 10 days**. Patients with severe diphtheria do not develop a high fever but may develop a swollen neck and an obstructed airway.

How is diphtheria prevented?

The most effective way to prevent diphtheria is to maintain high levels of immunisation in the community. Diphtheria toxoid vaccine is given in combination with tetanus toxoid and pertussis vaccines (DPT vaccine). Namibia introduced a combination of vaccines that includes vaccines like diphtheria, pertussis, hepatitis B (Hep B), hemophilus influenza type b (Hib).

6.2. Tuberculosis

What is Tuberculosis?

Tuberculosis is a bacterial infection that is caused by Mycobacterium tuberculosis which usually attacks lungs but can also affect other parts of the body including the bone, joints, and brain.

How is TB spread?

TB is spread from one person to another through air droplets from an infected person.. TB spreads rapidly especially where people are living in **crowded conditions, have poor access to health care, and are malnourished**. A variety of TB called **Bovine tuberculosis is transmitted through drinking raw milk from infected cattle**.

People of **all ages contract tuberculosis**. But the risk of developing tuberculosis is highest among children younger than three years old and in older people. People with TB infection who have weakened immune system (for example people with HIV/ AIDS) are more likely to develop the disease.

What are the signs and symptoms of TB?

The period from infection to development of the first symptom is **usually for two twelve weeks**, but the infection may persist for **weeks even years, before the disease develops**.

The symptoms of TB include **general weakness, weight loss, fever and night sweats**. TB of the lungs called pulmonary tuberculosis, the symptoms include **persistent cough, coughing up of blood and chest pain**. In young children however the only sign of pulmonary TB may be **stunted growth or failure to thrive**. Other signs and symptoms depend on the part of the body that is affected. For, example the tuberculosis of the bones and the joints there may be swelling, pain and crippling effects on the hips, knees, or spine.

How is the TB prevented?

Immunization of children with **Bacilli Calmette Guerin vaccine (BCG)** can protect against meningitis and other severe forms of TB in children less than five years old. BCG vaccine is not recommended after 12 months because the protection provided is variable and less certain.

6. 3. Tetanus:

What is Tetanus?

Tetanus is acquired through exposure to a gram-positive anaerobic spore forming **bacterium called Clostridium tetani**, which is universally present in the soil. The disease is caused by the action of the potent neurotoxin produced during the growth of the bacteria in dead tissue. e.g. in dirty wounds or in the umbilicus following non sterile delivery.

People of all age can develop tetanus. But the disease is particularly common and **serious in newborn babies.** This is called **Neonatal Tetanus.** Most infants who get the disease die. Neonatal tetanus is more common in rural areas where **most deliveries are at home without adequate sterile procedures.**

How is Tetanus spread?

Tetanus is **not transmitted from person to person.** A person usually becomes infected with tetanus when **dirt enters a wound or a cut.** **Tetanus germs are likely to grow in deep puncture wounds caused by dirty nails, knives, tools, wood splinters and animal bites.** Women face an additional risk of infection if a **contaminated tool is used during childbirth or during an abortion.**

A newborn baby may become infected if the knife, razor or other instrument used to cut its umbilical cord is dirty, if dirty material is used to dress the umbilical cord, or if the hands of the person dressing the cord are not clean.

Infants and children may also contract tetanus when dirty instruments are used for circumcision, scarification, and skin piercing, and when dirt, charcoal or other unclean substances are rubbed into a wound.

What are the symptoms of Tetanus?

The time between getting infection and showing symptoms is usually between three and ten days. But it may be as long as ten weeks.

In Children and **adults muscular stiffness of the jaw is usually the first sign of Tetanus.** This symptom is followed by **stiffness in the neck, difficulty in swallowing, stiffness in the stomach muscles, muscle spasms, sweating and fever.** Newborn babies with Tetanus are **normal at birth, but stop sucking between three and 28 days after birth. They stop feeding and their bodies become stiff while severe muscle spasms and contractions occur. Death follows in most cases.**

How is Tetanus Prevented?

Immunizing infants and Children with DPT or DT prevents tetanus. A combination vaccine (Pentavalent) that includes vaccines for Diphtheria, Tetanus, Pertussis, Hepatitis b (hep), Hemophilus influenza type b (Hib).

Neonatal tetanus can be prevented by immunizing women of child-bearing age with Tetanus toxoid, either during pregnancy or outside pregnancy. This protects the mother and enables tetanus antibodies to be transferred to her baby. A woman should receive five (5) doses of tetanus toxoid vaccine between 15 – 49 years of age.

Clean practices (environment, hands and instruments) anywhere are especially important when a mother is delivering a baby, even if she has been immunized. People who recover from tetanus do not have natural immunity and can be infected again and therefore need to be immunized.

6. 4 Pertussis: (Whooping Cough)

What is pertussis?

Pertussis or whooping cough is a disease of the respiratory tract caused by bacteria that live in the mouth, nose and throat. Many children who contract pertussis have coughing spells that last four to eight weeks. The disease is more dangerous in infants.

How is Pertussis spread?

Pertussis spreads easily **from child to child in droplets caused by coughing or sneezing**. Children exposed to the germs become infected. In most countries the disease occurs in regular epidemic cycles of three to five years.

What are the signs and symptoms of pertussis?

The incubation period is five to 10 days. At first the infected child appears to have a **common cold with runny nose, watery eyes, sneezing, fever, and a mild cough**. The cough gradually worsens, and involves many bursts of rapid coughing. At the end of these bursts the child takes in air with a high-pitched whoop. The child may turn blue because he or she does not get enough oxygen during a long burst of coughing. Vomiting and exhaustion usually follow the coughing attacks, which are particularly frequent at night. During recovery coughing becomes less intense. Children do not usually have a high fever during any stage of the illness.

How is pertussis prevented?

Prevention involves immunisation with pertussis vaccine, which is usually given in combination with diphtheria and tetanus (DPT). A combination of vaccine (Pentavalent) that includes vaccines for diphtheria, tetanus, pertussis, hepatitis B (hepB) and Hemophilus influenza type b (Hib).

6. 5. Poliomyelitis:

What is polio?

Poliomyelitis or polio is a crippling disease caused by anyone of the three related viruses, polioviruses types 1, 2 or 3.

How is Polio spread?

The only way to spread polio is through the fecal/oral route. The virus enters the body through the mouth when people eat food or drink water that is contaminated with feaces. The virus then multiplies in the intestine, enters the blood stream, and may invade certain types of nerve cells, which it can damage or destroy. Polioviruses spread very easily in areas of poor hygiene.

Children are most likely to spread the virus between 10days before and ten days after they experience the first symptoms of disease. It is important to know that the great majority of the people who are infected do not have symptoms, but they can still spread the disease. The incubation period is 6 to 20 days.

What are the signs and symptoms of Polio?

Most children infected by poliovirus never feel ill. Less than 5% of the infected may have general **flue like symptoms such as fever, loose stools, sore throat, upset stomach, headache and stomach ache**.

Paralytic polio begins with mild **symptoms and fever**. These symptoms are followed by **severe muscle pain and paralysis, which usually develops during the first week of the illness**. Patients may loose the use of one or both arms or legs. Some patients may not be able to **breathe** because **respiratory muscles are paralyzed**. A diagnosis of polio is confirmed by **laboratory testing of stool specimens**.

How is Polio prevented?

Polio can be prevented with Oral Polio Vaccine (OPV) or inactivated polio vaccine (IPV)

6.6. Measles:

What is Measles?

Measles is a highly infectious disease caused by a virus. Measles kills more children than any other vaccine preventable disease.

Because the disease is so infectious, it tends to occur as epidemics, which may cause many deaths especially among malnourished children.

How is measles spread?

Measles is spread through **contact with nose and throat secretions of infected people and airborne droplets released when an infected person sneezes or coughs.**

A person with measles can infect others for several days before and after he develops the symptoms. The disease spreads easily where infants and children gather, for example the health centers and schools.

What are the signs and Symptoms of Measles?

The first sign is a **high fever, which begins approximately 10 to 12 days after exposure and lasts several days.** During this period a patient may develop a **runny nose, a cough, red and watery eyes, and small white spots inside his or her cheeks.** After several days a slightly raised rash develops, usually of the face and upper neck. Over a period of about three days, the rash spreads to the body and then to the hands and feet. It lasts for six days and then fades. The incubation period from exposure to the onset of the rash averages 14 days, with a range of 7 to 18 days.

How can it be prevented?

Measles can be prevented through immunization at the age of 9 months.

6.7. Hepatitis B

What is Hepatitis B?

Hepatitis B is caused by a virus that affects the liver. Most infants affected at birth become chronic carriers, that is, they carry the virus for many years and can spread the infection to others.

How is Hepatitis spread?

The Hepatitis B virus is carried in the blood and other fluids. It is usually spread by contact with the blood in the following ways:

1. Through unsafe injection or needle stick. Unsterilized needles and Syringes can contain hepatitis B virus from an infected person, for example from a patient or a needle user.
2. Transmission of the virus from the mothers to their babies during the birth process when contact with blood always occurs. (Vertical)
3. Transmission between children during social contact through cuts, scrapes bites, and scratches. (Horizontal)
4. Transmission during sexual intercourse through contact with blood and other body fluids.

What are the signs and symptoms of Hepatitis B?

The incubation period averages six weeks but can be as long as six months. Infection in young children is usually asymptomatic. However a large proportion of children may become chronic carriers compared to adults.

Symptoms are associated with **weakness, stomach upsets** and other **flue-like symptoms.** They may also have **very dark urine and pale stools.** **Jaundice** is common (Yellow skin and yellow color in the whites of the eyes) the symptoms may last several weeks or months. A laboratory test is required for confirmation. Many children become chronic carriers.

How is Hepatitis B prevented?

It is recommended that all infants receive three doses of hepatitis B vaccine during their first year of life. A combination vaccine (Pentavalent) which includes vaccines for diphtheria, pertussis, hepatitis B (hep B) and Hemophilus influenza type B (Hib) is provided **at 6, 10 and 14 weeks. A birth dose of hep B is given at birth within 24 hours; however babies who are reporting after 24 hours up to 14 days can still be vaccinated.** It would therefore be most feasible to deliver this vaccine dose **just after birth to all infants who are born in health facilities as part of the other routine treatments for the new – borne.** Optimum efficacy in preventing the peri – natal HBV infection is achieved when the Hep B. vaccine is given within 24 hours after birth.

6. 8 Hemophilus influenza type b (Hib)

What is Hemophilus Influenza type b?

Hemophilus influenza type B (Hib) is one of the six related types of bacterium (a,b,c,d,e,f) that cause illness but type B is responsible for 90% of the serious infections, which include **bacteria meningitis and pneumonia.** Other Hib infections include **epiglottitis, septicemia, septic arthritis, osteomyelitis, cellulites and pericarditis.**

How is Hib spread?

The Hib bacterium is commonly present in the **nose and throat.** Bacteria are **transmitted from person to person in droplets through sneezing and coughing.** **Infected children may carry Hib bacteria without showing any signs and symptoms of illness, but they can still infect others.** The risk of disease is highest for children between **six months and two years of age.** **Hib disease should be suspected in the case of any child with signs and symptoms of meningitis or pneumonia.**

What are the signs and symptoms of Hib?

Pneumonia and Meningitis are the most important diseases caused by Hib bacteria. In developing countries, pneumonia is more common than meningitis in children with Hib disease. Hib disease should be suspected in any case of any child with signs and symptoms of meningitis or pneumonia.

How is Hib disease prevented?

Several Hib conjugate vaccines are available. All are effective when given in early infancy and have virtually no side effects except occasional temporary redness and swelling at the injection site. It is given at 6, 10 and 14 weeks as a combination vaccine (Pentavalent) DPT-hep B and Hib.

Pneumococcal Disease

1. What is pneumococcus?

Pneumococcal, also called *Streptococcus pneumoniae*, is a bacterium that is commonly found in the nose and throat of healthy people without causing disease. But it can spread in the body to the different organs to cause a variety of diseases, one of which is pneumonia. It is the leading cause of bacterial pneumonia.

2. What diseases does pneumococcus cause?

There are 2 kinds of pneumococcal disease:

- a) The more serious invasive pneumococcal disease (IPD) is due to infection of a normally sterile site and causes significant morbidity and mortality. IPD includes:
 - Pneumonia (bacteraemic)
 - Meningitis
 - Febrile bacteraemia
 - Arthritis

- Peritonitis
 - Osteomyelitis
- b) The more common pneumonia - by direct spread from the nasopharynx.
Less serious, but more common pneumococcal disease includes:
- Otitis media (middle ear infection)
 - Sinusitis
 - Bronchitis

3. How common is pneumococcal disease?

Of the syndromes caused by pneumococcal disease, the following two are the most prevalent - pneumonia and meningitis

- Pneumonia is a very important health problem in children causing about 15-20% of deaths among young children. Pneumonia kills more children than any other illness - more than AIDS, Malaria and measles combined.
- Meningitis among children can lead to death in 10 to 45% of children and to life-long disability - hearing loss, learning disabilities, and other physical disabilities - in 15-20% children who survive

4. Who are most at risk of pneumococcal disease?

- Children under five years of age, and especially those under two years of age, are the most at risk of developing and dying from pneumococcal disease.
- Older people over age 65 years
- Other factors that place individuals at higher risk include HIV infection, sickle cell disease, chronic renal disease, and for infants, lack of breast-feeding and indoor smoke exposure. (A+B)

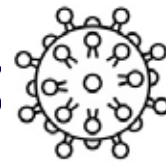
5. How is pneumococcal disease spread?

The noses and throats of up to 70% of healthy people contain pneumococcus at any given time. It is spread from person to person through bacteria from respiratory droplets - by coughing, sneezing or close contact.

Rota virus disease

What is rotavirus disease?

- Rotavirus disease is a diarrheal disease caused by a virus called rotavirus
- The name rotavirus comes from the wheel-like appearance of the virus under the microscope
- Rotavirus is a virus that infects the intestines
- Rotavirus is the most common cause of severe diarrheal disease in infants and young children worldwide
- Rotavirus is not the only cause of diarrhea, several other agents may also cause diarrhea



What are the signs and symptoms of rotavirus infection?

- Three main symptoms of rotavirus infection:
 - Fever
 - Vomiting
 - Watery diarrhea
- Abdominal pain may also occur
- Diarrhea usually stops after 3 to 7 days
- Young children can become dehydrated, requiring urgent treatment

5 | Introduction to rotavirus disease and vaccine, Module 1 | 17 June 2014



How is rotavirus disease diagnosed?

- Confirmation of a diarrheal illness such as rotavirus requires laboratory testing
- Strains of rotavirus may be further characterized by special testing with enzyme immunoassay or polymerase chain reaction
 - Such testing is not commonly available or necessary

6 | Introduction to rotavirus disease and vaccine, Module 1 | 17 June 2014



How does rotavirus spread?

- Rotavirus infection is highly contagious
- Rotavirus spread by fecal-oral route
 - The primary mode of transmission of rotavirus is the passage of the virus in stool to the mouth of another child



7 | Introduction to rotavirus disease and vaccine, Module 1 | 17 June 2014



National Immunization Schedule in Namibia

Age	Antigens since November 2014
At birth	BCG Hep. B OPV0
6 weeks	OPV1, Pentavalent 1 (DPT, Hep. B, Hib) Rotavirus 1 (RV1) and Pneumococcal vaccine (PCV1),
10 weeks	OPV2, Penta 2, RV2, PCV2
14 weeks	OPV3, + IPV, Penta 3, PCV3
6 months	Vitamin A – 1st dose
9 months	Measles
15 months	Measles/Rubella
5 years	OPV, DT (Booster dose)
10 years	OPV, DT (Booster dose)
Stat dose at first contact*	TT 1
One month after the 1st dose	TT 2
Six months after the 2nd dose	TT 3
1 year after the 3rd dose	TT 4
1 year after the 4th dose	TT 5
9 – 13 years.	HPV

*TT is for women at childbearing age

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MODULE 2: NUTRITION AND HEALTHY LIFESTYLE

Overall objective:

To understand the basics of nutrition including food groups, different types of malnutrition and nutritional needs across the lifespan and to provide guidance on healthy lifestyle to support positive learning outcomes.

Module summary table

Unit	Content	Time	Activity	Materials
1	Overview of Nutrition: Key definitions of nutrition terms and concepts	45 min	Presentation and demonstration	PowerPoint presentation, Policy documents and Guidelines, posters and local food products
2	Food Groups	1 hour	Food group exercise	Photos or pictures of different foods
3	Healthy lifestyle What is a healthy weight? How to measure BMI	4 hours	Measuring and classifying BMI	Handouts, PowerPoint presentation, posters and videos
4	School Feeding Programme: Overview and implementation highlights	1 hour	Presentation	PowerPoint presentation

Glossary:

BMI: Body Mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²).

Complementary feeding: Complementary feeding begins at the age of 6 months with continued breastfeeding up to 2 years. Complementary foods are needed at the age of 6 months because breastmilk alone is no longer enough to support growth needs.

Diet: Diet is a term that describes the total foods and drinks eaten by an individual or a group of people at a given time.

Eating disorders - Eating disorders are extremes in eating behaviour. Eating too little or too much are both extremes.

Exclusive breastfeeding – The period from birth to 6 months when an infant only receives breastmilk

Food allergies: Food allergy is an immune response, allergies are an overreaction of the body's immune system to a protein.

Food groups: Foods are grouped together because they provide similar amounts of key nutrients.

Food intolerances: Food intolerance is a 'chemical' reaction that some people have after eating or drinking some foods; it is not an immune response. Food intolerance does not involve the immune system and does not cause severe allergic reactions (anaphylaxis).

Malnutrition: Malnutrition is an impairment of health resulting from a deficiency, excess or imbalance of nutrients.

Micronutrients are needed to maintain various body functions and they make chemical processes happen, such as energy production and use, immune system function including healing, digestion and secretion of fluids.

Micronutrients: Micronutrients are minerals and vitamins and they are essential for life.

Overnutrition - Over-nutrition occurs when nutrient intake is higher than what is needed.

School Feeding Programme: The Namibia School Feeding Programme (NSFP) is a nationally-run and funded government programme providing meals to approximately 270 000 school children across the country. The meal consists of 125 grams (475 kilocalories or 1,988 kilojoule) of fortified maize blend that is cooked at schools and served as a midmorning meal.

Stunting: A form of growth failure measured by height relative to age

Undernutrition: Under-nutrition occurs when nutrient needs are higher than nutrient intake.

Wasting: A form of growth failure measured by weight relative to height



Unit 1: Overview of basic definitions and concepts regarding nutrition

Specific objectives:

At the end of this unit, the trainers will have:

1. Understood the different definitions associated with nutrition; and
2. Understood the nutritional needs across the lifespan.

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, coloured markers, coloured pencils, paper plates



Facilitator's Notes

1.1. Introduction: definition of nutrition

The World Health Organisation (WHO) defines nutrition as the intake of food, considered in relation to the body's dietary needs. Good nutrition is an adequate, well balanced diet combined with regular physical activity. It is one of the cornerstones of good health. Nutrition is the process by which the body acquires and uses food. This includes ingestion, digestion, absorption and utilisation of food items.

Nutrients are the substances found in food and fluids that promote growth, protect the body against disease, provide the body with energy and maintain the body processes. There are two broad categories of nutrients; macronutrients (water, energy, protein, fats and carbohydrates) and micronutrients (vitamins and minerals).

Food is what we eat. Food is the vehicle for providing us with the nutrients our bodies need to grow, develop and to sustain life.

Diet is a term that describes the total foods and drinks eaten by an individual or a group of people at a given time. The term diet is not the same as 'dieting' where a person is voluntarily choosing to reduce or increase their dietary (food) intake with the aim of losing or gaining weight or for other health reasons.

A balanced diet provides nutrients in adequate proportions to meet the nutritional requirements of an individual. A balanced diet refers to a diet that is without excess or deficiency.

Micronutrients are minerals and vitamins and they are essential for life. Micronutrients are needed to maintain various body functions and they make chemical processes happen, such as energy production and use, immune system function including healing, digestion and secretion of fluids. Examples of micronutrients are vitamin A, B, C, D, E, K and calcium. Nutritional status is the condition of the body resulting from the intake and expenditure



Figure 2.1: Article 24 of the Convention of the Rights of the Child stipulates that children have the right to safe drinking water and nutritious food.

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of nutrients. A normal nutritional status is a balance between nutrient intake and expenditure. It is achieved by eating a variety of food in adequate quality and quantity for one's needs. It can be determined through a medical evaluation and nutrition assessment, including physical examination, laboratory investigations, a dietary history and anthropometric measurements.

1.2 Malnutrition

Malnutrition is an impairment of health resulting from a deficiency, excess or imbalance of nutrients.

Malnutrition affects people of every age, although infants, children, and adolescents may suffer the most because many nutrients are critical for normal growth and development. Older people may develop malnutrition because aging, illness, and other factors can sometimes lead to a poor appetite, so they may not eat enough.

There are two types of malnutrition:

Over-nutrition occurs when nutrient intake is higher than what is needed. Over-nutrition can lead to overweight and obesity, which are conditions that increase a person's risk for diabetes, hypertension and cardiac disease.

Under-nutrition occurs when nutrient needs are higher than nutrient intake. It is a state in which physical function of an individual is impaired to the point where he/she can no longer maintain adequate bodily performance processes such as growth, physical work, and resistance to infection. Under-nutrition contributes directly and indirectly to illness and death of children.

Figure 2.2: Malnutrition occurs when a child eats a diet in which nutrients are either not enough or are too much such that the diet causes health problems, in other words, imbalanced diet.



There are different forms of under-nutrition:

Type of under-nutrition	Referred to as	Measurement	Cause
Wasting (thinness)	Acute malnutrition	Weight for Height or MUAC	Result of recent weight loss or failure to gain weight
Stunting (shortness)	Chronic malnutrition	Height for Age	Result of inadequate nutrition over a long period of time, usually not apparent until after 2 years of age
Underweight	Acute and chronic malnutrition	Weight for Age	Can result from recent weight loss or long term inadequate nutrition

In Namibia, according to the National Demographic and Health Survey (DHS) 2013, the percentage of children aged 0 - 5 years that are wasted, stunted and underweight is as follows:

Type of under-nutrition	Total Malnutrition %	Severe Malnutrition %
Wasting (thinness)	6.2 %	2.0 %
Stunting (shortness)	24 %	8.2 %
Underweight	13%	2.6 %

Stunting is a form of undernutrition particularly severe in Namibia. It is caused by a variety of factors:

- poor dietary intake either due to poor infant feeding practices or food insecurity
- lack of or poor sanitation and hygiene practices
- environmental factors that impact on food supply and food choices such as floods, drought and other natural disasters
- social and political factors such as policies about food imports and pricing
- policies about access to health care
- agricultural factors such as variety and amount of food produced nationally and at small scale household level, which if interrupted can result in food insecurity.

Stunting is a consequence of multiple factors that are often linked to poverty. While stunting can lead to developmental problems it can be prevented. Interventions during the first 1000 days of a child's life, which is from conception to 2 years old, can prevent or reverse the negative effects of stunting. After age 2, the developmental problems caused by stunting are likely to be permanent and therefore result in children not reaching their full potential.

Children who are stunted often do less well in school and therefore have fewer professional opportunities later in life and earn less, perpetuating poverty in their families. Low income, lack of healthcare and reduced access to proper nutrition will continue to impact the health of their children, thereby perpetuating the cycle of undernutrition from generation to generation.

1.3 Nutritional requirements across the lifespan

1.3.1 Birth to 3 years

Infancy is a time of rapid growth and development. Throughout the first 2 years of life, there are high needs for a balance of nutrients to promote growth and development and to prevent under and over nutrition.

Infants should be fed only breastmilk from birth to age 6 months. Breastmilk is the perfect 'food' providing all of the nutrients, energy, and fluid that an infant needs in their first 6 months of life. At age 6 months however, breastmilk is no longer enough to meet the increasing nutritional needs for growth and development.

At age 6 months, the infant also needs to be given other foods and drinks in addition to breastmilk. This is known as complementary feeding. Complementary foods should be energy and nutrient rich. They should be of a suitable texture for the age of the child, the amount given at each meal and the frequency of meals should be appropriate for the child's age. Hand washing before feeding infants and young children is critical to prevent disease and infections.

The following micronutrients are essential for good nutrition:

Iron, vitamin A, iodine and folate - These play a vital role in the mother's survival in pregnancy and childbirth and in the child's development.

Vitamin A is essential for the functioning of the immune system. Vitamin A deficiency (VAD) causes blindness and renders children susceptible to common childhood killers: measles, diarrhoea, malaria and pneumonia.

Iodine is a critical nutrient for the proper functioning of the thyroid gland which regulates growth and metabolism. Iodine deficiency can cause learning disabilities and brain damage. The body needs iron to manufacture haemoglobin – the protein in red blood cells that carries oxygen around the body – and several enzymes necessary for muscle, brain and the immune system. The body's iron requirements increase during menstruation, pregnancy, breastfeeding and high-growth periods.

Folate, a B vitamin, is needed for the formation of red blood cells and also the development of nerve cells in the embryo and foetus stages of development.

1.3.2. Three years to adolescence

Nutritional requirements gradually increase with increasing age and physical activity level. From age three the requirements are based on a need for increased variety and amount of food and a range of different textures of food. As a child grows they are more likely to begin consuming 'family foods' whereby they are eating the same foods as the older children and adults in the house.

Adjustments need to be made to the amount of food given to children as they grow to accommodate their physical growth and increased activity level. It is advised that children consume a variety of foods, choosing from each of the 4 food groups; fruits and vegetables, meats, chicken and fish, dairy and dairy products, breads and cereals, which includes staples such as maize, mahangu, rice, pasta and bread. Drinking adequate quantities of safe water is also important.

In order to prevent childhood overweight and obesity, foods high in added sugar such as sweets, cakes, biscuits and cool drinks should be avoided. Fried foods may be consumed in limited amounts.

Every child should aim to eat 2 servings of fruit and 5 servings of vegetables every day in order to promote optimal health, growth and development. A serving of fruit is equivalent to 1 piece of fruit, such as an apple, banana or orange. A serving of vegetables is equivalent to ½ cup of cooked or raw vegetables. It is important to eat a variety of different vegetables at all meals in order to get the vitamins and minerals needed for growth and development.

1.3.3. Nutritional needs during adolescence

Adolescence begins at the onset of puberty and is the transition period between childhood and adulthood. For girls, puberty typically occurs between ages 12 and 13, and for boys 14 and 15 years. It is one of the fastest growth periods of a person's life and is characterised by physical changes that may affect the body's nutritional needs. Changes in lifestyle may also affect eating habits and food choices. Teenagers need additional calories, protein, calcium, and iron to support the growing body and prevent future health problems.

Protein is important for growth and maintenance of muscle. Adolescents need between 45 and 60 grams of protein each day. Sources of protein include beef, pork, chicken, eggs, dairy products and some vegetable sources, including legumes, seeds and nuts.

Figure 2.3: Meat, fish, eggs and dairy produce are excellent sources of protein, calcium and iron.



Source: Peakoil.com

Adequate calcium intake is essential for development of strong and dense bones during the adolescent growth spurt. Inadequate calcium intake during adolescence and young adulthood puts individuals at risk for developing osteoporosis later in life. In order to get the required 1,200mg of calcium, teenagers are encouraged to consume three to four servings of calcium-rich foods each day. Good sources include milk, yogurt, cheese, calcium-fortified juices, and calcium-fortified cereals.

As adolescents gain muscle mass, more iron is needed to help muscle cells obtain oxygen for energy. A deficiency of iron causes anaemia, which leads to fatigue, confusion and weakness. Adolescent boys need 12 milligrams of iron each day, while girls need 15 milligrams. Good sources of iron include beef, chicken, pork, legumes (including beans and peanuts), enriched or whole grains, and leafy green vegetables such as spinach, collards, and kale.

1.4. Nutrition related issues during adolescence

Globally, adolescents face a serious nutritional challenge affecting not only their growth and development but also their livelihood as adults. They remain a largely neglected, difficult-to-measure and seemingly hard-to-reach population. The needs of adolescent girls in particular are often ignored. Good nutrition is essential for survival, physical growth, mental development, performance and productivity, health and well-being. Adolescent girls in particular need access to information and services related to nutrition, reproductive health, family planning, and general health. Programmes can reach girls through a variety of avenues, including schools, workplaces, marriage registration systems, and youth-oriented health programmes.

Twenty percent of total growth in height and 50% of adult weight gain occur during adolescence. Adequate nutrition is important to support optimal growth. While the nutritional status of children and adolescents has generally improved many problems remain to be addressed. These include:

- **Under nutrition:** Inadequate food supply, especially in poor households, is a major factor contributing to undernutrition. For adolescent girls, gender-based discrimination in the distribution of, and access to, food within the family can be a strong factor in under nutrition.
- **Micronutrient deficiency:** Vitamin A, iodine and iron deficiencies are common among adolescents. The adverse effects of these deficiencies include delayed growth spurt, stunted height, delayed/retarded intellectual development, anaemia and increased risks in childbirth. Micronutrient deficiencies are often associated with poverty but they may also result from unhealthy eating behaviours, associated with the intake of highly processed, nutrient low, energy- dense foods.
- **Overweight and obesity:** Due to rapid urbanization and economic growth there is a rise in obesity. Lifestyle changes related to high-fat diets and low levels of physical activity have resulted in a rising prevalence of overweight and obese adolescents, particularly in urban areas.
- Overweight and obesity during childhood and adolescence tends to continue into adulthood, increasing the likelihood of health conditions including cardiovascular diseases, diabetes and some cancers. The topic of weight is a sensitive issue. Although there is no “perfect” weight, being overweight can have serious health consequences. Prevention of obesity among adolescents is crucial, particularly in settings with conducive eating patterns and lifestyles.

1.5. Eating disorders

Adolescents are increasingly confronted with the pressure to have a “perfect” body shape - informed in great part by celebrity culture.

Eating disorders are extremes in eating behaviour. Eating too little or too much are both extremes.

The most common eating disorders are anorexia nervosa and bulimia nervosa (usually called simply “anorexia” and “bulimia”). But other food-related disorders, like binge eating, body image disorders, and food phobias, are becoming more and more common. Many young people who develop an eating disorder are between 13 and 17 years old. This is a time of emotional and physical changes, academic pressures, and a greater degree of peer pressure.

While the issues surrounding eating disorders are complex, in many cases the condition is associated with poor self-esteem.

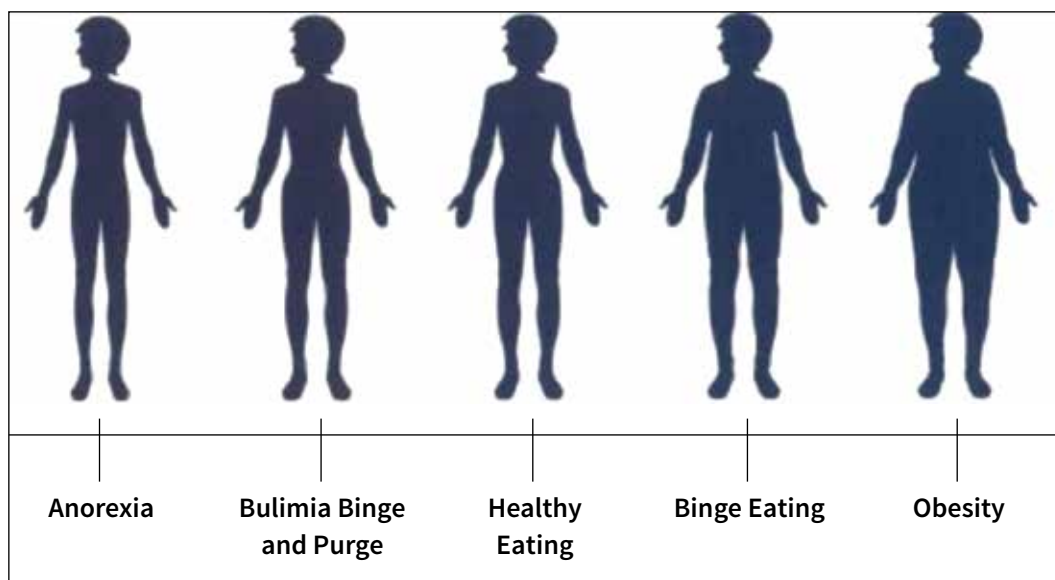
For girls, even though it's completely normal (and necessary) to gain some additional body fat during puberty, some respond to this change by becoming very fearful of their new weight. They might mistakenly feel compelled to get rid of it any way they can.

Athletes are also vulnerable to eating disorders as they may seek to stop or suppress growth - both height and weight - in order to maintain performance. Bodybuilding on the other hand, may encourage rapid 'bulking up' which is unhealthy and can cause excessive weight gain in later life.

Unhealthy eating patterns tend to begin gradually and build to the point where a person feels unable to control them.

Adolescents with eating disorders often do not recognize or admit that they have a problem. As a result they may not want to get treatment and, as such, need the support of family members to ensure that treatment is obtained.

Figure 2.4: Spectrum of eating disorders



Unit 2: Food Groups

Specific Objectives At the end of this unit, the trainers will have:

1. Understood the differences between different food groups and identify important sources of nutrients; and
2. Understood how to make a nutritious and well-balanced meal;
3. Learned the definition of food allergy and learned how to recognize the symptoms of the most common food allergies.

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, coloured markers



Facilitator's Notes

2.1. Food groups

Foods are grouped together because they provide similar amounts of key nutrients. For example, key nutrients of the milk, yoghurt, cheese and alternatives group include calcium and protein, while the fruit group is a good source of vitamins, especially vitamin C.

Choose a variety of foods

Eating a varied, well-balanced diet means eating a variety of foods from each food groups daily, in the recommended amounts. It is also important to choose a variety of foods from within each food group because different foods provide different types and amounts of key nutrients.

Namibia's Food Groups

According to the Namibian Food and Nutrition Guidelines, there are four food groups from which one should eat every day.

The four food groups are:

1. Cereals and Grains (whole grain or high fibre)

This food group is a good source of carbohydrates and fibre.

Examples of foods within this group are; maize, mahangu, wheat, sorghum, rice, bread and pasta (macaroni, noodles), oats and root vegetables such as potatoes.

Ideally choose unprocessed grains and cereals as these have higher fibre and nutrient content. Examples are multi-grain breads and cereals products, whole oats, wholemeal pasta and brown rice.

2. Fruit and vegetables

The fruit and vegetable group contains foods that provide vitamins, minerals and fibre. Examples of foods within this group are: dark green leafy vegetables (e.g. broccoli, spinach, cabbage and kale), orange and red coloured vegetables (e.g. carrots, pumpkin, orange sweet potato, red capsicum, yellow squash etc), and fruits of all kind.

Ideally include a wide variety of vegetables and fruits in your diet each day. Eating fruits whole with skin (if appropriate) provides more fibre and nutrients. Substituting fruit juice for whole fruit is not recommended, because fruit juice has little or no fibre.

3. Lean meats, poultry, fish, eggs and milk/ milk products

This group contains foods that are good sources of protein, iron, zinc and calcium. Examples of foods within this group include; beef, mutton, chicken and other poultry, fish, eggs from chickens or ducks, cow's milk, goat's milk, yoghurts and cheeses.

Red meat is a very good source of iron, however due to the high content of animal fat in meat, choose lean red meat or trim off visible fat before cooking and do not eat the fat. Remove skin from chicken or other poultry before cooking. Avoid eating large quantities of processed meats such as biltong, sausages or salami. These meats are also very high in sodium.

Eggs, fish and white meats such as chicken are good source of protein and have a lower content of animal fats.

Dairy foods, such as milk, yoghurt and cheese are a good source of calcium and magnesium. Limit the amount of cheese eaten as it is also high in animal fat.

4. Beans, lentils, nuts and peas

This group of foods contains beans, peas, lentils, groundnuts, nuts and seeds, soybeans and soy products. These foods are a good source of plant protein, fibre, vitamins and minerals. They are an inexpensive source of protein.



Occasional Foods

Not all foods that are available to us are suitable for eating every day. Some foods should only be eaten occasionally or for 'special occasions' such as birthdays or celebrations. Some foods do not fit into the four food groups because they are not necessary for a healthy diet. These foods are called 'discretionary choices' and they should only be eaten occasionally. They tend to be too high in either energy (kilojoules), saturated fat, added sugars, added salt or alcohol, and have low levels of important nutrients like fibre.

Examples of 'discretionary choices' or occasional foods are:

- sweet biscuits, cakes, desserts and pastries
- processed meats and fattier/salty sausages, biltong, savoury pastries and pies, commercial burgers with a high fat and/or salt content
- sweetened condensed milk
- ice cream and other ice confections
- confectionary and chocolate
- commercially fried foods
- potato chips, crisps and other fatty and/or salty snack foods including some savoury biscuits
- cream, butter and spreads which are high in saturated fats
- soft drinks and cool drinks with added sugar, sports or energy drinks and alcoholic drinks

2.2. How to include the 4 food groups in your diet

Try your best to include foods from the four food groups into snacks and meals. Some suggestions include:

Vegetables and legumes – raw or cooked vegetables can be used as a snack food or as a part of lunch and dinner. Salad vegetables can be used as a sandwich filling. Vegetable soup can make a healthy lunch. Stir-fries, vegetable patties and vegetable curries make nutritious evening meals. Try raw vegetables like carrot and celery sticks for a snack 'on the run'.

Fruit – this is easy to carry as a snack and can be included in most meals. For example, try a banana with your breakfast cereal, an apple for morning tea and add some wild berries in your yoghurt for an afternoon snack. Fresh whole fruit is recommended over fruit juice and dried fruit. Fruit juice contains less fibre than fresh fruit and both fruit juice and dried fruit, and are more concentrated sources of sugar and energy. Dried fruit can also stick to teeth, which can increase the risk of dental caries.

Bread, cereals, rice, pasta and noodles – add rice, pasta or noodles to serves of protein and vegetables for an all-round meal. There are many varieties of these to try. Where possible, try to use wholegrains in breads and cereals.

Lean meat, fish, poultry, eggs, nuts, and legumes – these can all provide protein. It's easy to include a mixture of protein into snacks and meals. Try adding lean meat to your sandwich or have a handful of nuts as a snack. You can also add legumes to soups or stews for an evening meal.

Milk, yoghurt and cheese – try adding yogurt to breakfast cereal with milk, or using cottage cheese as a sandwich filling. Shavings of parmesan or cheddar can be used to top steamed vegetables or a salad. Use mostly reduced fat products.

2.3. Serving Size Guide

Serving sizes of vegetables and legumes/beans:

One standard serving of vegetables is about 75 g or:

- ½ cup cooked vegetables
- ½ cup cooked dried or canned beans, peas or lentils
- 1 cup salad vegetables
- ½ cup sweet corn
- ½ medium potato or other starchy vegetables (such as sweet potato)
- 1 medium tomato.

Serving sizes of fruit

One standard serving of fruit is about 150 g or: one medium piece (apple, banana, orange, and pear) two small pieces (apricots, plums, and mandarins)

- 1 cup diced, cooked or canned fruit (no added sugar).
- Or only occasionally: 125 ml (½ cup) fruit juice (no added sugar)
- 30 g dried fruit (such as 4 dried apricot halves, 1½ tablespoons sultanas).

Serving sizes of grain (cereal) foods

Choose mostly wholegrain and/or high cereal fibre varieties of grain foods.

One serve equals:

- One slice of bread (40 g)
- ½ medium bread roll or flatbread (40 g)
- ½ cup cooked rice, pasta, noodles, barley, buckwheat, semolina, polenta (75-120 g)
- ½ cup cooked porridge (120 g)
- ¼ cup muesli (30 g)
- 2/3 cup breakfast cereal flakes (30 g)
- ¼ cup flour (30 g)

Serving sizes of lean meats and poultry, fish, eggs, nuts and seeds and legumes/beans

One serve equals:

- 65 g cooked lean red meat (such as beef, lamb, pork, and mutton), ½ cup lean mince, 2 small chops, 2 slices of roast meat (about 90-100 g raw weight)
- 80 g cooked poultry such as chicken or turkey (about 100 g raw weight)
- 1 cup (150 g) cooked dried or canned beans, lentils, chick peas or split peas
- 100 g cooked fish fillet (about 115 g raw weight) or 1 small can of fish
- Two large eggs (120 g)
- 1 cup (150 g) cooked dried or canned legumes or beans, such as lentils, chickpeas or split peas (no added salt)
- 30 g nuts or seeds, or nut/seed pastes (no added salt), such as peanut or almond butter

Serving sizes of milk, yoghurt and cheese

When choosing serves of milk, yoghurt and cheese or alternatives, choose mostly reduced fat.

One serve equals:

- 1 cup (250 ml) fresh, long-life or reconstituted powdered milk
- ½ cup (120 ml) evaporated unsweetened milk
- 2 slices (40 g) hard cheese (such as cheddar)
- ½ cup (120 g) ricotta cheese
- ¾ cup or one small carton (200 g) of yoghurt
- 1 cup (250 ml) soy, rice or other cereal drink with at least 100 mg of added calcium per 100 ml.

3.4. Serves for Children and Adolescents Daily

Children and adolescents	Grains (cereal),rice, pasta and noodles	Vegetables, legumes	Fruit	Milk, yoghurt, cheese	Meat, fish, poultry, eggs, nuts, legumes
Children 2-3 years	4	2 ½	1	1 ½	1
Children 4-8 years	4	4 ½	1 ½	2 for boys 1.5 for girls	1 ½
Children 9-11 years	5 for boys 4 for girls	5	2	2 ½ for boys 3 for girls	2 ½
Adolescents 12-13 years	5.5 for boys 5 for girls	5 ½ for boys 5 for girls	2	3 ½	2 ½
Adolescents 14-18 years	7 for boys 7 for girls	5 ½ for boys 5 for girls	2	3 ½	2 ½
Pregnant and breast-feeding girls under 18 years	7	5 ½	2	4	2 ½

3.5. Why is breakfast the most important meal of the day!

Learners who attend school without having had breakfast will not be able to concentrate properly in class and therefore they will not be able to learn or perform well academically. Eating breakfast before arriving at school is important for learners' concentration levels and attentiveness in class. Many children in Namibia however, go to school without having eaten breakfast.

This might be due to not having enough food at home, not enough money to buy food, or the learner may choose not to eat breakfast. If teachers are aware of learners arriving at schools without having eaten breakfast, consider introducing a 'snack' break before the first class, whereby learners are allowed to eat a piece of fruit or other healthy snack. Waiting for the school feeding programme meal may be too late, especially if it is served at the end of the school day.

Learners who skip breakfast are more likely to perform poorly in school and are therefore more likely to drop out of school.

Teach learners about the importance of breakfast, the importance of eating before they arrive at school. Teach them how to enrich porridge (mahangu, maize or oat) with protein and nutrient rich foods. Teach learners and their parents how to add meat, dried fish, butter or oil to the porridge to increase the nutritional value of the meal.



activity

Food Groups – 30 minutes

Break into small groups and distribute sets of food pictures or photographs. Ask each group to sort the foods according to the 4 food groups. Ask each group to name two nutrients that are provided by each food group.

Ask learners to develop a menu of meals suitable for themselves for one day and present these to the whole group.

2.4. FOOD ALLERGIES

Food allergy is an immune response, while food intolerance is a chemical reaction. Food intolerance does not involve the immune system and does not cause severe allergic reactions (anaphylaxis). Symptoms of food allergy include wheezing, stomach upsets and skin rashes. The most common food allergens include cow's milk, egg, peanuts, tree nuts, shellfish, fish, sesame, wheat and soy products. Anaphylaxis is a severe allergic reaction and can be life threatening.

Allergies are an overreaction of the body's immune system to a protein. These proteins may be from foods, pollens, house dust, animal hair or moulds. They are called allergens. The word allergy means that the immune system has responded to a harmless substance as if it were toxic.

Food intolerance is a 'chemical' reaction that some people have after eating or drinking some foods; it is not an immune response. Food intolerance has been associated with asthma, chronic fatigue syndrome and irritable bowel syndrome (IBS).

Food intolerance

Causes of food intolerance

The foods that tend to cause intolerance reactions in sensitive people include:

- dairy products, including milk, cheese and yoghurt
- chocolate
- eggs, particularly egg white
- flavour enhancers such as MSG (monosodium glutamate)
- food additives
- strawberries, citrus fruits and tomatoes
- wine, particularly red wine
- Histamine and other amines in some foods.

Symptoms of food intolerance can include:

- nervousness, tremor
- sweating
- palpitations
- rapid breathing
- headache, migraine
- diarrhoea
- burning sensations on the skin
- tightness across the face and chest
- breathing problems – asthma-like symptoms
- Allergy-like reactions.

Food Allergy

Causes of food allergy

Peanuts, tree nuts, eggs, milk, wheat, sesame, fish, shellfish and soy cause about 90 per cent of food allergic reactions. Peanut allergy is one of the most common allergies in older children as only approximately one in four children will outgrow peanut allergy.

The symptoms of food allergy can be life threatening. Common symptoms include:

- itching, burning and swelling around the mouth
- runny nose
- skin rash (eczema)
- hives (urticaria – skin becomes red and raised)
- diarrhoea, abdominal cramps
- breathing difficulties, including wheezing and asthma
- vomiting, nausea

Anaphylactic shock is life threatening.

Anaphylaxis, is a severe allergic reaction that needs urgent medical attention. Foods (such as peanuts, tree nuts, milk and egg), insect stings and some medicines are the most common allergens that cause anaphylaxis.

Within minutes of exposure to the allergen, the person can have potentially life-threatening symptoms, which include:

- difficult or noisy breathing
- swelling of the tongue
- swelling or tightness in the throat
- difficulty talking and/or a hoarse voice
- wheeze and/or persistent cough
- persistent dizziness or collapse
- Becoming pale and floppy (in young children).

Several factors can influence the severity of anaphylaxis, including exercise, heat, alcohol, the amount of food eaten, and how food is prepared and consumed.

To prevent severe injury or death, a person with anaphylaxis requires an injection of adrenaline. Injections of adrenaline, which can be given by the person themselves or their family or carer. Consult with a medical professional about where these injections can be obtained.

Unit 3: Healthy Lifestyle

Specific objectives

At the end of this unit, the trainers will have:

1. Understood the notion of healthy lifestyle;
2. Understood how to maintain a healthy weight and how to monitor one's weight using Body Mass Index; and
3. Gained a basic understanding of food allergies.

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, coloured markers



Facilitator's Notes

3.1. Tips for Healthy Living

In addition to eating a well-balanced diet, doing regular physical activity, drinking safe water and following good hygiene practices and avoiding risky behaviour such as smoking, drinking alcohol or using drugs, can result in a more enjoyable and satisfying life. Health is not just about avoiding disease or illness, it is also about physical, mental and social wellbeing.

The following are some tips to maintain a healthy lifestyle:

- Eat a balanced diet including foods from all four food groups each day
- Maintain a healthy body weight
- Drink at least 1.5 litres of clean water a day
- Wash hands with soap after defecating, before handling food and before eating
- Use a toilet instead of going to the 'bush'
- Avoid smoking cigarettes and using other types of drugs
- Avoid drinking alcohol
- Do at least 30 minutes of physical exercise a day
- Spend quality time with friends and family each day
- Participate in community events and groups to build a strong social network
- Seek medical help when you are sick or you think you are sick
- Seek assistance and help if you ever feel depressed or suicidal

3.2. What is a Healthy Weight?

BMI classification

Body Mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m^2). For example, an adult who weighs 70 kg and whose height is 1.75m will have a BMI of 22.9.

The BMI calculations for adults should never be used for adolescents or children. Specific BMI for age charts should be used in order to avoid misclassification. Below are BMI-for-Age tables for girls and boys.

GIRLS 5-18 Years (WHO 2007)

BMI-for-Age Table, GIRLS 5-18 Years (WHO 2007) Age: (years/ months)	Obese	Overweight	Normal	Mild malnutrition	Moderate malnutrition	Severe malnutrition
	≥ +2 SD	≥ +1 to < +2 SD	≥ -1 to < +1 SD	≥ -2 to < -1 SD	≥ -3 to < -2 SD	< -3 SD
	(BMI)	(BMI)	(BMI)	(BMI)	(BMI)	(BMI)
5:1	≥ 18.9	16.9-18.8	13.9-16.8	12.7-13.8	11.8-12.6	< 11.8
5:6	≥ 19.0	16.9-18.9	13.9-16.8	12.7-13.8	11.7-12.6	< 11.7
6:0	≥ 19.2	17.0-19.1	13.9-16.9	12.7-13.8	11.7-12.6	< 11.7
6:6	≥ 19.5	17.1-19.4	13.9-17.0	12.7-13.8	11.7-12.6	< 11.7
7:0	≥ 19.8	17.3-19.7	13.9-17.2	12.7-13.8	11.8-12.6	< 11.8
7:6	≥ 20.1	17.5-20.0	14.0-17.4	12.8-13.9	11.8-12.7	< 11.8
8:0	≥ 20.6	17.7-20.5	14.1-17.6	12.9-14.0	11.9-12.8	< 11.9
8:6	≥ 21.0	18.0-20.9	14.3-17.9	13.0-14.2	12.0-12.9	< 12.0
9:0	≥ 21.5	18.3-21.4	14.4-18.2	13.1-14.3	12.1-13.0	< 12.1
9:6	≥ 22.0	18.7-21.9	14.6-18.6	13.3-14.5	12.2-13.2	< 12.2
10:0	≥ 22.6	19.0-22.5	14.8-18.9	13.5-14.7	12.4-13.4	< 12.4
10:6	≥ 23.1	19.4-23.0	15.1-19.3	13.7-15.0	12.5-13.6	< 12.5
11:0	≥ 23.7	19.9-23.6	15.3-19.8	13.9-15.2	12.7-13.8	< 12.7
11:6	≥ 24.3	20.3-24.2	15.6-20.2	14.1-15.5	12.9-14.0	< 12.9
12:0	≥ 25.0	20.8-24.9	16.0-20.7	14.4-15.9	13.2-14.3	< 13.2
12:6	≥ 25.6	21.3-25.5	16.3-21.2	14.7-16.2	13.4-14.6	< 13.4
13:0	≥ 26.2	21.8-26.1	16.6-21.7	14.9-16.5	13.6-14.8	< 13.6
13:6	≥ 26.8	22.3-26.7	16.9-22.2	15.2-16.8	13.8-15.1	< 13.8
14:0	≥ 27.3	22.7-27.2	17.2-22.6	15.4-17.1	14.0-15.3	< 14.0
14:6	≥ 27.8	23.1-27.7	17.5-23.0	15.7-17.4	14.2-15.6	< 14.2
15:0	≥ 28.2	23.5-28.1	17.8-23.4	15.9-17.7	14.4-15.8	< 14.4
15:6	≥ 28.6	23.8-28.5	18.0-23.7	16.0-17.9	14.5-15.9	< 14.5
16:0	≥ 28.9	24.1-28.8	18.2-24.0	16.2-18.1	14.6-16.1	< 14.6
16:6	≥ 29.1	24.3-29.0	18.3-24.2	16.3-18.2	14.7-16.2	< 14.7
17:0	≥ 29.3	24.5-29.2	18.4-24.4	16.4-18.3	14.7-16.3	< 14.7
17:6	≥ 29.4	24.6-29.3	18.5-24.5	16.4-18.4	14.7-16.3	< 14.7
18:0	≥ 29.5	24.8-29.4	18.6-24.7	16.4-18.5	14.7-16.3	< 14.7

BOYS 5-18 Years (WHO, 2007)

Age (years: Months)	Obese	Overweight	Normal	Mild malnutrition	Moderate malnutrition	Severe malnutrition
	$\geq +2$ SD	$\geq +1$ to $< +2$ SD	≥ -1 to $< +1$ SD	≥ -2 to < -1 SD	≥ -3 to < -2 SD	< -3 SD
	(BMI)	(BMI)	(BMI)	(BMI)	(BMI)	(BMI)
5:1	≥ 18.3	16.6–18.2	14.1–16.5	13.0–14.0	12.1–12.9	< 12.1
5:6	≥ 18.4	16.7–18.3	14.1–16.6	13.0–14.0	12.1–12.9	< 12.1
6:0	≥ 18.5	16.8–18.4	14.1–16.7	13.0–14.0	12.1–12.9	< 12.1
6:6	≥ 18.7	16.9–18.6	14.1–16.8	13.1–14.0	12.2–13.0	< 12.2
7:0	≥ 19.0	17.0–18.9	14.2–16.9	13.1–14.1	12.3–13.0	< 12.3
7:6	≥ 19.3	17.2–19.2	14.3–17.1	13.2–14.2	12.3–13.1	< 12.3
8:0	≥ 19.7	17.4–19.6	14.4–17.3	13.3–14.3	12.4–13.2	< 12.4
8:6	≥ 20.1	17.7–20.0	14.5–17.6	13.4–14.4	12.5–13.3	< 12.5
9:0	≥ 20.5	17.9–20.4	14.6–17.8	13.5–14.5	12.6–13.4	< 12.6
9:6	≥ 20.9	18.2–20.8	14.8–18.1	13.6–14.7	12.7–13.5	< 12.7
10:0	≥ 21.4	18.5–21.3	14.9–18.4	13.7–14.8	12.8–13.6	< 12.8
10:6	≥ 21.9	18.8–21.8	15.1–18.7	13.9–15.0	12.9–13.8	< 12.9
11:0	≥ 22.5	19.2–22.4	15.3–19.1	14.1–15.2	13.1–14.0	< 13.1
11:6	≥ 23.0	19.5–22.9	15.5–19.4	14.2–15.4	13.2–14.1	< 13.2
12:0	≥ 23.6	19.9–23.5	15.8–19.8	14.5–15.7	13.4–14.4	< 13.4
12:6	≥ 24.2	20.4–24.1	16.1–20.3	14.7–16.0	13.6–14.6	< 13.6
13:0	≥ 24.8	20.8–24.7	16.4–20.7	14.9–16.3	13.8–14.8	< 13.8
13:6	≥ 25.3	21.3–25.2	16.7–21.2	15.2–16.6	14.0–15.1	< 14.0
14:0	≥ 25.9	21.8–25.8	17.0–21.7	15.5–16.9	14.3–15.4	< 14.3
14:6	≥ 26.5	22.2–26.4	17.3–22.1	15.7–17.2	14.5–15.6	< 14.5
15:0	≥ 27.0	22.7–26.9	17.6–22.6	16.0–17.5	14.7–15.9	< 14.7
15:6	≥ 27.4	23.1–27.3	18.0–23.0	16.3–17.9	14.9–16.2	< 14.9
16:0	≥ 27.9	23.5–27.8	18.2–23.4	16.5–18.1	15.1–16.4	< 15.1
16:6	≥ 28.3	23.9–28.2	18.5–23.8	16.7–18.4	15.3–16.6	< 15.3
17:0	≥ 28.6	24.3–28.5	18.8–24.2	16.9–18.7	15.4–16.8	< 15.4
17:6	≥ 29.0	24.6–28.9	19.0–24.5	17.1–18.9	15.6–17.0	< 15.6
18:0	≥ 29.2	24.9–29.1	19.2–24.8	17.3–19.1	15.7–17.2	< 15.7



activity

Determining BMI - 15 minutes

Ask each learner to determine his or her BMI using the tables provided. Weighing scales and a height measurement stick will be required.

Unit 4: School Feeding Programme

Specific Objective

At the end of this unit, the trainers will have:

1. Understood the importance of the School Feeding Programme in Namibia; and
2. Received practical knowledge about implementing the School Feeding Programme in their own school.

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, coloured markers



Facilitator's Notes

The Namibia School Feeding Programme is a nationally-run and government funded programme which provides meals for learners in primary schools across the country. The meal consists of 125 grams (475 kilocalories or 1988 kilojoule) fortified maize meal which is cooked at school and served midmorning.

The school feeding programme not only helps to relieve short-term hunger for children who have limited access to sufficient food at home, but also increases school attendance and concentration in class.



activity

Importance of school feeding – 20 minutes

Ask participants to brainstorm on the importance of school feeding. Why do children need this programme in school?

Groups give feedback. During plenary, emphasise the use of food grown in school gardens such as spinach, potatoes, cabbage, pumpkin, corn.

Background

The school feeding programme in Namibia was launched by WFP in 1991 to respond to the food needs of school children in drought-affected areas in the southern part of Namibia. In 1996, WFP handed over the programme to the Government of the Republic of Namibia, which gradually expanded the programme into other parts of the country to relieve short-term hunger and equalise educational opportunities to orphans and vulnerable children. The Namibian School Feeding Programme (NSFP) went through a full transition to national ownership, and is fully institutionalized and funded by the national government with at least 75% of the school feeding food basket sourced locally. Today, the programme covers approximately 320,000 children in 1,422 schools across the country, and is managed exclusively by the Ministry of Education, Arts and Culture.

Reviewing the Programme

In 2009, WFP commissioned a capacity gap analysis, which revealed an array of shortcomings in the implementation of the school feeding programme. The review identified problems related to storage and distribution of food; lack of monitoring; inadequate and low quality food rations; limited community support; inadequate targeting and internal controls; and a general weakness in the management of the programme. These bottlenecks contributed to inefficiencies in the implementation of school feeding programme and inhibited the full attainment of the programme objectives. In 2012, the school feeding case study was undertaken as a follow-up to the initial analysis. This review shed light on gaps within the design and implementation of NSFP, and recommended a number of actions to improve the efficiency and effectiveness of the programme.

A Strategic Partnership

In 2012, the Ministry of Education and the World Food Programme established a strategic partnership for technical assistance to strengthen the school feeding programme. Under this partnership framework, WFP provides technical assistance in four main areas:

1. Policy and strategic guidance
2. Systems strengthening and development
3. Knowledge generation and management
4. Capacity building and programme support



Source: World Food Programme Photo Library

Learner enjoying a mid-morning meal of porridge and soup

WFP provides technical assistance to the Ministry of Education, Arts and Culture (MOE) to strengthen the Namibian School Feeding Programme (NSFP) in four main areas:

- 1) Policy Guidance:** WFP provides policy guidance to shape decisions on school feeding. Under this technical area, national guidelines for school feeding management has been developed. WFP is working with the MOE to develop a national school feeding policy that will transform the NSFP into a national recognized, sustainable and effective programme. To date a discussion paper identifying key issues to be considered for formulation of the policy has been drafted and will guide the next steps in formulation of the school feeding policy.
- 2) Knowledge Generation & Management:** WFP is supporting the government to strengthen the evidence base on the school feeding programme. In 2012, WFP in partnership with PCD and NEPAD, supported the MOE to undertake an operational review of the school feeding programme. Other studies that have been carried since 2012 include the NSFP Transition Study, NSFP Cost Analysis, NSFP Baseline Survey and World Bank SABER study. These studies have been crucial in informing decisions around improvements in the school feeding programme that are currently being undertaken by the government.
- 3) Systems Development & Strengthening:** Through WFP's technical support, a comprehensive Monitoring and Evaluation (M&E) system has been developed to enhance performance monitoring and accountability. This M&E system includes the Namibian School Feeding Information System (NaSIS) and M&E Plan. The M&E plan describes the conceptual framework and defines the NSFP monitoring system (including Logical Framework, monitoring matrix, workflows for the monitoring of indicators, and describes the M&E roles and responsibilities of the NSFP actors); introduces specific M&E tools and provides guidelines for evaluating the NSFP. The NaSIS is an online database that captures real time data from schools and service providers and is used to track the progress of school feeding implementation.
- 4) Capacity Building & Programme Support:** Capacity building and programme support activities are undertaken to strengthen the management and implementation of NSFP. WFP has trained more than 2,100 government staff and service providers on school feeding implementation guidelines, monitoring and evaluation and reporting. Programme support involves promotion of standards, supporting advocacy activities, coordination, reporting and facilitating peer learning and partnerships with private sector.



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Learners washing hands before mid-morning meal.

Key Facts

1. The Namibian School Feeding Programme is fully funded and managed by the Government of the Republic of Namibia.
2. The programme supports about 320,000 school learners in 1,422 schools across the country with a mid-morning meal comprised of a fortified maize meal blend.
3. Targets pre-primary and primary school learners in rural schools and in selected schools in peri-urban poor communities.
4. The objectives of the Namibian School Feeding Programme are to contribute to:
 - Increased enrolment, attendance and retention
 - Learning performance and progression through grades
 - Improved health and nutrition of school learners through the provision of foods that have been fortified with essential nutrients.
5. The annual budget for the NSFP for FY 2014/2015 is approximately US\$9,000,000
6. The programme enjoys strong political support and is embedded in several national policies and strategies, including the fourth National Development Plan (NDP4).

The goal of the partnership is to enhance the Government's capacity to plan, manage and implement the school feeding programme efficiently and effectively.

References:

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MODULE 3: MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

Overall Objectives

1. To equip participants with knowledge and information on mental health and psychosocial problems
2. To be able to detect and identify mental disorders at earlier stages and refer to appropriate services
3. To be able to promote and protect the rights of people with mental illnesses
4. To promote and support psycho-social well-being of learners

Module summary table

Unit	Content	Time	Activity	Materials
1	Introduction to mental health: <ul style="list-style-type: none"> • Mental disorders • Prevention strategies • Mental health promotion in schools 	3 hours	Presentation discussions and group work	PowerPoint Presentation, Hand-outs: guidelines, policy flip chart papers markers
2	Overview of psychosocial well-being: Basic information on Substance Abuse	2 hours	Presentation, and case studies	Policy Documents, Guideline, PowerPoint presentation, posters, tool kits and picture codes

Glossary:

Adolescence: A stage of development between childhood and adulthood. When young people develop adult body features.

Discrimination: When a person is treated unfairly or unjustly because they have a particular attribute. **GRIEF** Emotional, mental and physical pain experienced about someone's death. **INFANT** A child who is at the earliest stage of development, aged 0 to 5 years.

Life Skills: Skills that help an individual to live a productive life as a member of a social group or community. E.g. communication skills, negotiation skills, literacy, numeracy.

Mental health: Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/ her community.

Mental illness: Is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior.

Psychosocial Support: An ongoing process of meeting the emotional social, mental, spiritual and physical needs of a child. This is done through ongoing care and contact with the child.

Psychosocial Well-being: Refers to an enhanced emotional, mental, physical and social state of a person, within their economic, social and cultural settings.

Self Awareness: A knowledge and understanding of oneself and one's strengths and weaknesses.

Stigma: When a person is thought of or treated in a negative or judgmental way because of a particular attribute.

Stress: Mental strain. Feeling stress is a normal response to the psychological or social challenges most people encounter at some time or another.

Trauma: A long lasting emotional shock.

Vulnerable Child: A child who is living in circumstances which may pose a threat to their physical, social, emotional, mental or spiritual well-being.

Unit 1: Introduction to Mental Health

Specific Objectives

1. To equip participants with an understanding of mental health issues
2. To understand the concept of mentally healthy schools
3. To empower and involve students in promoting mental health
4. To clarify what routes to take in promoting mental health
5. To understand causes of mental illnesses
6. To understand a comprehensive approach to mental health and mental disorders

Methodology: PowerPoint presentation, information sharing, demonstration

Materials: Flipchart paper, markers



Facilitator's Notes

The Constitution of Namibia prohibits unfair discrimination against people with mental illness or mental disabilities; and Namibia has entered into various international commitments pertaining to mental health, including the UN Convention on the Rights of Persons with Disabilities.

1.1. What is mental health and mental illness?

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/ her community. Mental health is an integral part of health; indeed, there is no health without mental health. Mental health is more than the absence of mental disorders. Mental health is determined by socioeconomic, biological and environmental factors .

Mental illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning .”

Depression is the most common type of mental illness, and it has been estimated that by the year 2020, depression will be the second leading cause of disability throughout the world, trailing only ischemic heart disease.

Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity and many risk behaviors for chronic disease; such as, physical inactivity, smoking, excessive drinking, and insufficient sleep.

Indicators of mental health representing three domains are grouped below self-acceptance:

Emotional well-being	Psychological well-being	Social well-being
<ul style="list-style-type: none"> perceived life satisfaction happiness cheerfulness peacefulness 	<ul style="list-style-type: none"> self-acceptance personal growth optimism hopefulness self-direction sense of purpose 	<ul style="list-style-type: none"> Social acceptance beliefs in the potential of people self-worth sense of community



activity

Brainstorming mental health – 10 minutes

- Ask question to all students on: What do you understand mental health and mental illnesses?
- Ask them to write down on a piece of paper and keep it folded without showing to anyone

Purpose: Students to reflect on their understanding and attitudes towards mental health and mental illnesses

To provide a baseline snapshots of students' ideas of mental illnesses that can be reexamined at the end of the unit.

1.2. What are the most common mental health problems and illnesses affecting Namibian school children?

Mental health problems refer to the more common struggles and adjustment difficulties that affect everybody from time to time. Feeling stress is a normal response to the psychological or social challenges most people encounter at some time or another. Mental health problems are short-term reactions to a particular stressor, such as a loss, painful event, or illness.

The burden of mental illnesses or disorders continues to grow with significant impacts on health and major social, human rights and economic consequences in all countries of the world.

Worldwide 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s. Neuropsychiatric conditions are the leading cause of disability in young people in all regions. If untreated, these conditions severely influence children's development, their educational attainments and their potential to live fulfilling and productive lives. Children with mental disorders face major challenges with stigma, isolation and discrimination, as well as lack of access to health care and education facilities, in violation of their fundamental human rights .

Mental illnesses or disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.

Mental disorders include: depression, anxiety disorders, bipolar affective disorder, schizophrenia, dementia, and developmental disorders including autism. There are effective strategies for preventing mental disorders such as depression. There are effective treatments for mental disorders and ways to alleviate the suffering caused by them. Access to health care and social services capable of providing treatment and social support is key.

1.2.1. Depression

Depression is a common mental disorder and one of the main causes of disability worldwide. Globally, about 400 million people of all ages suffer from depression. More women are affected than men. Depression is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. Sufferers may also have multiple physical complaints with no apparent physical cause.

Signs and symptoms

- Sadness
- Aches such as stomach and headaches
- Sleep disorders: too little or too much sleep
- Feelings of guilt and worthlessness
- Eating disorder: eating too little or too much
- Having little energy and lack of interest

What you can do if you suspect Depression?

If the disorder is more intense or the person is suicidal, as an educator or a school health nurse you should immediately refer the learner to a health professional. Ideally this should be done in collaboration and with the active support of the school guidance counsellor. There are effective treatments. Mild to moderate depression can be effectively treated with talking therapies, such as cognitive behaviour therapy or psychotherapy. Antidepressants can be an effective form of treatment for moderate to severe depression but are not the first line of treatment for cases of mild depression. They should not be used for treating depression in children and are not the first line of treatment in adolescents, among whom they should be used with caution.

Once back at school it is important that you be part of the ongoing treatment team and help develop and address learning needs. You may also need to continue to provide realistic emotional support.

Prevention

Prevention programmes have been shown to reduce depression, both for children (e.g. through protection and psychological support following physical and sexual abuse) and adults (e.g. through psychosocial assistance after disasters and conflicts).

Make sure that the child has a good social support system, both at home and through teachers, other family members, and friends who can provide encouragement and understanding.

1.2.2. Anxiety Disorder

People with this disorder worry constantly about themselves or their loved ones, financial disaster, their health, work or personal relationships. These people experience continuous apprehension and often suffer from many physical symptoms such as headache, diarrhoea, stomach pains and heart palpitation. Phobias are part of anxiety disorder. Everyone has mild or irrational fears, but phobias are intense fears about particular objects or situations which interfere with our lives. These might include fear of heights, water, dog, closed spaces, snakes or spiders, etc.

Signs and symptoms

- Excessive worry for unspecific reasons
- The worry is out of proportion to the concern or event
- Often the learner present with physical complaints such as headaches, fatigue, muscle aches and upset stomach
- The symptoms tend to be chronic and young people may miss school or social activities

What you can do if suspect Anxiety Disorder?

Refer the learner to an appropriate health professional for medical attention. Engage the school counsellor to ensure continued support for the learner.

Prevention

Since stress is a normal part of life, there is usually no way to prevent generalised anxiety disorder in someone who is vulnerable. However, once diagnosed, various treatments can effectively reduce symptoms.

Panic Disorder.

Panic Disorder is characterized by recurrent, unexpected, anxiety (panic) attacks that involve triggering a number of frightening physical reactions.

Signs and symptoms

1. Palpitations
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath
5. Feeling of choking
6. Chest pain or discomfort
7. Feeling dizzy, unsteady, lightheaded or faint

What to do if it is Panic Attack?

Refer to counselors/psychologist for counseling and to a health care provider for medication

1.2.3. Bipolar affective disorder

This disorder affects about 60 million people worldwide. It typically consists of both manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated or irritable mood, over-activity, pressure of speech, inflated self-esteem and a decreased need for sleep. People who have manic attacks but do not experience depressive episodes are also classified as having bipolar disorder. Effective treatments are available for the treatment of the acute phase of bipolar disorder and the prevention of relapse. These are medicines that stabilize mood. Psychosocial support is an important component of treatment.

Signs and symptoms

- Feel very happy or act silly in a way that's unusual
- Have a very short temper
- Talk really fast about a lot of different things
- Have trouble sleeping but not feel tired
- Have trouble staying focused
- Do risky things.

What you can do if you suspect Bipolar disorder?

Refer the learner to a the health care provider and make sure the school counsellor are informed.

Prevention

Shield a child who is at risk from bipolar disorder by avoiding chronic stress and provide a healthy physical and psychological environment.

1.2.4 Psychotic disorders: Schizophrenia

Schizophrenia is a severe mental disorder, affecting about 21 million people worldwide. Psychotic disorders such as schizophrenia are characterized by distortions in thinking, perception, emotions, language, sense of self and behaviour. Common psychotic experiences include hearing voices and delusions. The disorder can prevent people from being able to work or study normally.

Stigma and discrimination can result in a lack of access to health and social services. Furthermore, people with psychosis are at high risk of exposure to human rights violations, such as long term confinement in institutions. Schizophrenia typically begins in late adolescence or early adulthood. Treatment with medicines and psychosocial support is effective. With appropriate treatment and social support, affected people can lead a productive life, be integrated in society and even recover.

What you can do if you suspect Schizophrenia?

If an educator suspects psychosis, a referral to the most appropriate health provider should be made following discussion with the parents. A young person with psychosis will require immediate effective treatment.

Prevention

- There's no certain way to prevent psychosis. However, early treatment may help get symptoms under control before serious complications develop and may help improve the long-term outlook.
- Encourage learner to stick with the treatment plan in order to help prevent relapses or worsening of symptoms.

1.2.5. Neuro-developmental disorders including Autism

Developmental disorder is an umbrella term covering intellectual disability and pervasive developmental disorders including autism. Developmental disorders usually have a childhood onset but tend to persist into adulthood, causing impairment or delay in functions related to the central nervous system maturation. They generally follow a steady course rather than the periods of remissions and relapses that characterize many other mental disorders.

Intellectual disability is characterized by impairment of skills across multiple developmental area such as cognitive functioning and adaptive behaviour. Lower intelligence diminishes the ability to adapt to the daily demands of life. Symptoms of pervasive developmental disorders, such as autism, include impaired social behaviour, communication and language, and a narrow range of interests and activities that are both unique to the individual and are carried out repetitively. Developmental disorders often originate in infancy or early childhood. People with these disorders occasionally display some degree of intellectual disability.

Family involvement in care of people with developmental disorders is very important. Knowing what causes affected people both distress and wellbeing is an important element of care, as is finding out what environments are most conducive to better learning. Structure to daily routines help prevent unnecessary stress, with regular times for eating, playing, learning, being with others, and sleeping. Regular follow up by health services of both children and adults with developmental disorders, and their carers, needs to be in place. The community at large has a role to play in respecting the rights and needs of people with disabilities.

1.2.6. Attention deficit hyperactivity disorder (ADHD, ADD)

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).

Causes

Genetic and environmental factors and also brain injuries.

Signs and symptoms

Children who have symptoms of inattention may:

- Be easily distracted, miss details, forget things, and frequently switch from one activity to another
- Become bored with a task after only a few minutes, unless they are doing something enjoyable
- Have difficulty focusing attention on organizing and completing a task or learning something new
- Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Not seem to listen when spoken to
- Have difficulty processing information as quickly and accurately as others
- Struggle to follow instructions

Children who have symptoms of hyperactivity may:

- Fidget and squirm in their seats
- Talk nonstop
- Dash around, touching or playing with anything and everything in sight
- Have trouble sitting still during school
- Have difficulty doing quiet tasks or activities

Children who have symptoms of impulsivity may:

- Be very impatient
- Blur out inappropriate comments, show their emotions without restraint, and act without regard for consequences
- Have difficulty waiting for things they want or waiting their turn
- Often interrupt conversations or others' activities

What teachers can do to help

Refer the child to the hospital for diagnosis and management by the health care providers

As a teacher, your role is to:

- Evaluate each child's individual needs and strengths.
- Assure the learner that you'll be looking for good behavior and quality work, and when you see it, reinforces it with immediate and sincere praise.
- Look for ways to motivate a learner with ADD/ADHD by offering rewards on a point

Classroom accommodations for students with ADHD.

As a teacher, you can make changes in the classroom to help minimize the distractions and disruptions of ADHD.

Prevention

- Though there is no way to prevent ADHD, there are ways to help all children feel and do their best at home and at school.
- Giving a child a healthy, balanced diet from an early age is good for all children, whether or not they have ADHD.
- For older children, with or without ADHD, having a homework routine in place can make the after-school time more effective. Set aside an area away from distractions for doing homework.

1.2.7. Conduct disorder

Conduct disorder refers to a group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as “bad” or delinquent, rather than mentally ill. Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse or neglect, genetic vulnerability, school failure, and traumatic life experiences.

Children or adolescents with conduct disorder may exhibit some of the following behaviors:

Aggression to people and animals

- bullies, threatens or intimidates others
- often initiates physical fights
- has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)

Serious violations of rules

- runs away from home
- often truant from school

What you can do if you suspect Conduct disorder?

Refer children who exhibit such behavior to receive a comprehensive evaluation by an experienced mental health professional.

Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special educational programs in the home and at school.

1.3. How can the human rights of people with mental health conditions be promoted and protected?

People with mental health conditions around the world are exposed to a wide range of human rights violations. The stigma they face means they are often ostracized from society and fail to receive the care they require or the services and support they need to lead full lives in the community. In some communities, people with mental health conditions are banished to the edge of town where they are left semi-naked or in rags, tied up, beaten and left to go hungry.

People with mental health conditions also face discrimination on a daily basis including in the fields of education, employment and housing. Some countries even prohibit people from voting, marrying or having children. How can these violations be prevented?

Ratify the UN Convention on the Rights of Persons with Disabilities (CRPD).

Namibia has already ratified the convention however the country should align the policies and laws to the Convention.

Change attitudes and raise awareness. Ministries of Health, organizations of people with mental health conditions, health professionals, NGOs including Disabled Peoples' Organizations academic institutions, professional organizations and other stakeholders should unify their efforts in educating and changing public attitudes towards mental illness.

Figure 3.1: One in four individuals suffer from mental health problems. Mental illness is nothing to be ashamed of and stigma does only harm. Mental health awareness day is celebrated every 10th October.



Improve human rights in mental health facilities. Ways to assess quality of care and human rights conditions should be established to protect against inhuman and degrading conditions

Empower people with mental health conditions and their families. Create and strengthen organizations of people with mental illnesses as well as family organizations.

Replace psychiatric institutions with community care. Institutions associated with human rights violations, should be replaced by community mental healthcare services, backed by psychiatric beds in general hospital and home care support.

Increase investment in mental health. Governments need to dedicate more of their health budget to mental health. In addition the mental health workforce at each level of the health care system needs to be developed and trained.



activity

Mental health language session – 20 minutes

Class is divided into 4 groups.

Each group will be given a piece of flipchart paper with one of the four topics written at the top – physical health; mental health; physical illnesses; mental illnesses 10 minutes to brainstorm on all the words that come to their mind when they see one of those four topics.

- One student from each group to read out the words they put on their flipchart
- Ask students what they notice about similarities and differences between physical and mental health and illnesses
- Ask them to think why there are differences

Purpose: An icebreaker for open discussion about a topic that is not often addressed in the classroom; To get an idea of students' knowledge, fears and misconceptions;

To highlight the way we tend to conceptualise mental illnesses (stereotypes).

1.4. Mental Health Promotion in Schools

Mental Health Promotion is about creating environments that promote and sustain positive mental health for everyone. Activities and interventions are designed to enhance protective factors and minimise risk factors (individual, family related, environmental and economic in nature). Schools are an ideal setting in which to promote mental health for children and youth, providing an opportunity to reach large groups of children during their formative years of cognitive, emotional, and behavioural development .

The most effective school based programmes for promoting mental health are comprehensive and target multiple health outcomes, involve the whole school, focus on personal skill development, include parents and the wider community and are implemented over a period of time. Research shows that school based mental health promotion programme can:

- Increase mental well-being
- Enhance regulation of emotions
- Enhance coping and problem solving skills
- Increase engagement, achievement and attendance
- Enhance empathy and respect for diversity
- Decrease bullying and aggression



Key Notes: Suggestions to School Management for Mental Health Promotion in School Initiative

Adopting an approach that promotes mental health in a positive way will not only serve to strengthen student engagement and academic function, but also will pro-actively address key relationship concerns such as the prevention of bullying and oppositional behaviours and attitudes. This contributes to the development of environments where individuals experiencing personal distress and challenges can find supportive connections, use and develop their strengths, and develop a greater sense of autonomy or self-determination.

Establishing a Mental Health Promotion Team

The team should comprise of people with the necessary expertise and interest in issues relating to the mental and emotional well-being of the adults and learners at the school. An existing committee or group may be willing to undertake this task or the school may wish to establish a new group of volunteers who are prepared to examine the issues. Ideally this team would be given a formal place within the school's organizational structure and be acknowledged and supported by the school management.

Developing a Plan of Action

Schools are strongly encouraged to integrate any mental health promotion in schools work planning into the strategic planning that establishes goals for the school. For any goal setting to bring about change it needs to follow some fundamental criteria:

- The goals must be clear, understandable, controllable, straightforward and achievable i.e. what do you want to achieve?

Some activities for consideration

- Create a school based/community mentor programme
- Link students with school or community mentors who have specialised knowledge or skills related to areas of students interests
- Host a mental health week with different activities highlighting aspects of being mentally healthy
- Have students create murals or posters which illustrate positive mental health
- Anti-bullying campaigns and discussions throughout



activity

Revision of Unit 1 – 30 minutes

Questions for students:

- What is mental health?
- What is mental illness?
- Name some mental illnesses that you've heard of?
- How a person with mental illness does look like or act?
- If you learned that one of your classmate has mental illness. What would you feel about him or her?

Unit 2: Overview of psychosocial well-being

Specific Objectives

1. To have a common understanding on psychosocial issues affecting learners
2. To identify psychosocial problems among learners and underlying causes
3. Roles and responsibilities of Health Workers, Learners and Stakeholders in Addressing Psycho-social issues
4. Promote the use of available services and institutions within the community
5. Identify, assess and refer psycho-social problems of learners to relevant institutions

Methodology: PowerPoint presentation, information sharing

Materials: Flipchart paper, coloured markers



Facilitator's Notes

2.1. What is Psychosocial Well-being?

Psychosocial well-being is a state in which one is able to master life tasks and give meaning to daily life .

It is a condition of holistic health in all its dimensions: physical, cognitive, emotional, social, physical, and spiritual. It is also a process of the full range of what is good for a person; participating in a meaningful social role; feeling happy and hopeful; living according to good values, as locally defined; having positive social relations and a supportive environment; coping with challenges through the use of appropriate life skills; and having security, protection, and access to quality services.

Consider those key characteristics when assessing one's own psycho-social well being:

- Ability to enjoy life – Can you live in the moment and appreciate the "now"? Are you able to learn from past and plan for the future without dwelling on things you can't change or predict?
- Resilience – Are you able to bounce back from hard times? Can you manage the stress of a serious life event without losing your optimism and sense of perspective?
- Balance – Are you able to juggle the many aspects of your life? Can you recognize when you might be devoting too much time to one aspect, at the expense of others? Are you able to make changes to restore balance when necessary?
- Self-actualisation – Do you recognise and develop your strengths so that you can reach your full potential?
- Flexibility – Do you feel, and express, a range of emotions? When problems arise, can you change the expectations of life, others, yourself – to solve the problem and feel better?

2.2. Psychosocial problems among learners and underlying causes

Most common psychosocial problems in the community in Namibia are;

- Substance abuse (drug and alcohol abuse)
- School drop-out and juvenile delinquency
- Suicide

2.2.1. Substance Abuse

Drug Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

Recent estimates are that in 2008, 155 to 250 million people, or 3.5% to 5.7% of the world's population aged 15-64, used other psychoactive substances, such as cannabis, amphetamines, cocaine, opioids, and non-prescribed psychoactive prescription medication. Globally, cannabis is the most commonly used (129-190 million people), followed by amphetamine type stimulants, then cocaine and opioids.

The use of psychoactive substances causes significant health and social problems for the people who use them, and also for others in their families and communities. WHO estimated that 0.7% of the global burden of disease in 2004 was due to cocaine and opioid use, with the social cost of illicit substance use being in the region of 2% of GDP in those countries which have measured it.

Most drugs of abuse are addictive. Addiction is a chronic, relapsing disease characterized by compulsive drug seeking and use despite negative consequences and by long-lasting changes in the brain. People who are addicted have strong cravings for the drug, making it difficult to stop using. Most drugs alter a person's thinking and judgment, which can increase the risk of injury or death from drugged driving or infectious diseases (e.g., HIV/AIDS, hepatitis) from unsafe sexual practices or needle sharing. Drug use during pregnancy can lead to neonatal abstinence syndrome, a condition in which a baby can suffer from dependence and withdrawal symptoms after birth. Pregnancy-related issues are listed in the chart below for drugs where there is enough scientific evidence to connect the drug use to negative effects. However, most drugs could potentially harm an unborn baby.

Cocaine

Cocaine is a powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. It produces short-term euphoria, energy, and talkativeness in addition to potentially dangerous physical effects like raising heart rate and blood pressure.

Heroin

Heroin is an opioid drug that is synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin usually appears as a white or brown powder or as a black sticky substance, known as “black tar heroin.” Heroin can be injected, inhaled by snorting or sniffing, or smoked. All three routes of administration deliver the drug to the brain very rapidly, which contributes to its health risks and to its high risk for addiction, which is a chronic relapsing disease caused by changes in the brain and characterized by uncontrollable drug-seeking no matter the consequences.

Figure 3.2: Most commonly abused drugs generate different kinds of effects on the pleasure centres in the human brain followed by severe adverse consequences for the human brain



Source: <http://todayrehabrecoveryplace.com/the-most-commonly-abused-drugs/>

Marijuana/Cannabis

Marijuana is a dry, shredded green and brown mix of leaves, flowers, stems, and seeds from the hemp plant *Cannabis sativa*. In a more concentrated, resinous form, it is called hashish, and as a sticky black liquid, hash oil. People smoke marijuana in hand-rolled cigarettes (joints) or in pipes or water pipes (bongs). They also smoke it in blunts—emptied cigars that have been partly or completely refilled with marijuana.

Methamphetamine

Methamphetamine (also called meth, crystal, chalk, and ice, among other terms) is an extremely addictive stimulant drug that is chemically similar to amphetamine. It takes the form of a white, odorless, bitter-tasting crystalline powder. Methamphetamine is taken orally, smoked, snorted, or dissolved in water or alcohol and injected. Smoking or injecting the drug delivers it very quickly to the brain, where it produces an immediate, intense euphoria. Because the pleasure also fades quickly, users often take repeated doses, in a “binge and crash” pattern.

Club Drugs

Club drugs are psychoactive drugs that tend to be abused by teens and young adults at bars, nightclubs, concerts, and parties. Gamma hydroxybutyrate (GHB), Rohypnol, ketamine, as well as MDMA (ecstasy) and methamphetamine (which are featured in separate DrugFacts) are some of the drugs included in this group. GHB and Rohypnol are available in odorless, colorless, and tasteless forms that are frequently combined with alcohol and other beverages. Both drugs have been used to commit sexual assaults (also known as “date rape,” “drug rape,” “acquaintance rape,” or “drug-assisted” assault) due to their ability to sedate and incapacitate unsuspecting victims, preventing them from resisting sexual assault.

Tobacco

Cigarettes and other forms of tobacco—including cigars, pipe tobacco, snuff, and chewing tobacco—contain the addictive drug nicotine. Nicotine is readily absorbed into the bloodstream when a tobacco product is chewed, inhaled, or smoked. Cigarette smoking accounts for about one-third of all cancers, including 90 percent of lung cancer cases. Smokeless tobacco (such as chewing tobacco and snuff) also increases the risk of cancer, especially oral cancers. In addition to cancer, smoking causes lung diseases such as chronic bronchitis and emphysema, and increases the risk of heart disease, including stroke, heart attack, vascular disease, and aneurysm. Smoking has also been linked to leukemia, cataracts, and pneumonia. On average, adults who smoke die 10 years earlier than nonsmokers.

Alcohol Abuse

Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies. Environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are relevant factors in explaining differences and historical trends in alcohol consumption and related harm.

Alcohol use can have serious harmful effects on young people’s health including:

- Loss of coordination and judgement
- Doing risky things while drunk
- Damage to the liver, heart and brain
- Loss of appetite and malnutrition
- Blackouts (loss of memory)
- Hangovers (nausea, headache)
- Increased vulnerability to violence
- Greater likelihood of unplanned, unwanted or unprotected sexual activity (high risk to HIV)
- Becoming less fearful to commit crime
- Car accidents
- Hurting oneself and others

A wide range of effective global, regional and national policies and interventions are in place to reduce the harmful use of alcohol, with a promising trend over the past few decades.

- **Alcohol consumption:**

- Worldwide consumption in 2010 was equal to 6.2 litres of pure alcohol consumed per person aged 15 years or older, which translates into 13.5 grams of pure alcohol per day.
- A quarter of this consumption (24.8%) was unrecorded, i.e., homemade alcohol, illegally produced or sold outside normal government controls. Of total recorded alcohol consumed worldwide, 50.1% was consumed in the form of spirits.
- Worldwide 61.7% of the population aged 15 years or older (15+) had not drunk alcohol in the past 12 months. In all WHO regions, females are more often lifetime abstainers than males. There is a considerable variation in prevalence of abstention across WHO regions.
- Worldwide about 16.0% of drinkers aged 15 years or older engage in heavy episodic drinking.
- In general, the greater the economic wealth of a country, the more alcohol is consumed and the smaller the number of abstainers. High-income countries have the highest alcohol per capita consumption (APC) and the highest prevalence of heavy episodic drinking among drinkers.

- **Health consequences**

- In 2012, about 3.3 million net deaths, or 5.9% of all global deaths, were attributable to alcohol consumption.
- There are significant sex differences in the proportion of global deaths attributable to alcohol, for example, in 2012 7.6% of deaths among males and 4% of deaths among females were attributable to alcohol.
- In 2012 139 million net DALYs (disability-adjusted life years), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption.
- There is also wide geographical variation in the proportion of alcohol-attributable deaths and DALYs, with the highest alcohol-attributable fractions reported in the WHO European Region.

- **Policies and interventions**

- Alcohol policies are developed with the aim of reducing harmful use of alcohol and the alcohol-attributable health and social burden in a population and in society. Such policies can be formulated at the global, regional, multinational, national and subnational level.
- Delegations from all 193 Member States of WHO reached consensus at the World Health Assembly in 2010 on a WHO Global strategy to reduce the harmful use of alcohol.
- Many WHO Member States have demonstrated increased leadership and commitment to reducing harmful use of alcohol over the past years.
- A significantly higher percentage of the reporting countries indicated having written national alcohol policies and imposing stricter blood alcohol concentration limits in 2012 than in 2008.

2.2.2. School drop-out and juvenile delinquency

A number of sociocultural problems prevent children from attending school in Namibia. These include a low demand for education in certain households, norms surrounding child labour and teenage pregnancy, violence against children, high HIV infection rates, substance abuse and disability.

Figure 3.3: As part of the Global Campaign on Road Safety #SaveKidsLives, Namibian learners took a stand against alcoholism and drunk driving at the Sam Nujoma Stadium on the 24th May 2015 (the event was organized by Ministry of Education, Arts and Culture and the National Road Safety Council).



Source: Ministry of Health and Social Services, Republic of Namibia

In order to better understand Namibian children out of school, it may be useful to identify which children are particularly vulnerable to exclusion from education. Namibia's National Policy Options for Educationally Marginalised Children (2000) identified thirteen groups of children most likely to be educationally marginalised:

1. Children of farm workers
2. Children in remote rural areas: San
3. Children in remote rural areas: Ovahimba
4. Street children
5. Working children
6. Children in squatter areas
7. Children in resettlement camps
8. Children in refugee camps
9. Children with special educational needs
10. Overage children
11. Young offenders
12. Orphans
13. Teenage mothers.

The first three groups are affected most by physical isolation, given their location in remote areas. This makes education more expensive than it would have been otherwise because in addition to the costs of uniforms, parents would have to pay for transport to and / or accommodation at schools for their children. Moreover, children in more rural schools have much lower chances of survival to grade 12 (1 percent) than those in urban schools (58 percent).

Figure 3.4: The San and Ovahimba children have historically been semi-nomadic which further decreases their school attendance.



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Teenage motherhood is another serious issue affecting school participation. In 2009 Namibia's Cabinet approved the 'Implementation of the policy on pregnancy among learners' which specifically granted pregnant teenagers the right to stay in school until the day of delivery and to return as soon as they are fit and willing. However, the policy has not been implemented consistently with some schools complying with the policy but others insisting that pregnant learners leave as soon as they show signs of pregnancy.

Juvenile delinquency is a general phenomenon that an increasing number of children find themselves in trouble with the law. Namibia is no exception. The causes for children's involvement in the criminal justice process differ from country to country. In a developing country like Namibia the socioeconomic circumstances play an important role in juvenile delinquency. These circumstances include the political history, poverty, poor and unequal access to education and inadequate social services. Youth are the least able to support themselves and are often the victims of critical poverty. Namibia today must face the challenge of providing viable solutions for the problems of juveniles who come into conflict with the law.

Juvenile delinquency is largely limited to adolescence-limited and often occurs as a result of peer pressure. It predominantly affects male individuals for whom it is a way of adapting to contradictory demands of their context: they are often told "you are too young for that" while they must "wait to be grown up, hence they are trapped in a kind of maturity gap between their biological and social age. In most cases, delinquency disappears spontaneously as opportunities to assume adult roles appear more readily, though at times only with strong social support. However, in some cases delinquency persists into adulthood thus severely limiting the individual's opportunity to lead a productive life.

UN Convention on the Rights of the Child Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Legal Assistance Centre (LAC) has developed the so-called “diversion” strategy for offenders under the age of 18 under the auspices of Prosecutor General. The “diversion” strategy has the aim of minimising the conflict between the under-age offender and the law in three ways:

1. Diversion from arrest and pre-trial detention through mediation between victims and offenders and also through the avoidance of detention by linking up children with family members.
2. Diversion from court procedures by linking juveniles into a life skills programme.
3. Diversion from prison sentences in the form of community-based alternative sentencing options.

2.2.3. Suicide

Every year more than 800 000 people take their own life and there are many more people who attempt suicide. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. Suicide occurs throughout the lifespan and was the second leading cause of death among 15–29-year-olds globally in 2012. Suicide does not just occur in high-income countries, but is a global phenomenon in all regions of the world. In fact, 75% of global suicides occurred in low- and middle-income countries in 2012. Suicide is a serious public health problem; however, suicides are preventable with timely, evidence-based and often low-cost interventions. For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed.

While the link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established in high-income countries, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness. In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behaviour. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex (LGBTI) persons; and prisoners. By far the strongest risk factor for suicide is a previous suicide attempt.

It is estimated that around 30% of global suicides are due to pesticide self-poisoning, most of which occur in rural agricultural areas in low- and middle-income countries. Other common methods of suicide are hanging and firearms. Knowledge of the most commonly used suicide methods is important to devise prevention strategies which have shown to be effective, such as restriction of access to means of suicide.

Suicides are preventable. There are a number of measures that can be taken at population, sub-population and individual levels to prevent suicide and suicide attempts. These include:

- reducing access to the means of suicide (e.g. pesticides, firearms, certain medications);
- reporting by media in a responsible way;
- introducing alcohol policies to reduce the harmful use of alcohol;
- early identification, treatment and care of people with mental and substance use disorders, chronic pain and acute emotional distress;
- training of non-specialized health workers in the assessment and management of suicidal behaviour;
- follow-up care for people who attempted suicide and provision of community support.

Suicide is a complex issue and therefore suicide prevention efforts require coordination and collaboration among multiple sectors of society, including the health sector and other sectors such as education, labour, agriculture, business, justice, law, defense, politics, and the media. These efforts must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide. Namibia Suicide Support Network contacts are provided in Annex 12.

Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need. The prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major public health problem and the taboo in many societies to openly discuss it. To date, only a few countries have included suicide prevention among their health priorities and only 28 countries report having a national suicide prevention strategy.

Raising community awareness and breaking down the taboo is important for countries to make progress in preventing suicide.



How to recognise a suicidal learner in school context? – 20 minutes

The best way to prevent suicide is to recognize these warning signs and take them seriously. There are various misconceptions about suicide which often prevent timely preventive action.

Read out the following 5 statements about suicide ask the participants to decide whether they are true or false and provide reasons. Record their answers on a flipchart and then discuss them against the background provided here.

Common Misconceptions about Suicide

1. People who talk about suicide won't really do it.

FALSE: Almost everyone who commits or attempts suicide has given some clue or warning. Do not ignore suicide threats. Statements like “you’ll be sorry when I’m dead,” “I can’t see any way out,” — no matter how casually or jokingly said may indicate serious suicidal feelings.

2. Anyone who tries to kill him/herself must be crazy.

FALSE: Most suicidal people are not psychotic or insane. They must be upset, grief-stricken, depressed or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.

3. If a person is determined to kill him/herself, nothing is going to stop them.

FALSE: Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.

4. People who commit suicide are people who were unwilling to seek help.

FALSE: Studies of suicide victims have shown that more than half had sought medical help in the six months prior to their deaths

5. Talking about suicide may give someone the idea.

FALSE: You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true—bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

Source: SAVE – Suicide Awareness Voices of Education

2.3. Roles and Responsibilities of Health Workers, Learners and Stakeholders in Addressing Psycho-social issues

Psychosocial support is activities designed to improve psychosocial well-being through reducing risk factors and increasing protective factors, thus restoring resilience. (IASC Guidelines on mental Health and Psychosocial Work in Emergencies, 25 June 2010).

All children have the right to be cared for, loved, and protected. Psychosocial support is ensuring that children have love, care and protection. It is support for the emotional and social aspects of a child's life, so that they can live with hope and dignity. Psychosocial support is best provided by families and communities.

What is psychosocial support for children?

All children have material needs such as food, shelter, health care and education. But children also have the right to be cared for, loved, and protected. Psychosocial support is ensuring that children have love, care and protection. It is support for the emotional and social aspects of a child's life, so that they can live with hope and dignity.

Figure 3.5: Community can do a lot to support the vulnerable children by ensuring their needs are met and that children who show signs of mental health problems are supported from the onset.



Source: *The Psychosocial Support Source Book for Vulnerable Children in Malawi*

Why is psychosocial support important?

Psychosocial support is the right of every child. Children and youth exposed to the devastating effects of poverty, conflict, HIV and AIDS are especially entitled to care for their emotional and social (psychosocial) wellbeing. Many have lost parents and family, experienced deprivation and abuse, been stigmatized, witnessed atrocities, and suffered overwhelming grief. This generation of children will soon be leading our countries and our communities. They need the right support if they are to grow into capable and compassionate adults, and active citizens engaged in their communities.

How can we provide psychosocial support?

Psychosocial support includes:

- ensuring the meaningful participation of children in issues affecting them
- listening and responding to children's problems
- allowing children to express their feelings and needs
- helping children to appreciate their history and identity

- encouraging children to set goals and reach their potential
- ensuring that children have positive, nurturing relationships and connections in their lives
- Providing life skills for children and youth
- Providing children with safe spaces to play

Psychosocial support is best provided by families and communities. We can strengthen the ability of families and communities to provide love, care and protection for their children. All services for children (for example: education, health, humanitarian support in emergencies) should be delivered in a way that takes account of their psychosocial wellbeing.

What can we do?

- We can plan for the wellbeing of our children, by providing laws, policies, programmes and activities.
- We can commit resources to ensuring the wellbeing of our children.
- We can prioritize children's rights in the work that we do.
- We can ensure children's participation in all levels of society.

Investing in psychosocial support is an investment in our shared future. Let's work together to develop healthy, capable and secure citizens who are able to control their future, and make positive contributions to society.



activity

Review Activity: Preconditions for effective psychosocial support

Facilitator asks participants to brainstorm on:

1. What are the main features of psychosocial well-being and psychosocial support?
 2. What are the main characteristics a person providing psycho-social support to the child should ideally possess?
- Write responses on the flip chart.
 - Discuss with the trainers whether the following aspects of providing psycho-social support have been captured in their exercise:

Listening skills; Patience; Caring attitude; Trustworthiness; Approachability; Empathy; Non-judgmental approach; Kindness; Commitment.

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MODULE 4: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Overall Objectives

To provide participants with knowledge and information on sexual and reproductive health and rights.

Module summary table

Unit	Content	Time	Activity	Materials
1	Basics of Reproductive Biology: Female and male reproductive systems Puberty	1 hour 30 minutes	Presentation and information sharing	PowerPoint presentation, Guidelines and posters
2	Sexual risk behaviours Types Consequences Traditional practices	1 hour	Presentation and case study	PowerPoint presentation, posters and videos
3	Learner pregnancy Contributing factors Consequences Prevention Education Sector Policy on Learner Pregnancy	2 hours	Presentation, role play, demonstration and case study	PowerPoint presentation, videos and posters
4	Contraceptives	1 hour	Presentation, demonstration and case study	PowerPoint presentation, videos, posters and flip charts
5	Sexually Transmitted Diseases HIV and AIDS: Prevention Management Disclosure Stigma	2 hours	Presentation and case study	PowerPoint presentation, videos posters, flip and charts
6	Sexual rights and responsibilities	1 hour 30 minutes	Presentation, demonstration and case study	Policy documents, guidelines and posters

Glossary:

Adolescent friendly health services: Programmes & services with policies, procedures, practices, and other attributes that attract young men & women of varied ages to access health services.

Baby dumping: the act of abandoning or discarding a child younger than 12 months in a public or private place with the intent of disposing of them.

Comprehensive sexual education: a planned curriculum that is part of a comprehensive school health education approach which addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality.

Contraceptives: a device or a drug that serves to prevent pregnancy

Emergency contraceptive pills: hormonal method of contraception that can be used to prevent pregnancy following an act of unprotected sexual intercourse.

Learner pregnancy

Reproductive biology: The study of the sexual or asexual process by which organisms procreate.

Reproductive rights: the basic right of individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence (World Health Organization).

Sexual health: state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (World Health Organization).

Sexual risk behaviours: behaviours that increase the risk of a negative outcome such as increasing the chance of contracting or transmitting a disease or increase the chance of the occurrence of unwanted pregnancy.

Sexuality: a person's capacity for sexual feelings.

Sexually transmitted infections: An infection transmitted through sexual contact, caused by bacteria, viruses, or parasites.

Sexual and Reproductive Health Rights: Sexual and reproductive health and rights encompass efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality sexual and reproductive health services, including contraceptive services, and to address sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and sexual and reproductive health needs of adolescents (UNFPA might have a better definition)

Sexual risk behaviors: Sexual risk behaviours are defined as behaviours which increase the risk of contracting sexually transmitted diseases including HIV or the occurrence of unintended pregnancies.

Learner pregnancy: Learner pregnancy is defined as a pregnancy of a female under the age of 20, usually between the age of 13 and 19.

Contraceptives: Contraceptives or also called birth control, are usually used to prevent pregnancies

Sexually Transmitted Diseases: are passed on from one person to another through sexual contact and sometimes by genital contact. The infection can be passed on via vaginal intercourse, oral sex and anal sex.

Adolescent friendly health services: are based on a comprehensive understanding of what young people in any given society or community want and need. It is also based on an understanding of, and respect for, the realities of young people's diversity and sexual rights.

Sterilization: A surgical procedure to close or block the fallopian tubes. Generally its irreversible and recommended for women with children.

Unit 1: Basics of reproductive biology

Specific Objectives

By the end of this Unit the participants should be able to:

1. Identify basic parts of the female and male reproductive system
2. Understand the impact of puberty on the young person's body and outline stages of adolescence

Methodology: PowerPoint presentation, interactive activities, information sharing

Materials: Flipchart paper, coloured markers, coloured pencils, paper plates



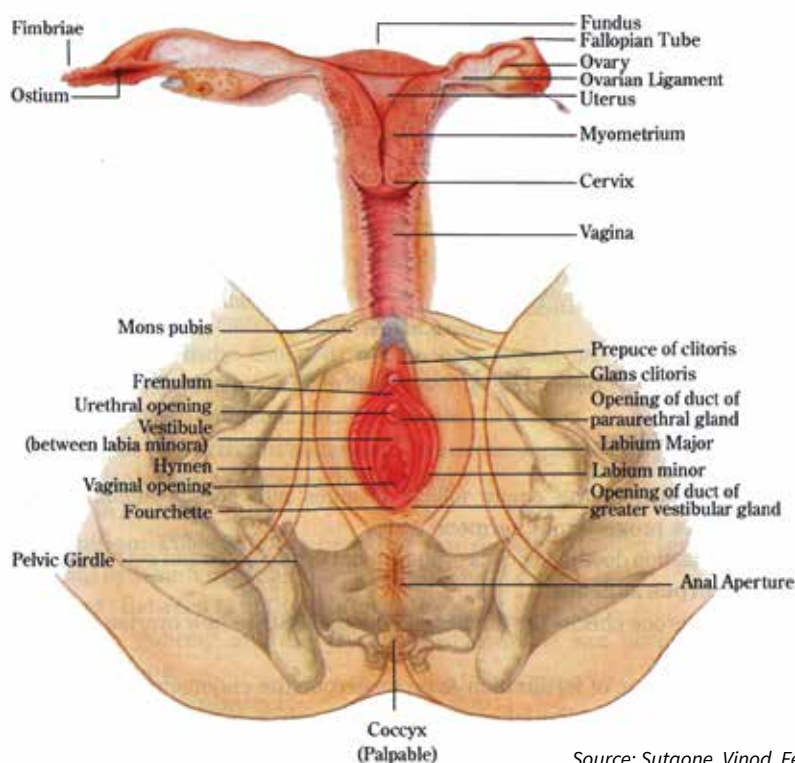
Facilitator's Notes

1. Basics of Reproductive Biology

The reproductive system is a unit composed of internal and external components. The internal components, located within the lower abdomen are called internal sex organs. Meanwhile the components visible outside the body are called external sexual organs or genitals. Male and female reproductive systems are complementary, with the genitals marking difference between the two. In fact, for every part of the male reproductive system, there is a corresponding female part of the reproductive system similar in function.

1.1. The Female Reproductive System

Figure 4.1: The Female Reproductive System



Source: Sutaone, Vinod. Female Reproductive System.

Table 4.1: Parts and Functions of the Female Reproductive System

Reproductive Organ	Function
Cervix	Opening of the uterus. Connects the womb to the upper part of the vagina.
Clitoris	Small, sensitive organ above the vagina that responds to stimulation during sexual intercourse.
Fallopian Tubes	Two hollow like structures that connect the ovaries to the uterus on either side.
Hymen	Thin membrane covering the opening of the vagina.
Labia majora (major lips)	Outer lips of vulva covered with hair that protects the labia minora and internal organs.
Labia minora (minor lips)	Inner lips of vulva covering and protecting the vaginal opening.
Ovaries	Produce eggs (ova) and two major hormones, estrogen and progesterone.
Pelvis	The bones containing and protecting the internal reproductive organs.
Urethra	Narrow tube for passage of urine from the bladder to the outside.
Uterus	Organ where implantation takes place and holds a growing fetus. The inner lining sheds once every 28 days during menstruation and comes out the vagina as blood.
Vagina	Passage from the outside of the body to the mouth of the uterus. The penis is placed in it during sexual intercourse and the baby passes through it during delivery.
Vaginal fluid	Fluid produced by a pair of glands in the vagina to moisten the vagina.
Vulva	The external component of the female reproductive organs.

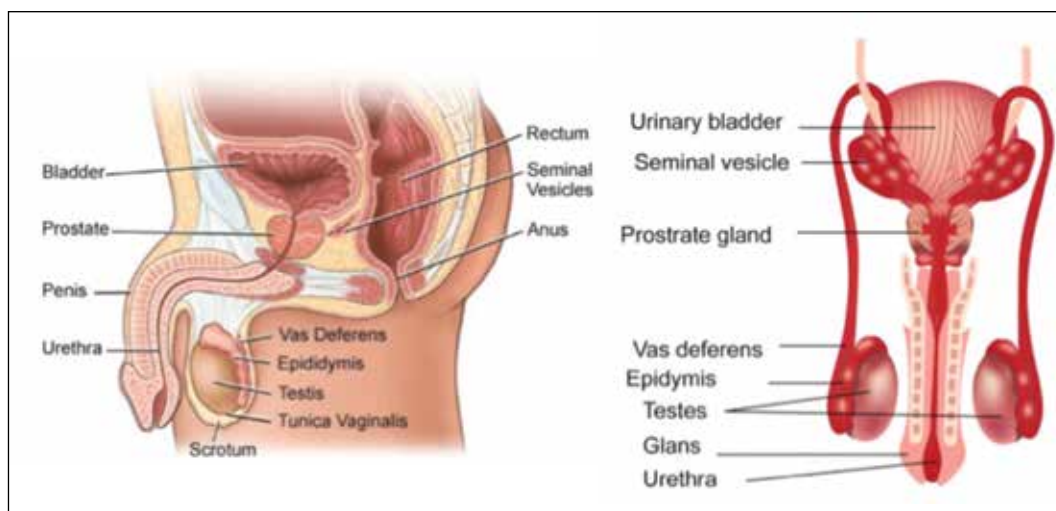
Source:

1.2. Menstruation

- Girls are born with hundreds of thousands of tiny eggs, called ova – one is called an ovum.
- These egg cells are only half formed.
- At puberty, hormones tell the ovaries it is time to start releasing ova.
- Usually one egg at a time matures (develops) and is released from an ovary.
- At the same time the uterus starts to grow a thick lining on the inside wall.
- The lining has lots of tiny blood vessels.
- The lining is there to protect and feed an egg that has combined with a sperm to form a fertilized egg.
- If the egg does not meet a sperm, the lining is not needed, and is then shed. This is often called a period. N.B. Menstrual health has been addressed in Module 5 (WASH) Unit 2 of this Training Manual.

1.3. The Male Reproductive System

Figure 4.2: The Male Reproductive System



Source: Diagram site

Table 4.2: Parts and Functions of the Male Reproductive System

Reproductive Organ	Function
Cowper's Gland	Produces fluid, which helps create a good environment for the sperm in the penile urethra.
Epididymis	Coiled tubes leading from testes to the Vas Deferens where sperm mature.
Penis	Male organ for sex used for placing sperms into the vagina and also for passing urine.
Prepuce	Foreskin that protects the head of the penis.
Prostate	Produces fluid which helps create a good environment for the sperm.
Scrotum	A sac which holds the testes and protects them against extreme temperatures.
Seminal Vesicles	Are like pockets or glands where the semen is produced and the sperms stored.
Testes	Two sets of glands that produce sperm and male hormones. They are responsible for the development of secondary sexual characteristics in man.
Urethra	Long narrow tube inside the penis through which both sperms and urine pass.
Vas Deferens	Tubes through which sperm passes from the testicles to the penis.

Source:

1.4. Spermatogenesis

- Hormones makes the testicles grow and they start making more testosterone and producing sperm.
- After puberty you make 200,000 – 400,000 sperm cells a day for the rest of your life.

1.5. Erection and Ejaculation

- If semen is going to come out of the penis it is likely to be erect.
- A penis gets erect when blood rushes into it.
- Muscles push the semen into the urethra and out the penis.
- This is called ejaculation.
- If a boy wakes up and finds a wet sticky spot on his pyjamas, semen came out when he was sleeping. This is called nocturnal emissions, or a “wet dream”.
- Some boys have wet dreams and some don’t.

1.6. Puberty

Puberty is a time when the bodies of boys and girls change, they grow bigger and taller, genitals develop, and body hair appears. Puberty happens because new chemicals called hormones are developing in the body, turning young people into adults. Usually, puberty starts between ages 8 and 13 in girls and between ages 10 and 15 in boys, although some young people start puberty earlier or later. Typically, but not always, girls begin puberty about two years before boys. During puberty, a girl becomes physically able to become pregnant, and a boy becomes physically able to father a child.

1.7. Stages of Adolescent Development

Early Adolescence (10-13)

- Onset of puberty and rapid growth
- Impulsive, experimental behavior
- Beginning to think abstractly
- Adolescent’s sphere of influence extends beyond her/his own family
- Increasing concern with image and acceptance by peers

Middle Adolescence (14-16)

- Continues physical growth and development
- Starts to challenge rules and test limits
- Develops more analytical skills; greater awareness of behavioral consequences
- Strongly influenced by peers, especially on image and social behavior
- Increasing interest in sex; special relationships begin with opposite sex
- Greater willingness to assess own beliefs and consider others

Late Adolescence (17-19)

- Reaches physical and sexual maturity
- Improved problem-solving abilities
- Developing greater self-identification
- Peer influence has less impact
- Reintegration into family
- Intimate relationships more important than group relationships
- Increased ability to make adult choices and assume adult responsibilities
- Movement into vocational life phase



Adolescence Puberty - 20 minutes

- Divide participants in 4 groups preferably of five participants in each group and request the groups to discuss:
 - Stages that occur to boys and girls during puberty
- Groups present their discussions during plenary sessions.

Unit 2: Sexual Risk Behaviours

Specific Objectives

By the end of this module participants should be able to:

1. Understand and identify sexual risk behaviours;
2. Understand the factors leading to and consequences of sexual risk behaviours.



Facilitator's Notes

2. Sexual Risk Behaviours

Sexual risk behaviours are defined as behaviours which increase the risk of contracting sexually transmitted diseases including HIV or the occurrence of unintended pregnancies. National health statistics indicate that about half of girls aged 15 to 19 are sexually active and about two thirds of boys in that age group. Some adolescents engage in sexual activities well before the age of 15.

It is important to note that a female can become pregnant if she has unprotected sex around the time of her first ovulation - before her first menstrual cycle.

Sexual risk behaviours comprise:

- Early sexual debut is commonly defined as having had first sexual intercourse at or before age 14;
- Unprotected sex means having sex without a condom;
- Multiple sexual partners means having more than one sexual partner;
- Multiple concurrent partnerships means having overlapping sexual relationships with more than one partner;
- Intergenerational sex means having sex with an older partner usually with an age gap of 10 years;
- Sex under the influence of alcohol as it likely leads to unprotected sex.

2.1. Reasons for risky sexual behaviour in adolescence:

- Major physical, cognitive, emotional, sexual, and social changes occur during adolescence that affect young people's behavior.
- New social relationships, especially with peers, begin to gain greater importance as family influence decreases.
- Curiosity, sexual maturity, a natural inclination toward experimentation, and peer pressure lead to risky behavior such as unprotected sex, substance use, reckless driving, and dangerous recreational activities.
- A sense of omnipotence, invulnerability, and impulsiveness can lead to a lack of future planning and enhance risk-taking, thereby compromising protective behavior.

- Adolescents must attain social and economic maturity and autonomy in culturally specific ways during their second decade of life. This involves moving away from dependence on the family, both psychologically and emotionally.
- In some cultures, young men are encouraged to take risks as a way of proving their masculinity.

Factors which contribute to risky sexual behaviour in adolescents:

- Alcohol and drug abuse;
- Poverty;
- Peer pressure;
- Low self-esteem.

2.2. Types of risk-taking behavior and its consequences

- Impulsive decision-making resulting in dangerous situations.
- Reckless behavior resulting in accidents and injuries.
- Provoking, arguing, and testing limits with peers and adults, resulting in emotional and physical damages.
- Experimentation with substances, resulting in short- and long-term consequences including effects on most other risk-taking behavior (i.e., decision-making and sexual activity).
- Unprotected sexual activity, resulting in immediate and long-term health, emotional, psychological, social, and economic consequences.



Key Notes: Important things to remember

- Risk-taking among adolescents varies with cultural factors, individual personality, needs, and social influences and pressures, including available opportunities.
- Adolescents tend to test their limits and minimize costs of risk-taking; this type of behavior is age-appropriate, but adults must assist adolescents to avoid serious consequences.
- Some risk-taking results in injuries and poor decisions that can be mended or forgiven. Adults can help young people to learn from their experiences.
- Other risk-taking results in very serious consequences such as an unwanted pregnancy or HIV that can have devastating and multi-layered repercussions. Providers should help young people understand the far-reaching consequences of sexual risk-taking.

Some important statistics describing the SRH situation of adolescents in Namibia:

- Percentage of 15 - 19 year old males engaging in sex before age 15 highest in Namibia at 19 % (NDHS 2013)
- High teenage pregnancy at 15.4 % (NDHS 2013)
- Latest estimates show that 53% of new infections are among young people aged 15 - 29 and 60% of these are among young women (MoHSS 2012)
- Low rates of HIV testing amongst adolescents and young people due to access, fears of HIV and lack of confidentiality, and low perceived risk
- Out of school adolescents and young people in need of SRH inadequately served
- Contraceptive prevalence rate for young people 15–19 years is 24.5% and 56.4% for 20-24 years (NDHS 2013).
- 62% of young women and 51% of young men have comprehensive knowledge of HIV/AIDS (NDHS 2013)
- Age at first sex, is an indicator of exposure to the risk of HIV, pregnancy and sexually transmitted infections, a higher percentage of young men (13%) than young women (5%) have had sex before age 15 (NDHS 2013)
- 42% of women and 57% of men aged 18-19 had sexual intercourse before age 18. (NDHS 2013)
- Percentage at which girls have begun child bearing at age 15 (3.6%), at age 17 (9.5%), at age 18 (25.5%) and age 19 (33.6%) (NDHS 2013)



activity

Consequences of risky sexual behaviour – 30 minutes

Divide the participants into five groups. Distribute one flip chart to each group and have them brainstorm answers to the question below. Each group will present its ideas to the larger group during plenary session. Process the ideas with the entire group.

Questions for discussions:

- Factors that contribute to early teenage pregnancy
- What are the consequences of early pregnancy for the mother of the baby?
- What are the consequences of early pregnancy for the father of the baby?
- What are the consequences of early pregnancy for the baby?
- What are the consequences of early pregnancy to the families of the couple?
- What are the consequences of early pregnancy to the community?

Unit 3: Learner pregnancy

Specific objectives:

By the end of this module participants should be able to understand:

1. Which factors lead to an increase in learner pregnancies;
2. How learner pregnancies affect educational outcomes (consequences);
3. How to decrease the number of learner pregnancies (prevention); and
4. What is the Education Sector Policy on learner pregnancy in terms of prevention and management?



Facilitator's Notes

3. Definition of learner pregnancy and contributing factors

Learner pregnancy is defined as a pregnancy of a female under the age of 20, usually between the age of 13 and 19. A pregnancy can take place at any time before or after puberty, with menarche (the first menstrual cycle) taking places between the ages of 12 and 13.



3.1. Consequences of early and unwanted pregnancy among adolescents

It is important to note that there are usually very serious consequences of teenage pregnancy for the mother, father, the baby as well as the wider community in terms of education, health and economy. These consequences are outlined below.

The teenage mother

- She may experience difficulties in labour
- There are greater chances of having a Caesarian section during childbirth
- Premature labour
- Experience birth complications
- Disrupted plans for life, education and career
- Isolation from peers
- Emotions and increased suicide rates
- Problems of single parenting
- Unsafe abortion

The teenage father

- Anger from family members (on both sides)
- Maintenance will be sought
- Decreased educational and occupational opportunities
- Frustration and suicidal tendencies
- Limited legal rights to child
- Forced marriage
- Problems of single parenting
- Have high risk of contracting STIs
- Possibilities of engaging in criminal activities

The baby

- Generally small (weight)
- Higher rate/frequency of congenitally abnormal babies
- Insecurity
- Have fewer opportunities in life
- Frequent abuse, neglect and/abandonment
- Poor health
- Lack of proper care and provision of daily needs such as food, clothing and shelter

Community

- Could influence other adolescents to have babies in the community
- Government will spend more money to build schools and clinics
- Street kids
- More responsibilities
- Argument between families
- Losing hope
- Increase in illiteracy
- Argument
- Increase in unemployment
- More schools drop outs etc.

Health consequences

- Elevated risks of maternal death
- Elevated risk of obstetrics complications
- Low birth weight
- High risk of infant mortality

Educational consequences

- School dropout
- School absenteeism
- Poor academic performance
- Lower educational attainment
- Poorer cognitive development of children
- Poorer educational outcomes for children

Economic consequences

- Lower family income
- Increased dependency ratio
- Exacerbated poverty
- Children most likely to be poor

Social consequences

- Stigma and discrimination
- Less likely to be married
- Most likely to suffer abuse
- Less supportive & stimulating home environment for children
- Increased behaviour problems among children
- Higher rates of imprisonment among sons
- Children more likely to give birth as teens

3. 2 Termination of Pregnancy/Abortion

Abortion is a safe way to end a pregnancy and involves the removal or forcing out from the womb of a fetus or embryo before it is able to survive on its own.

It is important not to confuse arguments about whether abortion is right or wrong with facts about the medical procedure.

Having a safe abortion does not affect your future ability to have children.

Where abortion is illegal and not performed in a medical setting, it can be very dangerous.

Abortion is illegal in Namibia except under the following circumstances:

- if the pregnancy endangers the life of the woman
- if the pregnancy resulted from rape or incest
- if the foetus has serious congenital deformity
- if the pregnant woman will be unable to raise the child due to mental or physical disability

In Namibia, abortion is defined in the Abortion and Sterilization Act 2 of 1975 as: “the abortion of a live foetus from a woman with intent to kill it. The killing or aborting of an unborn child in contravention of the provisions of this Act is a crime.”

The Act contains strict instructions regarding the procedure a doctor must follow before procuring an abortion and heavy penalties are imposed for unlawful abortions.

Unsafe Abortion

An unsafe abortion is the termination of a pregnancy by people lacking the necessary skills or in an environment lacking minimal medical standards, or both. The following are examples of unsafe abortion:

- self-induced procedure in unhygienic conditions
- procedure performed by a medical practitioner who does not provide appropriate post-abortion care

Unsafe abortion is a significant cause of maternal mortality and morbidity.

Most unsafe abortions occur:

- in countries where abortion is illegal
- in countries where affordable well-trained medical practitioners are not readily available
- in situations where modern contraceptives are unavailable

About one in eight pregnancy-related deaths worldwide is associated with unsafe abortion.

Unsafe abortion causes substantial suffering, disability and death, among adolescents.

All women with miscarriage/abortion complications need quality post-abortion care, including post-abortion family planning counselling and services.

Reasons for seeking abortion

Contraceptive failure – due to incorrect or inconsistent use

Sexual Assault Victim

Parity – having children already and/or having young children

Not liking the father – and therefore having a child with him will potentially ruin other relationship prospects

Education – fear of expulsion from school or interruption of education

Economic – poverty and limited resources to care for a child

Social – being condemned by society or bringing shame to their parents

Relationship – not having a stable relationship and support

3.3 Baby dumping

Reasons for baby dumping

The top three reasons given for baby dumping are:

1. The father denies paternity
2. The mother is a student
3. The mother does not know about options such as foster care, adoption and institutional care

Alternatives to baby dumping

1. Foster care

A person outside the family takes care of a child for a temporary period until the child can either return home or be placed for adoption. Sometimes a child will live in foster care for many years, possibly even until the child becomes an adult. When you place your child in foster care, you are still the parent of your child. You still have legal rights and responsibilities towards your child. However, you will not make the day to day decisions about the care of your child.

2. Kinship care

A relative or a close family friend takes care of the child for a temporary period until the child can either return home or be placed for adoption. If a relative or close family friend is caring for your child and wants to access the foster care grant, you must go through the same process as for placing your child in foster care with a stranger.

3. Adoption

A person takes care of a child on a permanent basis. When you give your child up for adoption, you are no longer the parent of the child. You will not have any legal rights or responsibilities towards the child. Some people say that adoption is a foreign idea and that is not very Namibian. But giving your baby up for adoption is much better than dumping your baby.



activity

Reasons to seek termination of pregnancy – 15 minutes

As a group, discuss the possible reasons why a young woman would seek to terminate a pregnancy.

List answers on a flip chart.

3.4 Prevention of Learner Pregnancy

Results from many countries show that combined interventions such as educational and contraceptive promotion can play a key role in reducing unintended pregnancies among adolescents. Interventions implemented at schools, the community or health-care facilities should take into account the socio-economic opportunities available to adolescents, as well as their cultural values.

In order to prevent learner pregnancy among young people there is clear evidence that comprehensive sexuality education information can help young people to delay sexual activity and improve their contraceptive use when they begin to have sex. There is also evidence that young people need to have access to adolescence or youth friendly health services in order to reduce the risks of sexual activity namely, unintended pregnancy and sexually transmitted infections (STIs).

3.5 Comprehensive Sexuality Education (CSE)

Comprehensive sexuality education (CSE) is culturally and age appropriate information that teaches young people about HIV and other health issues.

There are six topics recommended to be discussed:

- Relationships
- Values, attitudes and skills
- Culture, society and human rights
- Human development
- Sexual behaviour
- Sexual and reproductive health

What is discussed in these topics depends on the age of the child, with an understanding of the culture and norms where the young person lives. CSE programmes in schools and communities will vary from place to place and from country to country. UNESCO Technical guidelines on CSE suggest that covering these six topics will best ensure young people are well equipped for the future.

What are the Benefits of CSE?

The International Planned Parenthood Association (IPP) defines CSE as an opportunity to equip young people with knowledge and skills to make responsible choices in their lives, particularly where HIV prevalence is high.

Providing CSE to children has positive benefits, as children who have received CSE in school or through clubs are more likely to:

- Abstain from or delay sexual relations
- Avoid or reduce the frequency of unprotected sex when they become sexually active
- Have fewer sexual partners when sexually active
- Use protective and preventative methods against unintended pregnancy and sexually transmitted infections (STIs) if they engage in sexual activities.

3.6 Adolescent friendly health services (AFHS)

Definition

Adolescent-friendly health services, as defined by the IPP, are based on a comprehensive understanding of what young people in any given society or community want and need. It is also based on an understanding of, and respect for, the realities of young people's diversity and sexual rights.

Challenges to providing adolescent friendly health services

- Many of the facilities' working environments are not youth friendly and are poorly publicized. Young people are therefore not aware of the facilities that are available to them.
- Negative attitudes of service providers are a barrier to adolescent and young people seeking these services.
- Service providers do not have access to any policies, protocols or standards/guidelines related to providing quality youth-friendly sexual and reproductive health services.
- Services are designed, implemented, and evaluated without the involvement of youth and there is also lack of adequate IEC materials.
- Lack of privacy and confidentiality. Adolescents will definitely avoid a health centre where the service provider is not reliable and cannot keep secrets.

Adolescent Friendly Health Services

- Are programmes & services with policies, procedures, practices, and other attributes that attract young men & women of varied ages
- Provide youth with a comfortable and appropriate setting
- Meets their needs
- Retains them for follow-up and repeat visits
- Are free from barriers that would deter access by young people

Services package should include:

- Information & counseling on sexuality, safe sex, and reproductive health
- Family Planning - Contraception method provision
- STI diagnosis and management
- HIV counseling and referral
- Basic maternal care - Pregnancy testing, antenatal and post-natal care
- Counseling and referral for violence and abuse
- STI/HIV/AIDS Education
- Post-Abortion Care counseling

Characteristics of Adolescent Friendly Services

Facility/Physical Environment

- Convenient hours
- Convenient location
- Integrated services
- Unmarked consulting rooms
- Private counseling area
- Comfortable and clean surroundings
- Appropriate and sufficient supplies

Staff/Providers

- Are professional and trained in Adolescent Sexual and Reproductive Health (ASRH)
- Respect and are interested in and motivated to work with youth
- Treat client information confidentially
- Spend sufficient time with youth
- Speak the local language
- Trains peers to provide information and services
- Are knowledgeable, supportive, open, accepting and of services

Service Provision

- Youth are served without regard for age, gender, marital status, or social circumstance
- AFHS are integrated and available at all opening times
- Staff are sensitive to both males and females
- Sufficient and appropriate IEC materials are available
- Delay of pelvic exam on first visit if possible
- Youth are counseled on dual protection
- Counseling is offered by trained professionals
- Supplies and equipment are adequate & appropriate



activity

Adolescent Friendly Health services – 15 minutes

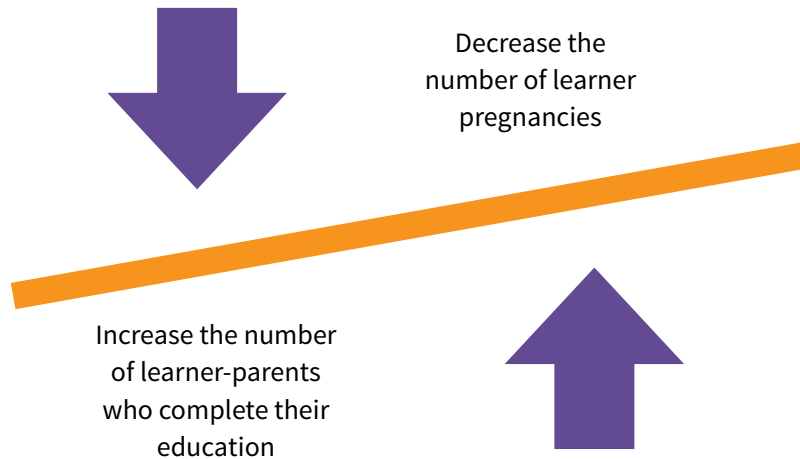
Discuss the biggest challenges in providing SRH services and education in an adolescent-friendly manner and how to tackle these issues.

Groups give feedback. Highlight the main points.

3.7 Education Sector Policy on the Prevention and Management of Learner Pregnancy

Goal of the Policy

To improve the prevention and management of learner pregnancy



3.7.1 Why we encourage learners to complete education

Impact on the child	Impact on the pregnant learner/learner mother	Impact on society
Children of uneducated mothers are more likely to be malnourished and uneducated	Learners in school are less likely to get pregnant ; the fertility rate for educated women is lower than for uneducated women	If people are able to support themselves and do not require government support, resources can be used for other things such as the improvement of schools and hospitals
Children of educated mothers are more likely to go to school themselves	Learners who complete their education will be able to get better paid employment or be more productive if they make a living through subsistence farming	The more people there are in employment, the greater the gross domestic product of the country

Guiding Principles

- 3.1 Right to education: All children in Namibia have the right to education, without discrimination on the basis of sex (Article 20 of the Namibian Constitution). This right to education includes the right of a learner not to be discriminated against or disciplined because of pregnancy or parenthood.
- 3.2 Prevention: The main focus of this policy is to provide the learner with information and preventative measures in order to discourage pregnancy amongst learners. However, this must be accomplished by appropriate prevention measures and not by punishment of pregnant learners.
- 3.3 Information: Schools should aim to prevent learner pregnancies by providing an environment in which learners are fully informed about reproductive health matters and have the information and guidance they need to make responsible decisions. To achieve this goal full-time Life Skills teachers need to be responsible for counselling and guidance at schools.

3.7.2 Policy Provisions for Prevention

- Reproductive and sexual health
- Life skills and supplementary programmes
- Promoting safe leisure activities
- Gender-specific support and mentoring for learners
- Counselling
- Possible partners
- Family and community involvement
- Safe environment
- Exemplary behaviour by education staff

Management

In cases where prevention measures fail and learners become pregnant, the school management is tasked to endeavour to manage the situation.

This is done by supporting pregnant learners, expectant fathers and learner-parents to combine continuation of their education with parenthood.

Attending school during pregnancy

A pregnant learner may continue to attend school until 4 weeks before the birth.

A pregnant learner might choose to take leave from school much sooner.

The learner, parents or caregiver and school should agree for how long the learner will attend school.

The learner must provide a health certificate if she stays in school past the 26 week (6 months) of pregnancy.

The school can request a letter confirming the due date.

If the learner does not provide this information the school may ask her to take a leave of absence.

School Assignments

The learner has the main responsibility for making sure that they keep up to date and get their school policies.

The school should make reasonable efforts to assist the learner provided that she makes reasonable efforts to maintain contact, provide curriculum packages if requested and help find a tutor if needed/available.

Education After Birth

A learner-mother may return to school if:

- a social worker (or the Principal) is satisfied that the infant will be cared for by a responsible adult
- a health care provider provides a statement that the learner-parent is in a suitable state of health and well-being
- a health care provider provides a statement that the infant is in a suitable state of health and well-being
- the learner-parent and her parents, primary caretaker or guardian provide a signed statement on how the infant will be cared for and agree to maintain communication with the school.

Extended Leave

A learner-mother may choose to take up to one year of leave counted from the date she left school before the birth.

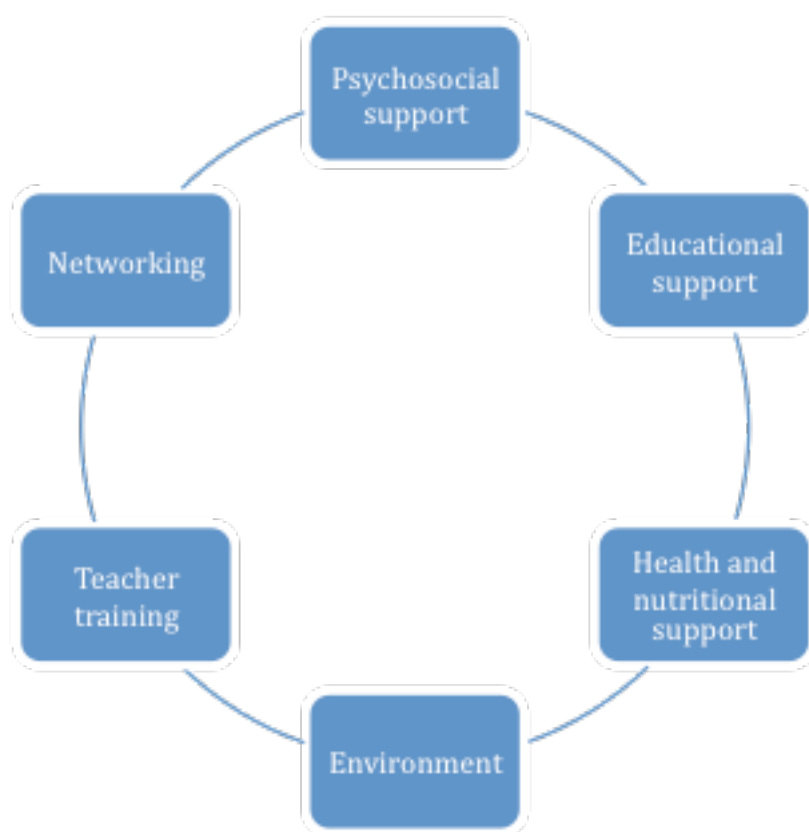
Learner must maintain clear communication with the school regarding the proposed date of return.

Her place will be kept open for her until she returns.

This does not apply if the learner decides to change schools.

A learner-mother could also choose to take longer leave, but then must re-apply as her place will not be kept open for her beyond the 12 month period indicated above.

3.7.3 Role of the School



The role of partner ministries

Ministry responsible for health	Ministry responsible for child welfare	Ministry responsible for safety and security	Ministry responsible for youth
To assign a nurse to oversee a school/cluster to assist with implementation	To assign a social worker to oversee a school/cluster to assist with implementation	To provide prompt and sensitive social services and investigation of cases where rape or any other crime has occurred	To provide safe entertainment options for learners in an alcohol-free environment.
Additional responsibilities of MoHSS	Provide adolescent-friendly health services, pre- and post-natal medical care, medication, information, counselling on HIV infection and mother-to-child transmission, information and access to legal abortions and other related services, family life empowerment services, the promotion of effective parenting and information on pregnancy prevention		

Unit 4: Contraceptives

Specific Objectives

To provide an overview on contraceptives and their use

Methodology Presentation, case study, demonstrations

Materials PowerPoint presentation, videos, posters, flip charts, models and commodities



Facilitator's Notes

4.1 Contraceptive methods: Introduction

Contraceptives or also called birth control, are usually used to prevent pregnancies. The best method to prevent HIV, sexually transmitted diseases (STIs) or pregnancy is abstinence. However, many young people are sexually active and need to have more information regarding the different contraceptive methods available to them.

In general, with the exception of male and female sterilisation, all methods that are appropriate for healthy adults are also potentially appropriate for healthy, post-pubertal adolescents. Methods that are physiologically safe for adults are also physiologically safe for adolescents, post-puberty. Informed contraceptive decision-making entails consideration of more than just medical safety.

Before discussing contraceptive options, adolescents must be given the opportunity to express their needs and to decide freely whether they want to protect against pregnancy or need to protect against STI/HIV.

Once a decision is made for protection, sexually active adolescents should be presented with options that, if used consistently and correctly, will prevent pregnancy and, depending upon an individual's circumstances, prevent sexually transmitted infections.

Counseling dialogue between the adolescent and members of the health-care team should be structured to assist the adolescent in making a decision that is informed, voluntary and appropriate to the adolescent's particular circumstances.

When selecting a method, each adolescent should consider:

- the nature of his/ her sexual relationship(s)
- sexual behaviours engaged in
- frequency of intercourse
- risk of STIs/HIV
- efficacy of the method
- ability to comply with use
- ability to tolerate side-effects
- services available
- cost
- convenience

- religious beliefs
- partner(s) attitudes
- additional personal factors that may influence the decision and method compliance

When sexual activity is infrequent or if multiple partners are likely, condoms may be a priority option.

Emergency contraceptive pills are an option in the event of condom breakage, slippage, or other causes of unprotected intercourse.

Adolescents who engage in frequent intercourse may opt for methods that are not coitally related to protect against pregnancy, but will still require routine condom use for STI/HIV prevention.

The following section briefly reviews all modern contraceptive options.

In addition, traditional approaches such as fertility-awareness methods, lactational amenorrhoea and withdrawal will be briefly discussed.

We will focus specifically on aspects of the method that, based on currently available evidence, may be important to adolescents, or deserve emphasis when in dialogue with adolescents.

While the primary emphasis presented here is upon information unique to adolescents, information critical to the understanding of a particular method (or to providing counselling about it) is also provided, even though such information may be equally applicable to adults and adolescents.

4.2 Contraceptive methods appropriate for young people

It is important to stress the following when dealing with adolescents:

- o **There are two main options – either don't have sex, or if you are going to have sex, use contraception. Both boys and girls should use condoms as a dual method of protection.**
- o **A girl can become pregnant:**
 - The first time she has sexual intercourse
 - If she has sex during ovulation before she's had her first period
 - Even if she has sex during her period
 - Even if a boy pulls out (withdraws his penis) before he comes/ejaculates
 - Even if she has sex standing up
 - Even if she forgets to take her pill for just one day
- o **A decision needs to be made to use contraception:**
 - To prevent pregnancy
 - To prevent STI/ HIV
 - To prevent pregnancy and STI/ HIV (dual protection)

4.3 Combined Oral Contraceptives (COCs)

What Are They?

COCs are tablets containing the hormones estrogen and progestin. A woman takes one tablet daily to prevent pregnancy.

How Effective Are They?

If 100 young women used COCs for one year, typically eight of them would become pregnant. If taken consistently every day, COCs are highly effective (one pregnancy among 1,000 young women). There is a higher failure rate for adolescents than all other ages, since adolescents have trouble remembering to take pills regularly.

How Do COCs Work?

COCs work by preventing the release of the egg from the ovary. Without an egg to be fertilized, a woman cannot become pregnant.

Advantages

- Are safe, effective, and easy to use.
- Can be used before the onset of menses.
- May lead to lighter, regular periods with less cramping.
- Can become pregnant again after stopping the pill.
- Don't interfere with sex.
- May be beneficial for adolescents who have irregular or heavy periods, menstrual cramps, or acne.
- Decrease risk of cancer of the female reproductive organs.

Disadvantages

- Have some side effects.
- Must be taken every day.
- Don't protect against STIs/HIV.

Possible Side Effects

Most adolescents experience no side effects. Occasionally, a young woman may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness.

4.4. Male Condom

What Are They?

The condom is a thin sheath worn over the erect penis when a couple is having sex.

How effective are they?

If used correctly with every act of intercourse, condoms are highly effective in protecting against pregnancy and most STIs.

How Do Condoms Work?

The condom catches the man's sperm so that it cannot enter the vagina.

Advantages

- It is safe, effective and easy to use.
- Does not require a prescription or medical examination.
- Excellent option for someone who does not need ongoing methods
- May prevent premature ejaculation.
- Protects against STIs/HIV.



Source: <http://science.howstuffworks.com/innovation/everyday-innovations/condom6.html>

Disadvantages

- Interrupts the sex act.
- May cause decreased sexual sensitivity.
- Requires skills to use properly and negotiate their use with a partner.
- A new condom must be used each time the couple has sex.
- A supply of condoms must be available before sex occurs.
- A condom may occasionally break or slip off during intercourse.

Possible Side Effects

- Most adolescents have no side effects. Occasionally, an adolescent may have an allergic reaction, which causes itching, burning, or swelling.

4.5. Female condoms

What Is It?

The female condom is a plastic pouch that covers the cervix, the vagina, and part of the external genitals. A woman uses the female condom during intercourse to prevent pregnancy.

How Effective Are They

The female condom also effectively prevents many STIs, including HIV, when used correctly every time an adolescent and her partner have sexual intercourse.

How Does the Female Condom Work?

The condom catches the man's sperm so that it does not enter the vagina.

Advantages

- Is safe and effective.
- Does not require a prescription or medical examination.
- Can be inserted prior to sexual intercourse.
- Female controlled.
- Excellent option for someone who does not need ongoing contraception.
- Can be used with oil-based lubricants and transfers heat, making it very sensitive.
- Protects against STIs/HIV.
- Does not alter vaginal flora and reduces the chance of irritation or allergic reaction.

Disadvantages

- May be noisy or awkward.
- Sometimes negatively associated with sex workers.
- Is female initiated, but requires skills to use properly and to negotiate their use with a partner.
- Can be difficult to insert.
- Occasionally, a condom may break or slip out during intercourse.



Source: <http://www.ripnroll.com/femalecondoms.html>

Possible Side Effects

Most adolescents experience no side effects. Rarely, an adolescent may experience an allergic reaction or irritation.

Note for the facilitators: Facilitator should emphasize that a condom is the most preferred method for sexually active youth as it is a dual method.

4.5.1. Depot Medroxyprogesterone Acetate (DMPA): The Injectable Contraceptive

What Is It?

Depot Medroxyprogesterone Acetate (DMPA) is similar to the hormone called progesterone, which is produced in the body by the ovaries. DMPA is an injection containing the hormone progestin. The injection is given every three months commonly referred to as Depo-Provera

How Effective Is It?

DMPA is highly effective if the injections are given every three months. If 100 young women use DMPA regularly for one year, typically only one of them might become pregnant.

How Does DMPA work?

DMPA works by preventing the release of the egg from the ovary. Without an egg to be fertilized, a woman cannot become pregnant.

Advantages

- Is safe and effective.
- Lasts for three months.
- Periods become very light and often disappear after a year of use.
- Completely reversible can become pregnant again after stopping DMPA, although there might be a delay of several months.
- Can be used while breastfeeding.
- Does not interfere with sex.
- May improve anemia.

Disadvantages

- Menstrual pattern will probably change.
- Increased appetite may cause weight gain.
- Typically a four-month delay in getting pregnant after stopping DMPA.
- Doesn't protect against STIs/HIV.
- May be difficult for adolescents to remember to return for next injection.

Possible Side Effects

Most adolescents experience no side effects. Occasionally, an adolescent may experience irregular spotting, prolonged light to moderate bleeding, bleeding that becomes lighter, less frequent, or stop altogether, weight gain or headaches.

4.5.2. Emergency Contraception Pills (ECPs)

(Note: information is for low-dose combined pills only, not progestin pills)

What Are They?

ECPs are a hormonal method of contraception that can be used to prevent pregnancy following an act of unprotected sexual intercourse.

How Effective Are They?

If 100 young women used ECPs once, typically two of them would become pregnant.

How Do ECPs Work?

ECPs are thought to prevent ovulation and fertilization. They are not effective once the process of implantation of a fertilized ovum has begun.

Advantages

- Are safe for all adolescents and readily available.
- Reduce the risk of unwanted pregnancy and need for abortion.
- Are appropriate for use after unprotected intercourse (including rape or contraceptive failure).
- Provide a bridge to the practice of regular contraception.
- Drug exposure and side effects are of short duration.

Disadvantages

- Do not protect against STIs/HIV.
- Do not provide ongoing protection against pregnancy.
- Should be used within five days (120 hours) of unprotected intercourse as effectiveness decreases with time.
- May change the time of the adolescent's next period.
- Are inappropriate for regular use (high cumulative pregnancy rate).

Possible Side Effects

Most adolescents experience no side effects. Occasionally, an adolescent may experience nausea, vomiting, headaches or dizziness, cramping, and breast tenderness. Side effects generally do not last for more than 24 hours

4.5.3. Intrauterine Device (IUD)

(Information is for the TCU 380A IUD.)

What Is It?

An IUD is a small plastic and copper device that is inserted into the uterus to prevent pregnancy.

How Effective Is It?

If 125 young women used the IUD for one year, typically one of them would become pregnant.

How Does the IUD work?

The IUD works by preventing sperm from joining with the egg.

Advantages

- Is safe, effective, and long-acting (10 years).
- Easy to remove if the adolescent wants to become pregnant.
- Does not interfere with sex.
- Does not interfere with breastfeeding.

Disadvantages

- Not suitable for adolescent women with multiple sexual partners, or whose partner has other sexual partners, due to an increased risk of Pelvic Inflammatory Disease.
- Should be initiated with caution, only after thorough risk assessment and, if possible, lab screening, especially in high risk areas.
- Menstrual pattern may change.
- Greater risk of expulsion and painful menses for women under the age of 20 who have not given birth.
- Slight pain during the first few days after IUD insertion.
- Does not protect against STIs/HIV.

Possible Side Effects

Most adolescents experience no side effects. Occasionally, an adolescent may experience cramping, pain during and immediately after insertion, an increase in vaginal discharge, an infection, heavier and/or longer periods, which normally decrease during the first and second years.

4.5.4. Lactation Amenorrhea Method (LAM)

What Is It?

The Lactational Amenorrhea Method (LAM) is the use of breastfeeding as a temporary family planning method and a bridge to a longer term method. (“Lactational” means related to breastfeeding and “Amenorrhea” means not having menstrual bleeding.)

How Effective Is It?

If 100 young women use LAM in the first six months after childbirth, typically two of them would become pregnant. While breastfeeding exclusively, LAM is even more effective (one pregnancy among 200 young women).

How Does LAM Work?

LAM works by preventing ovulation, because breastfeeding changes the rate at which natural hormones are released.

Advantages

- Effective in preventing pregnancy for at least six months.
- Encourages the best breastfeeding practices that have health benefits for the mother and baby.
- Can be used immediately after childbirth.
- No need to do anything at the time of sexual intercourse.
- No direct cost for family planning or for feeding the baby.
- No supplies or procedures needed to prevent pregnancy.

Disadvantages

- Effectiveness after six months is not certain.
- Frequent breastfeeding may be difficult for some adolescent mothers.
- Does not provide protection against STIs/HIV.
- If the mother has HIV, there is some chance that breast milk will pass HIV to the baby.

Possible Side Effects

There are no side effects associated with LAM.

4.5.5. Progestin Only Oral Contraceptives (POPs)

What Are They?

POPs are tablets containing only a very small amount of one hormone, a progestin. A young woman takes one tablet daily to prevent pregnancy. POPs are the best oral contraceptive for breastfeeding adolescents.

How effective are they?

POPs are very effective for breastfeeding adolescents, about 1 pregnancy per 100 young women in the first year. As commonly used, they are less effective for non-breastfeeding adolescents.

How do POPs work?

POPs work by thickening the cervical mucus, making it difficult for sperm to pass through and by preventing the release of the egg from the ovary in about half of menstrual cycles.

Advantages

- Safe
- Can be used by nursing mothers starting 6 weeks after childbirth.
- No estrogen side effects.
- Can become pregnant again after stopping the pill.
- Doesn't interfere with sex.
- May help prevent benign breast disease, endometrial and ovarian cancer, and pelvic inflammatory disease.

Disadvantages

- For women not breastfeeding, menstrual periods may change.
- Must be taken at the same time every day.
- Doesn't protect against STIs/HIV.

Possible Side Effects

Amenorrhea or irregular bleeding or spotting for young women not breastfeeding. Less common side effects include headache and breast tenderness.

4.5.6. Sterilization

These are birth control methods that are not reversible and are suitable for women or men who have already have families.

What is it?

- A surgical procedure to close or block the fallopian tubes
- Techniques include:
 - Laparoscopy – special instruments are inserted through two tiny incisions (less than 1 cm long) in the abdomen
 - Mini-laparotomy – also requires a small cut in the abdomen
 - Hysteroscopy – use of a thin telescope inserted into the uterus

Fallopian tubes may be blocked by using one of the following:

- A clip or a ring
- Cautery (an electric current)
- Removing a small piece of each tube
- Hysteroscopy for the insertion of tubal plugs (Essure)

How does it work?

- The fallopian tube is blocked and therefore the sperm and egg cannot meet

What are the advantages?

- No daily contraceptive routine required; nothing to remember
- Private
- Does not interfere with intercourse
- No significant long term side effects

What are the disadvantages?

- Usually permanent and difficult to have reversed
- Possible post-sterilization regret
- Possible short-term surgery-related complications: abdominal discomfort; bruising, bleeding, or infection at the incision site; reaction to anaesthesia
- If pregnancy occurs, there is a higher chance that it will be an ectopic pregnancy
- Does not protect against STIs.



activity

Contraceptive methods – 1 hour

Divide into four groups. Provide each group with a scenario to perform:

Group 1: You need to inform a boy about condom use. What will you do?

Group 2: You need to counsel a girl about the advantages and disadvantages of using the pill.

Group 3: A girl comes to you and tells you that she had sex the previous evening and that the condom burst. What advice will you give her?

Group 4: You need to talk to a class about family planning. What will you tell them?

Note on flipchart and feedback to plenary.

Unit 5: Sexually Transmitted Infections including HIV

Specific objectives

At the end of this unit participants will have knowledge on prevention, care and treatment services be able to make referrals.

Methodology Presentation, case study

Materials PowerPoint presentation, videos, posters and flip charts



Facilitator's Notes

5.1 STIs, STD or venereal disease

WHO estimates indicate that one in every twenty adolescents contract a sexually transmitted infection (STI), each year. Young people may not seek help for STIs because they do not believe they have an infection, because they are too embarrassed to go to a clinic or because they may not have access to treatment. Late-treated or untreated STIs can potentially hinder an adolescent's long-term health and fertility.

STIs are passed on from one person to another through sexual contact and sometimes by genital contact. The infection can be passed on via vaginal intercourse, oral sex and anal sex.

Many young people contract STIs including HIV. When having fun, they do not think about the consequences. Neither will they be able to recognise the symptoms for some of the STIs; they will need to be tested to protect themselves and their partners. Fortunately, all of the STIs can be treated and bacterial STIs can be cured with antibiotics. Learners often are not even aware that they might have an STI. Information regarding common STIs should be discussed in the school curriculum.

The table below details some common STI's , their symptoms and treatment:

STI	Symptoms	Treatment/protection
Human Papilloma Virus (HPV). It is usually spread sexually through oral, anal or vaginal sex, but also by skin-to-skin contact.	Most types of HPV have no symptoms, but some cause genital warts. Others infect the mouth and throat, while others cause cancer on the cervix, penis, mouth or throat	Two vaccines can protect against these cancers.
Chlamydia is spread mostly by vaginal or anal sex, but can also be spread through oral sex.	An odd discharge from the vagina or penis, or pain or burning when urinating. Most often people do not get symptoms	Antibiotics
Gonorrhoea	Discharge from the vagina or penis, or pain or burning when urinating. Most men with gonorrhoea get symptoms, but only about 20% women do.	Antibiotics

STI	Symptoms	Treatment/protection
<p>Syphilis is a disease with four stages.</p>	<p>Primary stage: a sore that can look like a cut or ingrown hair or harmless bump.</p> <p>Secondary stage: rash on your body followed by sores in your mouth, vagina or anus.</p> <p>Latent stage. The symptoms usually disappear. The stage can last for years or the rest of your life.</p> <p>Late stage: causes organ and nerve damage, even brain damage.</p>	<p>Antibiotics, especially Penicillin (early treatment is crucial to prevent the bacteria from spreading to and damaging other organs)</p>
<p>HIV/AIDS (AIDS is not curable and treatment focuses on keeping HIV levels in check)</p>	<p>Inflammation of the liver</p> <p>Most people who are infected with HIV experience a short, flu-like illness that occurs two to six weeks after infection. After this, HIV often causes no symptoms for several years.</p> <p>It's estimated that up to 80% of people who are infected with HIV experience this illness.</p> <p>The most common symptoms are:</p> <ul style="list-style-type: none"> • fever (raised temperature) • sore throat • body rash <p>Other symptoms can include:</p> <ul style="list-style-type: none"> • tiredness • joint pain • muscle pain • swollen glands (nodes) <p>The symptoms usually last one to two weeks but can be longer. They are a sign that your immune system is putting up a fight against the virus.</p> <p>However, these symptoms are most commonly caused by conditions other than HIV, and do not mean you have the virus.</p> <p>If you have several of these symptoms, and you think you have been at risk of HIV infection within the past few weeks, you should get an HIV test.</p>	<p>Antiretroviral drugs</p>



STI	Symptoms	Treatment/protection
Genital herpes (cannot be cured)	Most people with genital herpes never have sores or mild symptoms that can be mistaken for insect bites or a skin condition. General symptoms are decreased appetite, fever, muscle ache in the lower back, buttocks, thighs or knees, swollen and tender lymph nodes in the groin during an outbreak, genital symptoms include small, painful blisters filled with clear or straw-coloured fluid on the vaginal lips, vagina, cervix, around the anus, on the thighs and buttocks, penis, scrotum, tongue, mouth, eyes, gums, lips, fingers and other parts of the body, other symptoms are painful urination, vaginal discharge	Antiviral medication will reduce the length and severity of both the initial and subsequent herpes outbreaks
Genital warts	Flesh-coloured, soft-to-the touch bumps on the skin that may look like the surface of a cauliflower, usually painless but may itch.	Often the warts go away with no treatment. Some may be treated by freezing them, injections of interferon

HIV

HIV stands for Human Immunodeficiency Virus. To understand what that means, let's break it down:

- H – Human – This particular virus can only infect human beings.
- I – Immunodeficiency – HIV weakens your immune system by destroying important cells that fight disease and infection. A “deficient” immune system can't protect you.
- V – Virus – A virus can only reproduce itself by taking over a cell in the body of its host.

HIV is a lot like other viruses, including those that cause the flu or the common cold. But there is an important difference – over time, your immune system can clear most viruses out of your body. That isn't the case with HIV – the human immune system can't seem to get rid of it. That means that once you have HIV, you have it for life.

We know that HIV can hide for long periods of time in the cells of the body and that it attacks a key part of the immune system (T-cells or CD4 cells). The body has to have these cells to fight infections and disease, but HIV invades them, uses them to make more copies of itself and then destroys them.

Over time, HIV can destroy so many of your CD4 cells that your body can't fight infections and diseases anymore. When that happens, HIV infection can lead to AIDS.

However, not everyone who has HIV progresses to AIDS. With proper treatment, called “antiretroviral therapy” (ART), you can keep the level of HIV virus in your body low.

ART is the use of HIV medicines to fight HIV infection. It involves taking a combination of HIV medicines every day. These HIV medicines can control the virus so that you can live a longer, healthier life.

5.2 Prevention

The ABC approach was originally devised to tackle the growing HIV epidemic in sub-Saharan Africa. ABC stands for: Abstinence, Be Faithful and Condom Use.

Abstinence is defined as not having any kind of sex play with a partner.

Being continuously abstinent is the only way to be absolutely sure that you won't have an unintended pregnancy or get an STI.

'Be Faithful' means only having sexual relations with one partner at a time, preferably one that has been tested for HIV. Knowing the status of a partner means that proper care can be taken to protect one another.

Condoms are the most effective weapon available to sexually active individuals and couples who want to protect themselves from HIV.

It is now widely believed however that effective HIV prevention requires more than simply ABC and that interventions need to take into account underlying socio-cultural, economic, political, legal and other contextual factors.

UNAIDS advocates for combined approaches to HIV prevention which is defined as: "rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections".

Biomedical Intervention

One example of a biomedical intervention, male circumcision, is a simple medical procedure that has been shown to reduce the risk of HIV transmission by up to 60 percent during unprotected heterosexual sex.

Male circumcision is the surgical removal of the foreskin from the human penis. Male circumcision is often opted for religious reasons and personal preferences, but nowadays male circumcision is done to reduce the risk of HIV infection through penile-vaginal sex, because the foreskin is more susceptible to HIV infection than other penile tissue. It is important to note that male circumcision alone will not prevent transmission of HIV; it only reduces the chance of getting HIV.

Some of the other interventions included in this category are:

- Male and female condoms (see detailed information on contraceptives in Unit 6)
- Sex and reproductive health services
- Voluntary medical male circumcision (VMMC)
- Antiretroviral drugs (ARVs) for the prevention of mother-to-child transmission (PMTCT), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and treatment as prevention (TasP)
- Voluntary counselling and testing (VCT)
- Testing and treatment of STIs
- Needle and syringe programmes (NSPs)

Behavioural interventions

Behavioural interventions seek to reduce the risk of HIV transmission by addressing risky behaviours. A behavioural intervention may aim to reduce the number of sexual partners individuals have, improve treatment adherence among people living with HIV, increase the use of clean needles among people who inject drugs (PWID), or increase the consistent and correct use of condoms. To date, these types of interventions have proved the most successful.

Examples of behavioural interventions:

- Information provision (e.g. sex education)
- Counselling and other forms of psycho-social support
- Safe infant feeding guidelines
- Stigma and discrimination reduction programmes

Structural interventions

Structural interventions seek to address underlying factors that make individuals or groups vulnerable to HIV infection. These can be social, economic, political or environmental.

Structural interventions deal with deep-rooted socio-economic issues such as poverty, gender inequality and social marginalisation.

In countries where same-sex relationships are criminalised, men who have sex with men may find it difficult to access condoms or treatment services.

A woman's subordinate status can affect her ability to negotiate condom use while a lack of infrastructure such as transport, prevents many people from accessing health clinics. By successfully addressing these structural barriers, individuals are empowered and able to access HIV prevention services.

Examples of structural interventions:

- Interventions addressing gender, economic and social inequality
- Decriminalise sex work, homosexuality, drug use and the use of harm reduction services
- Interventions to protect individuals from police harassment and violence
- Laws protecting the rights of people living with HIV

Sources: <http://www.avert.org/hiv-prevention-programmes> and <http://www.plannedparenthood.org/>

5.3 Summarize the session as follows:

Prevention

A comprehensive approach to prevention of HIV is most desirable especially for young people. Critical elements includes delayed initiation of sexual intercourse, reduction in number of sexual partner and increased use of condoms. The national policy promotes combination prevention which comprise a wide range of methods to control and reduce new HIV infections because a single strategy will never be sufficient to embrace complexity of HIV epidemic.

Abstinence Promotion

Young people who have not had their sexual debut are encouraged to practice abstinence until they have established a lifetime monogamous relationship. For those young people who have initiated sexual activity, returning to abstinence is the primary prevention message to them. Abstinence is the safest option for young people who are not yet sexually active however for those adolescents and young people who are already sexually active require full information to enable them to make informed choices and to protect themselves if they choose to remain sexually active.

Correct and consistent use of condoms

Studies have shown that adolescents who receive comprehensive reproductive health and HIV education that includes accurate information about contraception and condoms are more likely than those who receive abstinence-only messages to delay sexual activity and to use contraceptives when they do become sexually active.

HIV Testing and Counselling

Uptake of HIV testing and counselling (HTC) can lead to earlier diagnosis, more effective care, and reduced mortality. Given the increasing availability of ART and prevention interventions, early diagnosis can improve health outcomes by reducing HIV transmission and incidence as well as HIV-related morbidity and mortality. Adolescents who learn that they are infected with HIV are more likely to obtain emotional support and practice preventive behaviours to reduce the risk of transmitting HIV to others, and are more likely to seek HIV treatment and care earlier, when it can make more of a positive health impact. Access to HTC is also important for adolescents who do not have HIV to reinforce prevention messages and to facilitate access to prevention services and commodities.

Voluntary Medical Male Circumcision

There is strong evidence that voluntary medical male circumcision (VMMC) can reduce the risk of HIV infection from females to males and thus has the potential to have a significant impact on the HIV epidemic. Medical male circumcision reduces the risk of HIV transmission among heterosexual men by 60-70%. Thus VMMC is expected to reduce heterosexual women's probability of encountering an HIV-infected male sexual partner, thus decreasing their overall risk of contracting HIV. Thus VMMC can help reduce the risk of HIV infection among young heterosexual men.

Prevention of mother to child transmission (MTCT)

The term “MTCT” attaches no blame or stigma to the woman who gives birth to a child who is HIV-infected. It does not suggest deliberate transmission by the mother, who is often unaware of her own infection status and unfamiliar with how HIV is passed from mother-to-child. The term “MTCT” should not hide the fact that either the woman or her sexual partner may introduce HIV into a family—and that both of them share the responsibility for preventing transmission to the infant.

5.4 Implications of being HIV positive or negative

Disclosure and Confidentiality

Many children living with HIV are not aware of their status. There is broad evidence of the positive outcomes for children made aware of their status, including greater adherence to treatment. Disclosure to children is a process, not an event. Parents and caregivers are often uncertain how to counsel about disclosure, and opportunities to provide HIV testing and care, and to help families start the discussion about living with HIV are often missed.

Adolescents and young people should be supported to disclose safely to family members, peers and sexual partners. They should be appropriately counselled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine if, when, how and to whom to disclose. Disclosure of HIV status is an important part of the process of living with HIV, and is crucial to continuum of HIV care.

People living with HIV have a right to confidentiality. Your HIV status should not be disclosed by you to anyone except those people who absolutely need to know (doctors, health care providers, etc.), close friends, most-trusted confidants, and family members.

Dealing with Stigma and Discrimination

HIV& AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. The consequences of stigma and discrimination are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage, and a negative effect on the success of HIV testing and treatment.

Stigma may also vary depending on the dominant transmission routes in the country or region. In sub-Saharan Africa, for example, which includes Namibia, heterosexual sex is the main route of infection, which means that AIDS-related stigma in this region is mainly focused on promiscuity and sex work. Because it is about sex, then automatically people think you got it through sex and yet one could get it through other blood to blood contact including perinatal (from mother to child).

Living positively with HIV

Healthy life style and overall positive living with HIV are very fundamental for people living with HIV. For example, nutritional support, peer support, co-management of depression and substance use disorders and patient education are vital components of routine health and HIV care.

Teen Clubs also known as Support Groups offer comprehensive youth-friendly health services and psychosocial support for adolescents living with HIV/AIDS. Adolescents and young people are provided with comprehensive primary health care and HIV care, in an adolescent friendly environment. A full service clinic including clinicians, nurses, counsellors, social workers and lab services provides teens with ado

Unit 6: Sexual Rights and Responsibilities

Specific objectives

By the end of this Unit, participants should be able to:

1. Demonstrate an understanding of basic aspects of sexual rights and responsibilities;
2. Articulate, explain and respect individual values and their influence on the effective provision of SRH services to learners.



Facilitator's Notes

Methodology Presentation, case study

Materials PowerPoint presentation, videos, posters and flip charts

6.1. Reproductive rights and adolescents

A right is something that an individual or a population can legally and justly claim. For instance, individuals can claim equality within a population or such civil liberties as the right to vote. Reproductive rights are those rights specific to personal decision-making and behavior in the reproductive sphere, including access to reproductive health information, guidance from a trained professional, and reproductive health services. In addition to rights established within individual countries, major international conventions have articulated reproductive rights, including those that are specific to adolescents.

These policies provide the basis for the following adolescent rights:

- The right to good reproductive health.
- The right to decide freely and responsibly on all aspects of one's sexuality.
- The right to information and education about sexual and reproductive health so that good decisions can be made about relationships and having children.
- The rights to own, control, and protect ones' own body.
- The right to be free of discrimination, coercion and violence in one's sexual decisions and sexual lives.
- The right to expect and demand equality, full consent, and mutual respect in sexual relationships.
- The right to quality and affordable reproductive health care regardless of sex, creed, color, marital status, or location. This care includes:
 - Contraception information, counseling, and services.
 - Prenatal, postnatal, and delivery care.
 - Healthcare for infants.
 - Prevention and treatment of reproductive tract infections (RTI).
 - Legal, safe abortion services and management of abortion-related complications.
 - Prevention and treatment of infertility.
 - Emergency services.
- The right to privacy and confidentiality when dealing with health workers and doctors.

- The right to be treated with dignity, courtesy, attentiveness, and respect.
- The right to express views on the services offered.
- The right to gender equality and equity.
- The right to receive reproductive health services for as long as needed.
- The right to feel comfortable when receiving services.
- The right to choose freely one's life/sexual partners.
- The right to celibacy.
- The right to refuse marriage.
- The right to say no to sex within marriage.

Obstacles or barriers that may prevent adolescent rights from being fulfilled

The following are some obstacles/barriers that may prevent adolescent rights from being fulfilled:

- Provider's personal views.
- Heavy client load, lack of time.
- Local laws, customs, or policies.
- Religion.
- Provider was not adequately trained.
- No clinic guidelines exist to ensure adolescent rights are met.
- Community pressure.
- Family pressure.
- Peer pressure.
- RH services are not accessible to adolescents.
- Hours of RH services for adolescents are inconvenient.
- There is no method for providing client feedback.

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females.

Sexual health is defined as "...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006a)

There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights that are already recognised in international and regional human rights documents, other consensus documents and in national laws.

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination." (WHO, 2006a, updated 2010)

Sexual rights are critical to the realisation of sexual health and include:

- the right to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the right to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to find a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the right to information, as well as education
- the right to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights

The responsible exercise of human rights requires that all persons respect the rights of others.

Sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

Sexual orientation is used to describe a person's sexual identity in relation to the gender to which they are attracted.

A person attracted to another person of the same sex is said to have a **homosexual** orientation and may be called **gay** (both men and women) or **lesbian** (women).

Individuals attracted to persons of the opposite sex are said to have a **heterosexual** orientation. Individuals who are attracted to both men and women are said to be **bisexual**.

Transgender is a state in which a person embarks on a process to be able to fully live as a member of the opposite sex.

Transvestite refers to a person who dresses in the style and manner of the opposite sex (cross-dressing). Individuals who cross-dress generally have no desire to permanently change their sex.



activity

SRH – 30 minutes

Groups discuss the following and give feedback:

1. Young people are exposed to many new sources of information. What are these sources of information in Namibia?
2. Education on sexual and reproductive health should embrace positive messaging and also seek to counteract and correct the often misleading information and images conveyed through media.

Groups give feedback. Highlight the following points:

- Children obtain sexual health information from a variety of sources – friends, media, internet;
- Emphasise the need for sexual rights, sexual health and responsibilities involved (refer to explanations referred above)

6.2 Teaching Sexuality Education for young people with Intellectual Disabilities

The developmentally disabled person has a severe and chronic mental impairment that may limit success in several major life areas, and this impairment begins in childhood. Usually people with mental retardation, cerebral palsy, autism spectrum disorder, various genetic and chromosomal disorders such as Down syndrome and Fragile X syndrome, and fetal alcohol syndrome are described as having developmental disabilities. Developmental disabilities are usually classified as severe, profound, moderate or mild, as assessed by the individual's need for support.

Learning disabilities are developmental disabilities. People with learning disabilities have a chronic mental impairment. However, they are not mentally retarded. Typically they have average to above-average intelligence, but simply cannot learn in certain processing modes, and they must compensate for this disability.

People with intellectual disability (ID) have the same sexual needs and desires as those without disabilities. 60-90% of people with mild disabilities report wanting to marry and have children in the future.

Sexuality education for people with ID is particularly important because of the high rates of sexual abuse. Some statistics suggest that as high as 80% of women who have ID and 50% of men with ID will be sexually abused before the age of 18. It is important that we teach skills that make it less likely for people with ID to be victimized, and also more likely to report it if it does occur.

Stereotypes of people with intellectual disabilities

Common stereotypes of intellectually disabled people regarding sex:

1. They will forever remain childlike
2. They are and always will be asexual
3. They are unable to understand their sexual desires
4. They have incontrollable sex drives
5. They are potential sexual deviants, and should be denied sex education in case it 'gives them ideas'

Challenges for teaching sexual health to learners with intellectual disabilities

Approximately 90% of people with ID have difficulty with abstraction. This means that they may have trouble with visualizing and seeing pictures in their heads in the same way as others may be able to. Therefore, when they listen to someone speak, they can often repeat what they have heard but may not fully understand.

It is also very important to model and explain social norms. For example, if we hug a person with ID because they did a chore around the house but we do not explain the connection, they may learn that it is appropriate to hug people without reason. Every person with an ID learns differently. When teaching sexual health, it is optimal to teach the same thing in different ways, rather than using just one approach and teaching more slowly.

Things to consider when teaching sex education to intellectually disabled young people:

- Lack of knowledge about sexual issues. Any info may come from misinformed peers rather than reliable sources like books, parents or teachers. Parents and teachers have been traditionally less likely to speak about sex with youth who have disabilities;
- Mental age may be lower than their physical age;
- They may learn at a slower rate;
- May be at greater risk for sexual abuse because of their willingness to place total trust in others & their tendency to be overly compliant. May also be more dependent on parents and caregivers;
- May be overprotected from parents or caregivers. May have less opportunity for sex with oneself or with others due to a lack of privacy;
- May have difficulty with abstract thinking (ex: what is love?) or understanding the long term consequences of pregnancy or some sexually transmitted infections;
- Learners with intellectual disabilities may have trouble distinguishing between private and public behaviours, or private and public body parts.

Guidelines for teaching sexual health to learners with intellectual disabilities

- Repeat, repeat and repeat again. It is important to use repetition when teaching youth with intellectual disabilities. You can repeat the same concept from a few different angles to maximize the potential for understanding. Each lesson should begin with a review of the previous lesson(s).

- Stay concrete with your examples. Many young people with intellectual disabilities do not comprehend well abstract concepts such as love, or that a pregnancy results in having a baby nine months later. The examples used need to be concrete, in the present and almost tangible. Using pictures and videos is a good method.
- Don't overload with information. Going slower with the information is better. If you had wanted to do two sessions of sex education with the group, then schedule four sessions so that you have enough time for the students to process the information, ask questions and have discussions. You can also leave a few days between each lesson so that students have the time to think about the information.
- Assume that the learners have not had any sex education before (unless you know otherwise). You should start with the basics.



activity

Exploring attitudes, beliefs and perceptions SRH – 60 minutes

Purpose of this activity is to articulate, explain, and respect individual attitudes, beliefs and values, and their influence in the provision of effective sexual and reproductive health programmes for young people.

Materials needed: Agree,” “Not Sure,” and “Disagree” signs posted on walls

Note: This activity is highly participatory and can go beyond the allocated time. To stay within the time, the facilitator will have to decide about how much time is allowed for the discussions.

Instructions:

Before the session begins, you should have posted the signs in three parts of the room, as follows:

Agree ----- Not Sure ----- Disagree -----

Explain that this activity looks at individual attitudes, beliefs and values regarding sexual and reproductive health for young people. Ask participants to be as honest as possible with themselves and the group.

Explain that you will read a statement. Each participant should think about it and then move to the sign representing his or her opinion. Those who agree with the statement should stand near the “agree” sign. Those who disagree should stand near the “disagree” sign and those who are in the middle or unsure should stand near the “not sure” sign. It is also okay for them to stand between two signs if that more accurately expresses their opinion.

Note: For this session, it is extremely important that the facilitators remain neutral to expressed values, regardless of what the facilitators’ personal values

may be. You might want to nod your head after each person's response, affirming that value or that person's willingness to express the value. If a few participants are standing in a very small group or one is standing alone, it is important that the facilitator physically moves closer to that person or small group to appear supportive. In addition, it is important to remind participants of the ground rules – that all opinions and values will be respected. Do not permit debate between opposing groups.

Read the first statement and ask participants to stand near the sign that represents their opinion. Repeat the statement, if necessary. Once all participants have moved, ask a few of them in each category to explain why they are standing under a particular sign. After a few responses from each group, read the next value statement and repeat the process. Do not spend too much time with any one group – make sure that all groups have equal time to share views. As you read the statements do not answer questions or offer clarification; rather, let each participant clarify the values for herself or himself. Explain that if participants' values change according to others' arguments or explanations, they can move to another part of the room but that you do not want to influence where they stand.

Keep reading down the list at a comfortable pace, and do not let participants get too caught up on one or more statements. Ask people who have not yet spoken to share their values. Some participants may seem to dominate this session, and you want to encourage quiet people to participate vocally. If the allotted time elapses, omit some of the statements.

When you have completed the list (or when time is finished), have participants sit down and ask four or five of the following questions for group discussion (this part should take about 20 minutes). Be sure to probe for clarity and concrete examples of what they are saying:

1. What did you notice happening during this activity?
2. Were you surprised by any part of this activity?
3. How did it feel to do this activity?
4. If you were ever alone under a sign (or there were only a few of you), how did that feel? Was anyone scared? Did you feel angry or frustrated?
5. What influenced your decisions?
6. Why did we do this activity?
7. Why are values important in our work?
8. How do you think this activity will help you in providing effective sexual and reproductive health programmes to young people?

Emphasise that this activity assists participants in understanding their own and others' values related to sexual and reproductive health programmes for young people. It is important that we are each aware of where we stand on these issues and that we recognize where we may need to adjust our opinions to work effectively as a team. The purpose of this activity is not to divide the group but to

allow participants to recognize their differences and move forward. Facts and answers should only be provided at the end of the activity. The following are the facts/answers for each statement:

- Agree. The national policy on RH and Maternal and Child health calls for service provision for all sexually active individuals.
- Disagree. No girl should be blamed. In fact, most girls have their first sexual intercourse as forced sex.
- Disagree. It is biological function, determined by a mix of hormones in every individual. Therefore, people do not learn to be heterosexual or homosexual.
- Disagree. Efforts to change gays/lesbians e.g. through counseling have not been effective since it is largely determined by hormones.
- Disagree. Yes, abortion in Namibia is illegal except under certain conditions. But reproductive health services should be provided to those needing care after abortion.
- Agree: studies have confirmed that some girls do practice anal sex due to fear of pregnancy, and for religious and cultural purposes.
- Agree. These pills are available without the need for a prescription from a doctor and no need to pay at a public health facility.
- Agree. Girls are more concern about pregnancy than STIs including HIV. It is also for the same reason that most girls prefer hormonal contraceptives (preferably injections) instead of condoms.

Close this activity by emphasizing the following:

This activity can be controversial, as participants may hold strong and opinions. Having strong opinions is okay, but imposing these opinions on others is not okay. Stress that listening to another's point of view and sharing respect is important, even if a participant disagrees strongly with another opinion.

Source: http://www.unfpa.org/sites/default/files/resource-pdf/youth_participation.pdf

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MODULE 5: WASH - WATER, SANITATION AND HYGIENE

Overall Objectives

To promote the provision of safe water, food safety, sanitation, and hygiene programmes related to school health within the school community.

Module Summary Table

Unit	Content	Time	Activity	Materials
1	The School Environment Safety and Security in schools Water, sanitation, health Public health in schools	2 hours	Presentation, videos	Policy Documents and guidelines, posters
2	Personal Hygiene General hygiene Menstrual hygiene	2.5 hours	Presentation, focus group discussions, practical sessions	PowerPoint presentation, posters & videos
3	Safe water Principles of safe water Water sources Safe water in schools	1 hour	Presentation, role play & case study	PowerPoint presentations, videos and posters
4	Sanitation Principles of safe sanitation Water-borne diseases Sanitation technologies	1 hour	Presentation, case study	PowerPoint presentation, videos, posters and flip charts
5	Food hygiene and safety Food hygiene Food handling and storage Food poisoning	1 hour	Presentation, inspections, role play, testing and sampling	PowerPoint presentation, videos and posters
6	Waste disposal Sound waste management Recycling	1 hour	Presentation, information sharing	PowerPoint presentation, flipchart paper

Glossary:

Composting toilet: A dry toilet into which carbon-rich material can be added to the excreta in the pit, for example vegetable waste, straw, grass, sawdust or ash and special conditions maintained to produce inoffensive compost (environmentally friendly and without odour). A composting toilet may or may not have a urine separation device. The dry human waste should be removed from time to time and can be reused as fertiliser.

Dry sanitation: Disposal of human excreta without the use of water for flushing

Excreta: Faeces and urine.

Groundwater: Water which occurs in the zone of saturation below the ground.

Improved sanitation: Safe disposal and management of waste to prevent human exposure and environmental hazards. The components are: safe collection, storage, treatment and disposal/re-use/recycling of human excreta (faeces and urine)

Improved water sources: Water sources include protected springs and boreholes that are not contaminated by pollution from animals or drainage/flood water. Oshanas should not be used for human water supplies.

Pollution: Addition of harmful liquid, solids or gaseous substances to water, soil or air.

Sanitation: Interventions that improve the management (safe disposal or recycling) of human waste (including excreta and grey water), animal waste and industrial effluent to promote human and environmental health.

Surface water: Water from rain, storms or other precipitation, or street washing lying on or flowing across the surface of the ground.

Water table: The depth at which the ground becomes saturated with water.

Unit 1: The School Environment

Specific Objectives

By the end of this unit, participants will be able to:

- Build a safe environment for learning
- Provide information on responsibilities related to WASH
- Provide information on waterborne and water-related diseases

Methodology: PowerPoint presentation, information sharing

Materials: Hand outs, flipchart paper, markers, soap, bowl, water, towel



Facilitator's Notes

Definitions

Safety

The state of being safe; exemption from hurt or injury; freedom from danger.

Security

The condition of being protected from or not exposed to danger; safety.

Water, Sanitation, Health (WASH)

It is estimated that 36 per cent of the world's population lack improved sanitation facilities, and 768 million people still use unsafe drinking water sources. According to the Demographic and Household Survey of 2013 46 per cent of the Namibian population have no toilet facilities compared to 84 per cent with access to safe water.

Inadequate access to safe water and sanitation services, coupled with poor hygiene practices, kills and sickens thousands of children every day, and leads to impoverishment and diminished opportunities for thousands more.

Poor sanitation, unsafe water and poor hygiene practices have many other serious repercussions. Children and particularly girls are denied their right to education because their schools lack private and decent sanitation facilities.

Without WASH sustainable development is impossible.

The hygiene behaviour that children learn at school made possible through a combination of hygiene education and suitable water, sanitation and hygiene-enabling facilities are skills that they are likely to maintain as adults and pass on to their own children.

A. Public Health in Schools

Environmental challenges and opportunities vary considerably among schools around the country and within communities. Similarly, the resources available to schools to manage health hazards vary as widely as the threats themselves, often creating formidable management challenges i.e. some schools do not have access to safe water and sanitation facilities.

Provision of safe and sufficient water, sanitation, and shelter from the elements are basic necessities for a healthy physical learning environment. Equally important is the protection from biological, physical, and chemical risks that can threaten children's health in schools. Infectious diseases carried by water, and physical hazards associated with poor construction and maintenance practices are examples of risks children and school personnel face at schools.

B. Safety and Security of School Staff and Learners

Providing students a healthy and inviting learning environment where they are protected from physical and emotional harm is central to all schools. School climate is vital for student achievement, a teacher can be doing a phenomenal job inside their classroom, but if the rest of the school environment is not supportive the gains and achievement expected will not be reached.

A safe school climate includes a safe and clean school facilities, caring teachers, and caring, respectful relationships amongst learners. A child-friendly school must have accessible, gender-appropriate toilets and hand-washing facilities, access to potable drinking water and solid waste management with proper boundaries.

In addition, a supporting school environment must have a strong discipline policy and core rules/values that are followed. The policies and procedures put into place in a school must minimize distraction and interruption from the learning process.

Components of a healthy school environment (WHO)

COMPONENT	RISKS
Provision of basic necessities	<ul style="list-style-type: none"> • Shelter • Warmth • Safe Water • Sanitary facilities • Food • Light • Ventilation • Emergency medical care
Protection from biological threats	<ul style="list-style-type: none"> • Molds • Unsafe or insufficient water • Unsafe food • Vector-borne diseases • Venomous animals • Rodents and hazardous insects • Other animals (e.g. dogs)
Protection from physical threats	<ul style="list-style-type: none"> • Traffic and transport • Violence and crime • Injuries • Extreme heat and cold
Protection from chemical threats	<ul style="list-style-type: none"> • Air pollution • Water pollution • Pesticides • Hazardous waste • Hazardous materials and finishes • Asbestos, paint • Cleaning agents

In addition to the WHO check list above, there are the security issues to consider by keeping the learners and school staff safe from people entering the school grounds without permission and following the procedures laid down by the Ministry of Education.

Adhering to the procedures is most challenging where the school does not have a perimeter fence and security guards are not employed.

C. School Operations as they apply to the School Environment

Responsibilities as applied to WASH

Five main ministries and governmental bodies are involved in the provision of school water supply and sanitation facilities, namely:

Firstly, according to the National Water Supply and Sanitation Policy – 2008 (WSASP), it is the responsibility of the Ministry of Education (MoE) to ensure that safe water supplies (that meet the Class A water quality standards) and improved sanitation facilities to public schools in Namibia.

In urban areas, the water supply and sanitation (WATSAN) services are normally provided to the school by local authorities and regional councils supported by the Ministry of Regional and Local Government and Housing and Rural Development.

In rural communal areas, the water supply services are normally provided to the community by the Directorate of Water Supply and Sanitation Coordination (DWSSC). Sometimes a rural school will be connected to the community water supply system but if not, the MoE remains responsible for ensuring that a dedicated water source is provided to supply safe water to the school. In addition, the MoE is also responsible for providing on-site school sanitation services which in many cases will use dry sanitation technology but occasionally could be water-borne systems.

The Ministry of Works and Transport (MWT) is also an important partner when public buildings such as schools are concerned. In most regions, MWT will often be called upon by the Ministry of Education, Arts and Culture to provide the technical support for new school developments and also where major rehabilitation/extension works to existing facilities such as classrooms are being considered. When it comes to the maintenance of existing infrastructure, MWT is often asked to provide support to MoE by contracting an approved service provider to undertake agreed operation and maintenance activities.

The Ministry of Health and Social Services is an important partner for MoE when it comes to carrying out school health activities.



activity

WASH – 30 minutes

Divide into four groups. Groups think about their own environment. Discuss problems related to public health, safety and security in their school.

Groups discuss how they will solve the problems.

Groups give feedback.

Unit 2: Personal Hygiene



Specific Objectives:

- By the end of the UNIT, participants will:
- be able to demonstrate best practices related to personal hygiene
- Gain knowledge and skills to prevent and control communicable diseases that can occur due to poor personal hygiene

Methodology PowerPoint presentation, information sharing

Materials Hand outs, flipchart paper, markers, soap, bowl, water, towel



Facilitator's Notes

Definition

Personal hygiene is the cleaning of all parts of the body (face, hair, body, legs and hands). Some of these activities include showering, washing hair, cleaning teeth and changing into clean clothes when necessary.

2.1 General Hygiene

Hygiene is understood to be practices which are associated with ensuring good health, cleanliness and promoting quality of life (preventing illness). Key safe hygiene practices include the following:

- Proper use of improved toilet facilities, stopping open defecation;
- Hand washing with water and soap after using the toilet and before preparing food;
- Safe disposal of children's stools and hand washing with soap after handling children stools;
- Protecting food against flies
- Proper storage of water in the home

Germs can't be seen, but occur in many places. Germs are commonly transferred from one person to another in the following ways:

- hands - touching self or others or things
- mouths - touching it or coughing
- noses - touching it or sneezing
- cleaning self after using the toilet or a baby's bottom
- pets or other animals
- handles and buttons -eg. on home or car doors, railings, phones, light switches, etc.



Hand washing

Hand washing is critical at all times, when trying to promote improved hygiene practices in general, which can reduce diarrhea by one third and reduce malnutrition.

The critical times to wash your hands with soap are:

- Before and after eating
- Before, during and after preparing food
- After using the bathroom or changing diapers
- After blowing your nose, sneezing or coughing
- Before and after taking care of someone who is sick
- After touching animals, their toys, leashes, or waste (poop)
- After touching something that could be dirty (garbage can, dirty rags, etc.)
- Before and after cleaning a wound, giving medicine or inserting contact lenses
- Whenever your hands look dirty

Avoid using a communal hand washing bowl

Avoid washing hands in the same bowl with a number of people, particularly using the same water other people have used. This is because the germs that are washed off hands remain in the water. When you wash in the same bowl, you pick up some of your own germs and also those from the people who washed their hands before you.

A hand washing facility with soap and running water should be provided next to the latrine for easy access. Community and schools should provide hand washing facilities for the use of all including teachers and school learners. They should also decide how to ensure that there is adequate water and soap always for hand washing. Anything that allows clean water to run over the hands and prevents user from contaminating the water will be suitable. The size of the facility will depend on the number of users and the resources available to the community.

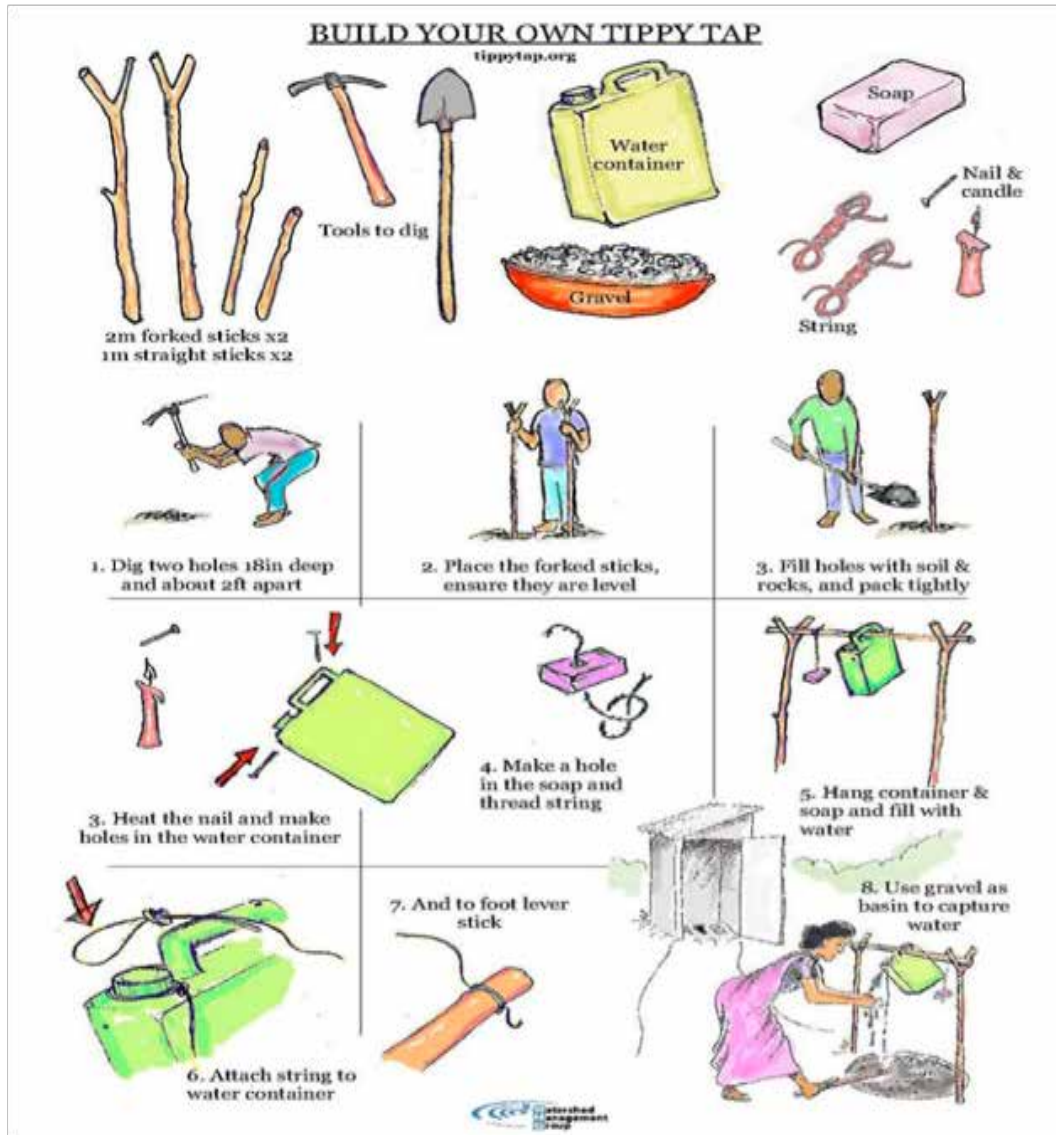
Hand washing tips

- Before you wash your hands, take off any jewellery.
- Wash with soap and not with ash. You don't need antibacterial soap to remove dirt and germs.
- Apply moisturiser to hands after cleaning them. Washing your hands can dry out your skin. If your skin is dry, it can develop small cracks, where germs can hide.
- Clean under and around fingernails and clip them.

Tippy Tap

A tippy tap is a simple way to wash your hands even if you don't have a tap. It primarily consists of a suspended water bottle. The bottle is tipped using a rope handle or a foot control so you don't touch the handle with dirty hands. When the bottle tips, water sprinkles out of a small hole in the side. Wet the soap and wash your hands. Only a small amount of water is needed (40 ml) to wash hands effectively.

Figure 5.2: How to make a tippy tap



Source: Ministry of Agriculture, Water and Forestry

B. Oral Hygiene

Specific Objectives

To help learners improve and maintain oral health

Methodology PowerPoint presentation, information sharing

Materials Hand outs, flipchart paper, markers, soap, bowl, water, towel



Facilitator's Notes

Definitions

Oral hygiene is the practice of keeping the mouth and teeth clean to prevent dental problems, most commonly, dental cavities, gingivitis, and bad breath. There are also oral pathologic conditions in which good oral hygiene is required for healing and regeneration of the oral tissues. These conditions included gingivitis, periodontitis, and dental trauma, such as subluxation, oral cysts, and following wisdom tooth extraction.

Refer to Module 1 Unit 4.

C. Menstrual Health

Menstruation

Menstruation is a natural process linked to the reproductive cycle of women and girls. It is not a sickness, but if not properly managed it can result in health problems which can be compounded by social, cultural and religious practices.

Menstrual hygiene management

It entails that women and adolescent girls use clean material to absorb or collect menstrual blood, and this material can be changed in privacy as often as necessary for the duration of menstruation. It also includes using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials.



Key Notes

Menstrual hygiene management is fundamental to the dignity of women and girls and is an integral part of basic sanitation and hygiene services for which every woman and girl has a right.

Many girls drop out of school at this stage because they do not know how to take care of themselves or lack the facilities in the school to manage their menstruation appropriately.

Keeping clean and avoiding soiling their clothes is important for girls who are menstruating, therefore girls should be encouraged to bath at least twice a day with soap during menstruation. This prevents bad odour and keeps girls fresh, healthy and confident.

Clean menstrual materials such as pads, cotton wool, clean cloth and towels should be used. As much as possible girl should avoid using toilet paper as this does not absorb properly and will make them soil their clothes.

Menstrual materials should be changed regularly during the day (at least twice). Soiled materials should be wrapped and disposed of properly in plastic bags made available by the school and then disposed of in an approved manner. They should not be thrown around the school compound.

During menstruation girls should carry extra materials to change during the day. Where cloth or towels are used these should be dried in the sun after washing and not in dark corners. If possible, they should be ironed and folded well before use.

Keep extra materials in a clean plastic bag to avoid contamination. To avoid infection, girls should never share the same re-useable menstrual materials.

Schools should be encouraged to provide a supply of menstrual materials held by the Life Skills teacher when girls start their menstruation period whilst at school.



activity

Menstrual hygiene management – 30 minutes

Divide into four groups. Groups think about their own environment. Discuss the major challenges towards menstrual hygiene management in the school and community.

Groups discuss how they will solve the problem and give feedback.

Unit 3: Safe Water

Specific Objectives

By the end of this unit, participants will:

- understand the principles on water
- be able to provide information on water supplies, water treatment, transport and storage methods
- be able to provide information on waterborne and water-related diseases
- appreciate that hand washing with soap prevents common diseases

Methodology PowerPoint presentation, information sharing

Materials Hand outs, flipchart paper, markers, soap, bowl, water, towel



Facilitator's Notes

Definition

Safe Water: Water that is considered safe contains no germs, has no colour and no odour or taste. The chemical, physical and bacteriological composition of the water should be of quality that does not pose a health risk to human beings.

Water quality: Water that is intended for drinking, cooking, personal hygiene, cleaning and laundry must be deemed safe for the purpose that it is being used.

Unsafe water: Water from ponds, rivers, streams, dams and lakes may contain germs, toxins and harmful materials. It may have an odour, contain sediment and is cloudy.

Drinking water standards: The taste and odour of drinking water need to be acceptable to learners and staff otherwise they might not drink enough, or may drink from other unprotected sources, risking their health. The drinking water quality standards are guided by WHO and Namibian Drinking Water Standards.

Water for other uses: Water for hand washing, bathing, dishwashing, food preparation and washing of utensils meet the Namibian Class A Drinking Water standards.

A. Principles of safe water

“Water is considered to be the most important resource for sustaining ecosystems, which provide life-supporting services for people, animals, and plants. Because contaminated water is a major cause of illness and death, water quality is a determining factor in human poverty, education, and economic opportunities”. *CDC*

Water treatment: Water is rarely pure. It can be contaminated when it flows underground and different substances and micro-organisms are dissolved or incorporated in the water. This is the reason why water, needs to be treated to be fit for human consumption.

The level of treatment depends on the source of water i.e. deep borehole water is usually fit for drinking purposes but may require disinfection. However, surface water from rivers, lakes and dams usually needs thorough treatment.

Water may be treated for use at a school with a municipal water treatment plant and later distributed to the school. This is the usual system that occurs in urban areas. Water treatment plants disinfect with chlorine to kill bacteria and other micro-organisms. They filtrate to remove solid materials and use powdered activated carbon (PAC) to adsorb taste-and-odour causing compounds.

- Water treatment plants disinfect with chlorine to kill bacteria and other micro-organisms. They filtrate to remove solid materials and use powdered activated carbon (PAC) to adsorb taste-and-odour causing compounds.

Water treatment and safe storage (WTSS) interventions can lead to dramatic improvements in drinking water quality and reductions in diarrhoeal disease - making an immediate difference to the lives of those who rely on water from unprotected sources such as polluted rivers, lakes and, in some cases, unsafe wells or piped water supplies.

Cross contamination of water: Even if water is obtained from a safe and protected source, water can also be contaminated during transportation and use.

Avoiding water contamination: ensure treated water does not come into contact with any source of contamination by covering containers and use of clean water containers.

B. Water Sources

There are various natural sources of water in Namibia which includes:

- Groundwater
- Perennial surface water
- Ephemeral surface water stored in dams
- Recycled or reused water and
- Seawater

Figure 5.3: Clean water saves lives



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It is important to differentiate between improved and unimproved water sources, as there is health risk when learners get water from unprotected water sources.

Access to an improved water source refers access to an adequate amount of water from an improved source, such as:

- a household connection,
- public standpipe,
- borehole,
- protected well
- protected spring

Unimproved sources include:

- surface water (livers, oshana etc)
- tanker trucks,
- unprotected wells
- unprotected springs.

There is a clear relationship between the quantity and quality of school infrastructure and the quality of learning. When no enough safe water outlets are available to learners and school staff for drinking and hand washing, learners can be disadvantaged through either themselves or their teachers being uncomfortable or sick.

C. Access and availability of safe water in school

Schools, particularly those in rural areas, often completely lack drinking water and sanitation facilities, or have facilities that are inadequate, or poorly maintained or operated unsatisfactorily limiting good hygiene behaviour and the effectiveness of hygiene promotion. It is common that most schools only have one tap and learners to use one tap to wash hands before lunch and after using the toilet during a short lunch break.

The lack of adequate water taps and hand washing facilities at schools hinders good hygiene practices. It is important that schools have a enough taps and hand washing facilities to encourage and sustain good hygiene practices.



activity

WASH – 30 minutes

In small groups, discuss the following question:

How do we keep water safe to avoid contamination in a typical rural household?

Write answers on flipchart paper, and ensure to emphasise points noted above in the Unit.

Unit 4: Sanitation

Specific Objectives

By the end of this unit, participants will be able to:

- promote the provision of standard sanitary facilities
- explain the faecal-oral transmission routes

Methodology PowerPoint presentation, information sharing

Materials Hand outs, flipchart paper, markers, soap, bowl, water, towel



Facilitator's Notes

Definitions

Sanitation: refers to the provision of efficient and effective sanitary facilities to safely contain and convey effluent materials to a final disposal point.

Hygiene: refers to behaviours that can improve cleanliness and lead to good health, such as frequent hand-washing with soap, face-washing and bathing with soap and water.

Open defecation is the practice of defecating outside and sometimes in public, without privacy, in and around the community, in the absence or inadequate supply of toilets, latrines or any kind of improved sanitation facility. Open defecation leads to contaminated food and water as well as unhygienic environment. This in turn causes diarrhoea and other related illnesses.

Water contamination is the contamination of water bodies (e.g. Rivers, oceans, dams, aquifers and groundwater). Water pollution occurs when pollutants are directly or indirectly discharged into water bodies without adequate treatment to remove harmful compounds.

Faecal contamination is traces of faeces (stools) coming into contact with areas of the body where they could potentially cause harm. For example, faecal contamination of an open wound, such as a pressure sore, could cause infection.

Faecal-oral transmitted diseases are diseases in which the infectious agent is found in faeces and enter the body through the mouth (oral-route) by way of food, water and unwashed hands.

Standard sanitary facilities: Sufficient, accessible, private, secure, clean and culturally appropriate toilets should be provided for schoolchildren and staff.

A. Principles of safe Sanitation

Well-constructed toilets can reduce diarrhoea by one third and also reduces intestinal worm infections and malnutrition when accompanied by other good hygiene practices such as hand washing with soap. Latrines also give women and girls privacy and increase their dignity.

Children attend schools that have toilets that are unusable. In some schools and hostels where sanitation facilities are available, there is no running water, soap, toilet paper or cleaning materials, and the smell of the toilets is unbearable. This leads to learners not using the toilet facilities. All schools must have toilets that are accessible and designed to accommodate staff and learners with disabilities.

Access to safe, potable water supplies and improved, functional sanitation facilities with hand washing facilities at schools and hostels is vital in ensuring a conducive and supportive learning environment.

The following indicators have been formulated as a basic guideline for a healthy school environment:

- Sufficient toilets:
 - one per 25 girls and one for female staff
 - one toilet plus one urinal per 50 boys and one for male staff
- Toilets should be accessible to all:
 - including staff and learners with disabilities
 - male and female toilets completely separated
- toilets provide privacy and security
- appropriate to local cultural and social conditions, age and gender
- hygienic and easy to clean and with disposal facilities (plastic bags) for female and girls
- convenient hand-washing facilities close by
- cleaning and maintenance routine in operation ensures clean, functioning toilets at all times

Effects of poor hygiene and sanitation

Education

Poor sanitation affects academic performance as school time of learners is lost due to sanitation related diseases. Many adolescent girls lose 25% of their school time or drop out of school due to lack of sanitation facilities to accommodate their menstrual cycles.

Health

Sanitation related diseases are the major causes of illness and death. Records on common illnesses from outpatient departments show that diarrhoea, worm infestations, eye infections and skin diseases are some of the most commonly reported cases among learners.

Socio-Economic

There is high expenditure for sanitation-related diseases in schools. The cost of ill-health affects all learners and school staff and affects productivity.

Environment

The environment is affected by poor sanitation through the haphazard disposal of human faeces, urine, garbage and dirty water. It is estimated that an average human being excretes 0.25kg of faeces daily. Therefore, a group of 1,000 people without latrines would pollute the environment with: $1000 \times 0.25\text{kg faeces} = 250\text{kgs}$ of faecal matter daily.

Waterborne and water-related diseases

The following diseases can be prevented through improved personal hygiene and access to adequate sanitation and clean water supply:



Disease	Cause	Symptoms
Diarrhoea	bacterial, viral and parasitic organisms spread by contaminated food and water	gastrointestinal infections, watery stool and passing stool more often than is necessary leading to severe dehydration
Cholera	bacterium <i>Vibrio cholerae</i> by eating food or drinking water that has been contaminated by the faeces of infected persons	acute infection of the intestine, which begins suddenly with painless watery diarrhoea, nausea and vomiting causing severe dehydration which could lead to death if treated in time
Hepatitis A	viruses transmitted through water and food via faecal-oral route, through contaminated water and from person to person. Also via food contaminated by infected food-handlers, uncooked foods, or foods handled after cooking	inflammation of the liver; abrupt onset of fever, body weakness, loss of appetite, nausea and abdominal discomfort, followed by jaundice within a few days
Ringworm (Tinea)	mild but contagious disease of the skin, scalp or nails caused by a fungus spread by direct contact with an infected person or animal (dogs, cats, guinea-pigs, cattle), contact with soil or by indirect contact with items	Scalp: a pimple or sore which spreads into a ring shape. Bald spots from hair loss. Body: red or pink, flat or slightly raised, patches on the skin which become enlarged with a ring of infected tissue around a clear centre
Scabies	contagious skin infection caused by a microscopic mite which burrows into the skin, deposits eggs and the larvae migrate to the skin surface, changing into the adult form. Mating occurs on the skin surface. An adult mite can live up to about a month on a person. Scabies spreads by direct skin-to-skin contact and contact with infested garments and bedclothes especially in overcrowded conditions	pimple-like rash typically found on the hands, between fingers, folds of the wrist, elbow or knee, penis, breast or shoulder which causes intense itching all over the body, especially at night. Scratching of itchy areas results in sores that may become infected by bacteria
Typhoid fever	infection of the intestinal tract and bloodstream caused by bacteria which are transmitted from faeces through ingestion	sustained fever (as high as 39°- 40° C), malaise, anorexia, headache, constipation or diarrhoea, rose-coloured spots on the chest area and enlarged spleen and liver
Schistosomiasis (Bilharzia)	parasitic worms that penetrate the human skin through swimming, bathing or washing in contaminated water	rash or itchy skin, fever, chills, cough, and muscle aches within 1-2 months of infection. The cause infection and eventually damage the liver, intestines, lungs and bladder

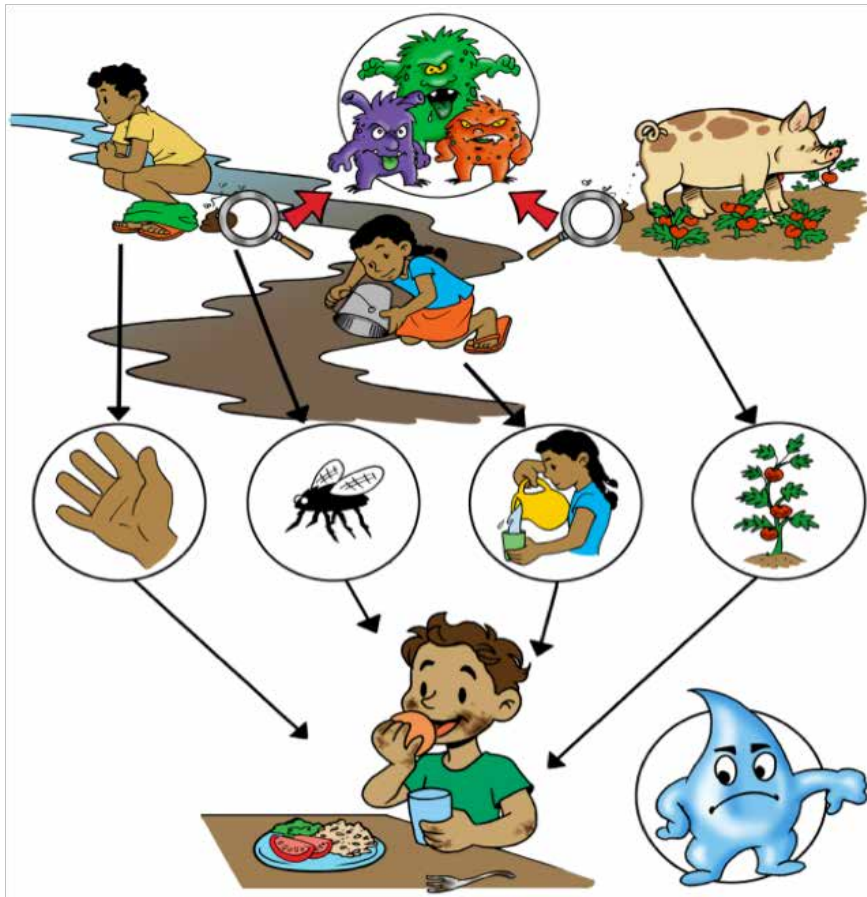
Source: http://www.who.int/water_sanitation_health/diseases/en/

See also Vector-Borne Diseases in Module 1, Unit 6, on page 36.

Transferring of faecal disease (F Diagram)

The F diagram shows the different transmission routes whereby pathogens are transferred from faeces: ie. through fluids, fields, fingers, and food. Some of the most effective primary and secondary (behavioural) barriers are indicated.

The following diagram is an indication of faecal disease transferred from one person to another:



Source: http://resources.cawst.org/asset/f-diagram-disease-transmission-presentation-bsf-pi_en#comment-1788

People also spread germs by walking in areas where others have defecated. The germs are transferred to hands, utensils and food and can cause serious illness. Where possible, always use a toilet and wash hands with soap immediately thereafter.



activity

Fecal-oral transmission routes – 30 minutes

Divide into four groups. Groups think about their own environment. Discuss where faeces go when people practice open defecation in their community. Groups discuss how they will solve the problem. Groups give feedback.

The following essential short-term measures should be implemented to protect health in schools:

- Provide basic sanitation facilities – with separate facilities for boys and girls (see page 175 for recommended ratio of toilets to learners)
- Provide water and soap (or ash) for handwashing
- Provide safe drinking water from a protected groundwater source or treated supply
- Fence school grounds so that a clean environment can be maintained
- Promote hygiene and the importance of a clean school environment

B. Different Sanitation Technologies

The selection of an appropriate technology from a range of possibilities is affected by various factors such as the availability of water, financial costs and affordability, design life, expectations and preferences, institutional capacity and environmental considerations.

It is important for learners to appreciate the type of sanitation facilities available at their school as this relates to their maintenance and operation. Different technologies have different requirements when it comes to operation and maintenance. Learners need to familiarize themselves with this requirements.

Sanitation System	Central Systems
Wet systems (flush toilets)	<ul style="list-style-type: none"> • Septic tanks and french drainage systems • Conservatory tank • Pour flush toilet • Decentralised Sewerage System
Dry Systems	<ul style="list-style-type: none"> • Ventilated Improved Pit latrine • Dehydration toilet (enviroloo, Otjitoilet, Urine Diversion System) • Ecosan toilet • Composting toilets • Enviroflush-type

C. Operation and Maintenance

Operation and maintenance refers to all of the activities needed to run a water supply and sanitation scheme. The overall aim of operation and maintenance is to ensure efficiency, effectiveness and sustainability of water supply and sanitation facilities.

The large number of people using a concentrated facility can cause problems if there is a lack of general maintenance, such as cleaning of the toilet and replacement of toilet paper. It is important that schools have a plan on the cleaning and maintenance of the sanitation facilities. This will ensure that the facilities are kept in clean condition and encourage the use by the learners in orders to maintain a healthy status amongst the learners and staff.

Unit 5: Food Hygiene and Safety

Specific Objectives:

By the end of this unit, participants will be able to explain the principles and practices of food safety and hygiene

Methodology

Materials



Facilitator's Notes

Definitions

Food safety: describes handling, preparation, and storage of food in ways that prevent foodborne illness.

Food hygiene: is used to describe the preservation and preparation of foods in a manner that ensures the food is safe for human consumption.

Food hygiene at school: includes proper storage of food before use, washing one's hands before handling food, maintaining a clean environment when preparing food and making sure that all serving dishes are clean and free of contaminants and sufficient cooking to ensure all germs are killed.

Food poisoning: is caused by germs like bad bacteria or toxins, which are poisonous substances. Mild cases of food poisoning usually with diarrhea and an upset stomach, are common.

A. Principles of good food hygiene

A polluted environment, lack of a safe water supply and poor sanitation increase the likelihood of food contamination in a school and hostel environment. Unsafe food remains a widespread public health problem.

Food can pick up germs from several places:

- dirty hands
- coughing
- sneezing
- unclean containers
- refrigerators etc.

Other ways germs get into our foods is through using dirty water or by storing foods improperly. In addition to germs, other food safety concerns are poisonous chemicals or toxins, such as Aflatoxins from improper production, harvesting or storage of certain legumes and grains. This section focuses on the hygiene and quality of handling foods from production to storage.

Food Cultivation and Production

Great care needs to be taken when cultivating crops or working with other food production eg. eggs

Avoid poisonous chemicals and fresh manure from getting into food while preparing the soil or treating plants against pests.

Avoid poisonous chemicals and fresh manure from getting into food while preparing the soil or treating plants against pests.

Chemical residues can remain on plants or on people applying the chemicals. Much care needs to be taken in their use and even better to avoid them altogether. Environmentally friendly alternatives are available through plant nurseries and agricultural outlets. Seek advice from local environmental officers.

Fresh manure (faeces) can introduce germs that cause illness. Use only matured compost from animals or people as a fertiliser. Animal foods also get contaminated during production – such as eggs. Ensure that animals being raised for food have a healthy clean environment.

Growing your own food gives you more control over what is put on the food. Organic and free-range products have gained in popularity because people are more conscious of healthy eating than before.

Food production facilities are inspected by relevant authorities to ensure compliance to hygiene standards. Foods in the market have to be labelled by law so that consumers can make a choice about what they eat.

Harvest

Harvest plant foods at their peak for the best quality. Foods harvested at the right time are often easiest to store, as well as having the best nutrient content and taste. eg. Grains which have not matured will contain more water and sugars instead of starch, making them more difficult to dry and store.

Foods harvested early or late spoil faster, and sometimes that spoilage is dangerous. (fungal Aflatoxins)

Fruits and vegetables taste better when allowed to fully ripen before harvesting. Strong local diverse food systems ensure access to good, clean food for all.

B. Food storage, preparation and handling

Everything used for and during storage needs to be clean to prevent spoilage. Some types of spoilage can't be seen but can cause illness.

Methods of preparing food and food storage include:

- Drying
- Freezing
- Pickling

- Salting
- Hanging etc.

Foods in storage must be monitored. Once any abnormalities are observed, they must be addressed quickly so that the problem doesn't get worse and spread to other food.

Be especially observant for signs of rodents (rats or mice), insects (cockroaches or flies) and other animals which can contaminate food.

Meal preparation

Germs have many opportunities to get into food during preparation:

- the food is at room temperature
- the food is exposed to moisture
- the food is handled by people

Prevention

Examine and inspect food items to ensure that they are clean and healthy. Knowing the source of foods, such as buying from clean shops and markets, and keeping food storage areas clean will help make sure that foods are safe and clean.

Check containers or other packaging for any abnormalities that might indicate spoilage. Not all types of spoilage can be seen initially.

All food handlers should be trained in basic food safety.

If kitchen staff have colds, flu, diarrhoea, vomiting or throat or skin infections within the past 48 hours, they should not handle unpackaged food.

Personal and environmental hygiene are very important when working with food:

- Any person handling food must be clean and wear clean clothes. A hairnet/ head covering should be worn.
- Hand washing with soap and clean water should be done frequently. Fingernails should be kept short and clean. Food-safe gloves may be worn.
- The kitchen and dining areas should be clean and be free of animals or insects.
- All surfaces, utensils, dishes and pots need to be cleaned with safe water and detergent.
- Kitchen towels can harbour germs if not washed and replaced often. Where possible, use air drying for hands and dishes.
- Meat and fish should not be kept at room temperature for too long. Use separate utensils and dishes for raw meats and plant foods, especially plant foods that are going to be eaten raw such as salads and fruits.
- Foods are at risk for germs as well as nutrient loss when prepared too far in advance.
- Food scraps must be disposed of quickly because they are potential reservoirs for bacteria.

- Leftover foods need to be stored in clean containers and covered to keep out any insects or animals.
- Cooked foods need to be kept cold in storage, either in a refrigerator or a freezer. Some foods can be dried again, such as cooked beans, but most foods are difficult to put back into long term storage. Avoid repeated heating and cooling of the same food as foods lose their nutrient quality, their taste and are more at risk for germs getting into them.

Whether preparing, working with or eating food, it is important that all utensils, dishes, pots, surfaces and the surrounding environment are kept clean and germ-free.



Key Notes

Food Poisoning

Food poisoning is caused by germs like bad bacteria or toxins, which are poisonous substances. Mild cases of food poisoning usually with diarrhea and an upset stomach, are common.

Foods from animals, raw foods, and unwashed vegetables all can contain germs that cause food poisoning. The most likely source is food from animals, like meat, poultry (such as chicken), eggs, milk, and shellfish (such as shrimp).

Common food poisoning bacteria:

Salmonella

Found in raw foods, contaminated with faeces. If these foods are not processed or cooked well, the bacteria stay alive in the food and can infect someone who eats it.

- eggs
- milk
- chicken
- turkey
- beef
- pork

E. coli

- undercooked minced beef
- vegetables grown in cow manure or washed in contaminated water
- fruit juice that isn't pasteurized

Care should also be taken when bathing or swimming in pools, dams, lakes or the ocean. If the water contains any human waste, it can carry the E. coli bacteria.

Signs and symptoms

- upset stomach
- stomach cramps
- diarrhea which may contain blood
- fever
-

Sometimes feeling sick from food poisoning shows up within hours of eating the bad food. At other times, someone may not feel sick until several days later.

Prevention

To avoid food poisoning, people need to prepare, cook, and store foods properly.

Some learners may bring food to school that has been prepared elsewhere – either at home or by street vendors. It may not adhere to the above recommendations. This issue should be addressed as part of hygiene education.

Food from animals, especially chicken and minced beef should be cooked until no longer pink in colour.



activity

Fecal-oral transmission routes – 30 minutes

Divide into four groups. Groups think about their own environment. Discuss where faeces go when people practice open defecation in their community. Groups discuss how they will solve the problem. Groups give feedback.

Unit 6: Waste Disposal

Specific Objectives

To explain the principles and practices of cleaning and waste disposal

Methodology PowerPoint presentation, information sharing

Materials Hand outs, flipchart paper, markers, soap, bowl, water, towel



Facilitator's Notes

Definitions

Waste management: involves the collection, removal, processing, and disposal of materials considered waste.

Waste disposal: Proper removal and handling of discarded or discharged material in accordance with local environmental guidelines or laws.

A. Principles of sound waste management practices

The School and Home Environment

Some guidelines for maintaining a clean school and home environment:

- Separate waste according to type – dry, wet, vegetable matter. Where recycling collection is available, provide separate bins for plastics, paper and cardboard, bottles and metals.
- Full dustbins lead to waste being scattered.
- Bins that smell indicate that they are harbouring decomposing waste that may harbour germs.
- Throw papers in a dustbin, rather than on the ground. If no bin is available, take it home or to a school bin.
- Avoid littering around or in water courses like streams, even if they are dry.
- Based on WHO standards, keep the rubbish pit at least 40 metres away from a well, borehole or river.

Keeping school environment clean

The following practices that are the responsibility of cleaning staff who should be given PPE will help to minimise health risks and create a pleasant environment for all:

- Classrooms and other teaching areas should be cleaned regularly to minimise dust and moulds, Infectious respiratory disease, asthma and allergies are aggravated by the presence of dust and the spores of moulds
- Floors and walls should be mopped with hot water and detergent where possible. Where this is not practical, daily sweeping should be done
- Outside and inside areas are free of sharp objects to reduce risk of injury

- Regular cleaning and maintenance to all areas of the school
- Broken furniture and windows should be reported and repaired or removed
- Solid waste is collected and disposed of safely
- Non-hazardous waste can be safely collected, stored and then disposed of through the municipal waste system, or burned or buried in a suitable and safe location
- Waste from on-site school laboratories, should be managed by the appointed technician or teacher, according to national and international guidelines. It should not be mixed with other waste from offices and classrooms.
- Wastewater is disposed of quickly and safely
- Handwashing points, flushing toilets, showers, kitchens, laundries and laboratories all produce wastewater. Functioning sewage systems or soakaway pits should be used where these are in place
- Ensure that wastewater systems do not contaminate groundwater
- All wastewater systems should be covered to avoid risk of disease-vector breeding and contamination
- All wastewater (except from toilets) may be used to water a school garden. Seek advice from local environmental health officers to avoid health risks.

Classroom cleaning duties should not ordinarily be given to learners because they are not protected from dust and are not familiar with the use of chemicals or have personal protective clothing.

B. Options for collecting and disposal of solid/liquid waste

It is important to understand the capabilities and limitations of different waste management options for the various types of wastes generated in order to make cost effective waste management decisions that are protective of human health and the environment. The following are the common waste management options:

Reuse

Instead of being disposed of, materials that are recovered from an incident and decontaminated may be able to be reused. Reusing these materials protects the environment by saving resources, including energy, virgin materials, and landfill space as well as reduces the economic impact of the affected site. This option should be considered before more permanent disposal options in order to minimize the amount of waste needing disposal.

Recycling

Recycling involves making materials that would otherwise be disposed of as waste into valuable resources for new products. Recycling these materials protects the environment by saving resources, including energy, virgin materials, and landfill space. This option should be considered before more permanent disposal options in order to minimize the amount of waste needing disposal.

Composting

Composting is the controlled biological decomposition of organic material in the presence of air to form a humus-like material. Controlled methods of composting include mechanical mixing and aerating, ventilating the materials by dropping them through a vertical series of aerated chambers, or placing the compost in piles out in the open air and mixing it or turning it periodically.

On-site burial

This disposal option refers to burying the waste in the ground at the school. This option should only be used when site characteristics allow it (e.g., depth to water table) and proper environmental controls to protect groundwater, surface water, and soil are put into place. Refer to local authority and national laws and regulations for the appropriate requirements.

Landfill disposal

This is a disposal option involving carefully designed structures built into or on top of the ground in which waste is isolated from the surrounding environment. There are different types of landfills, each designed to handle particular waste streams.

Open burning

This disposal option refers to the deliberate outdoor burning of waste. It can be done in open drums, in fields, and in large open pits or trenches. The use of this option is highly restrictive; many communities have laws regulating or banning open burning. Open burning should only be done when and where it is appropriate and if there are no other alternatives available. Open burning is prohibited for many waste streams and may require special permission for allowable waste streams. Refer to local authority and national laws and regulations for the appropriate requirements.

Incineration

Also called combustion, this treatment option burns waste under controlled conditions. As with landfills, different incinerators are permitted for different kinds of waste. Hazardous waste must be brought to an incinerator permitted to accept hazardous waste. Municipal solid waste incinerators are permitted to burn municipal solid waste. Medical waste incinerators are designed to handle pathogenic wastes.



activity

Waste management practices – 30 minutes

Divide into four groups. Groups think about their own environment. Discuss challenges of waste management practices in their communities
Groups discuss how they will solve the problem.
Groups give feedback.

Use the content in this session to highlight the main messages for this activity. For example, emphasize on:

- different waste management methods – open burning, recycling, composting;
- Separate waste according to type – dry, wet, vegetable matter
- Rubbish pit at least 40 metres away from a well, borehole or river.

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MODULE 6: LEARNERS WITH DIVERSE NEEDS

Overall Objectives

To provide information on the diverse needs of learners within the school community

Module summary table

Unit	Content	Time	Activity	Materials
1	Barriers to learning <ul style="list-style-type: none">• Inclusive Education• Referral to relevant support services	1.5 hours	Presentation and demonstration	PowerPoint presentation, policy documents and posters
2	Speech, language and communication	1 hour	Presentation and demonstration	
3	Physical barriers	1 hour	Presentation and demonstration	
4	Sensory barriers	1 hour	Presentation and demonstration	

Glossary:

Accessible education: An education that is reaching and benefiting all children within a rights based approach. Able to be reached, entered or understood.

Barriers: Obstacles that prevent learners accessing a full range of learning opportunities and limit their participation in education or in society. Disability is often considered to be due to 'disabling barriers' which can be addressed by providing equal opportunities to children with disabilities or other special needs in education by designing enabling, accessible environments. Barriers can be due to attitudes, language, culture, organisation of support services, power relations and structures within a school environment or society.

Cognitive: Refers to the mental process of comprehension, judgment, memory, and reasoning, in contrast to emotional and volitional processes

Child friendly schools: Such schools adopt a rights-based, multi-sectoral approach, concerned with the whole child. According to UNICEF, 'Schools should operate in the best interests of the child. Educational environments must be safe, healthy and protective, endowed with trained teachers, adequate resources and appropriate physical, emotional and social conditions for learning. Within them, children's rights must be protected and their voices must be heard. Learning environments must be a haven for children to learn and grow, with innate respect for their identities and varied needs. (UNICEF).

Discrimination: To act on the basis of a difference between people, make an unjust distinction on basis of, for example, gender, disability, language or ethnic background etc. Legislation is in place in many countries to ensure the right of individuals to be treated equally, for example in education and employment.

Equal opportunities: The same chances to take part in activities, access services, etc. with no barriers to education and equal life prospects for individuals.

Inclusive education: Inclusive education is about ensuring that all learners achieve their maximum growth during their learning process both academically and socially. Inclusive education is a commitment to removing all barriers to the full participation of everyone as equally valued and unique individuals. UNESCO (2009) give the following definition: 'Inclusive education is a process of strengthening the capacity of the education system to reach out to all learners ... As an overall principle, it should guide all education policies and practices, starting from the fact that education is a basic human right and the foundation for a more just and equal society'

Integration: Learners with special needs or those with disabilities taught in mainstream education settings with some adaptations and resources, provided that the learner can fit in with pre-existing structures, attitudes and an unaltered environment. This is generally linked to preparing pupils for placement in ordinary schools. It carries with it an idea that learners need to be educationally and/or socially 'ready' for transfer from special to ordinary school.

Physical disability: Any condition that prevents normal body movement and/or control.

Segregation: When placing learners with special needs including those with disabilities in separate special school, or separate unit within a school or providing them with a separate segregated courses within mainstream education settings.

A note on inclusive education from a rights-based perspective

The purpose of Education is to empower learners for the development of Namibia as a knowledge-based society. The four national goals, access, equity, quality and democracy of education should always be considered in any action taken in education.

The Namibian education sector promotes inclusivity because it ensures that no child is left out of benefiting from quality education irrespective of their abilities, socio-cultural backgrounds, race, colour or ethnic group, with emphasis placed on the most vulnerable children and children with disabilities.

The Ministry of Education, Arts and Culture developed the Sector Policy on Inclusive Education in 2013. This Policy paves the way for all children in Namibia to learn and participate fully in the education system, particularly in the schools commonly referred to as “mainstream schools”... (It) aims to create supporting learning environment which is accommodating and learner-centred” (2013). *“Inclusive societies are sustainable societies. A society that makes room for learners with disabilities makes room for everyone; a community can’t move forward unless it leaves no one behind. It’s time for change”* (UNICEF, 2013).

Special needs in education are factors that affect the ability to learn for example physical disabilities, hearing impairments including deafness, visual impairments including blindness, medical conditions, intellectual disabilities also called cognitive disabilities, as well as emotional and behavioural problems.

The Government of Namibia is committed to inclusive education through international agreements and national legislations and policies:

- The UN Convention on the Rights of Learners
- The UN Convention on the Rights of Persons with Disabilities
- The Jomtien World Declaration on Education for All
- The Constitution of Namibia
- UNESCO Salamanca Statement and Framework for Action. The purpose of the Salamanca Conference was to further the objective to further the objective of education as a fundamental human right.
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Figure 6.1: Disabilities in children do not necessarily constitute a limit in terms of what learners can achieve in life



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As a signatory of all of the above, the Government of Namibia strongly promote inclusive education. Respect to the rights of people with disability is strongly highlighted in many of the national and international instruments. In particular, Article 3 of the Convention on the Rights of Persons with Disabilities provides the following guiding principles:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
2. Non-discrimination;
3. Full and effective participation and inclusion in society;
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
5. Equality of opportunity;
6. Accessibility;
7. Equality between men and women;
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Unit 1: Barriers to Learning

Specific Objectives

By the end of this Unit participants should be able to:

1. Provide information about the various barriers to learning, the identification thereof and possible interventions;
2. Create awareness on the Sector Policy on Inclusive Education;
3. Provide information about referral to relevant support services.

Methodology: PowerPoint Presentation, group discussion, class discussion

Materials: Handouts, Sector Policy on Inclusive Education, guidelines, flipchart paper, markers



Facilitator's Notes

1. Types of Learning Barriers:

There are a number of barriers that affect learning such as:

- **Cognitive and learning difficulties:** Learning difficulties interfere with academic achievement and an individual's daily living. Some learners learn at a slower pace than their peers. In addition, it might take them a longer time to understand what they have learned in a classroom. This means that they will have to spend more time with the teacher or someone else explaining things to them so that they can catch up with their peers.
- **Communication:** Learners with physical disabilities, hearing and visual impairments might experience communication difficulties if they are not provided with the necessary aids such as wheelchairs, hearing aids and sign support or walking stick and Braille.
- **Physical barriers:** They comprise the inability to use one's legs, arms or body effectively because of pain, paralysis or other disabilities either through accident, disease (such as polio) or birth and old age. Physical disabilities may also contribute to other disabilities such as loss of memory, hearing loss, speech impairment and may affect the person's ability to move around if they are not provided with the necessary support.
- **Sensory:** People with sensory difficulties can be sensitive to sound, light, smell, taste and touch. Sensory difficulties range from very minor to major difficulties.

Figure 6.2: Types of learning barriers

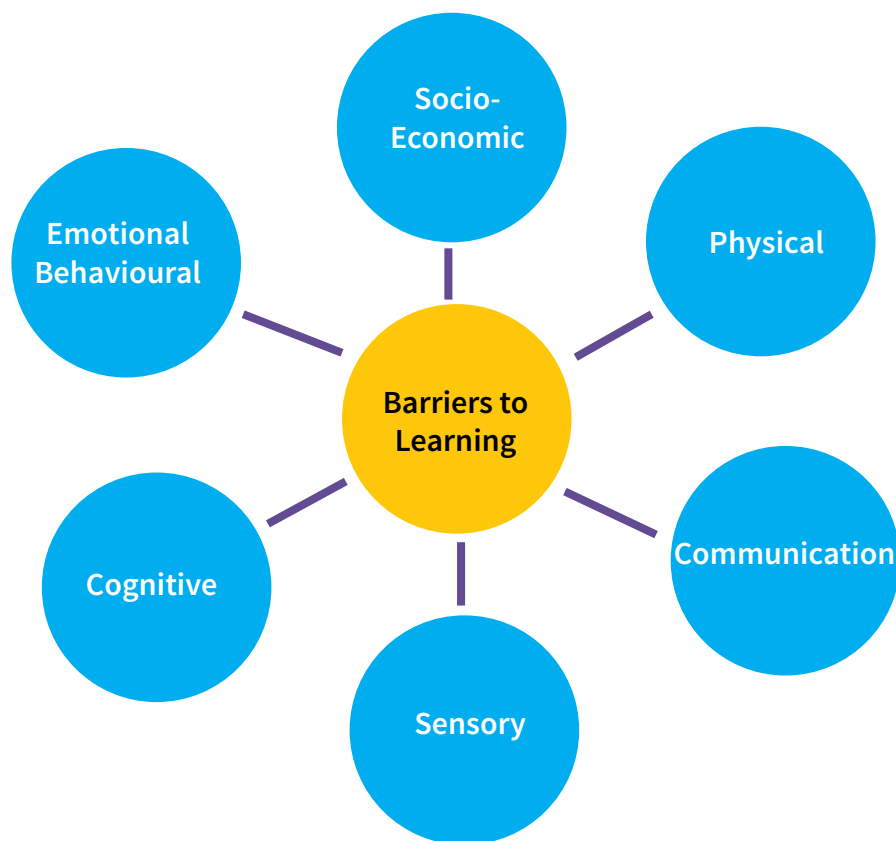


Figure 6.3: *The Convention on the Rights of Persons with Disabilities* defines discrimination on the basis of disability as:

“any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;



1.1 Cognitive or intellectual disability

Cognitive or intellectual disability refers to significant limitations in learning, thinking, solving problems, making sense of the world, and developing everyday life skills. Learners with cognitive disabilities are capable of learning, however, cognitive disability can affect a learner's ability to learn and remember, as well as interpersonal skills, communication, social, and self-care skills. Cognitive disabilities are often associated with other disabilities. It is important to support learners with a cognitive disability to enhance their self-esteem and to develop in them a sense of love and belonging. Promote a culture of caring through peer support in the classroom.

The Convention on the Rights of Persons with Disabilities is the first treaty to specially address the human rights of people with disabilities. This landmark agreement recognizes and protects the human rights of some 650 million people with disabilities worldwide. The Convention contains human rights found in other conventions and also shows how these rights specifically apply within the context of disability. Civil, political, social, economic and cultural rights are all included.

1.2. Cognitive learning barriers

Cognitive development is the development of the intellect. Cognitive activities include: perception, memory, concept development, abstract thinking, reasoning and problem solving. Learning barriers can affect any one of the cognitive abilities or a combination thereof.

Types of cognitive learning barriers:

Barrier	Signs and symptoms	Ways to support the learner
Giftedness		
Refers to learners with inborn potential or extraordinary abilities in one or more areas or born with high degree of general mental ability usually academically out performing their peers.	<ul style="list-style-type: none">• Long attention span.• Acutely observant.• Acute curiosity.• Outstanding memory.• Outstanding vocabulary.• Outstanding insight in Maths and sciences.• Rapid learning• Advanced abstract reasoning.• Questioning attitude.• Gets easily bored.• Gets easily irritable.	<ul style="list-style-type: none">• Accelerate learning by providing more advanced tasks.• Enrich the learning environment with various interesting and challenging activities.• Group gifted learners in one group and provide them similar activities while focusing on the other learners to bring them to speed.• Work with relevant professionals to support you.• Provide stimulating learning experiences.

Barrier	Signs and symptoms	Ways to support the learner
Intellectual disabilities		
<p>Learners with intellectual disabilities show impairment of adaptive abilities necessary for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).</p>	<ul style="list-style-type: none"> • Short attention span and easily distracted. • Difficulty making transitions, for example from one class to the next. • Speak and use language like a younger learner. • Difficulty with easy problem solving tasks. • Challenges with memory • Difficult to transfer knowledge to a new situation. • Fear to try out new things. • Limited reactions to play. • Poor balance. • Motor asymmetry. • Decreased perceptual-motor skills. • Decreased fine motor skills. 	<ul style="list-style-type: none"> • Communicate using simple phrases, and repeat important ideas. • Break difficult concepts down into simple ones. • Enrich the environment by making the classroom learner friendly. • Support development of functional skills, vocational skills and interests, social skills, and mobility skills. • Establish a consistent classroom routine where the learner feels comfortable participating in activities.
Learning disabilities		
<p>Learning disabilities affect a learner's ability to perform and master academic skills, process information, and communicate effectively. Learning disabilities affect the overall academic performance and future learning.</p>	<ul style="list-style-type: none"> • Dyslexia-difficulty with reading. • Below average expectation of the grade. • Confuses letters, words • Makes repetitions, omissions and reversals with letters, words. • Dysgraphia-difficulty with writing and with pencil grip, including untidy writing and difficulties with copying. • Dyscalculia-difficulty with maths- below average expectation of the grade including confuses numbers and maths signs and makes repetitions, omissions and reversals with number. • Can be disruptive. 	<ul style="list-style-type: none"> • Support well targeted play such as playing with words –recognition. • Promote socialization with peers in and out of the classroom. • Provide activities to strengthen perceptual-motor integration. • Provide activities to enhance writing skills. • Reach out to Occupational therapists, physiotherapists and speech therapists.





activity

Inclusive education – 20 minutes

Divide the class into four groups. Allow each group 5 minutes to discuss what they understand by inclusive education, giving examples.

Each group should provide their examples on flipchart and report back. Give learners a copy of the definitions taken from the Sector Policy on Inclusive Education and a copy on the Convention on the Rights of Persons with Disabilities.

Allow the learners 10 minutes to give feedback in class.

Unit 2: Speech, language and communication barriers

Specific Objectives

By the end of this Unit participants should be able to:

1. Understand the different types of speech language and communication barriers
2. Recognize the different speech, language and communication barriers.
3. Respect and support their peers with speech, language and communication barriers

Methodology: PowerPoint Presentation, group discussion, class discussion

Materials: Handouts, Sector Policy on Inclusive Education, guidelines, flipchart paper, markers



Facilitator's Notes

- Speech refers to production of sounds, the ability to form and pronounce words. Speech is a motor activity.
- Language refers to vocabulary, sentence construction and meaning and can be effected verbally, in writing or with gestures and signs.
- Speech, Language and Communication barriers are challenges caused by congenital disorders (like cleft palates and cleft lips, hydrocephalus, cerebral palsy) and other conditions which are a result of injuries and diseases (cerebral malaria, brain trauma, and neurological damage).

Figure 6.4: Cleft palate is the most common birth defect of the head and face.



Barrier	Signs and symptoms	Ways to support the learner
Speech and sound difficulties (articulation and phonology)		
<p>The learner might have difficulty with or mispronounce a number of sounds.</p>	<ul style="list-style-type: none"> • Sounds which should be produced at the back of the mouth are produced further forward in the mouth (“car” becomes “tar” or “par”) • Sounds are produced further back in the mouth (“pen” becomes “ten” or “ken”, “dog” becomes “gog”) • Longer sounds (f,v,z,s,sh,th) are pronounced as short as sounds (p,b,t,d,k) (“sun” becomes “tun”) • Leave out one of the two or three consonants, which occur together (“black” becomes “back”, “sweet” becomes “weet”) l, r and s are the most commonly omitted letters. 	<ul style="list-style-type: none"> • Develop a number of activities focusing on phonetics and let learners practice through games or quizzes. • Make the activity more interesting and attractive to the learners. • Use remedial teachers to support the learners with reading difficulties. • Provide more simple reading exercises for the learner experiencing difficulties with word and sound recognition • Communicate with parents to support the learner’s reading habit at home.
Disfluent speech		
<p>Stuttering is caused by when a person knows exactly what he or she wants to say but the flow of speech is disrupted by involuntary repetitions and prolongations of syllables, sounds, words or phrases as well as involuntary silent pauses when the person cannot produce sounds.</p>	<ul style="list-style-type: none"> • Repetition-of words, e.g. “and and then I left”. • Repetition of single sounds, e.g. “c-c-come h-h-here”. • Prolongation of sounds e.g. “sssome”. • Extra body movements may occur as the learner attempts to “push” the word out, such as stamping the feet, shifting the body position or tapping with fingers. • Facial tension-in the muscles around the eyes, nose, lips or neck. • The breathing pattern may be disrupted; for example, the learner may hold the breath while speaking or take an exaggerated breath before speaking. 	<ul style="list-style-type: none"> • Show that you are paying attention to the learner. • Speak slowly and calmly to the stuttering learner and request other learners and adults to do the same. • Seek the help of a speech therapist to assist learner. • Pay close attention to what the learner is saying and never show impatience or irritation. • Minimise questions or interruptions when the learner is talking and only ask after they have finished speaking.

Barrier	Signs and symptoms	Ways to support the learner
Receptive and expressive language challenges (understanding and using language)		
<p>A receptive and expressive language problem means that the learner has trouble understanding (or receiving) the meaning of information being given to him/her or conveying message. This can be in the form of speech, writing, sign language or gestures.</p>	<ul style="list-style-type: none"> • Give the impression he/she does not understand what has been said or asked e.g. says “huh?” alternatively, “I did not understand you”. • Look confused when spoken to • Rely on body language and facial expression in order to make out what is being said. • Often ask for the meaning of words. • Appear uninterested. • Have difficulty following instructions and remembering things. <p>A learner with an expressive language problem has trouble giving (or expressing) information to other people in a way that other people can easily understand.</p> <ul style="list-style-type: none"> • Have language skills that are on a lower level compared with peers. • Struggle to use language to meet needs (such as to ask questions, describe events, give instructions or tell a story). • Have a limited vocabulary and use very short and simple sentence structures. • Use words incorrectly in sentences. • Use incorrect sentence construction and grammar. • Sound confused and disorganized when speaking about an idea. • Have difficulty speaking about a sequence of ideas 	<ul style="list-style-type: none"> • Develop a number of activities focusing on phonetics and let learners practice through games or quizzes. • Make the activity more interesting and attractive to the learners. • Use remedial teachers to support the learners with reading difficulties. • Provide more simple reading exercises for the learner experiencing difficulties with word and sound recognition • Communicate with parents to support the learner’s reading habit at home.



Unit 3: Physical Disabilities

Specific Objectives

By the end of this Unit participants should be able to:

1. Understand the causes of physical disabilities
2. Appreciate that disability does not mean inability
3. Understand that persons with disabilities have the same rights as person without any disability

Methodology: PowerPoint Presentation, group discussion, class discussion

Materials: Handouts, Sector Policy on Inclusive Education, guidelines, flipchart paper, markers



Facilitator's Notes

There are many different causes for physical disabilities that can impair mobility and movement. Disability is the inability to use legs, arms, or the body trunk effectively because of paralysis, stiffness, pain, or other impairments. It may be the result of birth defects, disease, age, or accidents. These disabilities may change from day to day. They may also contribute to other disabilities such as impaired speech, memory loss, short stature, and hearing loss. It is important to provide a learner with any disability the necessary support they require in order to enhance their self-esteem and motivate them to learn and thrive

Physical Disabilities

- A physical disability is any condition that permanently prevents normal body movement and/or control.
- Physical disabilities are also known as developmental or motor function disorders.
- There are many different causes of physical disabilities which could be inherited or genetic such as muscular dystrophy.
- Some of the main causes of disability include, serious illness affecting the brain and spinal injury, nerves or muscles, such as meningitis and congenital disorder which are conditions present at birth, such as spina-bifida.

Barrier	Signs and symptoms	Ways to support the learner
Muscular dystrophies		
<p>The learner might have difficulty because the muscle fibres in the body gradually weaken over time.</p>	<ul style="list-style-type: none"> • Experience difficulty with social skills and academics owing to decreased motor coordination. • Muscle weakness that slowly gets worse. • Delayed development of muscle motor skills. • Difficulty using one or more muscle groups. • Drooling. • Eyelid drooping (ptosis). • Frequent falls. • Loss of strength in a muscle or group of muscles as an adult. • Loss in muscle size. • Problems walking (delayed walking). 	<ul style="list-style-type: none"> • Provide extra time for the learner to complete classwork or exams. • Provide support for development of a good self-esteem. • Support the learner to learn how to use parts of the body and develop physical skills through sports and play. • Ensure that the classroom space and learning materials are supporting the learning needs of the individual learner. • Refer the child to obtain assistive technology such as walkers and wheelchairs. • Be in constant communication with the parents and share information about the learner's progress or challenges with parents. • Encourage peer support.



Barrier	Signs and symptoms	Ways to support the learner
Acquired brain and spinal injuries		
<p>The learner may experience physical disabilities as a result from permanent injuries to the brain, spinal cord or limbs that prevent proper movement in parts of the body.</p>	<ul style="list-style-type: none"> • Difficulty with concentration, poor memory, confusion, sleep difficulties. • Tiredness, lack of motivation, depression. • Changes in behaviour such as irritability, impulsivity, loss of social skills, lack of awareness, difficulty managing anger, planning and carrying out activities. • Physical effects such as pain, changes in senses, seizures, dizziness, paralysis in part of the body. 	<ul style="list-style-type: none"> • Give the learner more time to complete tasks. • Use simplified language when talking to the learner and explain difficult words, images and gestures are also useful. • Provide lots of opportunities for the learner to practice alone and in groups. • Use a lot of praise and words of encouragement to motivate the learner and to build self-esteem. • Refer the child to obtain assistive technology such as walkers and wheelchairs.
Spina bifida		
<p>Spina bifida results from when the spinal cord (the nerves that run down the spine) did not develop normally during pregnancy.</p>	<ul style="list-style-type: none"> • Muscle weakness of the legs, sometimes involving paralysis. • Bowel and bladder problems • Seizures. • Deformed feet, uneven hips and a curved spine. 	<ul style="list-style-type: none"> • Adapt the learning environment through use of assistive technology. • Seek the support of an occupational therapist, physiotherapist and speech therapist. • Approach a special needs teacher to assist with how to adapt the classroom to address the specific needs of the learner.

Barrier	Signs and symptoms	Ways to support the learner
Cerebral palsy		
<p>Cerebral palsy is caused by damage to the parts of the brain which control movement. In most cases, this damage occurs during pregnancy or during birth and from brain injuries in early infancy (such as lack of oxygen from near drowning, meningitis, head injury or being shaken).</p>	<ul style="list-style-type: none"> • Inability to put the body in a chosen position and keep it there. • Difficulty with movement of body parts or the whole body. • Muscle weakness or tightness. • Involuntary muscle movements (spasms) • Difficulties with balance and coordination. • Difficulties with talking and eating. 	<ul style="list-style-type: none"> • Promote safe practice of motor skills through play and sports. • Provide support for development of a good self-esteem • Seek the support of an occupational therapist, physiotherapist and speech therapist. • Keep regular communication with the parents to share information on the child's progress and challenges at school.
Multiple disabilities		
<p>Some learners with physical disabilities will have other disabilities, such as intellectual, visual or hearing impairments. They may also have communication difficulties or other medical conditions such as epilepsy or asthma.</p>	<ul style="list-style-type: none"> • Exhibit delayed achievement of motor milestones and basic self-care skills that include difficulty with fine motor and gross motor skills including handwriting and ball skills. • Experience difficulty with social skills and academics owing to decreased motor coordination. • Have their speech and language disorders commonly co-occur 	<ul style="list-style-type: none"> • Provide individualised learning support to the learner. • Always praise the learner for trying. • Involve the learner in classroom discussions. • Promote safe practice of motor skills through play and sports. • Provide support for development of a good self-esteem. • Refer the child to obtain assistive technology such as walkers and wheelchairs. • Seek the support of an occupational, therapist, physiotherapist and speech therapist.



activity

Physical Disabilities – 30 minutes

Divide the class into two groups.

Group 1 discusses how to develop a disability friendly school environment for learners with physical disabilities (classrooms, libraries, sport facilities and transportation).

Group 2 discusses how the school should ensure that all children with disabilities are treated equally.

Each group should appoint a rapporteur and chairperson to lead the discussions. Each group should report back to the class and allow for at least 10 minutes to discuss and summarise the main points from each group.

Figure 6.5: Physical disability does not mean that learners cannot excel in sport or other activities



Source: National Disability Council

Unit 4: Sensory Difficulties

Specific Objectives

By the end of this Unit participants should be able to:

1. Have knowledge about the different sensory difficulties
2. Recognize a person with sensory difficulties
3. Respect and support their peers with sensory difficulties

Methodology: PowerPoint Presentation, group discussion, class discussion

Materials: Handouts, Sector Policy on Inclusive Education, guidelines, flipchart paper, markers



Facilitator's Notes

Sensory difficulties

Sensory difficulties contribute to a learner's poor performance at school, especially in class participation, tests and communication with peers and teachers, resulting in reduced academic achievement and often to school failure, especially in the lower grades. As a result of sensory difficulties, the learner often has poor communication skills resulting in poor self-esteem and subsequent social isolation. A learner with sensory difficulties requires support not only from the teacher but also from the peers and the entire school community to ensure that he or she feels that she is part of the school ecosystems and can learn without any discrimination.

Visual impairment

- Visual impairment: is a condition that prevents normal vision in one or both eyes. There are many problems with vision such as being near or short sighted (myopic), long sighted (hypermetropic), having normal vision in one eye only (monocular) or a turned eye (strabismus) also called a squint.
- Low vision: exists when a person's sight cannot be corrected to normal vision by wearing eye glasses or contact lenses but the person has some vision.
- Blindness: means that a person has no vision in one or both eyes. This may be due to damage to the eye, nerves or brain, or because the learner does not have an eye.
- It is important to note that a person with sensory difficulties can participate in any activity such as sports, education, play, shopping and so on, like a person without any sensory difficulty with the support of assistive technology.

Barrier	Signs and symptoms	Ways to support the learner
Visual Impairments		
Sight loss that cannot be fully corrected using glasses or contact lenses.	<ul style="list-style-type: none"> • Eyes that don't move together when following an object or a face. • Crossed eyes, eyes that turn out or in, eyes that flutter from side to side or up and down, or eyes that do not seem to focus. • Eyes that bulge, dance, or bounce in rapid rhythmic movements. • Pupils that are unequal in size or that appear white instead of black. • Repeated shutting or covering of one eye. • Unusual degree of clumsiness, such as frequent bumping into things or knocking things over. 	<ul style="list-style-type: none"> • Refer the learner for an eye test. • Ask the learner to sit in the front desks. • Request support about how to address the needs of the learner. • Communicate with parents regularly to share information about the learner's progress at home and at school. • Refer the child to obtain assistive technology such as braille and computers for the visually impaired. • Request peers to support the learner during class as well as outside activities
Low Vision		
Low vision exists when a person's sight cannot be corrected to normal vision by wearing eye glasses or contact lenses but the person has some vision.	<ul style="list-style-type: none"> • Frequent squinting, blinking, eye-rubbing, or face crunching, especially when there's no bright light present. • Sitting too close to the TV or holding toys and books too close to the face. • Avoiding tasks and activities that require good vision. 	<ul style="list-style-type: none"> • Use large print in class. • Let the learner sit in the front desks. • Allow the learner more time to complete classwork and tests. • If the learner does not wear glasses, refer the learner for tests.
Blindness		
A blind person is unable to see and cannot distinguish darkness from bright light in either eye. Some learners have congenital blindness, which means they were born visually	<ul style="list-style-type: none"> • A blind person may have no visible signs of any abnormalities appearing clumsy. • Difficulty locating needed items. • Discomfort in the eyes. • Lack of interest in activities or socialising. • Discharge from the eyes may be present or absent. 	<ul style="list-style-type: none"> • Refer the learner to be supported with braille or other assistive devices. • There are computers and cell technology in braille work with parents to support the learner to obtain such devices including a walking stick • Teach the learner to learn to look towards the speaker even though they

Hearing Impairment

- Conductive hearing loss - when sound cannot reach the inner ear (cochlea) loud enough. It can be caused by a number of things including impacted wax in the ear canal or fluid in the middle ear. This type of hearing loss is usually temporary and is often treatable medically or surgically.
- Sensorineural hearing loss- occurs when there is damage to the inner ear (cochlea) or auditory nerve going from the cochlea to the brain. This type of hearing loss may affect how loud and clear sounds seem. A sensorineural hearing loss is most likely permanent.
- Mixed hearing loss- is a combination of conductive and sensorineural hearing loss at the same time. It occurs when sound is not being transferred from the outer to the inner ear (cochlea) efficiently and there is also damage to the inner ear.
- Auditory Neuropathy Spectrum Disorder- is a rare condition where sound enters the ear normally, but there is a problem with the sound being transmitted along the auditory nerve from the cochlea to the brain. The cochlea receives the sound, but the brain does not properly recognize the sound.

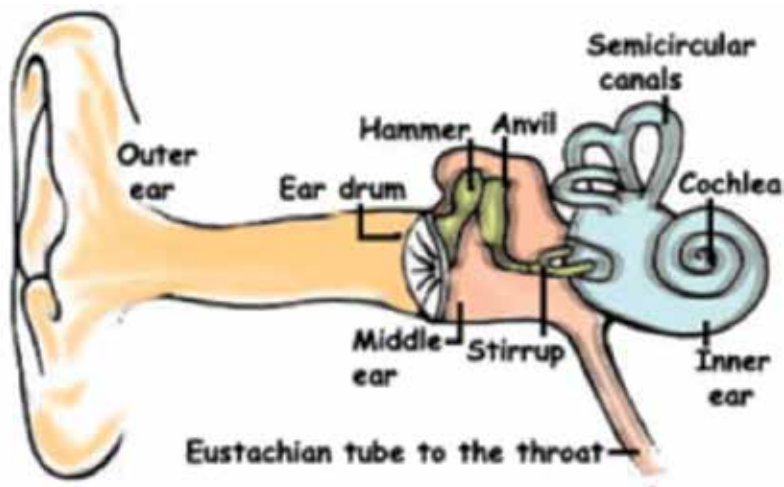
Barrier	Signs and symptoms	Ways to support the learner
Hearing Impairments		
<p>Learners diagnosed with hearing loss are unable to hear sounds in the same way as other learners. Having a hearing loss means that a learner has lost some hearing in one ear (called unilateral) or both ears (called bilateral). Hearing loss is usually described as mild, moderate, severe or profound.</p> <p>The ability to hear and understand the meaning of what a speaker is saying is affected.</p>	<ul style="list-style-type: none"> • Does not answer when called or spoken to at normal volume • Does not respond to or understand verbal instructions, information or explanations • Gives the wrong answer to questions or responds inappropriately • Appears to be inattentive, day-dreaming or confused • Is not aware of sounds or responds inconsistently to sounds • Cannot determine where the sound is coming from • Turns one side of his/her head to the sound • Looks around when spoken to or asks neighbour what was said • Avoids partaking in class discussions • Has difficulty remembering information that is presented only verbally • Is easily distracted • Has a short attention span and tires quickly 	<ul style="list-style-type: none"> • Make sure that your face is visible when speaking • Make eye contact with the learner and maintain a positive facial expression • Make sure that you sit or stand with the light in your face not from behind • Keep the distance between you and the learner between 1 and 2 metres for best listening and lip-reading • Speak slowly and clearly at a normal loudness level. Do not shout! • Use plain and simple language for the learner to follow instructions • When something is not heard or understood, do not repeat the exact words but rephrase • Provide context and repetition: announce what's about to happen and repeat it again • Make sure you have the learner's attention before you start to talk or change the topic • Check every once in a while with a W-question whether the learner understood what you or others are talking about

Barrier	Signs and symptoms	Ways to support the learner
Hearing Impairments		
The ability to hear and understand what the speaker is saying. It involves understanding the meaning of what is being said. Psychosocial and physical factors may be a barrier to listening.	<ul style="list-style-type: none"> • Has poor speech, i.e. replaces certain sounds with incorrect sounds, omits sounds or has poor voice quality • Has difficulties in social relationships, e.g. does not relate to other children, does not communicate, is either withdrawn or aggressive • Exhibits poor music or singing skills, e.g. is unable to reproduce a melody 	<ul style="list-style-type: none"> • Use facial expression, gestures and body language • Provide visual clues, e.g. pictures, key words on the blackboard • Be patient, positive and relaxed and talk to the learner not about him/her • Establish class rules for good listening and turn-taking in oral activities • Make the whole class aware about how to communicate with a hearing impaired class-mate • Seek support for the learner to receive hearing aids • Keep regular communication with the parents

Barrier	Signs and symptoms	Ways to support the learner
Conductive hearing loss		
A person with conductive hearing loss experiences a reduction in sound level, i.e. s/he has a reduced ability to hear soft sounds. This type of hearing loss can often be corrected medically or surgically.	<ul style="list-style-type: none"> • Difficulty to hear other people talking • Visible infection in the ear, a perforation of the ear drum or discharge • Built up wax in the ear canal or a foreign body in the ear canal • Abnormal growth of the middle ear bones (otosclerosis) • A tumor in the outer or middle ear 	<ul style="list-style-type: none"> • Ensure appropriate medical treatment • Try to get the learner's attention. Make sure s/he is aware you are talking to him/her. • Make sure the learner understands what you are talking about. If you are switching to a new topic clarify that as well. • Do not shout. Shouting will make it harder to hear. • Support what you are saying with gestures, such as nodding or shaking your head, pointing or directing

Barrier	Signs and symptoms	Ways to support the learner
Sensorineural hearing loss		
Depending on the degree of a permanent hearing loss (mild, moderate, severe or profound), spoken language can be heard muffled, distorted, fragmented or not at all.	<ul style="list-style-type: none"> • Difficulty to hear other people talking • Visible infection in the ear, a perforation of the ear drum or discharge • Built up wax in the ear canal or a foreign body in the ear canal • Abnormal growth of the middle ear bones (otosclerosis) • A tumor in the outer or middle ear 	<ul style="list-style-type: none"> • Ensure appropriate medical treatment • Try to get the learner's attention. Make sure s/he is aware you are talking to him/her. • Make sure the learner understands what you are talking about. If you are switching to a new topic clarify that as well. • Do not shout. Shouting will make it harder to hear. • Support what you are saying with gestures, such as nodding or shaking your head, pointing or directing

Figure 6.6:



<http://www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=114&np=306&id=1807#type>

Barrier	Signs and symptoms	Ways to support the learner
Mixed hearing loss		
Difficulty or inability to hear people clearly and fully	<ul style="list-style-type: none"> • Frequent requests for repetition or clarification • Avoidance of social situations because of difficulty following conversations in noisy environments • Pretends to have heard and understood • Exhausted at the end of the day from straining to hear 	<ul style="list-style-type: none"> • Ensure appropriate medical treatment • Explore whether the learner can benefit from hearing aids • Let the learner sit in front • Articulate clearly while facing the learner • Encourage class mates to do the same



Barriers to learning– 30 minutes

Divide the class into four groups.

Group 1 discusses how to develop a disability friendly environment for learners with diverse learning needs.

Group 2 discusses how to involve different stakeholders in teaching learners with diverse learning needs.

Group 3 discusses the screening procedures to be followed to detect learning barriers (Refer to Module 1, Unit 3, page 24 - School Health Services Package).

Group 4 brainstorm on contributing factors to learning barriers, e.g. malnutrition, disability, hearing impairment, etc.

Allow 10 minutes for group report back in class.

Facilitator summarises the session

- Summarize the important aspects from the session stressing the fact that learners with different learning needs have the same rights as anyone else to quality education, to be respected and treated with dignity.
- There are many different causes for physical disabilities that include inherited or genetic disorders. Support can be provided to all the learners with disabilities by changing the classroom environment to meet the needs, using extra support such as remedial teachers and peer to peer education and in some cases using devices such as wheelchairs, braille, hearing aids and walking sticks to support the learner.
- Namibia has a progressive policy on inclusive education, which places emphasis on the rights of all children in Namibia to a quality education and all learners should be supported through the implementation of the policy.
- Summarize the importance of the Convention on the Rights of Persons with Disabilities and the Sector Policy on Inclusive Education.
- Inclusive education is a process of addressing and responding to diversity of needs of all learners.
- Inclusive education aims to reduce exclusion within and from education.
- It involves changes and modifications in curriculum content, teaching approaches, structures and strategies.
- All learners of appropriate age range are included in the approach of inclusive education.

Figure 6.7: Braille is a tactile writing system used by blind people which can greatly facilitate their ability to read



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Module 7: Violence Against Children

Overall Objectives

By the end of this module participants will have basic understanding on violence against children including risks and protective factors, existing laws and roles of different stakeholders in service provision.

By the end of this module participants should:

- Have basic understanding of the nature of child abuse and the types of abuse against children
- Have increased knowledge on the risks and protective factors in relation to child abuse
- Have basic understanding of the dynamics of child sexual abuse
- Know where to refer children for professional help when abuse is suspected or reported

Module summary table

Unit	Content	Time	Activity	Materials
1	What is Violence Against Children Types of Abuse	3 hours	Brain storming and group work discussions, completion of a worksheet	PowerPoint, Worksheet
2	Risks and protective factors	1 hour	Discussions	PowerPoint
3	Child Sexual Abuse	1 hour	Discussions	PowerPoint
4	Legislative Framework	1 hour	Presentation, and role play	PowerPoint presentation, videos and posters
5	Roles of stakeholders	45 minutes	Discussions	PowerPoint
6	Child Online Protection	45 minutes	Presentation	PowerPoint

Glossary:

Adverse Childhood Experience (ACE): An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

Child Abuse: All forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment, and commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

Child Neglect: It is the failure to provide for a child's physical, medical, emotional, material and safety needs. It also includes failure to provide physical and intellectual stimulation and adequate supervision and guidance.

Child Protection: Refers to preventing and responding to violence, exploitation and abuse against children in order to protect children from both intentional and unintentional harm.

Cyberbullying: Involves acts of bullying and harassment through the use of electronic devices or technology

Grooming: When someone builds an emotional connection with a child to gain their trust for the purpose of sexual abuse or exploitation.

Online child abuse: Any type of abuse that happens on the web, whether through social media, playing online games or using mobile phones

Rape: Unlawful sexual intercourse or any other sexual penetration of the vagina, anus, or mouth of another person, with or without force, by a sex organ, other body part, or foreign object, without the consent of the victim.

Sexting: When young people are persuaded or forced to send or post sexually explicit images of themselves, take part in sexual activities via smartphone, have sexual conversations by text.

Violence against Children: All forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or commercial or other exploitation, including sexual abuse against children.

Unit 1: Violence against children and types of abuse

Specific Objectives:

By the end of the unit, participants will:

- be able to detect, address and refer cases of violence against children in all settings
- have knowledge on the impact of adverse childhood experience (ACE)

Methodology: PowerPoint presentation, information sharing, individual and group exercise

Materials: PowerPoint, hand-outs



Facilitator's Notes

1.1 Terms

What is Violence against Children?

Violence against Children	All forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or commercial or other exploitation, including sexual abuse against children.
Adverse Childhood Experience (ACE)	An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.
Child Abuse	<p>Child abuse or maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment, and commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.</p> <p>Child abuse can therefore be defined as:</p> <p>Any act or failure to act on the part of a parent or caregiver, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.</p>
Child Neglect	It is the failure to provide for a child's physical, medical, emotional, material and safety needs. It also includes failure to provide physical and intellectual stimulation and adequate supervision and guidance.
Child Protection	Refers to preventing and responding to violence, exploitation and abuse against children in order to protect children from both intentional and unintentional harm.
Rape	Unlawful sexual intercourse or any other sexual penetration of the vagina, anus, or mouth of another person, with or without force, by a sex organ, other body part, or foreign object, without the consent of the victim.

WHO & MGECW/UNICEF Child Protection Manual

1.2 Settings in which violence against children occurs

The UN Secretary General study on Violence Against Children has identified five settings in which violence against children may occur.

- Family and Home
- Schools and Educational Settings
- Care and Justice Systems
- Work Settings
- Community

1.2.1 Family and Home

From early infancy until 18 years of age, children are vulnerable to various forms of violence within their homes. Perpetrators vary according to the age and maturity of the victim and may include parents, stepparents, foster parents, siblings, other family members and carers.

Violence against very young children may cause permanent damage and even death. Harsh treatment and punishment of children is common in both urban and rural settings – often in the context of discipline and takes the form of physical, cruel or humiliating punishment.

Physical violence is often accompanied by psychological violence. Insults, name-calling, isolation, rejection, threats, emotional indifference and belittling are all forms of violence that can be detrimental to a child's psychological development and well-being - especially when it comes from a respected adult such as a parent. It is of critical importance that parents be encouraged to employ exclusively non-violent methods of discipline.

Neglect, including a failure to meet children's physical and emotional needs, protect them from danger, or obtain medical or other services when needed contributes to mortality and morbidity in young children. Disability also increases the risk of neglect. Disabled children may be abandoned, a practice which may sometimes be accepted and encouraged.

The occurrence of sexual violence in the home is increasingly acknowledged and documented.

Harmful traditional practices affect children disproportionately and are generally imposed on them at an early age by their parents or community leaders.

Situation in Namibia

Violence against children, especially sexual violence, is widespread and public tolerance is high. According to the Ministry of Gender Equality and Child Welfare, recent data on perceptions of violence and corporal punishment “point to a disturbing and endemic crisis in Namibian social and cultural conditions”

Below is a brief summary of statistics on violence against children in the home settings in Namibia:

Sexual Violence: In a 2006 study by the Legal Assistance Centre, one out of four responded in the 10-14 year old sample of rape cases had experienced sexual abuse from a parent or caregiver .

Domestic Violence: 78% of parents believe that hitting a child if he or she is disobedient is justified. And again close to 200 children are annually removed from their homes for their own protection according to Children’s Court statistics. (LAC 2012)

Alcoholism: Almost one-third of the 10-14 year olds surveyed in three regions had been given alcohol by a parent or guardian. (Namibia Demographic and Health Survey 2006-07)

Abandonment of Babies: In April 2008 staff at Gammams Water Care Works in Windhoek estimated that they discover an average of 13 babies of newborn babies each month amongst human waste flushed down toilets.

Fragmented Families: Only one quarter of all children in Namibia live with both parents. Just over a third does not live with either parent and 24% do not live with either parent despite both parents being alive. Namibia Demographic and Health Survey 2006-07

1.2.2 Violence in schools and educational settings

In most instances, children spend more time in the care of adults in educational settings than anywhere else outside of their homes. Schools have an important role in protecting children from violence. Adults who oversee and work in educational settings have a duty to provide safe environments that support and promote children’s dignity and development.

For many children educational settings expose them to violence and may teach them violence.

Violence perpetrated by teachers and other school staff, with or without the overt or tacit approval of education ministries and other authorities that oversee schools, includes corporal punishment, cruel and humiliating forms of psychological punishment, sexual and gender-based violence, and bullying. Corporal punishment such as beating and caning is standard practice in some schools, although this has been abolished at independence.

Violence in schools in the form of playground fighting and bullying of students also occurs. In some societies, aggressive behavior, including fighting, is widely perceived as a minor disciplinary problem. Bullying is frequently associated with discrimination against

students from poor families or ethnically marginalized groups, or those with particular personal characteristics (e.g. appearance, or a physical or mental disability). Bullying is most commonly verbal, but physical violence also occurs.

Schools are also increasingly affected by events in the wider community, eg. gang culture and gang-related criminal activity, particularly related to drugs.

Sexual and gender-based violence directed against girls, by male teachers and classmates is an ongoing problem, often involving the 'trade' of good grades for sexual favours, and contributing to the incidence of teenage pregnancies.

Violence is also increasingly directed against lesbian, gay, bisexual and transgendered young people.

1.2.3 Violence in the community

The community is a source of protection and solidarity for children, but it can also be a site of violence, including peer violence, violence related to guns and other weapons, gang violence, police violence, physical and sexual violence, abductions and trafficking. Violence may also be associated with mass media, and new information and communications technology. Older children are at greater risk of violence in the community, and girls are at increased risk of sexual and gender based violence

Situation in Namibia

UNICEF reports that data on violence against children in schools is limited and the fact that incidences of violence are generally unreported presents challenges for intervention. However below are some findings from various studies and reviews compiled for UNICEF in 2014:

- Almost 73% of the 380 youth surveyed in the Center for Justice and Crime Prevention study in four northern regions (2011) , reported that they had suffered corporal punishment at school, with little difference between boys and girls;
- Almost 38% of learners reported missing at least one day of school in the 30 days prior to the 2004 Namibia School-based Student Health Survey because of feeling unsafe at school, or on the way to or from school;
- Bullying was a universal theme throughout the studies with about half of the learners surveyed in the SBSHS (2004) reporting that they were bullied on at least one or two days during the past 30 days.
- The CJCP survey found that 46% of participating learners had experienced sexual assaults at school, 32% had been sexually assaulted two to five times, and almost one out of five (23%) had been sexually assaulted more than 10 times while at school;
- Data from the Ministry of Education shows that between 2005 and 2011, an average of 31 cases of sexual misconduct were reported each year resulting in an average of only 9 dismissals per year. It is reported that some teachers evade due process by either offering settlements to the victim's parents in lieu of a formal complaint or resigning and gaining teaching work elsewhere.

For some children, the journey to and from school may be their first independent exposure to the community; it may also be their first exposure to its risks. Others are exposed to violence when carrying out domestic tasks, such as when fetching water, fuel, food or fodder for animals. These tasks, which may involve walking considerable distances, are usually assigned to girls in rural areas.

Situation in Namibia

Information on violence against children in Namibian communities is limited and primarily based on police dockets and issue specific studies. It is also under-reported due to fears of retribution, to familiarity of perpetrators who may be family members or elders, and to the belief that nothing will be done to protect them. In some cases, the violent behavior is perceived as being normal, such as in boyfriend-girlfriend relationships. Below is a brief overview of the extent of violence against children in Namibian communities:

- Fighting, weapons and gangs: Gangs or groups of children on the street, some wielding weapons, appear to be common.
- More than one-third of the learners said that they had carried a weapon such as a gun, knife, club or panga on at least one day during the 30 days prior to the survey, with males more likely than females
- About one out of five learners, primarily male, said that they currently belonged to a gang.
- A direct link was found between physical fighting and substance use suggesting that adolescents who are likely to engage in physical fights are also likely to be engaged in other risky behaviours.

Children being used to commit crimes: It has been estimated that between 10% and 30% of children in conflict with the law are tempted or forced into criminal activity by adults. Once in the formal justice system these children are especially vulnerable to violence.

Gender-based and sexual violence: Young Namibians face a significant risk of sexual violence and a considerable amount of sexual abuse occurs in intimate relationships ranging from physical abuse such as slapping and hitting to sexual abuse, including rape:

- One-fifth of the learners reported having been physically forced to have sexual intercourse, with no differences between males and females,
- One out of every four 10-14 year olds reported having experienced one or more forms of sexual abuse,
- Adolescent girls can be particularly vulnerable to intimate partner violence when they engage in a relationship with a much older man as a route to economic benefits. The 2007 HIV and AIDS Study found that intergenerational sex is a widespread phenomenon.

1.2.4 Child Abuse and Culture

Some traditional practices can be abusive to children. Children cite the following as examples of harmful cultural practices in Namibia:

- forced child engagement,
- child marriage,
- sexual initiation, and
- cutting on the cheeks or back with blade

Namibia has a high number of teenage pregnancies which can be attributed to a number of factors including cultural traditions, unprotected sex, rape and the sexual exploitation of children due to poverty or unemployment. According to the Namibia Demographic and Health Survey 2006/7, almost one-fifth of women age 25-49 have given birth before reaching age 18, while 57 per cent have had a birth by age 20. The Ministry of Education EMIS 2011 data reports that 24.6% of the overall female drop-out rate was due to pregnancy.

- Any approach to child abuse must take into account the differing standards and expectations for parenting in the range of cultures within society.
- Different cultures have different rules about what are acceptable parenting practices.
- Research indicates that there appears to be general agreement across many cultures that child abuse should not be allowed and virtual unanimity where very harsh disciplinary practices and sexual abuse are concerned.

1.3 Perpetrators of Violence against Children

Perpetrators may include:

- Parents and other family members
- Caregivers
- Friends
- Acquaintances
- Strangers
- Others in authority – such as teachers, soldiers, police officers, and clergy
- Health care workers
- Other children



activity

Perpetrators of Violence against Children - 15minutes

Ask participants to list the potential perpetrators of violence against children. This can be done in a brainstorming session or in pairs. If in pairs ask different pairs to feedback at least one perpetrator they listed.

1.5 Challenges in Addressing Child abuse

- Violence against children by adults within the family is one of the least visible forms of child abuse
- It is nonetheless widely prevalent in all societies.
- Child abuse by parents and caregivers gives rise to difficulties when designing strategies for prevention and response services, since the perpetrators of the abuse are also the source of nurture for the child.



activity

Addressing child Abuse - 30 minutes

Divide participants in groups and ask them how the following would influence; prevention, identification and response to violence against children:

- The age of the child
- The setting in which the abuse occurs
- The relationship between victim and perpetrators

1.6 Adverse Childhood Experiences (ACE)

This concept is broader than child abuse and includes the following 10 types of experiences, grouped into three categories:

<p>Abuse</p> <p>Emotional: Did a parent or other adult in the household: 1) Often or very often swear at you, insult you or put you down? 2) Sometimes, often, or very often act in a way that made you afraid that you might be physically hurt?</p> <p>Physical: Did a parent or other adult in the household... 1) Sometimes, often or very often push, grab, slap, or throw something at you? 2) Ever hit you so hard that you had marks or were injured?</p> <p>Sexual: Did an adult or person at least 5 years older than you ever... 1) Touch or fondle you in a sexual way? 2) Have you touch their body in a sexual way? 3) Attempt oral, anal, or vaginal intercourse with you? 4) Actually have oral, anal, or vaginal intercourse with you?</p>	<p>Household Dysfunction</p> <p>Battered Mother: Was your mother (or step-mother)... 1) Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her? 2) Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? 3) Ever repeatedly hit over at least a few minutes? 4) Ever threatened with or hurt by a knife or gun?</p> <p>Parental Discord/ Discourse: 1) Were your parents ever separated or divorced?</p> <p>Mental Illness in Household: 1) Did you live with anyone who was a problem drinker or alcoholic? or 2) Did you live with anyone who used street drugs?</p> <p>Incarcerated Household Member: 1) Did a household member go to prison?</p>
<p>Neglect</p> <p>Emotional: 1) There was someone in my family who helped me feel important or special. 2) I felt loved. 3) People in my family looked out for each other. 4) People in my family felt close to each other. 5) My family was a source of strenght and support.</p> <p>Physical: 1) I didn't have enough to eat. 2) I knew there was someone there to take care of me and protect me. 3) My parents were too drunk or too high to take care of me. 4) I had to wear dirty clothes. 5) There was someone to take me to the doctor if I needed it.</p>	

Source: WHO Violence and Injury Prevention Short Course

1.7 Classification/identification of Violence

Physical Violence (1 – 20)

- 01 Hurt or caused pain to a person
- 02 Slap a person with a hand on his/her face or head as punishment
- 03 Slapped a person with a hand on his/her arm or hand
- 04 Twist someone's ear as punishment
- 05 Pulled someone's hair as punishment
- 06 Hit a person by throwing an object at him/her
- 07 Hit a person with a closed fist
- 08 Kick a person
- 09 Crushed someone's fingers or hands as punishment
- 10 Washed someone's mouth with something like soap or put something like pepper in his/her mouth
- 11 Made someone stand/kneel in a way that hurts to punish him/her
- 12 Made someone stay outside in the cold or heat to punish him/her
- 13 Burnt a person as punishment
- 14 Put someone into hot or cold water as punishment
- 15 Take someone's food away from him/her as punishment
- 16 Forced someone to do something that was dangerous
- 17 Choked a person
- 18 Tied someone up with a rope or belt
- 19 Tried to cut someone purposefully with a sharp object
- 20 Forced children to work for pay, profit or family gain

Emotional Violence (21 – 32)

- 21 Swear at a person
- 22 Deliberately insulted a person
- 23 Shout at someone to embarrass or humiliate him/her
- 24 Call someone rude or hurtful names
- 25 Purposely made someone feel stupid or foolish
- 26 Refer to someone's skin colour, gender, religion or culture in a hurtful way
- 27 Refer to any health problems someone might have in a hurtful way
- 28 Stop someone from being with other children to make him/her feel bad or lonely
- 29 Tried to embarrass someone because he/she is an orphan or without a parent
- 30 Embarrass someone because he/she is poor or unable to buy things
- 31 Stole or broke or ruin someone's belongings
- 32 Threaten someone with low school marks that he/she didn't deserve

Sexual Violence (33 – 43)

- 33 Touched someone's body in a sexual way or in a way that made him/her uncomfortable
- 34 Showed someone pictures, magazines, or movies of people or children doing sexual things
- 35 Made someone's take his/her clothes off when it was not for a medical reason
- 36 Opened or took their own clothes off in front of someone when they should not have done so
- 37 Make someone have sex with him/her forcefully

- 38 Make someone touch his/her private parts when the person didn't want to
- 39 Touch someone's private parts or breasts when the person didn't want them to
- 40 Give person money/things to do sexual things
- 41 Involve a person in making sexual pictures or videos
- 42 Kiss a person when he/she didn't want to be kissed
- 43 Threatened a person with low school marks that he/she didn't deserve if he/she refuse to have sex with the person

Psychological (44 - 52)

- 44 Threaten to harm someone, their children or their family if he/she leave the person
- 45 Threaten to harm themselves
- 46 Makes threats of violence
- 47 Threaten someone of abandonment
- 48 Threaten to destroy someone's personal property
- 49 Isolate someone from his/her family and friends
- 50 Confine someone to the home
- 51 Practice verbal aggression
- 52 Practice constant humiliation

Violence due to one's religion (53 – 56)

- 53 Tries to prevent a person from practicing his/her religious or spiritual beliefs
- 54 Making fun of someone's religious or spiritual beliefs
- 55 Force a person to raise his/her children in another religion or spiritual choice
- 56 Using someone's religious or spiritual beliefs to manipulate, dominate or control him/her

Violence due to culture (57 – 63)

- 57 Allows forced or early marriage
- 58 Practice rape in marriage
- 59 Practice Sexual slavery
- 60 Honour crimes
- 61 Initiate Sex
- 62 Practice arranged marriage
- 63 Practice wife inheritance

Verbal Abuse (64 – 71)

- 64 Constantly criticise a person
- 65 Curse a person
- 66 Practice name calling
- 67 Repeatedly insults someone
- 68 Recalling someone's past mistakes
- 69 Expressing negative expectations
- 70 Expressing distrust in a person
- 71 Threats of violence against a person, his/her children or other family members

Economic Abuse (72 – 80)

- 72 Destroy someone's personal property
- 73 Not allowing children to attend school
- 74 Forcing someone to work outside the home
- 75 Refusing to let someone work outside the home
- 76 Controlling someone's choice of occupation
- 77 Giving someone an allowance and requiring justification for all money spent
- 78 Take money needed for the care of the family
- 79 Refuse to contribute financially to family
- 80 Deny someone access to basic needs such as food and health care

Neglect (81 – 83)

- 81 Do not pay your bills
- 82 Do not provide needed medication, food, shelter or clean clothing
- 83 Leave children alone without supervision

1.8 Signs of abuse

The following signs can be an indication of abuse:

- Bruises, pressure marks, broken bones, abrasions (scratches) and burns may be an indication of physical abuse, neglect, or mistreatment.
- Unexplained withdrawal from normal activities, a sudden change in alertness, and unusual depression may be indicators of emotional abuse.
- Bruises around the breasts or genital area can occur from sexual abuse.
- Sudden changes in financial situations may be the result of economical abuse/exploitation.
- Bedsores, unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect.
- Behaviour such as insulting, yelling, foul language, threats and other uses of power and control by spouses are indicators of verbal or emotional abuse.
- Tense relationships, frequent arguments between the family members can also be signs of emotional/psychological violence which may result in physical violence.
- The person may feel depressed, withdrawn, anxious (fearful) or afraid to make his/her own decision.
- They may tell someone that they trust they are being abused, sleep too much or have the inability to sleep, hide something from a caregiver, avoid going to see a doctor or may run away from their residence.
- Most importantly, be alert. The suffering is often in silence. If you notice changes in a family member's personality or behaviour, you should start to question what is going on.



activity

Family violence – 1 hour

Divide into four groups.

Group 1 performs a scenario where a child comes to a social worker and complains about physical abuse. Indicate how to solve the problem.

Group 2 performs a scenario where a woman goes to the police and lays a complaint that her husband beats her. Give solutions.

Group 3 develops a poster to make the community aware of the consequences of gender based violence.

Group 4 performs a scenario where a child complains to her mother that her father is sexually abusing her and her mother does not believe her.

Give solutions and feedback to plenary.

1.9 Bullying

Violence in the school community takes many forms: physical and emotional violence, corporal punishment, abuse of power, sexual violence, intimidation and bullying.

Of these, bullying is the least understood and acted on effectively.

Definition

Bullying is a form of violence where there is an imbalance of social or physical power and occurs in all schools. It is an aggressive behaviour that intentionally inflicts injury or discomfort through physical contact, verbal attacks, fighting or psychological manipulation.

A bully can operate alone or within a group of peers and take one or all of the following forms:

Direct Bullying: e.g demanding someone's money or possessions

Indirect Bullying: e.g spreading harmful rumours about a learner

Cyber Bullying: harassment through e-mail, text messages and defamatory remarks on social media eg. Facebook

Characteristics of a Bully

Both boys and girls can be bullies.

Bullies like to dominate others and are generally focused on themselves. They often have poor social skills and poor social judgment. Sometimes they have no feelings of empathy or caring toward other people.

Some bullies believe they can make themselves feel more interesting or powerful by putting others down. In some cases, the behaviour of a bully is a reaction to their own hurt – he/ she may have been bullied by someone in their own family, a parent, older sibling or other adult.

Consequences

- Interpersonal difficulties
- Poor performance at school
- Low retention rates, high repetition rates, high drop out rates
- Poor school attendance
- Depression, loneliness
- Anxiety
- Poor self-esteem
- Suicide risk

Warning Signs

- Unexplained injuries
- Lost or destroyed books, clothing, possessions (phone etc.)
- Frequent headaches or stomach aches, feeling sick or faking illness
- Changes in eating habits (coming home hungry from school)
- Difficulty sleeping/nightmares
- Declining grades, loss of interest in school work, not wanting to go to school, absenteeism
- Sudden loss of friends & avoiding social situations
- Feelings of helplessness or decreased self-esteem
- Self destructive behaviours: running away from home, harming self, talking about suicide

Prevention and Intervention

Create safe environment and mechanisms for learners to report bullying

Report bullying to Life Skills teacher, teacher counsellor, school principal

Zero tolerance: enforce code of conduct

Holistic approach involving staff, parents, community and learners

School policy on bullying and violence

School Plan of Action

Using constructive discipline – alternatives to corporal punishment



activity

Bullying – 30 minutes

Two participants role-play a bullying situation and the group provides suggestions on how to handle the situation.

Discuss constructive ways to address bullying behaviour at schools and list on flipchart. Report back to plenary.



Key Notes

Facilitator Summarises the session

Use the points below to summarise and conclude the discussions.

- All cases listed are abuse cases. Emphasis this as some acts of violence may be regarded only as a form of discipline.
- Violence against women and children is usually marked by high levels of tolerance. All acts of violence against children are a violation of their basic human rights and should not be tolerated
- No violence against children is justifiable; all violence against children is preventable.
- There can be no compromise in challenging violence against children. Children's uniqueness — their potential and vulnerability, their dependence on adults — makes it imperative that they have more, not less, protection from violence.
- Note which of the acts participants are more willing to take action on. These may include sexual violence, severe acts of physical abuse. Stress the need for early intervention as many of the most gruesome acts of violence are indicative of a long, continued tradition of violence in families.
- Every society, no matter its cultural, economic or social background, can and must stop violence against children. This does not mean sanctioning perpetrators only, but requires transformation of the mindset of societies and the underlying economic and social conditions associated with violence

After discussions and your conclusion give the classification and identification of violence as a handout.

Unit 2: Risk and Protective Factors

Specific Objective

The core learning objective of this Unit is to provide a basic understanding of risk and protective factors for child abuse organized according to the ecological model.

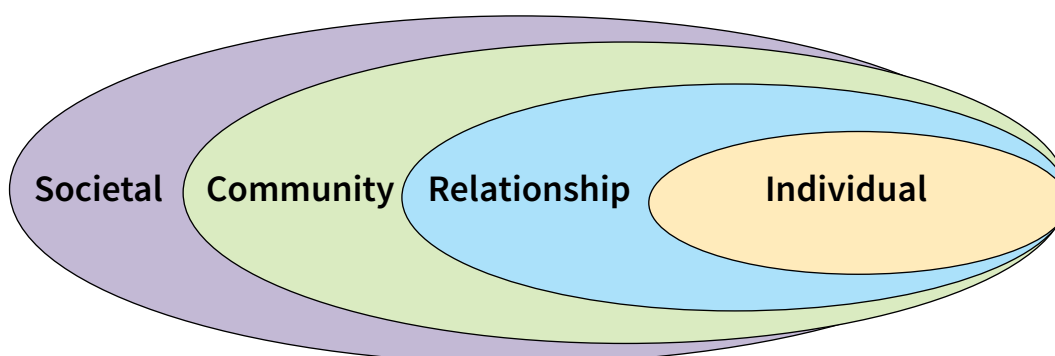
Methodology PowerPoint presentation, information sharing, small group work

Materials PowerPoint slides, Hand-outs of the Ecological Model



Facilitator's Notes

2.1 The Ecological Model



Source: WHO Violence and Injury Prevention Short Course

1. Individual

The first level of the ecological model seeks to identify the biological and personal history factors that an individual brings to his or her behaviour. In addition to biological and demographic factors, factors such as impulsivity, low educational attainment, substance abuse, and prior history of aggression and abuse are considered.

2. Relationship

The second level of the ecological model explores how proximal social relationships – for example, relations with peers, intimate partners and family members – increase the risk for violent victimization and perpetration of violence.

3. Community

The third level of the ecological model examines the community contexts in which social relationships are embedded – such as schools, workplaces and neighbourhoods – and seeks to identify the characteristics of these settings that are associated with being victims or perpetrators of violence.

4. Societal

The fourth and final level of the ecological model examines the larger societal factors that influence rates of violence.



2.2 Risk Factors, Protective Factors, and Causes

Risks Factors at the Individual Level

Increased risk of child abuse is associated with the presence of certain factors in the parent or other family members, including:

- Difficulty bonding with a newborn child
- A history of victimization as a child
- Inadequate knowledge of child development
- Poor parenting skills
- Inappropriate and excessive reaction to perceived misbehavior by the child
- Approval and use of corporal punishment to discipline children
- Physical and mental health problems
- Excessive use of alcohol and or other substance abuse
- Lack of self-control or inability to manage anger
- Social Isolation
- Involvement in criminal activity
- Depression, low self-esteem, or feeling of inadequacy
- Financial difficulties
- Whether abusers are more likely to be male or female, depends, in part, on the type of abuse.
- Women report using more physical discipline than men.
- Men are the most common perpetrators of life-threatening head injuries, abusive fractures and other fatal injuries.
- Sexual abusers of children are predominantly men in many instances.

Individual Level Risk Factors: Child Abuse

Risk factors related to the child do not mean that the child is responsible for the abuse he or she suffers, but rather that the child may be more difficult to parent because he or she:

- Was an unwanted baby or failed to fulfill the parent's expectations or wishes
- Is an infant with high needs
- Cries persistently and cannot be easily soothed or comforted
- Has physical features, such as facial abnormalities
- Shows symptoms of mental ill-health
- Demonstrates personality or temperament traits that are perceived by the parent as problematic
- Is one child out of a multiple birth which has taxed the parent's ability to support the child
- Has a sibling or siblings who are demanding of parental attention
- Is a child that either exhibits or is exposed to dangerous behaviour problems

Risk Factors Associated with Relation

Risk factors for child abuse linked to relationships with family, friends, intimate partners, and peers include:

- Lack of parent–child attachment and failure to bond
- Physical, developmental or mental health problems of a family member
- Family breakdown
- Violence in the family
- Gender roles and roles in intimate relationships that are disrespectful
- Being isolated in the community
- Lack of a support network to assist with stressful or difficult situations in a relationship
- Breakdown of support in child rearing from the extended family
- Discrimination against the family
- Involvement in criminal or violent activities in the community

Community Level Risk Factors for Child Abuse

- General tolerance of violence
- Gender and social inequality
- Inadequate housing
- Lack of support services for families
- High levels of unemployment
- Inadequate policies and programmes
- Poverty
- Easy availability of alcohol
- Presence of a local drug trade
- Social capital
- Migrant population
-

Societal Level Risk Factors for Child Abuse

- Social, economic, health, and education policies that lead to poor living standards or to socioeconomic inequality or instability
- Social and cultural norms that promote or glorify violence towards others
- Social and cultural norms that demand rigid gender roles for males and females
- Social and cultural norms that diminish the status of the child in parent-child relationships
- The existence of child pornography, child prostitution, and child labour
- Lack of a strong legal framework on the issue of child maltreatment

Protective Factors

In the same way that there are factors that increase the susceptibility of children and families to child abuse, there are also factors that may offer a protective effect.

Factors that appear to facilitate resilience include:

- Secure attachment of the infant to the adult family member
- High levels of paternal care during childhood
- Absence of associating with delinquent or substance-abusing peers
- A warm and supportive relationship with a non-offending parent
- A lack of abuse-related stress

Based on the current understanding of early child development, the risk factors for child abuse and evidence of the effectiveness of certain prevention strategies, it is clear that stable family units can be a powerful source of protection for children.



activity

Risk and Protective Factors - 40 minutes

Using the different level of the Ecological Model, divide participants in 4 groups. Assign each group one level of the Ecological Model and ask them to list possible risk factors under each level. The levels are:

- Individual risk factors
- Relationship
- Community
- Society

Unit 3: Child Sexual Exploitation

Specific Objective

By the end of the Unit, participants will be able to:

- Explain the different types of child abuse indicators
- Explain the different terminologies and concepts used in child exploitation
- Explain and demonstrate steps involved in responding to child abuse

Methodology PowerPoint presentation, information sharing, small group work

Materials PowerPoint slides



Facilitator's Notes

3.1 Child sexual abuse

Terminologies and concepts

Terms	Definition
Child Sexual Abuse	The inducement or coercion of a child to engage in any unlawful sexual activity; it can occur when one or more person involve the child in any activity for the purpose of their own sexual arousal including intercourse, touching, exposure of sexual organs, showing pornographic material, or talking in an erotic way. It can be violent or non-violent.
Child Prostitution	The exploitative use of children in prostitution or other unlawful sexual practices
Child Pornography	Exploitative use of children in pornographic performance and material
Commercial Sexual Exploitation of children	Sexual abuse by the adult and remuneration in cash or in kind to the child or a third person(s). The child is treated as a sexual object and as a commercial object
Ritual Abuse	Is abuse that occurs in the context of a belief system that among other, involves sex with children.

Source: MGECW/UNICEF Resource Training Manual on Child Protection

Child sexual abuse can include touching and non-touching offences:

Touching Offences	Non-Touching Offences
<ul style="list-style-type: none"> Fondling a child's genitals or asking the child to touch someone else's genitals Fondling in a way that makes the child feels uncomfortable Play sexual 'pants down' games Coercing the child to be sexual with animals Genital, oral and anal intercourse 	<ul style="list-style-type: none"> Showing pornographic materials to a child Exposing oneself naked Photographing a child in sexual poses Encouraging a child to watch or hear sexual acts; exposing the child to adult sexuality, performing sexual acts in front of the child, exposing genitals, telling dirty stories Verbal or emotional abuse of a sexual nature, e.g. making fun of a child's body parts, calling child 'slut' Sexually related correspondence, e.g. phone calls, internet, sms. Violations of privacy, e.g. forcing a child to undress, spying on a child in the bathroom or bedroom Exploitation, e.g. selling a child's services as a prostitute or a performer in pornography Child pornography and internet Sex tourism

Source: MGECW/UNICEF Resource Training Manual on Child Protection

Children and adolescents may be particularly vulnerable to sexual exploitation given their dependency on others and their limited ability to protect themselves. Below is a list of indicators that can help you as a health care worker or teacher to identify that there is potential sexual abuse of a child. The list is not exhaustive and confirmation of actual abuse should be empathetically sought through counselling with the child.

Types of Child sexual abuse indicators	Signs
Medical	<p>Pregnancy, venereal disease in a child, STI,</p> <p>Genital findings: semen in the vagina of a child, torn or missing hymen, other vaginal injuries or scarring, vaginal opening greater than 5 mm, injury to the penis or scrotum,</p> <p>Anal Findings: Perianal bruising or abrasion, shortening or eversion of the anal canal, fissures to the anal opening, wasting of gluteal fat, funnelling,</p> <p>Oral findings: injury to the palate, pharyngeal gonorrhoea</p>

Types of Child sexual abuse indicators	Signs
Sexual/psychological	<p>These differ depending on a child's age:</p> <p>Younger children: Statements indicating advanced sexual knowledge e.g. you know snot comes out of Uncle Joe's ding dong Sexually explicit drawings Sexual aggress toward younger or more naïve children Sexual activity with peers Sexual invitations or gestures to older persons Sexual interaction with animals or toys</p> <p>For all children: If a child reports that they are being sexually abused, there is a high probability that abuse is taking place</p>
Non Sexual behavioural indicators in young children	Sleep disturbances; bedwetting; voluntary and involuntary passage of stool in child over the age of 4, causing the soiling of clothes; self-destructive or risk taking behaviour; impulsivity, distractibility, difficulty in concentrating; refusal to be left alone; fear for the alleged offender; fear of people of a specific gender; fire-setting (more in boy's victims); cruelty to animals; role reversal in the family
Non-sexual behavioural indicators in older children	Eating disturbances (bulimia and anorexia); running away; substance abuse; suicidal gestures, attempts; self-harm; criminal activity; depression; withdrawal
Non sexual behavioural indicators in all children	Problems relating to peers; school difficulties and sudden noticeable change in behaviour

Source: MGECW/UNICEF Resource Training Manual on Child Protection

3.2 Responding to child sexual abuse

All interventions are to be based on:

- The right to life, survival and development
- Non-discrimination
- The best interests of a child
- Participation

Responding to disclosure by a child of sexual abuse

During disclosure

- Accept what the child says without judgment or over-reaction
- Keep calm
- Don't panic
- Don't seek help while a child is talking to you
- Be honest
- Look at the child directly
- Do not appear shocked
- Let them know that you need to tell someone else
- Assure them that they are not to be blamed for the abuse
- Never ask leading questions
- Try not to repeat the same question to the child
- Never push for information
- Never fill in words, finish their sentence, or make assumptions

Immediately after disclosure

- Be aware that a child may have been threatened
- Take proper steps to ensure the physical safety and psychological well-being of the child. This may include referring them for medical treatment or therapy
- Do not permit personal doubt to prevent you from reporting the allegation to the police or a social worker
- Let the child know what you are going to do next and that you will let them know what will happen next
- Reassure the child that it was right to tell
- Immediately seek help, in the first place from the police
- Write down exactly what the child has told you.
- Sign and date your notes
- Keep all notes in a safe place
- Seek help for yourself if you feel you need support

Guiding steps to follow in reporting child abuse:

- **Report:** a report must be made as soon as possible. Both oral and written reports are to be made to the police and social workers
- **Maintain confidentiality:** Be careful not to release the name or any other identifying information about the child. Do not discuss the case nor make reference to the child with teachers, friends, learners, other health workers or family, etc.
- **Knowledge:** Equip yourself with the facts, the dynamics involved, the different role players and the possible court case that could require your testimony
- **Preparations:** Stay calm. Remember that your responsibility is to make sure that the case is reported and not to investigate
- **Consultation:** Consult with other stakeholders in order to act in the best interests of the child
- **Personal Counselling:** Do not be afraid to seek personal counselling for yourself if you become distressed as a result of being involved with the child who has been abused

Unit 4: Legislative Framework

Specific Objective

By the end of the unit, participants will be able to:

- Understand the different laws, policies and guidelines that protect children against abuse;
- Demonstrate how to apply protective policies and laws;

Methodology PowerPoint presentation, role plays, information sharing, individual and group exercise

Materials PowerPoint slides, videos and posters



Facilitator's Notes

The aim of this Unit is not to provide a detailed presentation of the current legislative framework and its key provisions but to give participants an overview of key legislations in place for the protection of children's rights especially against abuse, violence and exploitation.

Facilitators are urged to get additional resources from the website of the Legal Assistance Centre. These detailed simplified versions of the legislations can be used to enhance presentation, and as handouts.

4.1 Legislative Framework

Brief overview of the legislative framework for the protection of women and girls

As the supreme legal instrument, the Constitution provides a comprehensive set of fundamental rights and freedoms for all Namibia's citizens. It protects life, human dignity and personal liberty; prohibits torture and cruel, inhuman or degrading treatment or punishment; guarantees equality before the law; and not only prohibits sex discrimination, but recognises the need for affirmative action to overcome the particular discrimination women were subject to during the colonial-apartheid era. In addition, the Government has enacted a number of laws to amplify and clarify what constitutes prohibited, often criminal, behaviour and to promote individual rights.

Since independence the Government has established a new legal framework to address violence against women and children which includes the Combating of Rape Act, the Combating of Domestic Violence Act and amendments to the Criminal Procedure Act designed to protect vulnerable witnesses. The provisions of these Acts are given at the end of the training manual. (Annex 13)

4.1.1. Child Care and Protection Act (Gazetted in 2015)

The Act replaces the old Children’s Act of 1960 and makes provision for a robust protection of children’s rights. It has made reporting of child abuse mandatory for teachers, school principal and school counsellor amongst others. Its states ‘ if a person who performs professional or official duties with respect to children, obtains during the course of performing those duties information that gives rise to a suspicion that a child is or may be in need of protective services, that person must report such information to a state – employed social worker or member of the police’. Non-compliance would carry an offence with a fine not exceeding NAD 20,000 or imprisonment for a period not exceeding five years or both.

The Act further requires officials who work with children to obtain a police clearance certificate in relation to offences committed against children. ‘All persons who manages or operates, or participates or assists in managing or operating and institution providing welfare services to children, including schools and early childhood development Centre and school, must apply for a police clearance certificate stating that such person does not have a criminal conviction in respect of any offences e.g child abuse etc. Non- compliance carries the same punishment as with mandatory reporting.

Unit 5: Service Providers

Specific Objective

By the end of the Unit, participants will be able to:

- Identify the different service providers
- Demonstrate how to use the national protection and referral network flow chart

Methodology PowerPoint presentation, information sharing, individual and group exercise

Materials Power point slides, hand-outs of the national protection and referral network



Facilitator's Notes

5.1 Women and Child Protection Units

Namibia has established instituted Women and Child Protection Units (WACPU) in 13 of the 14 regions. The unit provides a coordinated, holistic and multi-sectorial service to survivors of abuse. WACPU are headed by the Namibian Police (NAMPOL) with sectoral support from social workers of the Ministry of Gender Equality and Child Welfare. Although the units are not physically open 24 hours, they have an officer on stand-by after hours to intervene at any time of the day or night.

Police

The police have a statutory duty to investigate the circumstances of the alleged abuse and to report the facts to the court. This duty, however, needs to be balanced, with the welfare of the child being paramount. Usually the police would be the first point of contact in reporting the case. Some police stations have focal persons who have been trained to deal with cases of violence against women and children. It is advisable to request for such an officer when reporting an abuse case. This might minimize possible secondary victimisation and ensures that the case receive the attention and is handled with the sensitivity required.

Health Care Workers

Health care workers are often the first to be alerted to cases of child abuse. They are well placed to recognise when a child is potentially in need of help or services. They are also able to recognise when a caregiver or adult has problems which may affect his/her capacity as a caregiver that might pose the risk of harm to a child. Health care workers may have the following roles:

- Emergency care
- Contributing to enquiries about a child and family
- Referring concerns to appropriate agency
- Physical and psychological health care for the abused child
- Assessment of immediate safety needs
- Medical examination
- Medical treatment
- HIV/AIDS and pregnancy tests
- Adequate recording of medical evidence
- Informing victim of options and laying of criminal charges
- Advice and referring the child to other support services
- Presenting medical evidence in court
- Keeping up to date with child protection procedures
- Difficult issues for health care workers in child protection:
 - Confidentiality – Sharing information upon referral
 - Damage to health care worker-patient relationship, causing family disruption
 - Dealing with other agencies (police, social workers, etc.)
 - Being mistaken and repercussions

5.4 Social Workers

The role of social workers is also comprehensive, but the unit only addresses two immediate ones: during crisis intervention and risk assessment:

Crisis intervention

- To safeguard the well-being of the child
- Removal of the child if necessary
- Debriefing and support
- Assessment of emotional state of the child (To be used for court purposes at a later stage)

Risk Assessment

- Impact of the offender's behaviour on the child
- Severity of abuse/neglect
- Age, physical and mental abilities of the child
- Frequency of the alleged abuse/neglect
- Location and access of the offender to the child
- Parental willingness and ability to protect the child
- Level of cooperation of parent/caregiver
- The availability of resources to relieve parental stress and provide support and guidance to caregivers who may be predisposed to abuse

Social workers are involved with the case all the way through court proceedings and at times after court proceedings.



activity

Roles of Service Providers– 30 minutes

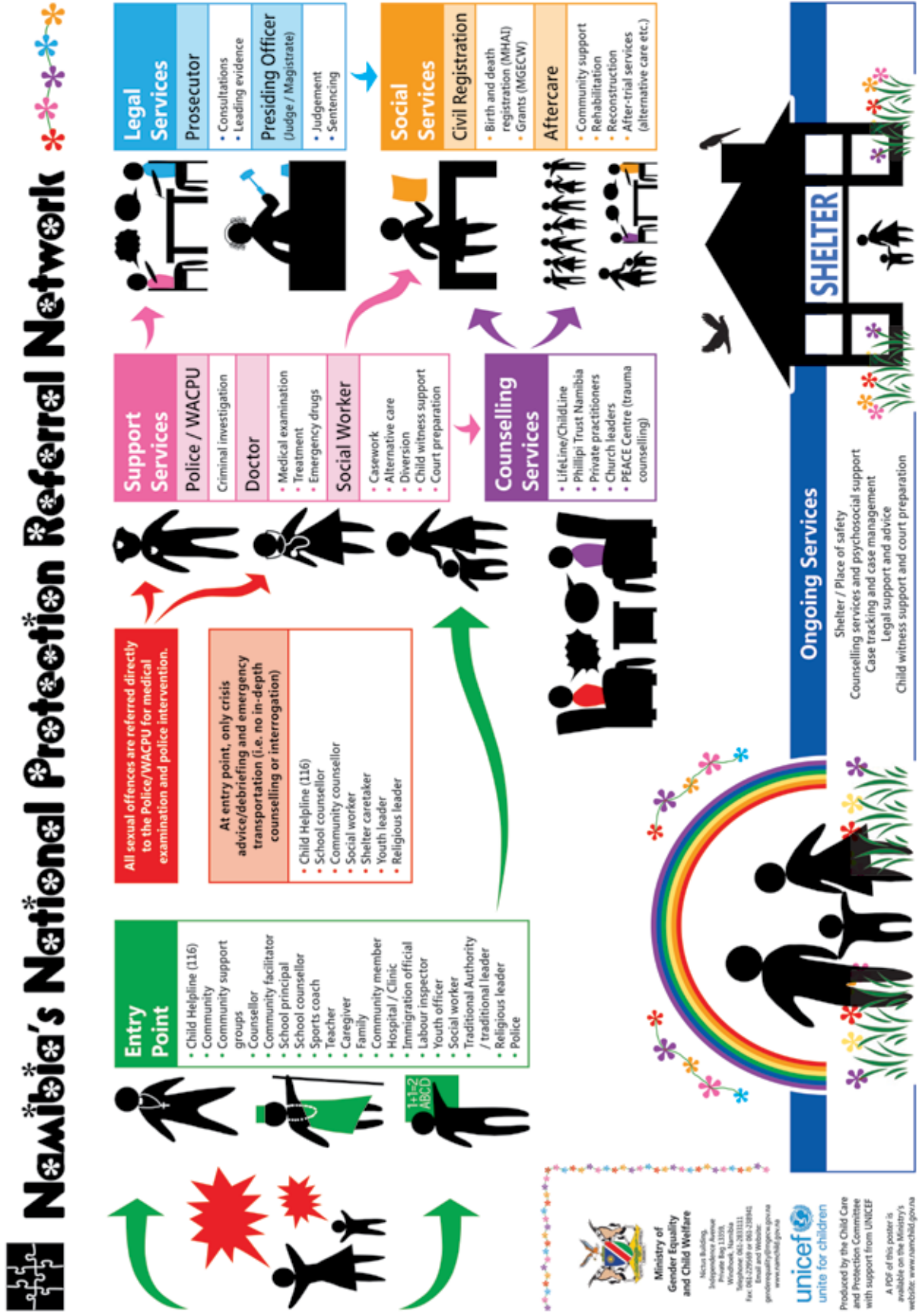
Divide into four groups.

Group 1 performs a scenario where a child comes to a social worker and complains about physical abuse. Indicate how to solve the problem.

Group 2 performs a scenario where a woman goes to the police and lays a complaint that her husband beats her. Give solutions.

Group 3 develops a poster to make the community aware of the consequences of gender based violence.

Group 4 performs a scenario where a child complains to her mother that her father is sexually abusing her and her mother does not believe her. Give solutions.



Unit 6: Child Online Protection

Specific Objective

By the end of the Unit, participants should be able to:

- Identify forms of child online abuse
- Know what measures to take in order to protect children from various forms of abuse in the online environment

Methodology PowerPoint presentation, information sharing, individual and group exercise

Materials Power point slides, hand-outs of the national protection and referral network



Facilitator's Notes

6.1 Introduction

In this digital age, where children and young people increasingly have access to the Internet and mobile phones, violence and abuse are no longer restricted to homes, schools and communities but also happen in an online environment.

While children have always been exposed to violence, exploitation and abuse, ICT has expanded the scale, scope, opportunities and types of risks to abuse and exploitation, with new forms of harm emerging through the internet, mobile phones or platforms for games and videos.

Globally and indeed in Namibia, the way in which children interact with each other and the world around them, increasingly takes place in cyberspace or through the use of mobile devices. The Internet, mobile phones and electronic media have unprecedented advantages for information sharing, communication, learning and development of young people. However the online space also puts children at risk; of having intimate and abusive images of them shared widely, of being lured by peers and adults into online or offline sexual exploitation, or of becoming the victim of cyber-bullying. Children can be both victims and perpetrators in the online space, these roles may inter-change frequently. Contrary to popular belief, child online abuse is not only an issue in high income countries. Global research has indicated that adolescents in countries all over the world, from low to high income societies, explore creative ways to express themselves and communicate using mobile devices and the Internet (source: Child Safety Online, UNICEF, 2011). Internet and mobile phone penetration is growing rapidly in most countries.

Most online engagement by children and adolescents happens outside the spheres of control of parents and teachers, who themselves have grown up in an age where the Internet did not exist. It is this mix of rapidly evolving technology, the opportunities the Internet provides for online abuse of children, coupled with the lack of awareness of most adults – teachers, parents, law enforcement staff and protection professionals alike- of the way in which children interact online, that not only puts children at risk of abuse but can also bring them –sometimes unknowingly- into serious trouble with the law as perpetrator.

The United Nations Committee on the Rights of the Child in 2011 adopted additional comments to Article 19 of the Convention on the Rights of the Child, which was ratified by Namibia, to include psychological bullying by adults and children, as well as acts committed via information and communication technologies (ICT), such as mobile phones and the internet.

In Namibia, legislation on this topic is evolving. The 2015 Child Care and Protection Act provides the overall protective framework against all forms of violence and abuse, while the draft Cyber Security Bill covers explicitly outlaws online child pornography. In recent years, courts in South Africa, the UK and the US have fined and indeed prosecuted children and adults engaging in online abuse and exploitation, from posting abusive content online to sexual violence crimes that started online and were perpetrated in the offline environment.

What is online child abuse? (source of this section: National Society for the Prevention of Cruelty to Children, UK, 2015: <http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/online-abuse/what-is-online-abuse/>).

Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse. Children can be at risk of online abuse from people they know, as well as from strangers. Online abuse may be part of abuse that is taking place in the real world (for example bullying or grooming). Or it may be that the abuse only happens online (for example persuading children to take part in sexual activity online).

6.2 There are three forms of child online abuse:

Cyberbullying is an increasingly common form of bullying behaviour which happens on social networks and mobile phones. Cyberbullying can include spreading rumours about someone, or posting nasty or embarrassing messages, images or videos.

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse or exploitation. Children and young people can be groomed online or in the real world, by a stranger or by someone they know - for example a family member, friend or professional.

Groomers may be male or female. Many children and young people don't understand that they have been groomed, or that what has happened is abuse.

Child sexual abuse online happens when young people may be persuaded, or forced, to:

- send or post sexually explicit images of themselves ("sexting")
- take part in sexual activities via a webcam or smartphone
- have sexual conversations by text or online. This may lead to offline meetings that pose children at high risk of violence or abuse.

6.3 What can you do as teacher?

It is important to remember that online and offline child abuse are part of the same spectrum of protection risks children face in their lives, and the same basic prevention and response messages can be used.

- Have a classroom discussion about the basic principles for the prevention of ‘real life’ child abuse, which also apply to the online environment:
- Discuss the difference between “good touch” and “bad touch”. Good touch includes hugs and kisses from family members and relatives, which makes you feel happy.
- Good touch also includes the touch of doctors and nurses in case of treatment for an illness. Bad touch involves touch that gives you a bad feeling, makes you feel ashamed or hurt. Bad touch can be done by strangers or by people you know well, adults or children.
- Good touch never involves keeping a secret. When someone who touches you, tells you to keep this a secret, you can go talk about this with an adult you trust, like a relative or a teacher.
- You always have the right to say no when some-one touches you in a way you do not like – practice in the classroom with the children how to say No firmly
- You run away, shout or tell someone you trust what happened
- From Middle Primary onwards, initiate a discussion about ethical use of mobile phones and the Internet. Discuss privacy of body parts also means images of body parts are private and are not to be shared with others – this is a breach of the law. When discussing bullying, discuss that this can be done through different channels, directly at the school yard, but also through the use of mobile phones or social media. The impact is equally traumatic. Discuss “smart” use of the Internet, to never give private information like your address or intimate information if you do not fully trust the person, and respect the privacy of the information and images of others. To do so, will put you at risk of abuse or perpetration of a serious crime.
- As teachers, be aware of the general signals and ‘red flags’ for abuse (see page X) and the fact that children vulnerable for ‘real life’ abuse are often those who are more vulnerable for online abuse. In certain age groups, bullying and abuse happening in the school environment often has an online dimension, or may have started as cyber-bullying.
- Make children aware of the protection services available to them (see Chapter X of this Unit). Children can also call the Child Helpline at the toll-free number 116, which connects children to phone counsellors to discuss anonymously any problem they may experience in their lives.
- Please remember that under the Child Care and Protection Bill, teachers and school councilors have a legal duty to report to the police or a social worker any suspicion of violence, abuse or neglect experienced by a learner, either at school, at home, or elsewhere. This includes violence and abuse that you suspect occurs online, or has an online dimension to it.

Resources for teachers and school counsellors:

<http://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/underwear-rule/>
<http://www.cde.ca.gov/ls/ss/ap/>

References:

Centre for Disease Control (2012) The Social-Ecological Model: A Framework for Violence Prevention. Retrieved on August 15th from http://www.cdc.gov/ViolencePrevention/pdf/SEM_Framework-a.pdf

Child Care and Protection Bill, Namibia. Revised Final Draft: June 2010

Pinheiro, Paulo Sérgio (2006) United Nations Secretary-General's Study on Violence against Children. Retrieved on August 15th from <http://daccess-ods.un.org/TMP/2741399.70541.html>

UNAM/UNFPA Gender Based Violence Module, FACULTY OF MEDICAL AND HEALTH SCIENCES, CONTEMPORARY SOCIAL ISSUES (CSI 3529) Gender Based Violence Sub- Unit, UNAM CORE-COURSE 20.

WHO (2012): Violence Against Children Factsheet: Situation in Namibia.

COMMON TERMS USED IN GENDER-BASED VIOLENCE

Definition of terms

Term	Definition
Gender Equality	Women and men enjoy the same status by having equal opportunity, for participating in and benefiting from a given situation. Gender equality also refers to when men and women have equal conditions, for realizing their full human rights and potential to contribute to national, political, economic, social and cultural development, and to benefit from the results
Gender Bias	The tendency to make decisions or take actions based on gender bias results when social cultural beliefs and structural arrangements favour men over women or vice versa. An example of bias would be, when you come across a car accident, to simply take the following generalization 'women are very dangerous on the road because they are over careful'
Gender Blindness	The inability to perceive that there are different gender roles, responsibilities, and gender based hierarchy. A lack of recognition that gender is an essential determinant of the life choices available to use in society, and consequently the failure to realize such policies, programmes and projects can have different impacts/ effects on men and women
Gender Discrimination	Prejudicial treatment of an individual based on a gender stereotype (often referred to as sexism discrimination), for example, if a male and a female apply for the same position in the nursing discipline, the institution is likely to recommend the female because it is generally accepted that nursing is a female career
Gender Mainstreaming	The process of putting a mechanism into place of identifying the gap between males and females that are employed
Gender Awareness	Gender awareness refers to the gender sensitive attitudes and a commitment to placing women's needs and priorities of the centre of development planning and programming. For example, having a mother-baby room at the workplace for breastfeeding purposes
Gender Disaggregated data	Statistical information that differentiates between men and women, for example. "Number of women and men in the labour force" instead of "number of people in the labour force". This allows one to see if there are gender gaps
Engendering	To make the purpose of activity to be gender sensitive or by incorporating gender needs and interest and/or eliminating gender discriminatory policies, strategies and practices
Sex	Refers to the biological differences; chromosomes, hormonal profiles, internal and external sex organs between men and women; they are universal.
Gender	Refers to social differences between men and women; they are: <ul style="list-style-type: none"> • Learned • Changeable over time • Very widely within and across cultures • Gender is a socio-economic variable for analysing roles, responsibilities, constraints, opportunities, and needs of men and women in a given context.

Source: UNAM/UNFPA Gender Based Violence Module, FACULTY OF MEDICAL AND HEALTH SCIENCES, CONTEMPORARY SOCIAL ISSUES (CSI 3529) Gender Based Violence Sub- Unit, UNAM CORE-COURSE 20

ANNEXES

Does the school accommodate boys, girls or both?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Boys only
Girls only
Both

Number of:	Male	Female	Total
Learners			
Teachers			
Institutional workers			

(f) Designated Focal Teacher(s):

Name: Contact No:

Name: Contact No:

2. Safe water, sanitation and other facilities

This section is aimed at obtaining data, in order to provide the following:

- *A safe, healthy environment*
- *Sufficient sanitation and water,*
- *Freedom from abuse and violence,*
- *A climate of care, trust, and respect,*
- *Social support and mental health promotion,*
- *Safe school grounds*
- *Opportunities for physical education and recreation*

2.1

Facilities

Water and Sanitation

	Yes	No
1. Are the toilets?		
1.1 Flush toilet		
1.2 Pit latrine		
2. Are the toilets clean?		
3. Are these toilets functioning?		
4. Are there functional toilets enough for the population size?		

4.1 How many for girls (1:25)		
4.boys (1:40)		
4.3 Urinal (1:40-60)		
5. Are there hand washing facilities?		
6. Are these hand washing facilities functional?		
7. Are the functioning hand washing facilities enough for the population size? (ratio/number)		
7.1 How many for girls		
7.2 How many for boys.....		
8. Are there hand drying facilities?		
9. Is there soap readily available		
10.If yes, what kind of soap?		
liquid bar		
11.Is safe drinking water provided?		
11.1 Is there daily access to safe drinking water?		
Physical Condition of structure		
12.Are the classrooms well ventilated?		
13.Do the classrooms include adequate space for each learner?		
13.1 Is a chair and desk available for each learner?		
Occupational Health and Safety		
14.Do the classrooms have sufficient lighting?		
15.Are the classrooms in good condition (wall, ceiling, windows, door and floors)?		
16.Is there a sick bay (corner) at the school?		
17.Is there a First Aid Kit?		
18.Is the First Aid Kit fully stocked?		
19.Is the school fenced?		

Waste Management		
20.	Are there enough refuse bins at the school?	
21.	Is refuse disposed of in an open dumping place not far from school?	
22.	Are there trees planted at the school that provide shade to learners?	
23.	Does the school offer gardening for learners?	
24.	Are there any shops/shebeens/slums in the vicinity of the school? Any mode of transport available at the school?	
25.	Is there any health facility nearby? How far.....Km	
26.	Are there institutional workers employed at school? If yes, indicate functions: Cleaning Gardening Cooking Others, specify	

***Note: 1:25 Cubical toilets for girls**

*** Note fully stock First Aid kit:**

2.2 HOSTEL FACILITIES

INSPECT AND ASK THE PERSON IN CHARGE OF THE SCHOOL HOSTEL

2.2.1 If it is a boarding school, please answer the section below:

Number of learners accommodated in the hostel:

Boys: _____

Girls: _____

Total: _____

2.2.2

Facilities	Yes	No
1. Are the toilets clean?		
2. Are the toilets functioning?		
3. Are the functioning toilet enough for the population size?		
3.1 How many for girls		
3.2 How many for boys		
4. Are there hand washing facilities?		
5. Is the hand washing facilities functioning?		
6. Are the functioning hand washing facilities enough for the population size?		
6.1 How many for girls		
6.2 How many for boys		
7. Is soap provided?		
8. Are there hand drying facilities?		
9. Is the condition of hostel facilities good?		
10. Are the hostel windows screened (with mesh)?		
11. Kitchen: are food storage facilities sufficient?		
12. Are foodstuffs stored separately e.g. meat, fruit, etc.		
13. Food utensils available?		
14. Taps available in the kitchen?		
15. Are the available taps functioning?		
16. Are sink /washing basin available in the kitchen?		
17. Are available sink/wash basins functioning?		
18. Are kitchen staff wearing protective clothing e.g. hairnets, aprons & gloves?		
19. Do kitchen staff under going regular medical examinations for food handlers?		
20. How often does the Environmental Health Practitioner visit the school and hostel facilities? Annually		

Twice a year Others, specify	
21.	

2.3 List any sport facilities available in the school.

FACILITY	DAILY	Twice a week	WEEKLY	MONTHLY	Never
1.					
2.					
3.					
4.					
5.					
6.					

2.4 Judgment criteria

How did the school perform in this section? Tick one of the following items

- Good: _____
 Fair: _____
 Poor: _____

Note:

- Performance is good when the items (numbered 2.1 :1-27&no 2.2:1-21) are all found Yes:
- Performance is fair when some of the items (number2.1:1-27&2.2:1-21) are found No:
- Performance is poor when most of the items (numbered)2.1:1-27& 2.2:1-21 are found or not functioning No:

2.5 The Outcome on this Section

.....

3. School Health Services

This section will aim at obtaining data to assist in providing access to health services, (screening, diagnosis, monitoring growth and development, vaccination, selected medications procedures and referrals) that may be most efficiently provided in the school setting, depending on school resources.

Based on your knowledge of health problems, indicate the common health problems encountered at your school and their effects on teachers, learners and the community, e.g. absenteeism, academic performance, school dropout, quality of teaching and burden on health services.

3.1 Which of the following major health issues are encountered at the school? (Please tick)

Health Problems	More Often	Less Often	Never
1. Alcohol use			
2. Other substance use			
3. Injury			
4. Hunger			
5. Disabilities			
6. Oral health problems			
7. Malaria			
8. HIV and AIDS			
9. Pregnancy among learners			
10. Violence			

11.Poor vision		
12.Poor hearing		
13.Lice		
14.Worm infestation		
15.Skin diseases		
16.Suicide		
17. Others, please specify		

3.2 Which of the following health services/programmes are provided at the school?

Health	Yes	No
1. A general physical examination		
2. Immunization		
3. Environmental inspection		
4. Health education		
5. Does the school have any peer educators		
6. Does the school have the life skills programme? “My future, My choice” or “Window of Hope”		
7. Counselling services for learners, institutional workers and teachers		
8. Integration of health services with other components of the health promoting school		
9. Is there a functional referral link between the school and support services (social, health, legal and ?		
10.Does this referral work well?		
11. Mental health services?		

3.3 What are the most common problems found during screening/ physical examination as reported by a nurse and teachers? (Please tick✓)

- Scabies
- Lice
- Malnutrition
- Infection
- Skin diseases
- Poor personal hygiene
- Poor vision
- Dental Disorders
- Hearing problems
- Physical disabilities
- Urogenital disorders
- Other specify: _____

3.4 Does the school provide any form of physical education?

Yes No

3.5 Are there any other programs provided to learners by other institutions?

Yes, specify – what and who)

3.6 Are there any learners who are of concern at the school? Yes No

Concern	Number of Boys	Number of Girls
1. Emotional behaviours		
2. Neglect		
3. Physical abuse		
4. Sexual abuse		
5. Physical Illness		

6. Substance abuse		
7. Other (please list)		

1.....

2.....

3.7 Do you think that some learners at the school are sexually active?

Yes

No

3.8 Is there any outlet for condom distribution?

Yes

No

If yes, where?.....

If not, please state reason

.....

3.9 Did any of the learners drop out of school during the last school term?

Yes

No

If yes, how many of these are boys and how many are girls? (Please state number)

Boys

Girls

3.10 How many girls dropped out due to suspected pregnancy during the last school term? (Please state)

.....

General Comments on this Section

.....

4. Nutrition Service

4.1 Does the day school provide meals to the children?
Yes No

If yes, name the food provided and how often

.....
.....

4.2 If yes, who provides the food and what was the process of obtaining this support?

.....
.....

General Comments on this section

.....
.....

5. School Health Policies

In the following question, the word “policy” refers to formal legislation adopted by the government or by the school. A school health policy is aimed at providing school health education, with curricula that improve learners understanding of factors that influence health and enable them to make healthy choices and adopt healthy behaviours throughout their lives, for example a policy that does not exclude pregnant girls, or a policy that promotes tobacco free lifestyles. A School Health Policy also includes curricula that include critical health and life skills, a focus on promoting health and well-being as well as preventing important health problems, and information and activities appropriate to learner’s intellectual and emotional abilities, training and education for teachers and parents. Government circulars, protocols and operational guidelines aimed at improving the school health environment are also considered “school health policies” for this purpose.

5.1 What policies are you aware of that promote the well-being of learners and teachers?

5.1.1 What are the policies the school is currently implementing or have adopted?

.....

 5.1.2 How often do parents and teachers meet to discuss issues affecting health and the education of their children? (State frequency)

.....
 5.1.3 What system is in place to monitor the implementation of the school health policies at your school?

.....
 5.1.4 What are the obstacles to the implementation of the school health policies?

(Tick)

- Financial
 Technical
 Collaboration with other sectors
 Other (Specify)

.....
 5.1.5 Is there an ongoing health education programme at your school?(Tick)
 Yes No

5.1.6 What support do teachers receive to help address the health concerns of young people? In particular, please describe any financial as well as technical support you receive from : (Please, tick)

Partner	Financial	Technical
1. The school administration		
2. Parents and the community		
3. Learners		
4. The Ministry of Education, Youth, MGECSW (e. g., financial support, curriculum materials, school health guidelines, etc.)		

5. The Ministry of Health		
---------------------------	--	--

6. Other (Please specify):

5.1.7 What role do you think your school should be playing to promote the health of learners and staff?

.....

.....

General Comments on this section

.....

.....

6. Skills-Based Health Education

6.1 What are the health issues that teachers teach to the learners?

.....

.....

6.2 What are the teaching methods used in health education? (Please tick)

Method	
1. Health talks	
2. Group discussion	
3. Drama	
4. Guest speaker	
5. Other	

(please

specify):.....

.....

6.3 Do you have any of the following teaching aids specifically for health education? (Please tick)

TEACHING AIDS	YES	NO
Posters		
Leaflets		
Video		
Audio		
Notice board		
Other	(please specify):	

.....

7. Overall outcome of the Assessment

7.1 Does this school qualify to be health promoting? (Please tick)
 Yes No

General comments

.....

Name of the Assessor:

Date assessed:

Signature:

Name of the Interviewee:

Date interviewed:

Signature:

Annex 2: External assessment Check list for Health Promoting School form



REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES
EXTERNAL ASSESSMENT CHECKLIST FOR
HEALTH PROMOTING SCHOOLS
FOR ALL THREE LEVELS
BRONZE LEVEL
SILVER LEVEL

&

GOLD LEVEL

To be completed by external team members

GUIDELINES FOR EXTERNAL EVALUATOR TOOL (PROCEDURE)

1. *Introduction of External Team members and the purpose of visits to the School Management*
2. *It is very important to get the number of toilets, washbasins, incinerators, etc from School management at the office before hand.*

Reason: This is done in order to concentrate on evaluation of standard
3. *Discuss findings (weakness, strength and recommendations) immediately (on site) to avoid disagreements.*
4. *Conduct supportive assessment and provide constructive feedback rather than policing.*
5. *Hold feedback sessions to allow schools to express their fears, difficulties, problems and also an appreciation for partnership.*
6. *Give a chance to Schools to talk and ask questions/clarifications*
7. *Remember to give compliments even if not really necessary to enhance commitments, please.*
8. *Thank the schools for their efforts and time in spite of their tight learning schedule.*

CHECK LIST FOR EXTERNAL EVALUATION**Component 1 Safe water and sanitation**

Availability of safe water for school population
 Good sanitation
 Sound environmental hygiene
 Safety measures in force

Component 2: School Policies

Health related school policies

Component 3 Skills-based Education

Previous exhibitions

Report on small research conducted (primary School Level)

Report on project exhibited (secondary School Level)

How many times previous year were people invited to address learners on health and social problems issues.

Any feedback from parents/community as regard to child education

This will be covered through the exhibition of projects at the NAMSTA Science Fair and performances by learners during the ceremony.

Component 4: Health and Nutrition services

Access to or linkages to health and nutrition services to sister school
 Sister school

Focus Core components

Bronze Levels = component 1

Silver Levels = component 1 + 2+3
Gold Levels = component 1 +2+3+

Additional facilities

All these will be covered through physical assessments of the structures.

Office Information

Date of visit: Time: From..... To..... State/Private.....
Name of school: Circuit..... District.....
Area Situated:
In which year was the school opened?
Built to accommodate how many learners?
Any expansion or extensions since?
Reason:
Intake this year: Total: Boys: Girls:
Current number of learners: Boys..... Girls..... Total.....
Any dropouts: Boys Girls..... Total.....
Reason for drop-out school:

Number of Teachers: M..... F Total.....
Institutional workers/Cleaners: M..... F..... Total.....
Secretary: Male..... Female Total:

ASSESSMENT OF COMPONENTS BY LEVEL CRITERIA

	• Bronze	• Silver	• Gold
<i>Availability of safe drinking water</i>	Just safe drinking water e.g.(bucket bucket, container, tank or tap)	Functional Tap/ fountain at the school	Fountain with adequate and functional t taps

	Sound Environment	Just available functional toilets with hand washing facilities/ bowls/basins and any soap and towels	paper in the toilets	Running tap Water liquid soap, container fixed to the wall, Disposable or Electronic hand drying facilities
	Type of Sanitation Tick/ fill in	Flush <input type="checkbox"/> VIPs <input type="checkbox"/> it <input type="checkbox"/>	Flush <input type="checkbox"/>	Flush <input type="checkbox"/>
<p><i>Number of functional Toilet</i></p> <ul style="list-style-type: none"> • <i>Learners</i> • <i>Enough Staff</i> • <i>Adequate Basins</i> <p><i>Non functional</i></p> <ul style="list-style-type: none"> • <i>Toilets</i> • <i>Basins</i> <p><i>Urinal boys</i></p> <ul style="list-style-type: none"> • <i>Functional</i> • <i>Non functional</i> <p><i>Incinerators girls</i></p> <ul style="list-style-type: none"> • <i>Functional</i> • <i>Non-functional</i> <p>Note: Urinal:40-60 boys</p>	<p>Boys Total.....</p> <p>Girls.....</p> <p>Male.....Female.....Total.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Boys Girl Staff.....Total</p> <p>Boys Girl Staff</p> <p>Total.....</p>	<p>Boys Total.....</p> <p>Girls Total.....</p> <p>Male.....Female.....Total.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Boys Girl Staff...Total</p> <p>Boys Girl Staff</p> <p>Total.....</p>	<p>Boys Total.....</p> <p>Girls Total.....</p> <p>Male.....Female.....Total.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Boys Girl Staff...Total</p> <p>Boys Girl Staff</p> <p>Total.....</p>	<p>Give comments on what Observed on the spot.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

	<p>1 Cubical/Toilet: 1:100 boys</p> <p>1 Cubical Toilet 1:25girls according to Policy Frame Work 2005 WHO</p>	<p>Total.....</p> <p>Total.....</p> <p>Total.....</p>	<p>Total.....</p> <p>Total.....</p> <p>Total.....</p>	
	<p>Toilet paper provision. Describe the method/approach used in particular school</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>Give comments on what observed on the spot</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Waste Management how regular: Per week Per month Who's responsible? Government Municipality</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Comments:</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

	<p>Safety Measures in place</p> <p>School Premises safety</p> <ul style="list-style-type: none"> • Fence • Gates • School Patrol <p><i>Presence of poisonous plants, cut bottles, rusty wires metal, sharp big stones</i></p> <ul style="list-style-type: none"> • Too higher step • Provision made for wheel chair • if not what measures are in place? • Littering 	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Applicable <input type="checkbox"/> not applicable <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Applicable <input type="checkbox"/> Not applicable <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Applicable <input type="checkbox"/> Not applicable <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p>Classroom</p> <ul style="list-style-type: none"> • Number of Learners/ Class average <p>Comment:</p> <ul style="list-style-type: none"> • Tidiness/decoration 	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

	<p><i>S</i></p> <ul style="list-style-type: none"> <i>Ventilation</i> <i>Learning/Teaching Aids</i> <i>School Health Charter</i> 	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Test knowledge about:</p> <ul style="list-style-type: none"> <i>Basic health</i> <i>Road safety</i> <i>Information e.g. HIV and AIDS</i> 	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Hygiene: Inspection of learners</p> <ul style="list-style-type: none"> <i>Nails</i> <i>Hair</i> <i>Shoes</i> <i>Socks</i> <i>Uniform</i> <i>General appearance</i> <i>Atmosphere in the class for mental health promotion</i> 	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

							
	Comments:	..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Policy on equal treatment for students	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Comments:	..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<ul style="list-style-type: none"> • <i>Implementation</i> • <i>Awareness ect.</i> 	Just available	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Shows familiarity <input type="checkbox"/> Implemented <input type="checkbox"/> Demonstrates <input type="checkbox"/>	
	Policy on drugs, Alcohol & abuse, Violence and bullying	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Comments:	..... ..... .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<ul style="list-style-type: none"> • <i>Implementation</i> • <i>Awareness ect.</i> 		Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Shows familiarity <input type="checkbox"/> Implemented <input type="checkbox"/> Demonstrates <input type="checkbox"/>	

C o m p o n e n t ?	<i>Teenage pregnancy policy</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Comments: <ul style="list-style-type: none"> • Awareness • Implementation • supported	..... ..... ..... ..... .....		Shows familiarity <input type="checkbox"/> Implemented <input type="checkbox"/> Demonstrates <input type="checkbox"/>	
	First Aid	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Comments: <ul style="list-style-type: none"> • fully stock • Utilization • Underutilization • Statistic	..... ..... ..... ..... ..... .....	..... ..... ..... ..... .....	..... ..... ..... ..... .....
	Overall policy support by school population	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Comments: <ul style="list-style-type: none"> • Implementation • Awareness	..... ..... ..... .....	Available <input type="checkbox"/> and familiar <input type="checkbox"/>	Shows familiarity <input type="checkbox"/> Implemented <input type="checkbox"/> Demonstrates <input type="checkbox"/>	

C o m p o n e n t			
Skills-based Education			
<i>Previous exhibition</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Written reports available and printed? Yes <input type="checkbox"/> No <input type="checkbox"/>	Reports available? Yes <input type="checkbox"/> No if yes give details.....
<i>Report on small research</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Written Reports available? Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Report on project exhibited</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>How many times visited /invited h/w to address learners on health and social issues</i>			.....
<ul style="list-style-type: none"> <i>Any feedbacks from parents/community with regard to child to child education</i> 	Yes <input type="checkbox"/> No <input type="checkbox"/>	if yes give details.....	if yes give details.....
Comments:			

<p>C o m p l</p>	<p><i>Linkages to health and nutrition services:</i></p> <ul style="list-style-type: none"> • <i>How many times health workers visit schools for adolescents and school health programs</i> <p><i>School feeding:</i></p> <ul style="list-style-type: none"> • <i>Does the school provide meals to learners?</i> 	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	
---	--	--	--	--

	<p>Comments: Implementation Awareness</p> <ul style="list-style-type: none"> 	<p>.....</p>	<p>.....</p>	<p>.....</p>
	<p>Skills Base Education</p>			
	<p>Previous Exhibitions</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p>Report on small research</p>	<p>Reports available? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes give details.....</p>	<p>Reports available? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes give details.....</p>	<p>Reports available? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes give details.....</p>
	<p>Sick bay</p>			
	<p>Comments</p> <ul style="list-style-type: none"> Utilization Under utilization Statistics 	<p>YES NO</p> <p>YES NO</p> <p>.....</p>	<p>YES NO</p> <p>YES NO</p> <p>.....</p>	<p>YES NO</p> <p>YES NO</p> <p>.....</p>
	<p>Store Room Comments</p>	<p>YES NO</p>	<p>YES NO</p>	<p>YES NO</p>

	<ul style="list-style-type: none"> • Sorting • Hygiene	...............	...............	...............	...............
	General Impressions <ul style="list-style-type: none"> • Entrance • Lawn • Plants • Trees • Reception	.........................	.........................	.........................	.........................
	Assessment Results Levels <ul style="list-style-type: none"> • Bronze • Silver • Gold	.....	.....	.....	.....
	Overall assessment comments:	..... ..... ..... ..... ..... ..... ..... ..... .....	..... ..... ..... ..... ..... ..... ..... ..... .....	..... ..... ..... ..... ..... ..... ..... ..... .....	..... ..... ..... ..... ..... ..... ..... ..... .....
	Interviewers' name	...............	...............	...............	...............
	Organization	...............	...............	...............	...............

	Program Designated Signature	..........	..........	..........
	Evaluators' name	..........	..........	..........
	Organization Designated Signature	..........	..........	..........



Annex 2: Parental Consent Form

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES
SCHOOL HEALTH CARE SERVICES
CONSENT FOR PARENTS

Please complete, sign this form and return it to School. (Please tick (✓)):

Dear Parent/Guardian: Mr./Mrs./Ms.:

The Health Personnel will visit.....
from/...../..... until/...../..... to examine the children. Name and address of the School

Do you give permission for your child: Name.....
to be included amongst the learners who will be:

Examined: Yes No
Immunized: Yes No

If No for examination, please attach the Doctor's proof of examination and immunization.

Give reason:

It is essential that **all children** bring their Health Passport/Immunization Card to school.

Indicate if you wish to be present during the examination and Immunization. Yes No

Is your child immunized against the following? (Please tick (✓))

	YES	NO	YES	NO	YES	NO
Measles						
Poliomyelitis(OPV)			Whooping Cough(DPT)	Hep & Hip	Diphtheria(DT)	
H1N1			Tuberculosis(BCG)		Tetanus(TT)	
			Meningitis		Yellow fever	

Did your child undergo any operations? Yes No
If yes specify

Is your child healthy at present? Yes No

If no give details.....

Has your child had any of the following diseases? (Please tick (✓))

	YES	NO	YES	NO	YES	NO

Measles		H1N1		Bilharzia
Poliomyelitis		Malaria		Asthma
Whooping Cough		Diphtheria		Hay Fever/Allergic
Tuberculosis		Rheumatic Fever		Fits/Epilepsy
HIV and AIDS		Diabetic Mellitus		

Does your child suffer from?

Frequent sore throats Yes No

Worms yes ..No

Is your child having a hearing problem? Yes No

Name & Surname of Parent/Guardian:

Postal Address:**Residential Address:**

Tel mother:**Cell:****Home:****Work:**

Tel Father:**Cell:****Home:****Work:**

Family Doctor:**Tel:**

PARENT/GUARDIAN: SIGNATURE.....**DATE:**

Annex 3: Referral Form

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES
REFERRAL FORM

Postal Address..... Tel: 06.....
..... Fax: 06.....
Namibia.....

Fax Email:

Enquires: Ref. No.: Date:

Region:

District:

Health Facility.....

Mr/Mrs/Ms/Dr/Prof.:

During examination of your child:

The following was observed:

.....
You are advised to take him/her to the Doctor/Dentist/HF

.....
SIGNATURE OF SCHOOL NURSE DATE

MINISTRY OF HEALTH AND SOCIAL SERVICES

Dear Doctor/Nurse concerned

The school nurse examines all school children on yearly basis. The aim is to exclude any abnormalities which the parent, teacher or either the child could not observe or feel.

It is important for the school nurse to know the real problem of this child if any. It will therefore be appreciated if you would be so kind to send feedback to the principal of the school for follow-up.

*Kindly fill the findings at the back of this form

Thank You.

FINDINGS AND RECOMMENDATION

.....

.....
SIGNATURE OF THE DOCTOR/DENTIST/HF NURSE

.....
DATE



Annex 4: Health Screening & Physical Examination Form

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES
HEALTH SCREENING AND PHYSICAL EXAMINATION SCHOOL GIRLS/BOYS

STRICTLY CONFIDENTIAL

(A) PERSONAL INFORMATION (Completed in advance by parent)

Surname: _____ First Name: _____
Date of Birth: _____ / _____ / _____ Age: _____
Present Grade: _____ YEAR MONTH DAY
Schools Attended:
1. _____ 3. _____
2. _____ 4. _____
Name of Parent: _____ Title: Mr / Ms _____
Physical Address: _____
Postal Address: _____ Occupation: _____

(A. II) PERSONAL INFORMATION (Completed in advance by teacher)

Living condition at home: _____
Is child in a hostel? No / Yes _____
State any disorders: _____

Remarks: _____
Official Use only: _____ Date: _____ / _____ / _____

LENGTH: _____
WEIGHT: _____

(B) Nurse observations:

(C) Remarks on other investigations in respect of health:

(D) Health screening and Physical examination: (Only disorders marked (x) qualify).

Date: _____	Findings	Referral	Follow up
Grade: _____			
Is parent present?: _____			
personal hygiene: _____			
Nutrition: _____			
Posture/Deformities: _____			
General Appearance: _____			
Anaemia: _____			
Teeth: _____			
Nose / Throat: _____			
Glands: _____			
Eyes Vision: _____			
Other: _____			
Ears Hearing: _____			
Other: _____			
Skin: _____			
Oral cavity: _____			
Known allergies: _____			
Respiratory: _____			
Abdomen: _____			

Genito-Urinary System: /Uro- Genito System _____			
Nervous System: _____			
Other abnormalities specified: _____ _____			
REMARKS: Treatment/Referrals or Healthy child			

Signature of Medical Inspector / Schoolnures: _____

(E) Recommendations of Medical Inspector/Schoolnures

NOTE

- If the child was absent during the health visit at school and no examination was done.

OR

- If parents do not wish their son / daughter to have an examination by the visiting health team.

THEN

These children must have such an examination by the family doctor.

AND

Within three weeks, hand the proof of examination to the school principal, who will forward it to the health workers.

DATE	TARGET GROUP	TOPIC	TEACHING AIDS
1.			
2.			
3.			
4.			

TOTAL NO OF CLASS ROOMS: **OVERCROWDED:**

LIGHTING AND VENTILATION (DARK, DAMP, HOT etc).....

TOTAL TOILETS: **CONDITION (HYGIENE):**

SOURCE OF WATER SUPPLY: **WASHING FACILITIES:**

SURROUNDING CONDITION: (1) SCHOOL:
 (2) HOSTEL (TOILETS, KITCHEN, DINNING ROOM & BEDROOMS):

SPORT AND PLAYGROUND CONDITION:

GENERAL REMARKS (CO-OPERATION OF PERSONNEL, LEARNERS etc):

RECOMMENDATIONS:

PERSONNEL WHO VISITED SCHOOL: PROFESSIONAL NURSES ENROLLED NURSES
 ASSISTANT NURSES HEALTH INSPECTORS

SIGNATURE: DESIGNATION: DATE:



Annex 7: School-based Inspection and Examination Report

SCHOOL BASE INSPECTION AND EXAMINATION REPORT

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES

Region.....
District.....
Constituency/Circuits.....

Name of school:

Communication (relationship between the health team and school personnel).....

Conditions of Buildings:

Time Spent:

	Total Examine	Referrals to Parents	Referrals to Dr	Follow-up
Primary School				
Grade 1.....
New comers.....
Grade 6.....
Special Grades
.....
.....
TOTAL				

GENERAL:

SIGNATURE OF NURSE

DATE

Annex 8: The Reporting Format

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES
REPORTING FORMAT FOR TRIMESTER REPORTS

ACTIVITY REPORT: School Health Programme
 The Health Promoting Schools Initiative (HPSI)
REGION: _____
DISTRICT/CIRCUIT _____
TIME PERIOD: _____

1. Introduction
 - 1.1 Number of Schools in the region

.....
 - 1.2 Number of participating schools at different levels of HPSI implementation
 - 1.2.1 Bronze:.....
 - 1.2.2 Silver:.....
 - 1.2.3 Gold:.....

* list of schools should be added as an appendix
- Activity undertaken
- 1.3 Activities

.....
- 1.4 Activity objectives
 - 2.2.1

.....
 - 2.2.2

.....
 - 2.2.3

.....
- 1.5 Outcome

.....

2. Funding Source (if applicable)

3.1 Where is the funding for the activity coming from?

Source of funding	Amount
National Budget	



Regional	
District Budget	
Donors	
Community	
Total=	

3. Collaboration and Coordination (if applicable) in carrying out the activity

For example, the establishment and functioning of the School Health Team

3.1 Collaboration with other relevant PHC programmes

Describe:

.....

3.2 Collaboration with other relevant key players

Describe:

.....

4. Technical Support Provided

Kind of technical support provided (if applicable) from:

4.1 District level:

.....

4.2 Regional level:

.....

4.3 National level:

.....

4.4 Others:

.....

5. Achievement

6.1

.....

6.2

.....

6.3

.....

Annex 9: Annual School Health Plan

**MINISTRY OF HEALTH AND SOCIAL SERVICES
SCHOOL HEALTH SERVICES ANNUAL PREPARATORY PHASE**

Activities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Programme planning <ul style="list-style-type: none"> ➤ Review draft programme according to the school intake ➤ Involve contact teachers ➤ Make request to meet parents during first school parents meeting. ➤ Get approval response from principals ➤ Write final programme and distribute to schools ➤ Copy to MoHSS and heads of schools ➤ Provide suggestion boxes for health related issues i 	↑											
Distribution of consent forms <ul style="list-style-type: none"> ➤ Distribute to schools in advance ➤ Parents to complete forms and be returned to schools at least two weeks before time 	↑	↑										
First term <ul style="list-style-type: none"> ➤ Address parents during the first school meeting ➤ Immunization Primary and Sec. School. TT for girls 15 year old. ➤ Physical examination to Gr. 1 and Gr. 6 ➤ Referral to clinics, dentists etc. ➤ Environmental Health: <ul style="list-style-type: none"> i) Safety ii) Sanitation iii) Water availability iv) Disease outbreaks ➤ Health Education planned to cover learners needs 			↑									
Second term <ul style="list-style-type: none"> ➤ Follow up on the following <ul style="list-style-type: none"> i) Referrals cases identified during first term ii) Whether all problems had been resolved iii) Conduct home visits if problems not solved iv) Health Education to be given according to the learners requests from the suggestion boxes 						↑						
Third term <ul style="list-style-type: none"> ➤ No activities at school nearly end of the year examination time. ➤ Meeting with contact teachers second week. ➤ Discuss findings with management, welcome suggestions and recommendations. ➤ Send copies of final reports to MoHSS and heads of schools. ➤ Draft next year's programme. ➤ Send copy to MoHSS only. 								↑		↑		

Annex 10: Immunisation Timetable

CHILDHOOD IMMUNISATION SCHEDULE						
AGE	VACCINE	DATE GIVEN	DATE DUE	GIVEN BY (SIGNATURE)	BATCH NUMBER	
New Born	Polio 0 + Heb B 0					
	BCG					
6 weeks	Polio, Pentavalent 1 (DPT, HEB B, HIB Influenza), Rotavirus, Pneumococcal					
10 weeks	Polio, Pentavalent 2 (DPT, HEB B, HIB Influenza), Rotavirus, Pneumococcal					
14 weeks	Polio, Pentavalent 3 (DPT, HEB B, HIB Influenza), Pneumococcal					
9 months	Measles					
15 months	Measles, Rubella (MR)					
5 years	Polio + DT					
10 years	Polio + DT					

NB: Hep B 0 to given within 24 hours of birth

Annex 11: Ten Steps to School Health

10 STEPS TO SCHOOL HEALTH

1. CRITICAL HEALTH AND LIFE SKILLS

Skills-based health education can enable children to make choices and adapt healthy behaviour throughout their lives.

2. A SAFE LEARNING ENVIRONMENT AND WORKING ENVIRONMENT

Schools must provide safe water and sanitary facilities and protection from diseases, violence and harmful substances.

3. FULL EDUCATION PARTICIPATION OF GIRLS

Improving and expanding education opportunities for girls are one of the best health and social investments a country can make.

4. INVESTMENT IN SCHOOLS

Every school must provide education that meets the full range of children's learning and developmental needs.

5. LOCAL AND INTERNATIONAL SUPPORT

Local and international support must be further developed to enhance the ability of regions, local communities and schools to promote health and education.

6. COMMUNITY AND SCHOOL INTERACTION

The school and the community must work together to support health and education.

7. SUCCESSFUL SCHOOL HEALTH PROGRAMMES

School health programmes must be well designed, monitored and evaluated to ensure successful implementation and outcomes.

8. TRAINING OF TEACHERS AND SCHOOL STAFF

Teachers and school staff must be valued and provided with the support necessary to enable them to promote health.

9. POLICIES, LEGISLATION AND GUIDELINES

Policies, legislation and guidelines must be developed to ensure the mobilization, allocation and coordination of resources at all levels.

10. AN ENTRY POINT FOR HEALTH PROMOTION AND INTERVENTION

Annex 12: Suicide Resources

ORGANISATION	TEL NO:	FAX NO:	POSTAL ADDRESS	PHYSICAL ADDRESS
Dutch Reformed Church Benevolence Board – Social Service Council	061 237296	061 227287	Box 3307, Windhoek	Windhoek Sinodial Church Office, 34 Feld Street, Windhoek
Helping Hand Welfare Organisation	061 257986	061 257086	Box 2842, Windhoek	Corner Pasteur and Schonlein Street, Windhoek
Helpline	064 402993 0811271002/3 0812330216/7	064 402993	Box 84, Swakopmund	9 Saphire Street, Vineta Swakopmund
Ministry of Gender Equality and Child Welfare	Regional Offices in all Regions			
Namibia Men for Change	061 224004 0812695967	061 224732	Box 70690, Khomasdal	CCN Building, 8521 Abraham Mashengo Street, Khomasdal
Namibia Women’s Association (NAWA)	061 262021	061 263539	Box 3370, Windhoek	Corner Mungunda and Shanghai Street, Katutura
Philippi Trust Namibia	061 259291	061 259210	Box 4447, Windhoek	Corner Beethoven and Strauss Street, Windhoek
Walvis Bay Child and Family Centre	064 209457	064 209457	Box 2481, Walvis Bay	Old North Hospital (behind police station), 11th Street, Walvis Bay
White Ribbon Campaign Namibia (WRCN)	061 236060	061 236054	Box 97475, Maerua Mall	White Ribbon Campaign Namibia c/o Misa Namibia
Women and Child Protection Units	Contact your nearest Police Station			

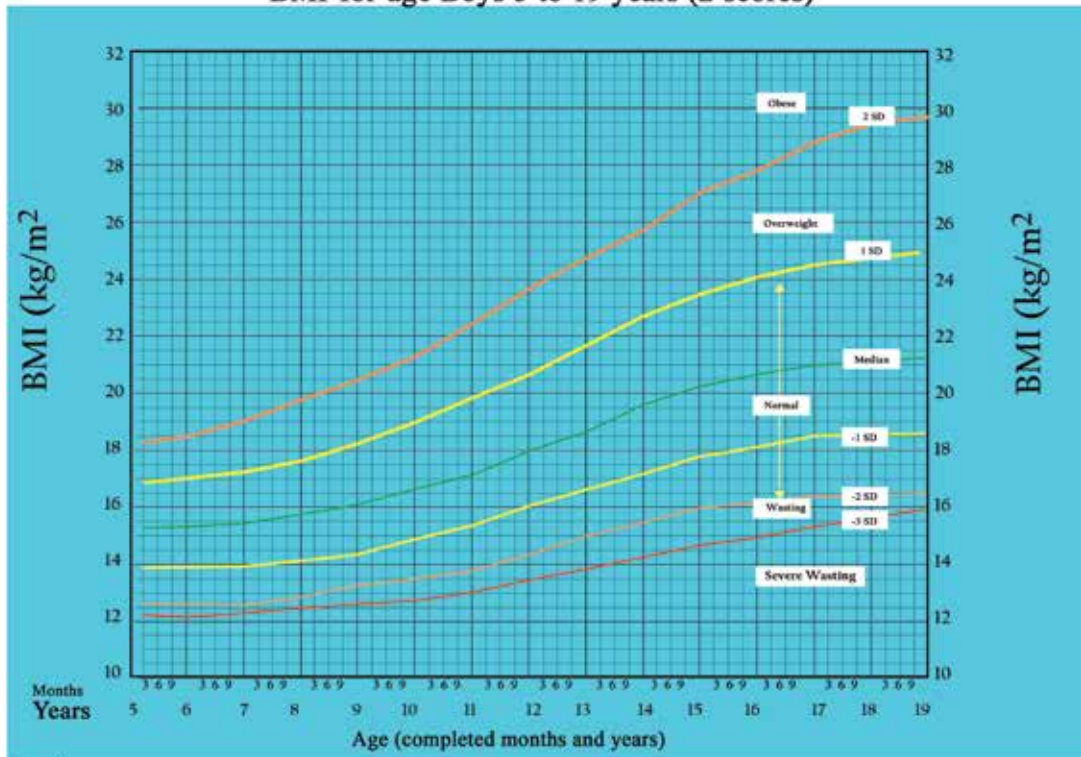
Annex 13: Legislative Framework for the Protection of Women and Girls in Namibia

Law	Description
Combating of Rape Act No.8 of 2000	Gives greater protection to young girls and boys against rape, provides for stiffer minimum sentences for rapists, and defines marital rape as an offence in the eyes of the law. Marital rape is explicitly criminalised in Article 3, and Sections 5 to 7 disallow a negative inference due to a delay between the alleged act and the complaint.
Combating of Immoral Practices Amendment Act No 7 of 2000	Was enacted just before the above mentioned Rape Act to amend pre-independence legislation. It remains out-dated and in need of further modernisation to bring it fully into line with the new laws. The amendment only sought to extend the prohibition of sexual or indecent acts to cover all young people aged 16 and under. It also redefined a 'sexual act' to comply with section 1(1) of the Rape Act, 2000 [No 8 of 2000] which was enacted after being delayed primarily due to debates concerning its provisions outlawing marital rape.
Combating of Domestic Violence Act No. 4 of 2003	Makes domestic violence a specific crime and has a broad definition of domestic violence that includes physical abuse, sexual abuse, economic abuse, intimidation, harassment and serious emotional, verbal or psychological abuse. The Act covers violence between husbands and wives, parents and children, boyfriends and girlfriends and between family members. It creates a Protection Order regime as an alternative or additional remedy to criminal prosecution and as a means to protect those who are subject to domestic violence by restricting the behaviour or relocating the abuser rather than institutionalising the person(s) who is being abused. Individuals who have suffered violence can use the simple, free procedure to obtain a Protection Order from a Magistrate's Court.
Criminal Procedures Amendment Act No. 24 of 2003	Introduces a new section (158A) to the Criminal Procedure Act [No. 51 of 1977] in order to address the needs of vulnerable witnesses, without derogating from the right of the accused to a fair trial. The Act sets out certain steps regarding "special arrangements" that can be taken by the court requiring a vulnerable witness to give evidence in criminal proceedings.
Prevention of Organised Crime Act No. 29 of 2004	Opens the way to address human trafficking. However, this issue is extremely controversial with some arguing that further legislation is required to bring Namibia fully into line with international standards and others arguing that the Act is adequate for the time being.

Married Persons Equality Act No.1 of 1996	Grants women equal legal status in the household. It eliminates the concept of marital power, the power of the husband over the person and property of his wife, and allows women more freedoms with regards to property which they share with their husbands. It also grants equal capacity to both spouses to administer and dispose of their jointly owned property; and those married “in community of property” must consult each other on all major transactions, being subject to identical powers and restraints
Maintenance Act No.9 of 2003	Is intended to advance women’s economic independence through a more workable system for obtaining child maintenance. The Act provides that all children are to be treated equally, regardless of the marital status of their parents, the order of their birth or any contrary provisions of customary law.
Communal Land Reform Act No. 5 of 2002	Provides for secure land tenure for widows and gives women the equal right to apply for and be granted land rights in communal areas and secures the right to inherit land for many women who were otherwise denied this by customary law and practices.
Labour Act No. 11 of 2007	Forbids any person from employing a child and from requiring or permitting the child to work in any circumstances prohibited in terms of section 3.
Children’s Act No.33 of 1960	Is regarded as outdated, but makes provision for best interests of the child. Work started on new legislation in 1994 with the view to have two new laws dealing with children’s status and child care and protection separately. In 2000 the then new MGECW assumed responsibility for finalising the draft bills which were discussed at a stakeholder workshop in October 2001. The Child Care and Protection Bill, having been identified as a law reform priority in 2008, and having undergone the largest national law reform consultation held to date in Namibia...that involved all sectors of society is soon to be tabled.
Children’s Status Act No. 6 of 2006	Provides parents with the rights of access, custody and guardianship to their children, including those born outside marriage whereas previously women alone had enjoyed these
Births, Marriages and Deaths Registration Act No. 81 of 1963	Reaffirms the constitutional right of all children to a name and nationality through the registration of birth and the issuing of a birth certificate as the first step to securing this right.

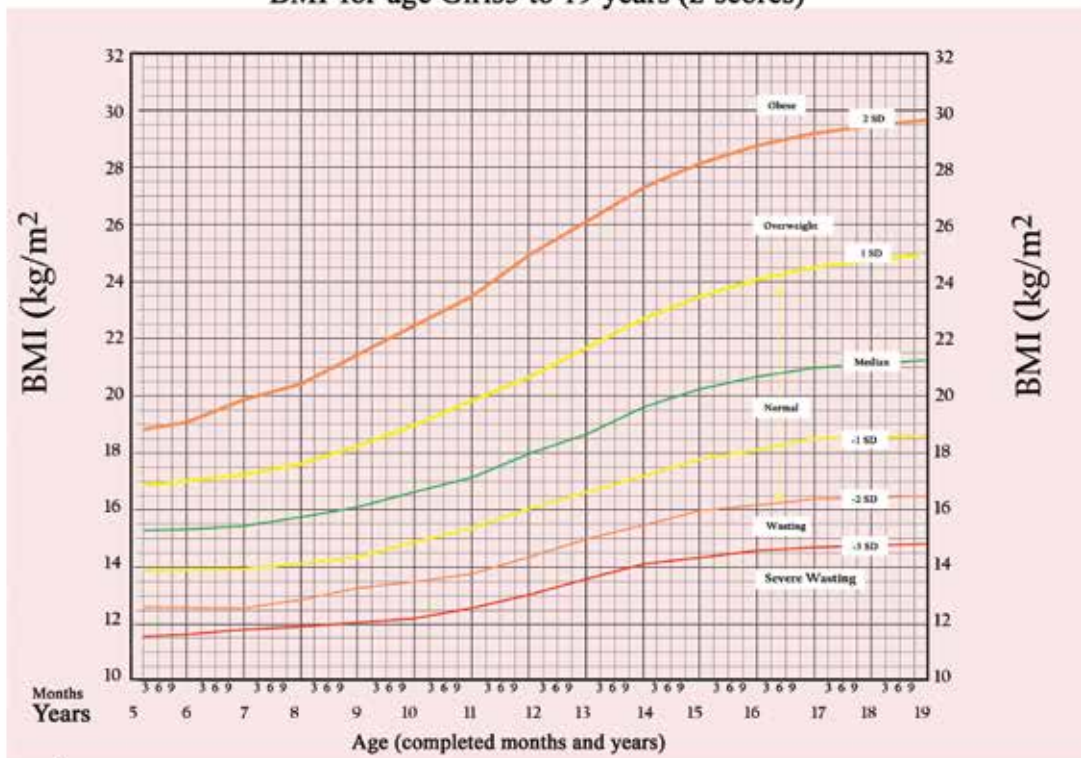
Annex 14: Body Mass Index for Boys and Girls

BMI-for-age Boys 5 to 19 years (z-scores)



Ministry of Health & Social Services
THE REPUBLIC OF NAMIBIA

BMI-for-age Girls 5 to 19 years (z-scores)



Ministry of Health & Social Services
THE REPUBLIC OF NAMIBIA

For more information, please visit the School Health Portal:
http://www.moe.gov.na/health_portal_view.php?id=1



MINISTRY FOR FOREIGN
AFFAIRS OF FINLAND



NATIONAL INSTITUTE
FOR HEALTH AND WELFARE

CRC@25
CONVENTION ON THE
RIGHTS OF THE CHILD



unicef
unite for children



**World Health
Organization**