COURSE GUIDE

PHS 302
SCHOOL HEALTH PROGRAMME

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CONTENTS **PAGE**

INTRODUCTION

PHS 302: School Health Programme- is a three-credit unit course meant to be taken in the second year by all students offering the first degree in community health programme. The materials have been developed to suit students studying at a distance. The promotion of the health of school children in schools is a critical step towards quality achievement in education. School Health Services therefore are actions taken by the health team in conjunction with the school authorities, teachers and parents to promote the highest possible level of health for school children throughout their years of study.

WHAT YOU WILL LEARN IN THIS COURSE

The course consists of 21 different units and a course guide. The course guide tells you briefly what the course is about, what course materials you will be using and how you can work with these materials. In addition, it prescribes some general guidelines on the amount of time you should spend on each unit of the course in order to complete it successfully.

It gives you guidance with respect to your tutor- marked assignment, which will be made available in the assignment file. There will be regular tutorial classes for those of you offering the course. It is advisable that you make yourself available for these tutorial classes. The course will prepare you to be able to organise and implement school health programme.

COURSE AIM

The course aims to provide you with an understanding of school health programme and how to plan, implement and evaluate school health service delivery.

COURSE OBJECTIVES

To achieve the goal of the course, each unit has its specific objectives. You should read these objectives before you study the unit. You may wish to refer to them during your study to check on your progress. You should always look at the unit objectives after completion of each unit. By doing so, you would have followed the instructions in the unit. Set out below are the comprehensive objectives of the course as a whole. By meeting the objectives, you can count yourself as having met the aims of the course.

On completion of the course, you should be able to:

- discuss the concept of School Health Programme
- explain the health needs of the children.
- explain how to manage health conditions among school children
- describe the procedure for carrying out medical examination of school children
- explain how to plan, implement and evaluate school health services
- describe how to promote good school environment
- explain how to manage school food vendors
- discuss health education/hygiene in school health programme.

COURSE REQUIREMENTS

To complete the course, you are required to read the study units and read the sets of books and other relevant materials you may lay your hands on. Each unit contains self-assessment exercises and at a certain point in time you would be required to submit written assignments for assessment purposes. At the end of the course you will be required to write the final examination. The course should take you a total of about 21 weeks to complete. Below you will find listed all the components of the course, what you have to do and how you should allocate your time to each unit in order to complete the course on time and successfully. This course requires that you spend a lot of time to read. I would advise that you attend the tutorial sessions, where you will have the opportunity of comparing your knowledge with that of other people.

COURSE MATERIALS

The main components of the course are:

1. The Course Guide
2 Study Units
3. References/ Further Reading
4. Assignments
5. Presentation Schedule

STUDY UNITS

There are 21 units in a total of four modules in this course. These are listed below:

Module 1

Unit 1 The Concept of School Health Services
Unit 2 Components of School Health Programme
Unit 3 Personnel, Parents and Community Involvement in School Health Programme.
Unit 4 Assessment of Health Needs and Resources for School Health Programme
Unit 5 Appraisal of Health Status of School Children

Module 2

Unit 1 Health and Hygiene Education
Unit 2 Healthy School Environment
Unit 3 Involving Children in Health Education
Unit 4 Evaluation of School Health Programme
Unit 5 Learning Disabilities

Module 3

Unit 1 Accidents, Emergencies and Management of Some Ailments in Schools
Unit 2 The School First Aid Box and First Aid Care
Unit 3 First Aid Treatment of Some Chronic Ailments 1
Unit 4 First Aid Treatment of Some Chronic Ailments 2
Unit 5 Treatment of Common Ailments among School Children

Module 4

Unit 1 Vaccine Preventable Diseases
Unit 2 Control of Communicable diseases
Unit 3 Child Abuse
Unit 4 Sexual Abuse
Unit 5 Home Visiting
Unit 6 Evaluation of School Health Programme

The first and second modules focused on the concept of school health programme, health & hygiene education in the school, school meal services and learning disabilities. The third module focused on how to manage accidents, emergencies and other common ailments in the school. Module four focused on vaccine preventable diseases, control of communicable disease, child abuse, home visiting and evaluation of school health programme. Each unit consists of one or two weeks' work and include an introduction, objectives, reading materials, exercises, conclusion, summary, tutor-marked assignment (

TMAs), references and other resources. The exercises and TMAs will help you to achieve the stated learning objectives of the individual units and of the course as a whole.

PRESENTATION SCHEDULE

Your course materials have important dates for the early and timely completion and submission of your TMAs and attending tutorials. You should remember that you are required to submit all your assignments by the stipulated time and date. You should guide against falling behind in your work.

ASSESSMENT

There are three aspects to the assessment of the course. The first is made up of the self-assessment exercises, the second is the tutor–marked assignments and the third is the written examination. You are advised to do the exercises. In doing the assignments, you are expected to apply information, knowledge and techniques you gathered during the course. The assignment must be submitted to your facilitator for formal assessment in accordance with the deadlines stated in the presentation schedule and the assignment file. The work you submit to your tutor for assessment will count for 30% of your total course work. At the end of the course you will sit for a final or end of course examination of three hours duration. This examination will count for
70% of your total course mark.

TUTOR– MARKED ASSIGNMENT

The TMA is a continuous assessment component of your course. It accounts for 30% of the total score. You will be given four TMAs to answer. Three of these must be answered before you are allowed to sit for the end of course examination. The TMAs would be given to you by our facilitator and returned after you have done the assignment. Assignments questions for the units in this course are contained in your reading, references, and study units. However, it is expected that in a degree course that you should demonstrate that you have read and researched more into your references, which will give you a broader understanding of the subject matter.

Make sure that each assignment reaches your facilitator on or before the deadline given in the presentation schedule a n d assignment f i l e. If for any reason you cannot complete your assignment on time, contact your facilitator before the assignment is due, to discuss the possibility of an extension. Extensions will not be granted after the due date, unless there are exceptional circumstances.

FINAL EXAMINATION AND GRADING

The end of course examination for the School Health Programme will be for about three hours and it has a value of 70% of the total course work. The examination will consist of questions, which will reflect the type of practice exercises and TMAs you have previously encountered. All areas of the course will be assessed. After you have completed the last unit, make sure that you revise the whole course before the commencement of the examination.

Course Marking Scheme	**Marks**
Assignments 1-4	Four assignments, best three marks of the four will attract 30% of the course marks
End of course examination	70% of overall course marks
Total	**100% of course materials**

FACILITATORS/TUTORS AND TUTORIALS

There are 21 hours of tutorials provided for those offering this course. You will be notified of the dates, time and location of these tutorials, as well as the name and the phone number of your facilitator, as soon as you are allocated a tutorial group. Your facilitator will mark and comment on your assignments and keep a close watch on your progress and any difficulties you might face and provide assistance to you during the course. You are expected to mail your TMA to your facilitator before the schedule date (at least two working days are required) . They will be marked by your tutor and returned to you as soon as possible. Do not delay to contact your facilitator by telephone or e-mail if you need assistance.

The following might be instances that you may need assistance and would have to contact your facilitator when:

- You do not understand any part of the study or the assigned readings. You have difficulty with the self- test.
- You have a question or a problem with an assignment or with the grading of an assignment.
- You should ensure that you attend the tutorials. This is the only opportunity that you have, for face to face contact with your course facilitator, to ask questions and receive immediate answers, as well as be able to discuss your challenges.

- To derive much benefit from your tutorials, prepare a question list before attending them. You will learn a lot by participating actively in discussions.

SUMMARY

School Health Programme is a course designed to enable you acquire the knowledge and skills that will make you provide effective school health services. Upon completing the course you will; understand the concept of school health programme and the needs of the school child. Management of common health conditions among school children, how to carry out medical examination of school children, how to organise health services to meet the needs of school children, how to promote good school environment and how to manage school food vendors.

In addition you should be able to answer the following type of questions: State the aims and objective of school health programme. Mention the importance of school health programme. Explain the components of school health programme. State the rational for needs assessment of school children. Explain the prevention and control of common health conditions among school children. Explain how to conduct daily hygiene inspection of school children. Explain how to organise the school health services to meet the needs of school children. Explain the criteria for selecting school food vendors. etc.

I wish you success in the course and I hope you will find it interesting and useful.

MAIN COURSE

CONTENTS **PAGE**

MODULE 1

UNIT 1 THE CONCEPT OF SCHOOL HEALTH SERVICES

CONTENTS

1.0 INTRODUCTION

This unit will serve as an introduction to the Organisation of School Health Services. It will help you to have a basic understanding of the concept of school health services.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define some terms used in school health service
- state the concept of health promoting school define school health services
- state the goal of school health programme
- mention the objectives of school health programme

- describe the importance of school health programme.

3.0 MAIN CONTENT

3.1 Definition of Terms

School is an institution for educating learners; it includes Early Child-Care Centres (ECCC), Primary and Secondary Schools, and Non-Formal Education Centres (NFE). School Community refers to all the people living/working within the school premises including pupils/students, the teaching and non-teaching staff as well as members of their families Health, according to the World Health Organisation (WHO) "is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Service is a system or arrangement that supplies public needs. It could be organised by an individual, group or the government. School Health Day, shall refer to a day set aside annually to create awareness on health related issues in the schools.

3.2 Concept of Health Promoting School

According to the WHO, a health promoting school is "one that is constantly strengthening its capacity as a healthy setting for living, learning and working". The characteristics of the school include:

- Fostering friendly, healthy and learning environment
- Integrating health and education officials, parents and the community in the efforts to make the school a healthy place
- Providing healthy environment, skill – based health education and school health services
- Striving to improve the health of learners, personnel and the community
- Building capacity for security, peace, shelter, education, food, gender equity, stable eco-system, social justice and sustainable development
- Preventing leading causes of death, disease and disabilities in the school community e.g. malaria, water borne disease, infections, drug and alcohol abuse, HIV and AIDS, injuries, and malnutrition
- Influencing health related knowledge, attitude, values, beliefs, skills, and behaviours

<u>The twelve (12) WHO criteria for a health promoting school</u>

1. Active promotion of self-esteem of all pupils by demonstrating that everyone can make contribution to the life of the school child.

2. Development of good relations between staff and pupils and among pupils in the daily life of the school.
3. Clarification of staff and pupils of the social aims of the school.
4. Prevision of stimulating challengers for all pupils through a wide range of activities.
5. Use of every opportunity to improve the physical environment of the school.
6. Development of good links between school, home and community.
7. Development of good links among associated primary and secondary schools to plan a coherent health education curriculum.
8. Active promotion of the health and well-being of the school and staff.
9. Consideration of the role of staff as exemplars in health-related issues.
10. Consideration of the complementary role of school meals (if provided) to the health education curriculum.
11. Realisation of the potential of specialist services in the community for advice and support in health education.
12. Development of the education potential of school health services beyond routine screening and towards active support for the curriculum.

3.3 Definition of School Health Services: define school health services as

The various actions that are taken by the health team in conjunction with the school authorities, teachers and parents to promote the highest possible level of health for school children throughout their years of study. It is essential that school children should be physically well, mentally alert, emotionally and socially stabilised.

School health is usually considered as an integral part of community health and of course an aspect of health education. It also includes school activities a n d measurement that are carried out within the community to promote and protect the health of the child and the school staff. School Health Programme therefore comprises all projects and activities in the school environment for the promotion of the health and development of the school community.

3.4 Goal School Health Programme (SHP)

The main goal of the SHP is to improve the health of learners and staff as responsible and productive citizens.

3.5 The objectives of SHP are to

- produce a well-adjusted physically vigorous child who is free from disease
- produce individuals who know how to care for their health, the health of the family and others
- bring about continuing appraisal of the child's health status to understand t he child's health needs and offer supervision and
- guidance for the child
- prevent and control diseases
- encourage the correction of remediable defects
- make a child become aware of the importance of health and develop healthy practices, health knowledge, attitude and appreciation towards health
- develop healthy physical and psychological environment for the
- Child, provide first aid care in accidents and emergency
- promote a state of health, treat minor ailments, prevent diseases and maintain the health of school population
- promote growth and development of every child taking into consideration the child's health needs
- create awareness of the collaborative efforts of the school, home and community in health promotion
- develop health consciousness among the learners
- create awareness on the availability and utilisation of various health related resources in the community
- promote collaboration in a world of interdependence, social interaction and technological exposure in addressing emergent
- health issue
- build the skills of learners and staff for health promotion in the school community.

3.6 Importance of the School Health Services includes

The school health services is needed because we know that the children in the school form a large proportion of the population and are targets for malnutrition, and some other diseases. If their health is taken care of therefore, a large percentage of the population will be covered. School children at this age undergo several physical, emotional and developmental changes. These changes may create problem for the school so the school authorities should recognise these problems and

give adequate solution. School age child comes to school and faces many risks e.g. accidents, emotional stress, and also communicable diseases. The school therefore is a centre of risk and so the school authority should take action to solve the problem. The school should care for the health of the child because teaching about health in school is usually more effective than teaching elsewhere eg. in the mass media.

4.0 CONCLUSION

In this unit you have learnt the concept of health promoting school and the twelve WHO criteria for a health promoting school .You also learnt about the definition of school health, its goal and objectives as well as the importance of school health for the promotion of the health and development of the school community. You should at this stage be able to define a health promoting school and the WHO criteria for health promoting school. You should also be able to define school health, its objectives and importance.

5.0 SUMMARY

This unit has focused on the concept of health promoting school as "one that is constantly strengthening its capacity as a healthy setting for living, learning and working" and also highlighted the twelve WHO criteria for health promoting school. The unit defined school health services as various actions that are taken by the health team in conjunction with the school authorities, teachers and parents to promote the highest possible level of health for school children throughout their years of study, stated the objectives of school health programme as well as its importance .

6.0 TUTOR-MARKED ASSIGNMENT

1. Mention ten criteria for identifying health promoting school.

7.0 REFERENCES / FURTHER READING

Lucas, A. O. & Gilles, H.M. (2 0 0 3). "A Short Textbook on Preventive Medicine for the Tropics". (4th ed.). Arnold Hodder , London: Sydney, Auckland and Toronto.

Federal Ministry of Health and Human Services. (1992) School Health Session Plans. Training and Manpower Development Division, Lagos, Nigeria.

Federal Ministry of Education Nigeria, National School Health Policy.

UNIT 2 COMPONENTS OF SCHOOL HEALTH

CONTENTS

1.0 INTRODUCTION

Having gone through unit 1, you would have learnt the definition, the concept and objectives of school health programme. This unit will help you to understand the components of school health programme. Let us have a view of what you should learn in this, as indicated in the objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify the components of school health programme
- discuss each of the components of school health programme.

3.0 MAIN CONTENT

The component of school health services embodies a total programme in health including all school activities that contribute to the understanding, maintenance and improvement of the health of the school population. It includes all school health activities planned, organised and conducted by the school under the jurisdiction of the teachers and the school staff, they are:

3.1 Healthful School Environment

Healthful School Environment is one of the interrelated aspects of the School Health Programme. The concept "Healthful School Environment" denotes all the consciously organised, planned and executed efforts to ensure safety and healthy living conditions for all members of the school community. A healthful school environment (physical, biological and socio-cultural) serves as a major determinant of health and greatly influences the individual's level of intellectual growth and development. Provision of healthful school environment must be guaranteed for efficient performance of staff and learners. All the necessary services, facilities and tools needed for the physical, social and emotional wellbeing of the school population must be assured, provided, safeguarded and sustained.

3.1.1 Objectives

The Objectives of a Healthful School Environment are to:

- Create a healthy and safe learning environment in the school
- Provide adequate safe water supply and sanitation facilities for use in schools.

3.1.2 Characteristics of Healthful School Environment

The major conditions required for healthful school environment include:

- Location of schools away from potential environmental hazards
- Protection of the school community from excessive noise, heat, cold and dampness
- Provision of adequate buildings, constructed in line with approved standards, with particular emphasis on facilities for physically challenged learners
- Provision of an appropriate and adequate amount of furniture for learners and staff
- Provision of an adequate number of gender-sensitive toilet facilities

- Provision of adequate safe water supply and sanitation facilities for the school community
- Provision of proper drainage and waste disposal facilities
- Provision of safe recreational and sport facilities
- Perimeter fencing of the school
- Observation of annual School Health
- Promotion of healthy human relationships in the school community
- Promotion of health related-school policies
- Promotion of a maintenance culture.

3.2 School Feeding Services

School feeding services are aimed at providing an adequate meal a day to all children enrolled in schools nationwide. The service builds upon the Government's current National Home-Grown School Feeding and Health Programme (HGSF&HP) which aims to contribute to the realisation of national and international initiatives for development.

3.2.1 Objectives

The objectives of the School Feeding Service are to:

- Reduce hunger among school children
  Increase school enrolment, attendance, retention and completion rates particularly among children in poor rural communities and urban neighbourhoods
- Improve the nutritional status of school children
- Enhance the comprehension and learning abilities of pupils/students.

3.2.2 Characteristics of School Feeding Services

The characteristics of school feeding services include:

- Provision of, at least, one adequate meal a day to school children
- Adequate sanitation and hygiene practices among food handlers including routine medical examination and vaccination
- Food fortification and supplementation
- Regular de-worming
- Promotion of health related-school policies.

3.3 Skill-Based Health Education

Skill-based Health Education is to promote the development of sound

health knowledge, attitudes, skills and practices among the learners. The subject is also aimed at meeting the growth and developmental needs and interests of learners.

Health education is education for life; therefore emphasis should be placed on skills necessary for promoting appropriate behaviours and practices as against just theory-based lessons.

3.3.1 Objectives

The objectives of Skill-Based Health Education are to:

- Provide information on key health issues affecting the school community
- Develop skill-based health education curriculum for the training of teachers and learners
- Provide participatory learning experiences for the
- development of knowledge, attitudes, skills and desirable habits in relation to personal and community health
- Evaluate learners' progress towards healthy development.

3.3.2 Characteristics of Skill-Based Health Education

The following broad areas will be covered by the Skill-based Health education Curriculum:

- Personal Health
- Diseases including HIV/AIDS
- Mental and Social Health
- First Aid & Safety Education
- Community Health
- Family Life Education
- Environmental Health
- Maternal and Child Health
- Nutrition
- Consumer Health
- Drug Education
- Ageing and Death (Bereavement) Education
- Parts of the human body
- Health Agencies.

3.4 School Health Services

School Health Services are preventive and curative services provided for the promotion of the health status of learners and staff. The

purpose of the School Health Services is to help children at school to achieve the maximum health possible for them to obtain full benefit from their education.

School Health Services should include pre-entry medical screening; routine health screening/examination; school health records; Sick bay, First Aid and referral services. It shall also provide advisory and counselling services for the school community and parents. Personnel for School Health Services should include medical doctors, school nurses, health educators, and environmental health officers, school guidance counsellors, community health workers, dieticians, nutritionists, school teachers and social workers.

3.4.1 Objectives

The objectives of school health services include:

- Provide basic services for disease prevention and management of injuries in the school
- Build capacity of the school community to identify, treat, and manage simple illness, injuries, infections and infestations.

3.4.2 Characteristics of School Health Services

Broadly, the School Health Services include:

- Appraisal of the health status of learners and school personnel through pre-entry screening,
  Routine medical and psychological examinations
- Health counselling of the school community by counsellor/social worker
- Referral and follow-up health services between the school, community and the health facilities
- Health screening and the maintenance of routine health records in the school
- Prevention and control of communicable and non-communicable diseases, through inspections, exclusions, re-admission, educational measures, immunisation, sanitation and epidemic control
- Provision of special health services for learners with special needs.

3.5 School, Home and Community Relationship

The first health educators of the child are the parents, who shape the child's habits from infancy. Long before the child is ready for school,

the parents should secure needed immunisation and medical care and inculcate good habits into the child. The success of the School Health Programme depends on the extent to which community members are aware of and willing to support health promotion efforts. Schools should encourage parents and community members to make inputs regarding the design, delivery, content and assessment of the SHP so as to respond to their concerns and obtain their commitment. At the same time, schools can play an important role in improving the health and development of the community as a whole. For a balanced development of the child, life at home should complement a healthy life-style provided in the school; therefore' regular contacts between schools and homes are essential.

3.5.1 Objectives

The objectives of promoting school, home and community relationship with regards to school health are to:

- Build and strengthen capacity for effective community involvement and participation in school management.
- Improve advocacy and community mobilization to bring about necessary support from Stakeholders.

3.5.2 Characteristics of School, Home and Community Relationship

The characteristics of school, home and community relationships that include:

- Home visits by teachers, school nurses and social workers
- Regular visit of parents to school
- Regular communication of the health status of the learner to the home by the school health personnel and the teachers
- Active participation of the school in community outreach activities and campaigns
- Active participation of the school in community health planning,
- implementation, monitoring and evaluation.
- Advocacy and community mobilisation for the SHP through traditional and modern media
- The community involvement in the promotion of health related school policies.

4.0 CONCLUSION

In this unit you have learnt that components of School Health

Programme include Healthful School Environment, School Feeding Services, Skill-Based Health Education, School Health Services and School, Home and Community Relationship. You have also learnt the objectives and the characteristics of these components.

5.0 SUMMARY

This unit has focused on components of School Health Services which can be summarised as follows:

a. Skill – based Health Education This is a series of learning experience directed towards developing health- related knowledge and practices. This can be taught in such area like nutrition, environmental health education, sex education.

b. Health Services: This comprises all the procedures designed to determine the health status of the child and to promote its maintenance. It enlists the student's co-operation on health protection, informs parents of any defect that may have been discovered by observation or screening procedures and promotes immunisation programmes for the prevention of disease.

c. Healthful School Environment: This is the provision of wholesome surroundings for students and teachers. It includes planning,
and supervising activities, procedures, facilities and equipment
that can affect physical and emotional health.

d. School Home and Community Relations: This refers to the co- operative efforts of the home, School and community on matters affecting the health of pupils.

e. School feeding Service: This aims at providing an adequate meal a day to all children enrolled in schools.

6.0 TUTOR -MARKED ASSIGNMENT

List the components of school health services and state their objectives.

7.0 REFERENCES / FURTHER READING

Lucas A. O. & Gilles H.M. (2003) "A Short Textbook on of Preventive Medicine for the Tropics". (4

ed.) Arnold Hodder
Group, London, Sydney, Auckland and Toronto.

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UNIT 3 SCHOOL PERSONNEL, PARENTS AND COMMUNITY INVOLVEMENT IN SCHOOL HEALTH PROGRAMME

CONTENTS

1.0 INTRODUCTION

Having mastered the components of school health in unit 2, this unit will help you to understand the involvement of School personnel, parents and the community in school health programme. Before we do this let us view what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe how to establish a working relationship with school personnel
- discuss the involvement of parents and the community in school health programme
- state the role of teachers in health education.

3.0 MAIN CONTENT

3.1 Establishing Working Relationship With School Personnel

Ways of establishing working relationship with the school personnel are as follows:

Having studied the objectives and components of the school health programme, it is obvious that all the objectives cannot be achieved by the health worker alone, effective and efficient teamwork is required. To effect this, you as the health worker have to work with other professionals to form a team for the school health services. The team includes the teacher who is the prime member since he sees the pupils daily and knows them best. Others are the school nurse, social worker, psychologist, physical education instructor etc, where they are available and of course the Primary health worker.

For the team to function well, a good working relationship must be established. To achieve this, at the planning stage, the head of the school will be visited, to inform him about the programme. It is at this meeting that the health worker will enlist their co-operation, present his programme and activities and discuss how to implement these with them. Together, they can decide when he should visit during the week, the pupils to be seen and also where he can examine the children and a place to keep his charts and other health documents in the school. The approach as a health worker is very important for them to co-operate, as without their support, it would be impossible to get the children to practice good hygiene.

3.2 Parent and Community Involvement

Partnership among schools, families, community groups and individuals should be designed to share and maximise resources and expertise in addressing the healthy development of children, youth, and their families. The family, the school and the community each has valuable resources that may be called upon to support schools and school health programme. Within the community, many organisations exist that influence the health, safety and learning potentials of students. The essential functions of family and community involvement in school health include:

Providing time, expertise, and resources;

Supporting student involvement in activities that support health;
Ensuring that students and their families receive needed health services;

Planning jointly to develop relevant and appropriate messages and services; delivering clear, consistent messages that support health, including high but attainable expectations and offering appropriate role modelling.

3.2.1 Involving Parents

Parents involvement in their children's education and health enhance the health, self-esteem, and academic potentials of the children, as well as empower the parents to be more responsible for the health and education of their children. Regular communication with parents is key to soliciting their involvement.

The following are ways parents can be involved in a coordinated school health programme:

1. **Health services:** Parents with training in universal precaution can be volunteers for school-based health services. The health team with the assistance of the PTA can plan and implement seminar/workshops for other
   parents on first aid, disease prevention and control, and injury prevention.
2. **Health Education:** Parents can volunteer to have a regular column on students and family health in the schools newsletter.
   Parents can ask teachers to require their students to share articles on health with their parents. Parents can hold health education workshops for other parents, and be involved in planning and implementation of such workshops. Parents can teach or speak about health related careers i.e. career counselling.
3. **Physical Education:** Parent (through the local PTA) can help sponsor awards for participation in sports that also encourage academic excellence.
   Parents can work with the school's physical education department to plan and / or implement field days and school dance performances or events.
4. **School Nutrition Services:** Parents can work with the school personnel to establish a parent- student school nutrition committee to help the nutrition services staff promote good nutrition practices. Parents can work with the school
   administration to invite other parents to eat at school with their children at least once or twice a year. Parents could help the school to organize a school party and invite some Role Models. These role models may give support and encouragement to students on a one - on -one basis.

5. **Counselling and Psychological Services:** In most cases, parents should be involved in any counselling and psychological services provided to their children (unless it is determined that it is not in the best Interest of the student). Parent canbring students to appointments. Parent and school staff members may collaborate to plan and implement training sessions for other parents.

6. **Healthy School Environment:** The local PTA, or other parent group, can work with the school administration to conduct an evaluation of the school environment.
   Parents can develop a school –sponsored project to improve some aspect of the school environment. Parents can work with the local school board to fund Projects to improve the school grounds and facilities.

7. **Staff Wellness Programmes**: Parents can work with school personnel to establish school staff wellness programs. Parents can volunteer to assist in sponsoring staff health screening. Parents can sponsor incentives for ongoing parent/ staff health improvement programs (e.g smoking cessation, weight control, exercise programs, and so Forth).

3.2.2 Parent Teacher Association (PTA)

Parents and the community may also become involved in the school health program through organisation such as PTA. PTA is a non- profit organisation of parents, educators, students, and other community members.

3.3 Organising Seminar/Workshop for Teachers and Parents

This should be organised for the Parents. Teachers Association by the health team to update their knowledge and skills in child health care thus:

Workshop – this is designed for people who are experienced in their own fields of learning. They will work together to find solutions to given problems within a specified period of time. Seminar – a method where a series of papers are presented on different topics under the same theme. The health team should first determine the topics to be covered during the seminar and the workshop.

For a Seminar

The following topics on health education will be presented.

a) Personal and environmental hygiene
b) Accident prevention Sex education Nutrition c) Dental Health
d) Immunisation
e) Dangers of smoking and drug abuse.

For Workshop

The following will be done,

- screening for: Disabilities
- Malnutrition
- Fever
- Epilepsy
- Pallor/ sickle cell disease
- Underweight.
- Assign the topics to those who will present them and
- Draw up a programme.
- Decide on the materials that will be required for the workshop.
- Inform those who will present, when they will by presenting and their topics for presentation. Ensure that all materials are ready before the day of the seminar or workshop.
- All participants (parents and teachers) must be informed of time, venue and objectives of the workshop / seminar.

3.4 Maintenance of Personal Health by Teachers

There is the great need for teachers to maintain personal health because they are not only teachers but also role models for the school children. The school children always try to copy what their teachers do and this will result to desirable behaviours if the teachers are good role models. Teachers will maintain good health by doing the following:

- Eating balance diet
- Washing hands before and after eating
- Washing hands after visiting the toilet
- Desisting from smoking, drinking alcoholic drinks and taking of hard drugs
- Having adequate rest and sleep
- Taking regular baths
- Going for regular medical check-up and taking of immunization as appropriate.
- Having regular exercise
- Keeping hair neat.
- Putting on clean clothes and shoes

- Keeping nails short and clean
- Keeping the teeth and mouth clean.

4.0 CONCLUSION

In this unit you have learnt how to establish a working relationship with the school personnel, especially teachers as well as parents and community involvement, including the Parents Teachers Association, in school health programme. You should at this point list other members of the school health team. You should also be able to describe the different roles that parents can play in order to contribute to a coordinated and effective school health service delivery.

5.0 SUMMARY

This unit has focused on personnel, parents and community involvement in school health programme – Effective and more coordinated school health programme requires a team effort. The school team includes the teacher ,the school social worker, psychologist, physical education instructor and the health worker. Parents, the community and the PTA can be involved in the different components of school health programme such as health service delivery, health education, physical education, school nutrition services, counselling and psychological services, healthy school environment
and staff wellness programme.

6.0 TUTOR-MARKED ASSIGNMENT

1. As a school health worker, describe how you can form a school health team.
2. Discuss how the school health team and the PTA can organise a HIV /AIDS awareness day for the staff and students of a school.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services , (1992). School Health Session Plans. Training and Manpower Development Division ,Lagos , Nigeria.

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UNIT 4 ASSESSMENT OF HEALTH NEEDS AND RESOURCES FOR SCHOOL HEALTH PROGRAMME

CONTENTS

1.0 I N T R O D U C T I O N

In order to effectively implement the components of school health services there is need to assess the needs of the school children as well as the available resources which will give the health team a baseline information to work with. This unit will enable you acquire an understanding of the rationale for needs assessment of the school child and how to conduct needs assessment. Before we do this let us have a view of what you should learn in this unit, as indicated in the unit objective below:

2.0 OBJECTIVES

At the end of this unit, you should be able to:

explain the rationale for needs assessment of the school child describe the methods used to collect information for the needs assessment of the school child explain the guidelines for prioritising the identified needs discuss how you can assess the resources for school health programme.

3.1 Rationale for Needs Assessment of the School Child

The needs assessment of the school child is necessary before the commencement of the school health services, because. It is necessary to know how big the need is and how serious or dangerous to the school children. If the need is assessed before and after intervention, it will be possible to show the impact of the programme. It will assist us to decide on the most appropriate way to deal with the need. It will assist in the setting of your objectives when you know what they lack, then you will have an idea of what to provide. The need assessment is more than the sum of illnesses, injury or negative health behaviour, it also includes the environment.

3.2 Methods used to collect Information for the Needs Assessment of the School Child

There are four main methods of information collection. They are:

Observation- which is collection of information by watching and listening.

Interviewing which involves discussion and questioning.

Review of records and documents which are written observations and experience of other people.

Physical examination – examining the school child from head to toe. Observation -What and how to observe; the children will be observed at play when they are on break and also at work in the classroom. The school environment will be observed for potable water supply, refuse disposal f acilitie s , latrine, safe playground, and equipment. The school environment must be conducive to the s c h o o l children . Also the nutritional status will be assessed during the examination. After collecting the information, you will come up with numerous problems and your activities in that school must focus on the particular needs and problems identified.

3.2.1 Description of Some of the Methods that Can be Used to Assess School Health Needs and Resources

Teachers' interview

- Questions are designed and directed to the parents or teacher
- The questions should cover all the objectives or needs of the program with the intention to find out the teachers' views and suggestions

- The interview is carried out by the health workers and each teacher is interviewed separately.

Students' Questionnaires:

- The questionnaire is designed and directed towards the students.
- They are usually set with many responses to be chosen from.
- The questionnaires are tested first before distributing them to the children.
- The children fill in the questionnaires by themselves
- After filling, they are returned to the teachers or health workers for compilation.

School attendance Records:

- A review of the school attendance register for that period will show the rate of absenteeism to sickness and the types of sickness.

  Health Services / PHC Statistics:
- Statistics from the health facilities which give attendance record of school children at the clinic, and the types of conditions they present will serve as baseline for the implementation of the school health programme.

3.3 Guidelines for Prioritising the Needs Identified

Faced with numerous needs and problems, the following guidelines will help you in prioritising your needs.

- Determine which problems are most common and widespread.
- This will indicate which should be given the highest priority in the health education and treatment programme.
- Distinguish between those diseases or problems that can be controlled by health education, immunisation and those over
- which the health worker has no control.
- Try to prevent the problems you discover, from getting worse either by drawing teachers attention to them or
- discussing with the parents to give their children whatever
- specialised care they need.

3.4 Assessment of Resources

Having determined the needs of the school children, the resources to meet these needs are assessed. The existing facilities and equipment are assessed to know if they will be adequate to meet the needs identified. If necessary, the health worker will organise the school to generate

resources. Once the members of the community are made aware of the identified needs and the danger of not meeting those needs, they will be willing to provide the resources.

The mobilisation of the community for such is through the parent's teachers association. The School Health Personnel should realise that people are the most important resource for any programme and should therefore involve the various stakeholders. Resources needed may include: People- health personnel, Teachers, social workers, psychologist, and other people in the community; -Drugs and supplies, first aid kit, water, transport, accommodation, etc

-Community Organisations: Non-governmental Organisations, (NGOs), Community Based- Organisations, (CBOs), Community Development Committees, PTA, etc.

3.5 D e v e l o p i n g Project Activities

Having conducted the needs assessment, the health team must draw up a list of activities for the school health programme, within the limits of available resources. This list must be put into a time-table or schedule. The schedule must state the time for the beginning and completing each activity, and who is responsible to see that it is done; thus:

Activities (What is	How (Task)	Where (Location)	When (Time)	By Whom (Human Resources)	With What (Material Resources)

4.0 CONCLUSION

In this unit, you have learnt the rationale for needs assessment of school children, the methods for conducting needs assessment, guidelines for prioritising the identified needs, the resources needed, and how to develop project activities. You should at this time be able to state the rationale for conducting needs assessment of school children as well as be able to mention the methods used in conducting needs assessment.

5.0 SUMMARY

This unit has focused on the rationale for needs assessment of the school child -which is necessary before the commencement of the school health services programme in order to have base-line information for project implementation and subsequent evaluation.

The methods used for collection of information were also discussed and these include observation, interviewing, review of records and documents, and physical examination of the school children. Guidelines for assessment of identified needs and how to assess available resources as well as how to schedule project implementation were discussed.

6.0 TUTOR-MARKED ASSIGNMENT

At the commencement of school health programme in a rural - urban community of your choice, describe how you will conduct needs assessment of the school children.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services (1992) . School Health Session Plans. Training And Manpower D e v e l o p m e n t Division ,Lagos , Nigeria.

Peter Olise (2007). Primary Health Care for Sustainable Development: Ozege Publications, Abuja, Nigeria.

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UNIT 5 APPRAISAL OF HEALTH STATUS OF SCHOOL CHILDREN

CONTENTS

1.0 INTRODUCTION

Since you have studied unit 4 you would have understood the rationale for doing a needs assessment for school children and the methods used, the appraisal of health status of school children and the various techniques used. Before we do this, let us look at the objectives of the unit, viz;

2.0 OBJECTIVES

At the end of this unit, you should be able to;

- define appraisal of health status
- state the objectives of appraising health status
  discuss the different techniques involved in appraising the health status of school children.

3.0 MAIN CONTENTS

3.1 Definition of Appraisal of Health Status

This is the evaluation of the health status of school children by a variety of procedures. It is the quality of health that is assessed through the use of teachers, observations, screening tests, health history, dental inspection, medical examination and psychological test. These tests may involve the parents, teachers and the health worker concerned. Specific screening tests may include test for vision, hearing, growth and development, dental inspection and speech.

3.2 Objectives of Appraisal of Health Status: The Objective of Appraisal of Health Status are

To determine the health status of school children: (the level of health / wellness). In cases of deviation: to institute quick intervention thereby limiting disability and to inform parents of child's impairment or disability for medical, physical and social services.

3.3 Different Techni ques of Health appraisal

The different t e c h n i q u e s f o r the health appraisal of school children are as follows:

3.3.1 Health History

This is the technique used in school to determine the present and past health history of the child.

The information is usually obtained from parents or from the child
Use a questionnaire to get information from parents through the child

- By oral questions
- By visitation to parents' homes
- By check list – the child will mark the one that affects him on the list.

The information will include the child's personal information – name, parents, and home. They will also contain child health information e.g. Mental health, health related behaviour and certain behaviours that are not related to diseases e.g. Truancy, Kleptomania. The health history is very important as it serves as a guide to medical information and also serves to determine the health status of the child.

3.3.2 Health Examination Includes

- Medical examination
- Dental examination

This should be done by the teachers and the health workers when looking for evidence of ill health and conditions that affect health. Medical examination can be done when a child wants to enter school or can be done at intervals of 2-3 years in the school or done annually in the classes to determine their health. Medical examination is case finding rather than just diagnosis. In all school medical examination acquaint both teachers and pupils with the importance of these medical examinations:

- They help to detect disease present in the child
- They serve as a means of counselling
- They are also a means of health instructions
- They can help to develop scientific attitude towards health.
- Health Examination includes personal interview whereby
- you can determine child's interest, recreational abilities and his choice of friends. It includes the following examination/tests:

Blood pressure, urinalysis, serological tests, visual/ hearing acuity test Teeth and gum inspection, temperature, weighing/ assessment of nutritional status Nose, throat, eye examinations goiter, skin, heart, chest and lung examinations.

3.3.3 Health Observation

This means the casual or formal observations made by the teachers, community health officers and parents in relation to child's health. It would be done by.

i. Inspecting the child generally to detect any abnormalities e.g. watery eyes, rashes, and refer to any medical institution.

ii. Observation – How the child looks. Observation will include these major ones: His progress at school, violation of law, speech and language, personal symptoms, skin rashes and weaknesses, can also observe the eyes, if they are watery, swollen or how he holds his book, observe the ear- any discharge, earache, noise in the ear, does he do lip reading?, is he always restless, inattentive, and disruptive?, does he shout?

3.3.4 Health Screening

This is described as investigations carried out by teachers, community health officer, physicians to assess children in order to determine those who need further treatment. Health Screening consists of those preliminary evaluations of vision, hearing and other functions and conditions administered by teachers or health workers to screen out those children needing further examination and diagnosis by qualified specialists.

The types necessary for the school child are:

- Vision test
- Hearing loss test
- Growth and weight assessments
- Chest X- ray
- Mantoux test
- Review of absenteeism

Physical inspection of the child

1. Vision Testing: Different instruments are used for measuring the sight/ vision.

   Look for obvious eye diseases in a child and these are evidenced by Swelling of the eye Inflammation Redness Pain Burning sensation Photophobia. The actual test is done by using the Snellen's or E chart. Procedure: For vision test using Snellen's chart. The instrument is hung at one side of a hall or room facing a source of light.

2. Explain purpose and procedure

   Stand or sit patient six metres from the eye test chart (Snellen's) Test one eye at a time. Cover the other eye using the palm of the hand or a cardboard. Starting from the top line of the test chart, the examiner asks the patient to read the alphabets in the chart, line by line.
   The last line that is seen correctly is the visual acuity for the eye. Then record the visual acuity accordingly at the side of the student's record.

a. Visual acuity is expressed as a fraction e.g. 6 / 24 where the numerator (6) indicates the distance of the patient from the chart, the enominator (24) is the distance at which a normal eye can read the particular line on chart at which the pupil stopped being

able to read.

b. Hearing Test: The different ways by which you can identify hearing problems are by observation: For example:

i. A child who always says "pardon me" consistently
ii. A child who does not respond when called
iii. A person who must turn his eye towards the speaker before he / she can hear
iv. A child who is restless in class may be a sign of frustration when he cannot hear
v. A child who shouts when he speaks to others.
vi. A child whose speech is below his age.

By different test eg

a. Whisper test
b. Watch test
c. Turning fork test

The hearing test as done under PHC has been fully described under the unit on care of the disabled.

3. Weight and Height Test: Weighing machine is used for weight while metre ruler for height. Weight measures should be done at least three times in the year. We then compare the past weight of the child with the new weight.

4. Mantoux Test:
Has been described under Diagnostic Services

5. Physical Inspection of the Child: This is to assess the general fitness of a child to find out whether the child is fit to perform the school work and physical activities.

After every test has been conducted, the findings are recorded in the Health History Form Height and Weight Charts Observation Forms Cumulative Health Records.

3.4 Conditions That Could be Screened by Teacher and Parents- These Include

- Poor visions or visual disability
- Hearing disability
- Learning disability
- Malnutrition
- Epileptic fits

- Pallor

3.4.1 Test for Vision by Teachers/Parents

- The examiner will stand about six metres away from the child
- Hold three fingers of one hand up
- Ask the child to count from that distance or
- To hold up the same number of fingers as the examiner
- If he cannot do either, then it means he has difficulty in seeing
- Find out if problem is in the night/ dark only or in the daytime.

3.4 2 Test for Hearing by Teachers and Parents

(This could be done using the counting method)

- Have child seated on a chair
- Examiner sits three metres away in front of the child.
- The examiner calls out some numbers making sure the child cannot see his/ her lips. The examiner covers his/ her mouth with his /her hand or paper but without allowing the hand or paper to touch his/ her mouth so that the words do not get distorted.
- The child is instructed to call out the number or hold up appropriate number of fingers corresponding to the numbers called.
- If the child cannot call out the numbers or hold up appropriate numbers of fingers, then it means he /she has a hearing disability.

3.4.3 Screening for Epilepsy

A child with epilepsy occasionally manifests with the following:

- Sudden insensibility
- Momentary loss of memory
- Convulsive movements (fits)
- Production of foaming saliva from the mouth during the fits.

4.0 CONCLUSION

In this unit you have learnt that appraisal of health status of school children is the evaluation of health status of school children by health workers, teachers and parents. You studied the objective of appraisal of health status as well as the different techniques involved in health appraisal of school children –including history taking physical examination, health observation and health screening. You should at

this point be able describe the different techniques used in health appraisal.

5.0 SUMMARY

This unit has focused on the definition of health appraisal which is the evaluation of health status of school children. It can be carried out by health workers, teachers and parents. The objective of performing health appraisal is to determine child health status, to treat if child is unwell or to inform parents of any defect or disability. The different techniques of health appraisal include history taking, medical and dental examination, daily inspection and observation of school children and various health screening such as vision test, hearing loss test, growth and weight assessment ,chest x-ray, Mantoux test, etc.

6.0 TUTOR-MARKED ASSIGNMENT

1. In your own words describe how parents can assess children under five years of age for the following:

   (a) Hearing.
   (b) Vision

7.0 REFERENCES / FURTHER READING

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MODULE 2

UNIT 1 HEALTH AND HYGIENE EDUCATION IN SCHOOLS

CONTENTS

1.0 INTRODUCTION

This unit will help you to have an understanding of how to conduct health education and hygiene education in schools. Before we do this, let us have a view of what you should learn in this unit as indicated in the unit objective below.

2.0 OBJECTIVES

At the end of this unit you should be able to:

- define health education
- state the objectives of health education
- explain the reason for conducting health education in school
- mention the factors to consider before deciding on health education topics
- discuss hygiene education
- describe how to conduct hygiene education.

3.0 MAIN CONTENT

3.1 Definition of Health Education

- Health Education can be defined as a process of transferring knowledge and skills that will bring about positive change towards a healthy living. • a method of obtaining information which may encourage change in attitude and behaviour towards healthy living.
- An art or science of giving simple accurate, scientific information in a way that it will be understood, accepted and put into practice in other words, health education refers to instructions given on how to achieve and maintain a good state of health. it is a planned and formal way of imparting health knowledge .

3.2 Objectives of Health Education in School Health Programme are to

- Make health a valued community asset by the school children
- Equip the children with knowledge, attitudes, and skills that will help them to maintain their own health.

3.3 Reasons for Conducting Health Education in Schools

These children need to have adequate knowledge and skills and to develop the attitudes and values that will improve their health. They need to be able to prevent common problems that occur in their own community and also learn what to do if they should fall sick. Children seem to be the pivot of any society, they are also the majority. As believed in the health sector, the health of the society can be assessed by the health condition of the children in that society. As such, it is of great importance that the children stay healthy. Children are like links between the health personnel and the community; they can carry positive health practices as far as possible. The school child is at a stage

where positive health habits can be instilled into him /her and once a health habit is formed at that stage, it becomes very hard for the child to do away with that habit even when he grows older. The child also acts as a reminder to parents on positive health practices because a child will always remind anybody to do the thing he believes in. It is good that a school child stays healthy or else it will affect his performance in school, so health education will go a long way to promote education. School children are a very good medium for spreading news, as such, when they get to learn of a positive health practices, the news spreads out fast.

3.4 Factors that Teacher Must Consider When Selecting A Health Education Topic

The prevalent health problem in the community where the school is situated is better to be discussed about the prevalent health problems in the community where the school is situated than just any problem. When the children learn about the cause, prevention and treatment of a problem, they can carry the information into the community and even help to educate more people about the health problems. The social and cultural roles of the children will determine the responsibilities that these children have to bear which they need to be trained on .e.g. School children in this culture usually have to take care of their younger siblings therefore they need to learn simple skills like O.R.S, first aid treatment, tepid sponging, etc.

Health practices by school children that are detrimental to health e.g. eating sweets which can lead to dental caries. Analysing the school health and absentee records will give one the clue to which types of illnesses affect the children most. Health education should focus on such problems. Age and maturity of the students should also be considered when choosing a topic. The topic should vary from age to age. What is taught to pupils in primary one will not be the same as that of senior secondary school students timing: Amount of time available for teaching will also determine the topics to be selected for health education in the school.

3.4.1 Topics for Health Education in Schools May include -

- Personal and environmental hygiene
- Nutrition
- Immunisation
- Sex education
- Smoking and drug abuse
- Accident prevention
- Oral health.

3.4.1.1 Why School Children Need Health Education on These Topics

The reasons for health education on these topics are:

- Personal and environmental health. Learning to keep their bodies and environment clean is a habit that will help them to remain healthy.
- Nutrition – good nutrition also goes a long way in promoting health. Good nutrition prevents
  Them from getting ill and makes them strong and attentive in the school.
- Immunisation – This will help them understand the importance of immunisation so that they will ensure that they obtain appropriate immunisation and so not be vulnerable to preventable Communicable diseases.
- Sex education – Unwanted pregnancies, and septic abortions are common in school children and it is good that they understand the basic functions of the body and the implications of early Sexual intercourse, as getting pregnant in school will not only put an end to their schooling but may cause them to be rejected by the society. • Smoking / Drug Abuse – School children like trying out things. It is important that they know the Dangers involved in smoking and drug abuse so that they will avoid these dangerous practices.
- Accident prevention- School children are more prone to accidents than other members of the society because they are always moving from home to school and from school to their homes.
  They are exposed to accidents along the roads, at home and in the school. It is necessary that they learn how to prevent these accidents.
- Oral Health – It is important that they learn about oral health because school children have many eating habits that are detrimental to dental health e.g. frequent consumption of sweets, soft drinks, biscuits, cakes etc. These need to be corrected. Also if they develop good oral health habits it will stay with them for life.

3.5 Hygiene Education

Hygiene education is aimed at bringing positive changes in hygiene behaviour of school children and thereby making children value health as a desirable asset.

3.5.1 Contents of Hygiene Education for School Children Should Include the Following

Hand washing with soap before preparing or handling food;

Hand washing with soap after using the toilet; Hand washing with soap after changing baby's napkins; Regular bathing; Clean finger nails and tidy hair; Cleanliness of uniforms, under wear, socks (no tattered or worm-out clothes); Hygiene education of food handlers at the school kitchen or sound sanitary habits and the need to safeguard food from contaminants.

3.5.2 Content of Environmental Hygiene Should Include: Cleanliness of the School Environment Including the Toilets

Cleanliness of the school kitchen and areas where foods are stored; Ensure that food and drinking water are kept covered and away from contaminants; Ensure use of sanitary dustbins for refuse collection and storage in and around the classrooms and hostels; Ensure timely disposal of refuse to final disposal site; Ensure proper sewage management; Ensure proper storm and waste water drainage; Adequate control of reared animals at staff residential area within the school premises.

3.6 Daily Inspection of School Children by Teachers

Areas of inspection by the teacher should include: general cleanliness; examination of the skin. appearance (alertness, nutritional status) any physical problems or defects.

3.6.1 How to Inspect School Children are

Children are lined up in front of their classroom or an open place like the field. General cleanliness is assessed by examining the child from head to toe: Head – Hair neatly cut, washed and combed. Body is properly washed and clean. Clothes are washed neatly and ironed, buttons well fitted and complete, not torn. Feet, whether the nails are clean and well cut. Finger nails, if clean and adequately cut.

Nostrils and ear orifices are inspected for any discharge.

The skin and scalp are inspected for any skin infection like ringworm, scabies, and dermatitis, lice in the hair, infection and dirt in between the toes. Appearance – The child's appearance is assessed for alertness.

The nutritional status can be assessed by checking the paleness of the conjunctiva, tongue and the nails. Any physical problems or defects of the child can be seen during inspection.

3.6.2 Actions to be taken by the Teacher after Inspection Include the Following

The teachers should record findings in the students' record book specifically for this purpose. Any deviation from normal is recorded. Health education on personal hygiene for dirty appearance, care of the teeth for dental caries, the need for good shoes, the mending of missed buttons and torn dresses, the cleaning of dirty nostrils and ear orifices where appropriate. Any skin infection and physical defects are reported to the health team or referred to the Health Centre nearby for better manage ment .

3.7 Methods of Hygiene Education Should Include

Person to person contact on an individual basis between the teacher and student to correct specific unhealthy hygiene behaviour. Group hygiene education is: In the classroom during formal teaching sessions on hygiene behaviour (subject lessons in Elementary/Health Science, etc), and other fora.

4.0 CONCLUSION

In this unit you have learnt the definition and objectives of health education, and the reasons for conducting health education in schools. You also studied the factors to consider before deciding on health education topic and how to conduct hygiene education in schools. You should at this point define health education and state the reasons for conducting health education in schools. You should also list the factors you will consider before deciding on health education topics for a junior secondary school in a rural community setting.

5.0 SUMMARY

This unit has focused on the definition of health education, as a process of transferring knowledge and skills that will bring about positive change towards a healthy living and the objective of health education was explained as to equip the children with knowledge, attitude and skills that will help them maintain their own health.

Apart from the fact that children are at impressionable age and as such can easily be influenced through health education, they can themselves act as change agents both in their families and communities by

influencing healthful practices. Therefore efforts should be made to consider such factors as age of the students, prevalent health problems in the community, knowledge, attitude, practices, culture of the community etc before deciding on the topic of health education. Hygiene education and daily inspection of school children is carried out in order to promote positive health behaviours amongst students.

6.0 TUTOR-MARKED ASSIGNMENT

1. Using your own words, define health education.
2. State five reasons for conducting health education in a secondary school.

7.0 REFERENCES / FURTHER READING

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UNIT 2 HEALTHY SCHOOL ENVIRONMENT

CONTENTS

1.0 INTRODUCTION

After the family, schools are the most important learning environment for children, in stimulating or initiating a behavioural pat ter n. This unit will therefore help you acquire basic understanding of a Healthy School Environment. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit you should be able to:

- describe a healthy school environment
- state the requirement for a healthy school environment
- state how to identify a healthy school environment.

3.0 MAIN CONTENT

3.1 A Healthy School Environment

The school environment is an integral part of the social component of the school child's entire environment and has an important role to play in the overall development of the child. Most childhood illness like measles, malaria, diarrheal diseases, malnutrition, etc are directly linked to filthy environmental conditions. Prevalence of injuries and accidents in children are also linked to hazardous conditions in the school environment. A healthy conducive school environment promotes learning and academic excellence by preventing school absenteeism due to illness and thus helps the school child to benefit maximally from educational Programmes.

Environment is the aggregate of all external conditions and influences, which affect the life and development of an individual. Next to the home, the school environment is the most influential factor on a child's development. Children are most vulnerable to environmental pollution and hazards because exposures, which may be relatively harmless to adults, can be potentially devastating to them. Major causes of childhood morbidity and mortality e.g. malaria, measles, malnutrition, diarrheal diseases and respiratory infections, all have direct links to the environment. Accidents are a leading cause of death and injury in the school-age group. Schools p r o v i d e a concentration of very active people, all carrying out a wide-range of activities. It is, therefore, important to be continually aware of, and ensure good safety and accident control practices in schools.

3.2 School Sanitation

School sanitation comprises those activities carried out in schools to protect the pupils and staff from the adverse effect of unsanitary and unsafe school environment. Unsanitary school environment exposes the child to physical, biological and psychosocial hazards. A conducive environment, devoid of accidents and communicable diseases is required to promote learning in schools.

3.3 The Goal of Promoting Healthy School Environment Is

To provide an optimal sanitary environment that is safe and conducive for physical, mental and emotional health of the school community in order for the child to achieve maximum benefits from educational programmes.

School Health Programme

3.3.1 The Objectives

- To promote conditions at schools as well as practices of school staff and
- children that shall prevent sanitation related diseases.

- To bring positive changes in hygiene behaviour of school children and through these children, in the community at large.

- To protect school children from hazards and insanitary surroundings To encourage the provision of sanitary facilities in schools. To encourage provision of safe recreational facilities in schools. To encourage compliance with stipulated sanitary standards for schools.

3.4 Elements of School Santation

3.4.1 Site

The school should be located in a reasonably level and well-drained ground; The school should be sited in a safe area away from noise sources such as factories, markets, airports, major highways, public motor parks etc; The school should have a walled fence with gates for security.

3.4.2 Size

The school should be large enough and proportionate to the number of children in the school (Approximately) o n e hectare of land for about 500 pupils).

3.4.3 Playground

There should be a playground proportionate to the school population; The playground should be kept tidy to avoid accidents, injuries and bites from reptiles; The playground should be free of visual barriers that would obstruct supervision; There should be adequate recreational facilities e.g. football and basketball fields, etc; The recreational equipment should be properly installed and at a minimum distance of 2.5 metres away from fences, buildings, wall walkways, tree branches and other obstructions; The fall zones (area under and around the equipment where protective surfacing is needed) shall extend by about 2.0 meters in all directions from the perimeter of the equipment. Fall zones to the front and rear of swings shall extend a distance of two (2)

times the height of the pivot point; The recreational equipment should be properly maintained and the regular maintenance programme documented.

3.5 Building Design

Occupancy: The architectural design should be pupil friendly and not pose any risk to staff and pupils; Provision of adequate space is necessary for good health. Materials used for the building shall be of adequate standard, durable, fire- resistant and pose no danger to health. Playg round and recreation space is essential to the physical and mental well-being of children and adults. Classrooms should have maximums of 36 pupils with six rows and six columns in a standard room not less than 19.4m2; Classrooms should be well lit;

Classrooms should be well ventilated to prevent mouldy conditions and promote high indoor air quality; Classrooms should maintain at least two (2) meters distance between the teacher and the first row.

3.6 Sanitary Facilities

3.6.1 Water Supply

3.6.2 Refuse

There should b e adequate supply of safe water for drinking, washing, cleaning and flushing of toilets; The School, where possible, should provide and maintain individual boreholes to ensure constant supply of water; There should be adequate wash hand basins with soap and clean towels in strategic places within school premises. There should be refuse containers that are covered, rust resistant, water and rodent proof; The containers should be adequate in capacity and in sufficient numbers to hold all refuse that accumulate between collections; The refuse containers kept within the school premises should be placed on a smooth surface (concrete or asphalt), which is graded to prevent; pooling of water; The refuse should be properly disposed using an appropriate sanitary method.

3.6.3 Toilet/Bath Facilities

There should be separate sanitary conveniences for boys and girls, male and female staff; School should have water carriage system of toilet preferably fitted with squatting bowl to facilitate easy flushing with small quantity of water. While the construction of multi- compartment Ventilated Improved Pit Latrines (VIPLs) in rural areas shall be promoted. In urban and semi urban areas where water supply is

intermittent the water carriage system should be complimented with VIPs; There should be at least a toilet for every 30 pupils; The School should provide fitted urinals for boys;

The School should provide adequate and separate washrooms for males and Females especially in boarding schools.

3.6.4 Waste Water Management

There should be adequate and functional drainage of waste water, storm water and surface run-offs. The storm water and surface run-offs may be collected for reuse.

3.7 Inspection of the School Environment by the School Health Team

Inspection of the school environment should be done by the health team at the commencement of the school health programme in a school and routinely, thus:

The site of the building - on elevated or low ground, near dump ground or not? Type of house - block house or mud, cement ceiled or unceiled. Ventilation of the building - through and through or cross.

Sanitary conveniences: Clean or dirty; adequate or inadequate compared to the number of school children and staff. Drainage – if provided, clean or dirty, adequate or inadequate? Overcrowding - are the classrooms spacious or not? Are they crowded or not? Water; provided in the premises or not?

Method of refuse collection and disposal: dust bin-accumulation of refuse? Clear space - adequate or inadequate as playground for children. Noise - noisy area or not?

Offensive odour - any? In and around? Any nuisance - Worthy of note? General impression of the premises: clean, fair or dirty?

3.7.1 Unhealthy School Environment

These can be identified as follows:

- Overcrowding
- Lack of basic sanitation
- Lack of adequate play space
- Lack of adequate ventilation and lighting

- Lack of or inadequate provision of sanitary conveniences Excessive noise, etc.

4.0 CONCLUSION

In this unit you have learned about healthy school environment - What it is, school s anitation, the goal of promoting healthful school environment, the objectives, e lements of school sanitation and sanitary facilities. The unit has also outlined how to inspect the school environment by the school health team and what constitutes an unhealthy school environment.

5.0 SUMMARY

This unit has focused on healthy school environment - School sanitation, elements of school sanitation and how to maintain sanitary facilities in the school premises. A healthful school environment affects a child's growth and development a n d behavioural p a t t e r n . The teacher is usually the most influential person in the school system to shape the development of the child, but it is the total environment, which establishes conditions, conducive or detrimental, to this development. After the family, schools are the most important learning environment for children in stimulating or initiating a behavioural pattern. Maintaining a healthful school environment will therefore help students recognise healthful living as desirable and n e c e s s a r y throughout their lives. For optimum learning, students also n e e d an environment that satisfies their physical and mental needs.

6.0 TUTOR-MARKED ASSIGNMENT

Outline the sanitary facilities that should be provided in a school.

7.0 REFERENCES / FURTHER READING

Policy Guideline on School Sanitation(2005), Federal Ministry of Environment, Abuja, Nigeria. Federal Ministry of Health and Human Services,(1992). Water and Sanitation Session Plans. Primary

Health Care Department, Training and Manpower Development Division. Lagos, Nigeria.

UNIT 3 INVOLVING CHILDREN IN HEALTH EDUCATION

CONTENTS

1.0 INTRODUCTION

Children can serve as change agents in the community and can influence a change in attitude and behavior among their peers. This unit will help you acquire an understanding of how children can be involved in health education.

But before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- discuss how school children can carry out a health education programme in the school
- discuss the child to child approach to health care

- describe how children can conduct a simple health survey in the community.

3.0 MAIN CONTENT

3.1 Health Education Programme By School Children In The School

School children can participate in organised health education programme sessions in the school to teach their peers. This exercise can be organized and facilitated by the teacher thus:

- The teacher tells the students to prepare session plans on the health education topics that will be taught to school children during the school health practice. • He/she divides the class into four groups; each group prepares session plans on different topics assigned as follows:

Group A

- Personal and Environment Health

Group B

- Nutrition
- Immunisation

Group C

- Sex Education
- Smoking and drug abuse

Group D

- Accident Prevention/ Oral Health

Each group prepares session plans for the topics and presents to other students during a school organised health education session, which would be supervised by the teacher.

3.2 Health Education by school children in the community

3.2.1 Definition of Child to Child Approach to Health Education

An approach used to promote the use of child's ability to spread and practice positive health message. The concept is to teach and encourage older children to concern themselves with the health and general car of younger ones in the school and community. Children are a target group as well as a resource for health education. It is a partnership between children and their community.

3.2.2 Aims of the Child to- Child Approach are

- To link health and education together within communities and so improve the life of both children and adults
- To involve children as well as adults in actively improving the health of the community.
- To encourage children to take action both individually and as a group so they can benefit both themselves and others without giving themselves extra burden.
- To create an opportunity for meaningful, active learning using a variety of approaches and methods.
- To achieve changes in behaviour and practices in both younger and older children.

3.2.3 Advantages of Child to Child Approach

- Working with older children who offer care to younger siblings has the possibility of affecting directly the health and development of younger children, by providing older children with information they can use in a care taking role.
- They can be trained to help assure that children under their care are vaccinated, treated with ORS when needed, fed properly, talked to , cuddled and played with.
- These older children caring for younger siblings have a potential for being effective because the older care – taker, although still children, will soon be parents themselves. By learning proper ways of caring for younger children, they will be better prepared for their own parenthood.
- When children are given information about new practices, they can communicate it to peers, parents, families and community members. This c o u l d b e through d i r e c t c o n v e r s a t i o n o r indirectly through skills or example.
- Children of primary school age can have an effect on care and development through direct actions taken in the community. They

develop active skills to help prevent diseases and help those who are already ill.

3.2.4 Activities that Can be Included in the Child to Child Approach are

- Oral dehydration therapy for diarrhea • Tepid sponging for high temperature
- First Aid Care for lacerations or simple cuts, convulsions, burns and scalds
- Use of arm circumference strip
- Proper use of toothbrush or chewing stick.
- Checking immunisation status of younger siblings • Balanced diet for growing children
- Messages can be developed into songs, stories or games for the children to learn and demonstrate in the community. Plays can be developed from messages.

With all these approaches, children will be educated and indir ec tl y members of the community will be educated too.

3.3 Simple Health Surveys that School Children can carry out include

- Environmental sanitation standard in the community
- Nutritional status of children 1-5 years
- Immunization status of children.

3.3.1 Environmental Sanitation Standard in the Community

This deals with the state of the toilet, bathroom, drainages and refuse disposal. To collect data to determine the hygiene status, a format for data collection has to be designed. This must be simple enough for the children to be able to complete. An example of such a form is shown below:

1. Address of house (Tick below as appropriate)
2. Type of Toilet: Pit | | water system | |
   Cleanliness of Toilet: Clean | |Dirty | |
3. Cleanliness of bathroom: Clean | | Dirty | _|
4. Drainages: Available | | Not Available | |
   Cleanliness: Clean | | Dirty | |

3.3.2 Nutritional Status of Children

School children can carry out nutritional assessment of other children by making use of the arm circumference strip. (The procedure for arm circumference measurement has been covered under unit on food and nutrition). The assessment form should be designed to include space for recording results from nutritional assessment.

3.3.3 Immunisation Status of Children

School children will be taught the number of immunisations that children are expected to receive and at what age they should take them as well as how it is recorded on the child's health card. To collect data on the immunisation status, the school children will look into the child's health card count the number of immunisation f o r the age and enter the result in the appropriate section. The result (immunisation status) is recorded as complete or incomplete.

3.3.4 Result of Analysis

After collecting the data, analysis of data will be carried out by calculating percentage of children fully immunised, percentage of malnourished children, and percentage of homes with clean toilets. etc, For example, when analysing nutrition status, they will calculate total number of children 1- 5 years of age; the total number of children with yellow or red arm circumference measurement. To calculate the percentages of malnourished children divide total number of children 1-5 years of age and multiply by 100.

3.4 Activities Children Can Participate in to Improve the School

Environment - Activities that children can participate in order to improve the school environment: School children can form health clubs like the school health scout or peer education club. This is usually a well organised and recognised club. The work of these groups is directly related to health and community development. Children who are members of this club can organise health activities or projects like a garden and if the garden is successful, the rest of the school & their community can learn new ideas and skills.

Such clubs can also make sure the school environment is conducive to healthy behaviour. They will make sure that all the resources to achieve these are provided in the school. They include - a clean and regular water supply, hand washing facilities, sanitary means of disposing refuse, playgrounds that are free from sharp and dangerous objects.

They give assistance where necessary in order to make all these available. Children in these clubs can also be trained to give simple first aid care in the school.

Children must be encouraged to participate in such clubs. Through it, they can co- operate with activities to improve the school environment.

3.5 Preparation for Field Work

The students can be divided into different groups for the field work thus:

1). Health inspection and a ppraisal of school children. They should prepare the format to use as well as all materials needed e.g. the chart for visual acuity test.
2). Health education – the session plan, teaching aids. Decision should be made before and concerning the class to be given the particular health education.
3). Health inspection of food vendors.
4). Workshop and seminar for teacher. This group will draw up a programme. Get materials ready. Inform school teachers how they will be involved.
5). Immunisation of school children. This group will ensure that materials are ready.
6). Simple health survey school children. The team will prepare questionnaires and other materials.

The school health team should inform the school (s) about the programme and how the teachers will be involved.

4.0 CONCLUSION

In this unit you have learnt about t h e involvement of school children in health education programme in the school and in the community. You learnt about child to child approach to health, its aims, advantages, and activities. You also learnt how school children can be involved in simple survey and various health activities in the community.

5.0 SUMMARY

This unit focused on the involvement of school children in health education programme in the school and in the community through child to child approach to health, which is an approach used to promote the use of child's ability to spread and practice positive health message. The concept is to teach and encourage older children to concern themselves with the health and general care of younger ones in the school and community. Children are a target group as well as a resource for health

education. It is a partnership between children and their community. The aims, advantages, and activities that can be included in the child to child approach were discussed as well as how the school children can carry out field work.

6.0 TUTOR-MARKED ASSIGNMENT

1. a. Define child to child approach in health care .
   b. Enumerate the advantages of this approach in health education.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services,(1992). Water and Sanitation Session Plans. Primary Health Care Department, Training and Manpower Development Division. Lagos, Nigeria.

Federal Ministry of Health and Human Services,(1992). School Health Session Plans. Primary Health Care Department, Training and Manpower Development Division. Lagos, Nigeria.

UNIT 4 SCHOOL MEAL SERVICES

CONTENTS

1.0 INTRODUCTION

Since you have studied Unit 2, you would have noted that School Feeding Services is one of the components of school health programme. This unit will help you to understand what school meal services are about. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below:

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the rationale for school meal services
- state the objectives of school meal services
- mention the history of school meal services
- describe the criteria for selecting school food vendors
- explain how school meals can be inspected.

3.0 MAIN CONTENT

3.1 Rationale for School Meal Services

The school meal services started when it was realised that the hours spent by children in school affect their growth and development, due to the fact that adequate nutrition is not provided for these children during the long hours at school.

Good health depends largely on the taking of balanced and adequate diet. If children are to grow into healthy citizens and the school children to study well throughout the school days, adequate food is required. A hungry child will be irritable, drowsy and inattentive in the class. Therefore, feeding the school children during school hours forms an important aspect of school health services. In many countries, supplementary feeding programmes are organised in school, this takes the form of school meals or snacks provided for school children.

3.2 Objectives of School Meal Services are

To provide the school children with an adequate, nutritional and balanced midday meal to supplement the home diet and ensure the provision of nutrients that might possibly be missing in the home diet especially protein and vitamins. To introduce to the school children varied diets. To teach the children normal table manners.

To aid in the teaching of nutrition to the school children and staff.

3.3 History of School Meal Services

History of school meal services in Nigeria started as the practice of selling food in schools in places like Lagos and Ibadan in Nigeria.

The practice in those places started a long time ago when the Ministry of Health felt that inadequate feeding during the hours spent by children in school affects their growth and development leading to borderline malnutrition. As a result the ministry started the central kitchen, where paid government staff prepared school meal. Initially, there were two central kitchens at Onikan for Lagos Island and at Yaba for Lagos Mainland. Meals were prepared and conveyed in a special vehicle (like meal on- wheels) to the school children. Menu varied and included Jollof Rice, Beans with Meat etc. Fruits were served with every meal. The pupils pay little amount because the government subsidised the cost of the meals. This was an expensive programme for the government and it was therefore decided that private individuals should be employed as school food vendors to provide the meals at very minimal profit.

3.4 Criteria for Selection of School Food Vendors

Before a school food vendor is employed, the following criteria must be fulfilled: Medical Examination, Home Assessment and training in-cooking school meals.

3.4.1 Medical Examination

Medical examination is carried out on the food vendors and they must be certified fit before they start work. In addition school food vendors have to undergo medical examination twice a year. This is because diseases can be transmitted through food. During the medical examination the following are done. History -taking and physical examination according to standing orders. Chest X-ray must be done to exclude tuberculosis or any other chest infection. Laboratory investigations that the Food Vendor will do include:

Stool:- For ova, or cyst of intestinal parasites. Urine:- for protein and sugar, Blood:- widal test to exclude typhoid. At the end, a card stating that the woman is medically fit is issued.

3.4.2 Home Assessment

If the result of the medical examination is satisfactory the prospective vendors' homes are inspected by the Health worker for the following: Hygienic conditions of the house: The environmental sanitation of the house should be satisfactory. There should also be good water supply, good food storage system, good drainage system and good refuse disposal system.

Kitchen – should be clean and free from contamination either from refuse, dust, sewage or pests.

Water supply – The water must be clean, safe, and adequate and potable at all times. If stored, the type of container is inspected. The container must have a well-fitting lid.

Food storage facilities – very essential and should be available for both cooked and uncooked food. It should be free from contamination from cockroaches and rodents.

Toilet facilities- There should be facilities for the disposal of faeces. This is to prevent faecal contamination of water or food in the environment. Pit Laterine should be sited away from kitchen area.

Refuse Disposal – Should be adequate and should not constitute a source of infection in the environment. Dustbins should have proper covers. The space available in the compound should be adequate for the inhabitants. It must not be over congested.

Since Malaria is endemic in Nigeria, the house must be screened against mosquitoes. This is to ensure that the woman will be in good health, free

from malaria most of the time. Report on the home assessment should be written and necessary recommendations made to the appropriate authority. Health education should be given to the prospective vendors as appropriate. Another home assessment will be carried out without prior notice to the woman, to confirm what was observed during the previous visit.

3.3.3 Training in Cooking School Meal

This training programme is usually funded by the government or voluntary organisation. It usually takes places during the school's long vacation. It is a one- week training programme. Each participating vendor is asked to produce the following:

- Two Passport–size Photographs Uniforms with head ties
- Pots with lids needed for cooking
- Bowels from where the food, will be sold Plates, spoons and cups
- Container for sponge and soap for washing up A bucket for fetching water A bowl for washing hands.

During the training, the food vendors are taught the following:

Food values, Food hygiene, kitchen and balanced diet, how to preserve nutrients in the process of cooking, the menu table, foods to be prepared from Monday to Friday. This differs from place to place. After the one-week training, a graduation ceremony is organised to which members of the public and some eminent persons are invited. This graduation ceremony will serve as a medium to enlighten the public about the training given to the food vendors, before they are allowed to sell food in schools. It will also let the parents know that the pupils are safe with the school midday meals, and thus encourage them to give money, plates, cups and spoons to their children. It will also heighten parent's confidence in food vendors.

Certificate of attendance is given to each participating vendor and refresher course is organised every two years for old school food vendors.

3.5 Inspection of the School Meal

Each school must select a teacher who inspects the meal daily. The health worker pays surprise visits to see that the vendor carries out the following.

- Keeps to menu
- Wears the uniform and head tie

- Has the bowl and pail of water, soap and sponge.
- Surprise visits are also paid to the vendors in their homes while preparing the food

4.0 CONCLUSION

In this unit, you have learnt a b o u t the school meal services; its rationale, objectives and the history of school meal services. You also learnt the criteria for selecting food vendors such as medical examination, home assessment, and training in cooking school meals. You also learnt how school meals are inspected.

5.0 SUMMARY

This unit has focused on School Meal Services, which is a school feeding programme organised to ensure that school children have opportunity to have at least one balanced/adequate meal during school hours to enhance their growth and development. The rationale, objectives and the history of school meal services were discussed and the criteria for selecting food vendors were discussed.

6.0 TUTOR-MARKED ASSIGNMENT

Explain the rationale for school meal services.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services. (1992). School Health Session Plans. Training and Manpower Development Division ,Lagos. Nigeria.

Federal Ministry of Education Nigeria, National School Health Policy. (2006).

UNIT 5 LEARNING DISABILITIES

CONTENTS

1.0 INTRODUCTION

This unit will enable learners acquire basic understanding of learning disabilities among school children and what could be done to assist these children. But before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objective below:

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe learning disabilities
- state possible characteristics of learning disabilities
- discuss the various categories of learning disabilities
- discuss academic skills disorders
- identify other learning disabilities
- explain how to educate children with learning disabilities
- describe how to counsel children with learning disabilities.

3.0 MAIN CONTENT

Learning Disabilities

A learning disability is a generic term for a heterogeneous group of disorders that affect how individuals receive, store, and retrieve information. Learning disabilities are found in individuals with average or above average intelligence but who, because of presumed central nervous system dysfunction have significant difficulties in any of a variety of achievement areas such as reading, mathematics, spelling and oral language. Often students with learning disabilities have difficulty with organisation, time management and/or attention. Learning disabilities may occur concomitantly with other disabilities (such as sensory impairments or psychological disabilities) or environmental influences (such as cultural differences or insufficient instructions) but learning disabilities are not the direct result of those influences.

3.1 Possible Characteristic of Learning Disabilities Include

Below grade level achievement in one or more subjects, slow language development, short attention span, poor memory, hyperactivity, poor impulse control and aggressiveness, immaturity, disorganisation. Persons with learning disabilities are said to have a "hidden handicap" because they appear deceptively "normal". They look the same as everyone else, but they do not learn in the same manner. Learning disabilities can be lifelong conditions that, in some cases affect many parts of a person's life, school or work, daily routine, family life and sometimes even friendships and play.

3.2 Learning Disabilities Can Be Divided into Three Broad Categories

1. Development speech and language disorders
2. Academics skills disorders
3. Other certain coordination disorders and learning handicaps not covered by the other terms.

3.2 1 Development Speech and Language Disorders

Speech and language problems are often the earliest indicators of a learning disability, people with development speech and language disorders have difficulty producing speech sounds, using spoken language to communicate, or understanding what other people say. Depending on the problem, the specific diagnosis may be.

i. Development
ii. Articulation disorder
iii. Development expressive language disorders or iv. Development receptive language disorder.

3.2.2 Developmental Articulation Disorders

Children with this disorder may have trouble controlling their rate of speech or they may lag behind playmates in learning to make speech sounds. Developmental articulation disorders appear in at least 10% of children younger than age 8. Fortunately, articulation disorders can often be outgrown or successfully treated with speech therapy.

3.2.3 Expressive Learning Disorder

Some children with language impairments have problems expressing themselves in speech. This disorder is known as developmental expressive language disorder. An expressive language disorder can take other forms: a 4- year old who speaks only in two word phrases and a 6 – years old who can't answer simple questions may have developmental expressive disorders.

3.2.4 Developmental Receptive Language Disorder

Some people have trouble understanding certain aspects of speech. Their hearing is fine, but they can't understand certain sounds, words, or sentences they hear. They may even seem inattentive. This is known as a receptive language disorder. Using and understanding speech are strongly related, and many people with receptive language disorders also have an expressive language disability.

3.3 Academic Skill Disorders

i. Developmental reading disorder
ii. Developmental writing disorder
iii. Developmental arithmetic disorder.

3.3.1 Developmental Reading Disorder

This type of disorder, also known asd ys lexiaisquite widespread. In fact, reading disabilities affect 2 to 8 percent of elementary school children. Reading involves the following processes. Focusing attention on the printed marks and controlling eye movement across the page. Recognise the sounds associated with letters. Understanding words and grammar, building ideas and images,

Comparing new ideas to what you already know and storing ideas in memory. A person can have problems in any of the tasks involved in reading. A significant number of people with dyslexia share an inability to distinguish or separate the sounds in spoken words. Some people with dyslexia may not be able to identify words by sounding out the individual letters. Others may have trouble with rhyming games, such as rhyming “cat” with “bat”. Fortunately, remedial reading specialists have developed techniques that can help many children with dyslexia acquire these skills.

There is more to reading than recognising words. If the brain is unable to form images or relate new ideas to those stored in memory, the reader can’t understand or remember the new concepts. Other types of reading disabilities can appear in the upper grades when the focus of reading shifts from word identification to comprehension.

3.3.2 Developmental Writing Disorder

Writing involves several brain areas and functions. The brain networks for vocabulary, grammar, hand movement and memory must all work together. A developmental writing disorder may result

from problems in any of these areas. A child with a writing disability, particularly an expressive language disorder might be unable to compose complete grammatical sentences.

3.3.3 Developmental Arithmetic Disorder

Arithmetic involves recognising numbers and symbols memorising facts such as the multiplication table, aligning numbers and understanding abstract concepts like values and fractions.

These may be difficult for children with developmental arithmetic disorders. Problems with numbers or basic concepts are likely to show up early in life. Disabilities that appear in the later grade are more often tied to problems in reasoning. Many aspects of speaking, listening, reading, writing and arithmetic overlap and build on the same brain capabilities. Children can be diagnosed as having more than one learning disability. For example the ability to understand language underlies learning speech. Therefore any disorder that hinders the ability to understand languages will also interfere with the development of speech which, in turn hinders learning to read and write. A single gap in the brains operation can disrupt many types of activity.

3.4 Other "Learning Disabilities"

These include other "motor" skills disorders" and specific developmental disorders, such as delays in acquiring language and academic and motor skills that can affect the ability to learn but do not meet the criteria for a learning disability. Also included in this category are coordination disorders, that can lead to poor writing skills and certain spelling and memory disorders.

3.4.1 Attention Disorders

Many school aged children have learning disabilities, some of them have a type of disorders that make them to appear to daydream excessively and often easily distracted. If they are quiet and don't cause problems, their problems may go unnoticed. They may be passed along from grade to grade without getting the special assistance they need. In a large proportion of affected children, the attention deficit disorder is accompanied by hyperactivity, known as Attention Deficit Hyperactivity Disorder or ADHD.

ADHD seems to affect boys more frequently than girls, while girls are more likely to have attention for deficit disorder without hyperactivity. Children with ADHD are hyperactive, impulsive and easily distracted. They act impulsively, running into traffic or toppling desk. They blurt out answer and interrupt. In games, they can't wait for their turn. These children 's proble ms are usually hard to miss because of their constant motion and explosive energy; hyperactive children often get into trouble with parents, teacher and peers.

By adolescence, physical hyperactivity usually subsides into fidgeting and restlessness. But the problems with attention impulsivity and concentration often continue into adulthood. At work adults with ADHD often have trouble organising tasks or completing their work. They don't seem to listen to or follow direction. Their work may be messy and appear careless. Attention disorders, with or without hyperactivity are not considered learning disabilities in themselves. However, because attention problems can seriously interfere with school performance, they often accompany academic skills disorders.

1. "Dyslexia" means a disorder of constitutional origin manifested by a difficulty in learning to read, write or spell, despite conventional instruction, adequate intelligence and sociocultural opportunity.
2. "Related disorders" includes disorders similar to or related to dyslexia such as developmental auditory imperceptions dysphas

ia, ,specific developmental dyslexia, developmental dysgraphia, and developmental spelling disability.

3.5 Diagnosis of Learning Disabilities: Screening for Disability is

"Checking closely to detect those children with conditions that can prevent individuals from performing an activity within the range considered to be normal for their age" Diagnosis of learning disabilities: Learning disabilities (LD) are a significant gap between a person's intelligence and the skills the person has achieved at each age. This means that a severely retarded 10 years old who speaks like a six years old probably does not have a language or speech disability. He has mastered language up to the limits of his intelligence.

On the other hand, a primary five pupil who cannot write a simple sentence probably does have a learning disability. Learning disorders may be informally flagged by observing significant delays in the child's skill development. A two year delay in the primary school is usually considered significant. For older students such a delay is not as debilitating, so learning disabilities are not usually suspected unless there is more than a two years delay. Actual diagnosis of learning disability however, is made using Standardised tests that compare the child's level of ability to what is considered normal development for a person of that age and intelligence.

Test outcomes depend not only on the child's actual abilities but also the reliability of the test and the child's ability to pay attention and understand the questions. Children with poor attention or hyperactivity may score several points below their true level of ability. Testing a child in an isolated room can sometimes help the child concentrate and score higher. Each type of learning disability is diagnosed in slightly different ways. To diagnose speech and language disorders, a speech therapist tests the child's pronunciations, vocabulary, and grammar and compares them to the developmental abilities seen in most children of that age. A psychologist tests the child's intelligence.

A primary health care provider checks for ear infections. In the case of academic skills disorders, academic development in reading, writing and mathematics is evaluated using standardized test. In addition, vision and hearing are tested to be sure the student can see words clearly and hear adequately. Attention Deficit Hyperactivity Disorder (ADHD) is diagnosed by checking for the long term presence of specific behaviours, such as considerable fidgeting, losing things, interrupting and talking excessively. Other sign include an inability to remain seated, stay on tasks or take turns. A diagnosis of ADHD is made only if the

child shows such behaviors substantially more than other children of the same age.

If the school fails to notice learning delay parents can request an outside evaluation. Parents also need to know that they may appeal the school's decision if they disagree with the findings of the diagnosis team. Parents always have the options of getting a second opinion. Some parents are confused when talking to learning specialist. Such parents may find it helpful to ask someone they like and trust, to go with them to school meetings. The person may be the child's clinician or caseworker or even a neighbor. It can help to have someone along who knows the child and can help understand the child's test scores or learning problems.

3.5.1 Identification of Learning Disabilities

Since learning disabilities are not of medical nature, but are of educational concern, the first to identify a learning disability is usually not the health worker but someone on the educational staff, such as a teacher or a counsellor. A school nurse might notice that a child is frequently visiting the clinic for various vague complaints or missing school days, for undocumented illnesses, or may be avoiding school. Frequently children who are having difficulty in school will think of ways to avoid being embarrassed in the classroom, and that coping mechanism is often described as "not feeling well" by the child. The school nurse should inquire about difficulty with learning when she or he is conducting a health assessment with these children. If the child describes difficulty with learning, then the health worker can relay this information to the parent, teacher, or counsellor.

The school health personnel often see children with learning disabilities when they need medication or screening for vision or hearing. The health worker should be aware of behaviour changes in children who are receiving medication for ADHD for the first time, or when their medication has been changed. Some of the side effects of these medications include depression, anxiety, agitation and aggression. Parents are usually the first to notice obvious delays in their child reaching early milestones. But the classroom teacher may be the first to notice the child's persistent difficulties in reading writing or arithmetic. As school tasks become more complex, a child with a learning disability may have problems mentally juggling more information. The learning problems of children who are quiet and polite in school may go unnoticed. Children with above average intelligence, who manage to maintain passing grades despite their disability, are even less likely to be identified.

3.6 Education for Children with Learning Disabilities

Although obtaining a diagnosis is important even more important is creating a plan for getting the right help. Because LD can affect the child and family in so many ways, help may be needed in a variety of ways: educational, medical, emotional and practical. In most ways children with learning disabilities are not different from children without these disabilities. At school they eat together and engage in sport, games and after school activities together. However, since children with learning disabilities do have specific learning needs, School should provide special education programs either in a separate all day classroom or as a special education class that the student attends for several hours each week.

Some parents may hire trained tutors to work with their child after school. If the problems are severe, some parents may choose to place their child in a special school for the learning of the disabled. If parents choose to get help outside the public schools, they should select a learning specialist carefully. The specialist should be able to explain things in terms that the child can understand. Special education teachers also identify the types of tasks the child can do and the senses that function well. By using the senses that are intact and by passing the disabilities, many children can develop needed skills. These strengths offer alternative ways the child can learn. After assessing the child's strength and weaknesses the special education teacher designs an Individualised Educational Program (IEP). The IEP outlines the specific skills the child needs to develop as well as appropriate learning activities that build on the child's strength. Many effective learning activities engage several skills and senses. For example, in learning to spell and recognise words a student may be asked to see, say, write and spell each new word. The student may also write the words down.

3.7 Counseling for Children with Learning Disabilities

Children with learning disabilities and attention disorders may have trouble making friends with peers. For children with ADHD, this may be due to their impulsive, hostile or withdrawn behavior. Some children with delays may be more comfortable with younger children who play at their level. Social problems may also be a product of their disability. Some people with LD seem unable to interpret tone of voice or facial expressions. Misunderstanding the situation, they act inappropriately, turning people away. Without professional help, the situation can spiral out of control. The more that children or teenager fail, the more they may act out their frustration and damage their self-esteem. The more they act out, the more trouble and punishment it brings, further lowering their self- esteem. Counselling can be very helpful to children with LD

and their families. Counselling can help affected children, teenagers and adults develop greater self- control and a more positive attitude toward their own abilities. Talking with a counsellor or psychologist also allows family members to air their feelings as well as get support and reassurance.

Parents and teachers can help by structuring tasks and environments for the child in ways that allow the child to succeed. They can find ways to help children build on their strength and work around their disabilities. This may deliberately make eye contact before speaking to a child with an attention disorder. For a teenager with a language problem, it may mean providing pictures and diagrams before performing a task. A counsellor can help identify practical solutions that make it easier for the child and family to cope w i t h the problem day by day. Every child needs to grow up feeling competent and loved. When children have learning disabilities, parents may need to work harder at developing their children's self-esteem and relationship building skills.

4.0 CONCLUSION

In this unit you have learnt about Learning disabilities, the characteristics of Learning disabilities, the different categories of Learning disabilities, as well as academic skills disorders. You have also learnt about other learning disabilities, remarkably Attention Deficit Hyperactive Disorder (ADHD). You should at this point be able to discuss Learning Disabilities and Academic Skills disorders and how they can affect the learning of the school child. You should also be able to discuss how the learning of the child with learning disability can be enhanced and how to counsel people with learning disability.

5.0 SUMMARY

This unit has focused on learning disabilities which are a generic term for a heterogeneous group of disorders that affect how individuals receive, store, and retrieve information. The possible categories include - below grade level achievement in one or more subjects, slow language development, s hort attention span, poor memory, hyperactivity, poor impulse control, and aggressiveness, immaturity and disorganisation.

This unit also focused on the different categories of learning disability which include developmental speech disorder and language disorder, developmental articulation disorder, developmental expressive learning disorder, developmental receptive language disorder, as well as academic skills disorders, such as d e v e l o p m e n t a l reading disorders, developmental writing disorders and developmental arithmetic disorder. The unit also focused on other learning disabilities, remarkably Attention Deficit Hyperactive Disorder (ADHD). Education for children with learning disability and counseling of people with learning disabilities were also discussed.

6.0 TUTOR-MARKED ASSIGNMENT

Describe academic skills disorders.

7.0 REFERENCES / FURTHER READING

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MODULE 3

UNIT 1 ACCIDENTS, EMERGENCIES AND MANAGEMENT OF SOME AILMENTS IN SCHOOLS TABLE OF CONTENT

1.0 INTRODUCTION

Since you have gone through the course guide, you would have an idea of the relevance of this unit to the course. The unit will help you to understand how to manage accidents and emergencies in school health service delivery. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below:

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define accident and emergency

- discuss types of accident and emergencies and their causes discuss the management of accidents and emergencies and other ailments in the school.

3.0 MAIN CONTENT

3.1 Definition of Accidents and Emergencies

Accidents are un-premeditated events resulting in a recognisable injury. Emergency can be defined as a sudden serious event for which immediate action is necessary. In other words, accident and emergency are unexpected situations that required urgent treatment.

3.2 Types and Causes of Accident and Emergencies

Accident can occur in the classrooms, playground and on streets when going to school. The various types include:

Laceration and wound which occur from sharp objects; Fractures and sprains which occur as a result of a fall, from a height or from a direct blow. Foreign body in the ear, nose, eyes or throat, for example coin, stone, nuts, beads, bites and stings from snake or scorpion, dog or human beings. Emergencies can be classified into two:

ÿ Minor Emergency ÿ Major Emergency

(1) Minor emergencies are treated with first aid. Examples are: Bruises, small cuts or wounds, fever, diarrhea and vomiting, sprains, headache and backache.
(2) Major emergencies are conditions that require referral to the clinic or hospital after first aid treatment. They include:

Fractures, bites from humans, snakes, scorpions and dogs, bleeding that has failed to respond to first aid treatment, head injury, chest injury, foreign bodies in the eyes, ears, nose or throat, obstruction of airway, unconsciousness, sickle cell crisis, minor ailments in schools: minor ailments in school may include; abdominal pain, headache, fever, diarrhoea & vomiting.

3.3 Management of Accidents and Emergencies and Minor Ailments in School by the Teacher or the Health Personnel

3.3.1 Lacerations and wounds Assess the Type of Injury and Size of the Wound

Clean the wound thoroughly using soap and water apply antiseptic solution or tincture of benzoin compound if wound is fresh and small. If the wound is deep, cover with clean or sterile dressing and apply firm bandage.

3.3.2 Sprains and Fracture

Observe whether there is any swelling, pain or distortion of the normal shape of the limbs. If there appears to be a fracture, immobilise the limbs with the aid of a splint. This splint could be made from length of wood and tied to the fracture limb with a piece of cloth or bandage. Transport the pupil to a health centre or hospital.

In emergency cases

- Note whether the casualty is breathing.
- Note if bleeding is present, also considering the amount and location. Note if casualty is conscious
- Then the casualty should be made as comfortable as possible.
- No food or liquid should be given especially to an unconscious casualty. Assess the severity of emergency
- For the benefit of the injured child and others in the classroom, try to remain calm, be objective and supportive during the crisis.
- All teachers or other school personnel who may be expected to assist injured children must have the following:
- A list of correct names of all pupils.
- The names of both parents and home addresses.
- Business or working place address of both parents or relatives to be called in case parents cannot be reached.
- Telephone number of fire service department.
- First aid box is always in the Headmasters office to treat some minor cases, like paracetamol for headache, ORT for diarrhoea and vomiting. All diseases detected are referred to the school clinic or hospital for proper management.

3.3.2 Prevention of Accidents: Teacher Should Try as Much as Possible to Prevent Accidents in the School By

Eliminating conditions that can cause accidents; filling up pot holes, removing any broken bottles or old tins and cans that can cause injury, preventing wet floors. Providing strict supervision during recreation periods, to prevent a fall. Educating pupils on dangers of putting foreign objects in the ear, nose or any orifice. Discouraging school children from fighting or using sharp objects when playing. Teacher should prevent the spread of diseases by supervising the cleaning and use of the latrines/toilets.

3.4 When to Call for Help

- A breathing problem Severe bleeding
- Anaphylactic reaction (shock)
- Burns (serious or covering a large area) Head, neck or back injury
- Concern about a heart problem Poisoning
- Loss of consciousness Seizures
- Serious limb injury or amputation Penetration injury
- Foreign object in the throat
- School personnel should be able to:
- Recognise that an emergency has occurred Provide immediate first aid care
- Transfer the child to the nearest clinic/hospital
- Notify the parent/guardian, or person identified as the emergency contact.

3.5 Communication in Emergencies

Record keeping and documentation must include every reportable school-related incident or emergency. Forms should be developed by the school to facilitate the inclusion of all necessary contents, including:

- Name, address, telephone number of parents
- Parent/guardian or contact person s name, address and telephone number
- Date, time & place of injury (e.g. classroom building) Brief description of injury or illness
- Person in-charge when injury or illness occurred Activity or circumstances at time of injury or illness A list of witnesses, if any
- Type of treatment given in school Record of transport

- Name, address and telephone number of receiving hospital or health care provider
- Additional treatment given at the hospital or by the primary health care provider if known
- Record of parent/guardian notification
- Name of person who prepared & filed the report & the date Names of corroborating individuals (teachers, students, etc.) The report should be prepared by the school health personnel or administrators.

3.6 Emergency Procedures -Allergic Reaction

An allergy is a systemic or local reaction to one or a combination of environmental o r physiological factors. Persons with allergies react to these factors as triggers, with a dysfunctional immune system response, o f t e n through the production o f an immunogbulin (IgE). IgE, when confronted with the presence of a trigger, or allergen (e.g. casein, a milk protein), initiates a process that includes cell degranulation and histamine release. This process can result in symptoms as mild as a sneeze or watery eyes to life threatening allergic anaphylaxis.

Common signs and symptoms of an allergic reaction may include one or a combination of any of the following:

- Hives
- Itching (any part of the body) Red and/or watery eyes Running nose Vomiting Diarrhoea
- Stomach cramps Change in voice Coughing Sneezing
- Wheezes including an acute asthma episode Throat tightness or closing Difficulty with swallowing Difficulty with breathing
- Sense of doom Dizziness
- Fainting or loss of consciousness Change of colour.

3.7 Things That Can Cause Allergic Responses

Foods that commonly produce allergic problem include cow s milk, soya milk, eggs, wheat, fish, shellfish, peanuts, etc. The family should notify the school authorities about any allergies. Insect/Bee stings can result in anaphylactic reactions, which may even lead to death. Latex allergy to latex can present as a simple and local contact dermatitis. Latex is a milky, organic substance produced by rubber trees.

4.0 CONCLUSION

In this unit you have learnt the definition of accident and emergency, types of accidents and emergencies that can occur in the school and their causes. The emergencies that can occur in schools were classified into minor and major emergencies and some minor ailments that can occur in schools were also identified. You also learnt how to manage accidents and emergencies and minor ailments when they occur in school. You should at this point be able to define accident and emergency. You should also be able to identify some accidents and emergencies that can occur in schools and state how to manage them.

5.0 SUMMARY

This unit has focused on the definition of accidents and emergencies as unexpected situations that require urgent treatment. These may occur in the classrooms, playgrounds, or on the streets when coming to schools. The various types include lacerations, fractures, foreign body in the ear, nose, eyes, and throat, bites and stings from snake or scorpion, dog or human beings. Emergencies were classified into minor and major emergencies. This unit also discussed how the teacher or the health personnel can manage these emergencies when they occur in the school.

6.0 TUTOR-MARKED ASSIGNMENT

1. Using your own words define Accidents and Emergency.
2. Make a list of 8 accidents and emergencies that can occur in schools in rural communities.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services, (1992). School Health Session Plans. Lagos, Nigeria: Training and Manpower Development Division.

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UNIT 2 THE SCHOOL FIRST AID-BOX AND FIRST AID CARE

CONTENTS

1.0 INTRODUCTION

Having gone through the previous unit that is on accident and emergency, you would realise the need for first aid care in the school. This unit will help you acquire basic understanding of the school first aid box and first aid care. But before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objective below.

2.0 OBJECTIVES

At the end of this unit, you should be able to :

- define first aid and first aid box
- enumerate the contents of first aid box and their uses
- describe the first aid management of emergencies in schools.

3.0 MAIN CONTENT

3.1 Definition of First Aid and First Aid Box

First aid is an emergency assistance given to a sick or injured person after an accident or onset of illness.

First aid box is a rectangular box of either iron or wood, built with lid, containing the materials needed for first aid care. This must be under lock and key when not in use.

3.2 First aid Box Content and their Uses First aid box content and their uses are as follows:

ÿ Cotton wool for cleaning wounds
ÿ Antiseptic solution eg dettol- for cleaning wounds ÿ Spirit for cleaning abrasions
ÿ Paracetamol tablets for pains and fever ÿ Scissors for cutting bandage etc.
ÿ Soap and hand towel for washing and drying hands ÿ Tongue depressor for unconscious patient ÿ Adhesive plaster to keep dressing on wounds ÿ Jar of petroleum jelly for burns and scalds
ÿ Triangular bandage for supporting dislocation or suspected fractured arm.
ÿ Gauze for dressing i.e to cover wounds
ÿ Tincture of Iodine for dressing to put on wounds after cleaning ÿ Embrocations for sprains ÿ Salt and sugar for ORT

The school authority should be instructed and encouraged to provide an up to date first aid box which must be accessible at all times.

3.3 First aid Care of Emergencies in Schools

A teacher in the school must be trained as a first aider in order to work or function effectively. The trained first aider must do the following in cases of emergency:

- Give immediate and proper first aid treatment -Notify the parent concerned
- Be sure that the injured or ill are placed under the care of parents, physician or health worker
- Minor ailments can be cared for as follows:
  Fainting which is a state of temporary unconsciousness i.e. the person is unaware of his/ her environment.
- Remove child to a shaded well-ventilated area away from other children and noise.
- Remove all tight clothing; make sure the nose and mouth are not blocked.
- Transport to health centre or hospital

Diarrhea and vomiting: When pupils develop diarrhea and vomiting, the teacher should prepare salt sugar solution and give it to the pupil to prevent or control dehydration.

Fever: This is when a person s body temperature rises above 37.5 degrees centigrade. The body will feel very hot to touch. When pupil develops fever in the school, the teacher should:

- Remove all clothing (provide privacy) Tepid sponge the child Give paractamol tablets Give a lot of fluids
- Refer to the clinic as early as possible.
- Foreign Body in the eye: Pull down the eye lid and touch gently to remove the foreign body. Avoid rubbing the eye as it can have serious consequences.
- Foreign body in the ear nose or throat must not be tampered with as it may go in further. Arrangement must be made for the transfer of the child to hospital for removal of the foreign body.
- Bites from snake and scorpion: The teacher should observer whether fang marks are visible on the skin, whether there is any swelling and whether the skin is discoloured. Let the pupil lie quietly. Transfer to the health clinic immediately.

Laceration and wounds

¸ Apply pressure to stop any bleeding ¸ Assess the type and size of injury

¸ Clean the wound with soap and water then apply antiseptic. ¸ Apply tincture of benzoin compound if wound is fresh and small. If the wound is deep, cover with, clean or sterile dressing and apply firm bandage.

¸ Refer the pupil to the school health clinic. Sprains and Fracture: ¸ Observe whether there is any swelling, pain or distortion of the normal shape of the limbs.

¸ If there appears to be a fracture, immobilize the limbs with the aid of a splint. This splint could be made from lengths of wood and tied to the fractured limb with a piece of cloth or bandage if available.

¸ Transport the pupil to a health centre or hospital.

4.0 CONCLUSION

In this unit you have learnt what first aid and first aid care are. You also learnt the content of first aid box and their uses. The unit also described the first aid care of emergencies in schools. You should at this point be able to define first aid care and the contents of first aid box. You should also be able to describe the first aid care of emergencies in school.

5.0 SUMMARY

This unit has focused on the definition of first aid as an emergency assistance given to a sick or injured person after an accident or onset of illness. A school must have a first aid box containing drugs and supplies and various instruments that could be used to give emergency care to the

school children and school personnel. A teacher in the school must be trained as a first aider in order to work or function effectively. First aid care of emergencies such as fainting, diarrhoea, fever, foreign body in the eye, ear, nose, or throat as well as bites from snake and scorpion, lacerations and wounds, sprains and fractures were discussed.

6.0 TUTOR- MARKED ASSIGNMENT

1. Define first aid in your own words.
2. List six items that should be included in the first aid box.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services, (1992). School Health Session Plans. Training and Manpower Development Division, Lagos , Nigeria.

Federal Ministry of Health & National Primary Health Care Development Agency, (1995), Standing Orders for Community Health Officers & Community Health Extension Workers, Training and Manpower Development Division, Nigeria.

UNIT 3 FIRST AID TREATMENT OF SOME CHRONIC AILMENTS 1

CONTENTS

1.0 INTRODUCTION

Since you have gone through First Aid Care in the previous unit, this unit will enable you acquire more information on first aid care of diabetes and asthma among school children. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objective.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe diabetes
- state the individual health care plan of diabetes discuss asthma
- discuss the prevention and management of symptoms of asthmatic episodes
- describe asthma first aid.

3.0 MAIN CONTENT

3.1 Diabetes

Diabetes mellitus (DM) is a chronic metabolic disorder, which is caused by the inability of the body to use or produce insulin. The cause of diabetes is unknown, but appears to be a combination of genetic and e nviron mentalfactors . There are two types of DM - Type 1 In diabe tes, th ere is insufficient insulin to lower the blood sugar level. Complications from diabetes occur because of chronic hyperglycaemia and include kidney failure, blindness, neuropathy and cardiovascular disease.

Type 2 diabetes previously called adult onset diabetes or non- insulin dependent diabetes mellitus (NIDDM), occur less frequently in children, though its incidence appears to be increasing among children and adolescents. This type of diabetes occurs when the body becomes resistant to the insulin produced by the pancreas. It is different from type 1 because insulin is still produced, but the diabetes become resistant to the persons own insulin. This resistance appears to be a genetic abnormality, but is also related to obesity.

At present time there is no cure for diabetes. The treatment plan is directed at managing or controlling the course of the disease. This is achieved by balancing insulin, food and exercise and it is critical for the child s family and school personnel to understand how to work with these three factors to achieve good glycaemic (sugar) control. For example low blood sugar or hypoglycaemia, m a y be caused by too little food, too much insulin or more exercise than usual. The reverse is true for too much food, too little insulin or less than adequate amounts of exercise. Any or all of these may result in hyperglycaemia, or a blood sugar level that is too high. A student s school performance suffers when their blood sugar level is too high, or too low. Without treatment both high and low blood sugar levels can affect the child s ability to concentrate on school work and participate in school related activities. School h e a l t h personnel may need to remind a student newly diagnosed with diabetes about the need to check their blood sugar during school hours as this will help them to better learn to detect hypo or hyperglycaemic episode early.

3.2 Individual Health Care Plan (IHP)

The school health personnel should be involved in the development of the IHP. The school health personnel will become the case manager of the child and establish school treatment and emergency plans, coordinate school health care and educate other school personnel

about the monitoring and treatment of symptoms. He/she is also responsible f o r involving the student s parents and primary health care provider to develop a safe and therapeutic environment in the school setting. The following information should be contained in an IHP for a student with diabetes of either type:

- ÿ Definition of hypoglycaemia for the student and the recommended treatment
- ÿ Definition of hyperglycaemia for the student and the recommended treatment
- ÿ Recommended frequency for blood glucose testing
- ÿ Written orders from the student s health care provider outlining the dosage and indications for insulin administration and / or the administration of glucagon if needed.
- ÿ Student may perform blood glucose testing in the classroom, if they are developmentally capable of doing so (optional)
- ÿ Times of meals and snacks and indications for additional snacks or exercise
- ÿ Authorisation for full participation in exercise and sports OR any contraindications to exercise or accommodations that must be made for that student.
- ÿ Education of all school personnel who may come in contact with the student, about diabetes how to recognize and treat hypoglycaemia and hyperglycaemia and how and when to call for assistance
- ÿ Medical and / or treatment issues that may affect the educational progress of the student with diabetes.
- Ÿ How to maintain communication with the student, the parents, the child s health care team, the school health personnel and the educational staff.

3.3 Asthma

Asthma is the most common chronic disease in children and it is one of the causes of school absence. Asthma is a chronic lung disease characterised by episodes or attacks of coughing, wheezing, chest tightness, and / or shortness of breath. These s ymptoms are caused b y an inflammation of the airways responding to a variety of stimuli or triggers . Often t h e inflammation itself becomes a trigger leading to a persistent level of cell damage and an ongoing repair process. There may be permanent abnormalities in the airway from untreated or under treated asthma. The triggers that cause an asthma episode vary with individuals. Some of the more common triggers are:

- Allergens, which can include seasonal irritants (e.g pollen) animal dung, dust mites, molds, or foods.
- Irritants which can include cold air or environmental pollutants (chemicals, chalk, dust, smoke, fumes).
- Upper respiratory infections, including regular colds, flu, or other viruses Physiological changes including physical exercise, laughing or crying. Climatic including very cold or windy or extreme heat.
- Students diagnosed with asthma should be under the care of a health care provider and most will be managed with a prescription medication. Many students may have identified what triggers their allergies and may need environmental modifications at school in order to avoid them. Some of these students will require an Individualised H e a l t h Care Plan (IHP). The school health personnel will need to strategise with the student s family and health care team about the management of the child s asthma at school. This may include some combination of a medication administration plan (either by the student or school staff, depending on developmental level), diet modification, physical activity plan, environmental assessment and restructuring as needed) and monitoring of the student overall health status.

3.4 Medication

Asthma medications f all into one of two general categories: long term control and quick relief. Long term control medicines includes inhaler and systemically administered corticosteroid and Beta2 agonists that work to reduce the chronic inflammation that is associated with airway hyper-responsiveness. Quick relief medicines such as short acting inhaled Beta2 agonists and anti-cholinergics, function primarily as bronchodilators to improve airflow in an acute episode or when a known triggers cannot be avoided. Many students with asthma will use a combination of these two types of medication.

Principles of asthma management are:

- Controlling symptoms
- Preventing acute asthma episode
- Reducing persistent airway inflammation.

3.4.1 Controlling Symptoms

The control of asthma is primarily attained through early and aggressive detection and management. Controlling symptoms involves both reducing exposure to triggers and pharmacologically managing the

persistent airway inflammation. Students or their families must provide the school health personnel with information about their particular triggers and disease pattern. This inf ormation c an then be included in the students IHP, and environmental modification at school can proceed as needed. Since a wide variety of stimuli can act as triggers, the school should be prepared to take the necessary time to develop as comprehensive a list as possible.

Early use of appropriate medications in both diagnosis and management of an individual s asthma episode plays a critical role in reducing the amount of airway inflammation and long term damage that can occur with this disease. The earlier a child is diagnosed with asthma; the sooner anti- inflammatory medication can be introduced. E vidence suggests that this early and aggressive therapy can lessen the overall severity of the disease. School health staff will encounter very young children on regular anti-inflammatory medication and will need to know how to administer it in its various forms.

3.4.2 Acute Asthma Episode

The management triad aimed at preventing acute episodes includes:

Avoidance of triggers. Monitoring of airflow and disease severity Pharmacotherapy. The students IHP should address how these three interventions will be implemented in the school setting. Identifying triggers that can cause acute symptoms such as exercise induced broncho-spasm (EIB) or the seasonal presence of environmental allergens may make necessary changes in the student s physical activity plans or field trip modifications. For example, children who have EIB can benefit greatly from using quick relief medication before they participate in activities known to aggravate their asthma.

3.4.3 Reducing Persistent Airway Inflammation

This goal can also be met through a combination of the three basic interventions already discussed and the use of long term anti-inflammatory medications. The school health personnel and health care team must be familiar with long term asthma medications and check that they are administered properly. This may require coordination with other school staff (i.e teachers and cafeteria workers) that may be able to assist the health care staff in reminding students about the presence of known triggers that may necessitate quick relief medications.

3.4.4 Recognising and Managing Acute Episodes

Signs of an acute episode may include: coughing (frequent, persistent, and / or paroxysmal), restlessness/ irritability, persistent rubbing of nose or throat, increased respiratory exercise intolerance, grunting, anxiety or a wide eyed appearance, or decreased ability to speak (e. g the child can only speak short phrases before becoming breathless). The school health personnel may also notice a barrel shaped chest (due to increased amounts of trapped air), a change in the students colour (bluish / gray), nasal flaring, or the use of accessory muscles to breathe, and the students may assume a tripod position (bent forward with hands on knees), in order to facilitate breathing. The m o s t c r u c i a l observation for all school staff to be aware of, however, is whether the student with asthma is exhibiting changes in behaviour, which may indicate an acute episode. The school health personnel should be aware of any students with asthma that require frequent quick relief medications at school as this may indicate that the child is not receiving long term pharmacotherapy. A consultation with the parents may be necessary to ensure that the child is receiving appropriate medications.

3.5 Asthma First Aid

An emergency care plan (ECP) or an IHP should be developed and available to all school staff that may come into contact with an asthmatic student. School may wish to develop policies that include training of school staff about how to respond in this type of emergency. When a child has an acute asthma attack that includes increase breathing difficulty, the following procedures should be followed:

- Have the child stop all activity
- Help the child assume an upright position. Sitting with legs crossed and elbows on the knees (tripod) will help relax the shoulders and may help them to breathe more easily. Speak reassuring and calmly to the students
- Encourage (and assist) the student to use the appropriate medication. This medication should be with the student or in an easily accessible, unlocked area.
- Notify the proper person (s) which may include the school health personnel, parent/ guardian, principal, and / or primary health care provider . Health care providers should be trained to manage acute asthma episode.

4.0 CONCLUSION

In this unit you have learnt the emergency care of two chronic ailments that may have acute symptoms, these are- diabetes a n d asthma. You learnt about diabetes and the individual health care plan of diabetes. You also learnt about asthma, prevention and management of asthma episodes and asthma first aid care.

You should at this point be able to discuss diabetes and asthma, with emphasis on first aid care of a child with either of these ailments.

5.0 SUMMARY

This unit has focused on Diabetes mellitus (DM), a chronic metabolic disorder, which is caused by the inability of the body to use or produce insulin. The individual health care plan of a diabetic school child was also discussed. The unit also focused on Asthma as a chronic lung disease characterised by episodes or attacks of coughing, wheezing, chest tightness, and / or shortness of breath and is the most common chronic disease in children and leading cause of school absence. The prevention and management of asthmatic episodes were discussed medication, controlling of symptoms and acute asthma episodes, reducing persistent airway inflammation, recognising and managing acute episodes and asthma first aid care.

6.0 TUTOR-MARKED ASSIGNMENT

Discuss how the school personnel can give first aid to a school child with an asthmatic attack.

7.0 REFERENCES / FURTHER READING

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UNIT 4 FIRST AID TREATMENT OF SOME CHRONIC AILMENTS 2

CONTENTS

1.0 INTRODUCTION

Since you have gone through First Aid Care, this unit will enable you acquire more information on first aid care of Seizure Disorder and prevention of sickle cell crisis among school children. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objective.

3.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe seizure disorders
- discuss the treatment of seizure disorder
- discuss how to manage seizure in the school state the emergency management of seizures describe sickle cell disorders
- discuss the causes of sickle cell disorders and the recognition of the disease
- discuss the prevention and management of sickle cell crises.

3.0 MAIN CONTENT

3.1 Seizure Disorder

Seizure disorders occur when clusters of nerve cells, or neurons, in the brain signal abnormally. In epilepsy, the normal pattern of neuronal activity becomes disturbed causing strange sensations, emotions and behaviour or sometime convulsions, muscle spasms, and loss of consciousness. Epilepsy ma y be caused by a variety of disorders. Anything that disturbs the normal pattern of neuron activity from illness to brain damage to abnormal brain development can lead to seizures. Epilepsy may develop because of an abnormality in brain wiring, an imbalance of nerve signalling chemicals called neurotransmitters or some combination of these factors. Two or more seizures are necessary for the diagnosis of epilepsy. Electroencephalograms (EEGs) and brain scans are common diagnostic tes ts f or epilepsy. There is currently no cure for epilepsy but the majority of those diagnosed (about 80%) gain excellent control of their seizures with antiepileptic medications.

Sometimes a seizures disorder can result from another physiological condition such as meningitis in which case patients are not diagnosed with epilepsy. These students may have more complicated medical care because they must manage both the seizures and the underlying problem. But the management of their seizures at school will be similar to a student with epilepsy. Children with seizures disorders face unique challenges at school. Children with epilepsy may develop behavioural and / or emotional problems from the stress and frustration of managing their seizures disorder. They may develop school avoidance because having seizures at school embarrass them or they become the target of teasing and bullying by other children. The seizures or the medication that prevent them may also affect learning, attention and memory.

Having a seizure at school can be socially damaging and unless handled well by staff can permanently mark a child as an outcast. When the school community is well informed and supportive an entirely different outcome is possible. Children with seizure disorders are at risk for two life threatening conditions -status epilepticus and sudden unexplained death. School staff under the guidance of the school health personnel must take part in intervention for these students, both psychosocially and physiologically.

3.2 TREATMENT

Most students with a seizures disorder will be managed by either one or a combination of antiepileptic medications. Since these

medications ma y be prescribed, as many as four times a day, the child will likely need to take this medication at school. The goal of all epilepsy treatment is to prevent further seizures, avoid side effects and provide as much normalcy to the student s life as possible. Most epilepsy medications are taken orally in the form of tablets, capsules, or syrup.

3.2.1 Side -Effects

Side effect from antiepileptic medications is generally minimal but they can differ significantly from medication to medication. They can affect school performance however, as the side effects includes drowsiness, fatigue, nausea, vision changes and clumsiness. Occasionally changes in emotional state, memory or activity level (e.g hyperactivity) can occur. The school health personnel and relevant staff (particularly teachers) need to monitor these side effects carefully and should report any of the following to the students health care provider and family: Unusual fatigue or clumsiness, lethargy, severe nausea or other signs of ill health.

Reducing the dose or substituting another medication can often manage side effect. It can take time to establish the right treatment regimen for a child with a seizure disorder and school personnel may encounter a variety of symptoms, physical, mental and emotional during this time. Occasionally however, the treatment of the seizure problems can cause other undesirable behavioural or cognitive problems and the student s health care provider may want to carefully weigh the benefits against the risks of various kinds of treatments. The school health personnel can gather information from teachers and other school staff (about behaviour, etc.) and use it to provide accurate and complete clinical information to the student s physician and family. This can make a significant difference in how quickly and easily a student with a seizure disorder finds the treatment regimen that is most effective. When controlled, a child can live as normal life as possible.

3.3 Managing Seizures at School

Any member of the school staff could be present while a student is having a seizure. The health worker should provide training to all school personnel about the nature of epilepsy and seizure disorder, the various types of seizures a student might have, how to recognize them and what to do in the event that one occurs. All staff should understand that they should call the health worker as soon as possible, in order to evaluate the student after the seizure has subsided and to determine if any further medical attention is needed. The following includes types of seizures and appropriate interventions:

Absence- Previously called petit mal seizures; these typically produce momentary loss of awareness, sometimes accompanied by movement of the face, blinking or arm movements. They may occur frequently, as many as 60 times a day. These seizures may be difficult to distinguish from the child who is day dreaming. The child with absence seizures may stop talking in the middle of a sentence and a few seconds later continue with their conversation. The child immediately returns to full awareness after one of these episodes.

Management - Make sure the child did not miss any key parts of the lesson.

Simple partial seizures - These are limited to one area of the brain.

Consciousness is not lost, though the child may not be able to control body movements. Senses m a y be distorted during the seizure so that the child sees, hears, smells or experiences feelings that are not real.

Management - If the child seems confused or frightened, comfort and reassure.

Complex partial seizure- Sometimes called psychomotor or temporal lobe epilepsy, these seizures produce a variety of automatic behaviour in which consciousness is clouded. The child may get up and walk around, be unresponsive to spoken direction (or respond inappropriately) may fling off restraints, may mutter or tap a desk in an aimless, undirected way. He or she may appear to be sleepwalking or drugged. Some children experience fear as part of the seizures and may try to leave the room. This type of seizure usually last only a minute or two, but feelings of confusion afterwards may be prolonged. The child will not remember what he or she did during the seizure. Their actions during the seizure are not under their control.

Management If a child has an episode of this type and appears dazed and oblivious to their surroundings, the teacher can take their arm gently, speak to them calmly and guide them back to their seat. Do not grab or hold the child or speak loudly. If the child resists, make sure that they are safe. If the child is seated ignore the automatic behaviour but have them stay in the classroom until full awareness returns. This may necessitate closing the classroom door to prevent wandering and / or possible injury. Help reorient the child if they seem confused afterwards.

Generalised tonic clonic- Previously called grand mal, these seizures are convulsions in which the body stiffens and / or jerks. The student may cry out, fall unconscious, and then continue massive jerking movements. Bladder and bowel control ma y be lost, seizures usually last a minute or

two. Breathing is shallow or even stops briefly and will renew as jerking movements subside. The child may be confused, weary or belligerent as consciousness returns.

Management First aid for a generalized seizure is focused on protecting the child from injury while the seizures run its course. There are no first aid steps that can alter the course of the seizure. When this type of seizure happens the teacher should:

Keep calm. Reassure other children that the student will be okay Time the length of the seizure and try to notice how it started and changed. Ease the child gently to the floor and clear the area around him or her of anything that could hurt them. Put something flat and soft (like a folder jacket) under the students head so it will not bang against the floor as their body seizes. Turn the student gently on his or her side. This will keep the airway clear and allow any fluid in their mouth to drain harmlessly away. DONT try to force open the mouth DON T try to hold on to the student s tongue. DON T put anything in the mouth. DON T restrain movements. When the jerking movements stop, let the student rest until full consciousness. Breathing may have been shallow during the seizures and may have stopped briefly. This can give the child s lips or skin a bluish tinge, which corrects naturally as the seizure ends. In the unlikely event that breathing does not begin again, check the airway for any obstruction. It is rarely necessary to give artificial respiration.

Some children recover quickly after this type of seizure, others need more time. A short period of rest (depending on the child s alertness following the seizures) is advised. If possible the child should remain in the classroom. After r e c o v e r y from the seizures, staying in the classroom (or returning to it as soon as possible) allows for continued participation in classroom activity and is psychologically less difficult for the student. It is not unusual to lose bowel and / or bladder control during a seizures. A change of clothes will reduce embarrassment, when this happens. If a child had frequent seizures handling them can becomes routine once teacher and classmate learn what to expect. One or two of the other students may be assigned to help while the others get on their work.

Other generalised seizures including akinetic , atonic and myoclonic can produce sudden changes in muscle tone that may cause the student to fall abruptly or jerk the whole body. A child with this kind of seizures may have to wear a helmet to protect their head. These seizures are more difficult to control than some of the others and in some cases, may be accompanied by developmental delay. Management The student should be helped to sit up, examined for injury from the force of the fall, reassured and allowed to sit quietly until fully recovered.

3.4 Emergency Management of Seizures

The average seizure in a child who has epilepsy is not a medical emergency. It usually resolves without problems and does not require immediate medical attention. But, when a child has a seizure and there is no known history of seizures or epilepsy, some other medical problem might be causing the seizures and emergency treatment of that problem might be required; viz:

Consciousness does not return after the seizures ends. A second seizure begins shortly after the first one without regaining consciousness between seizures. The seizures show no signs of stopping after five minutes. If a student hits his or her head with force either during the seizures or just before it began and has one or more of the following signs call for immediate medical attention: difficulty rousing after 20 minutes, vomiting, complaints of difficulty with vision, persistent headache after a short rest period, unconsciousness with failure to respond and dilation of the pupils of the eye, or if the pupils are unequal in size.

3.2 Sickle Cell Disorder

This is said to occur when a person s haemoglobin (i.e the red blood cell pigment) is of the sickle cell type only, (i.e. haemoglobin, SS) or haemoglobin S combined with another unusual haemoglobin, such as haemoglobin C, making haemoglobin SC. Haemoglobin SS is also referred to as sickle cell anaemia, while haemoglobin SC is known as Sickle Cell Haemoglobin C disorder. The two main types of sickle cell disorders in Nigeria are haemoglobin SS, and haemoglobin SC as defined above. Haemoglobin SS is common all over Nigeria, while haemoglobin SC is mainly seen in south -western Nigeria. Sickle cell trait

Haemoglobin AS is present in one of every four Nigerians, male or female. It is not a disease, and carriers of the trait live healthy normal lives. They have no anaemia. The same is true of haemoglobin C trait

(haemoglobin AC), which is found in about one of every eighteen Nigerians from the South Western region. The different types of haemoglobin are referred to as haemoglobin genotypes.

3.2.2 Causes

Sickle cell disorders are inherited from both parents. The parents may not have the full blown disorder, but may only have the trait. When both

parents carry the sickle cell trait, (i.e both have haemoglobin AS), each child can take the A from each parent, and have haemoglobin AA, or, A from one parent, and S from the other, and have haemoglobin AS, or S from each parent, and have haemoglobin SS. The chance of any child of such parents having haemoglobin AA, is 1 in 4 the chance of having haemoglobin AS, is 1 in 2, and SS, 1 in 4. In any such family, all their children can have haemoglobin AA, or all can have haemoglobin AS, or all can have haemoglobin SS, or they may each have different haemoglobin genotypes- (AA, AS, or SS).

3.2.2 Recognition of the Disease

An individual with Sickle Cell anaemia (i.e haemoglobin SS), or Sickle Cell Haemoglobin C disorder (i.e haemoglobin SC), may have the following symptoms and signs:-

- Painful swelling of back of hands and feet (in children between the ages six months and six years).
- Pallor (paleness of palms, soles of feet, nail beds and conjunctivae).
- Jaundice (yellow colouration of eyes). Recurrent bone pains and tenderness. Fever (from infections)
- Enlarged abdomen (with large spleen or liver)
- Retarded growth, especially in childhood and early adolescence. Priapism (prolonged and sometimes painful erection of the penis).
- Very dark yellow urine (when jaundice is marked).
- Leg ulcers around the ankle. This is seen only in patients above the age of 10 years.

Steady State: The Sickler (i.e. the patient with haemoglobin SS or haemoglobin SC,), is in a steady state most of the time. This means he is not ill and can perform his normal functions. However, because of constant anaemia (shortage of blood), especially in a patient with haemoglobin SS, he gets tired more easily on engaging in any physically strenuous activity, e.g. competitive sports.

3.2.3 Diagnosis

Diagnosis requires a special blood test done on the red cells. A small sample of the patient s blood is sent to the laboratory for haemoglobin genotype determination. A simpler test is the sickling test, but this only detects the presence of haemoglobin S, whether in haemoglobin AS, or SS or SC. It cannot differentiate the three genotypes.

3.2.4 Complications

Infection malaria, pneumonia, meningitis, osteomyelitis (bacterial infection of the bone). Failure to thrive in children, Painful hip bone (avascular necrosis,) resulting from reduced blood supply to the hip joint. This causes limping due to pain and shortening of the leg and leg ulcers.

Poor vision this is rare in haemoglobin SS, but more common in individuals with haemoglobin SC. Stroke (cardiovascular accidents). This is more common in children before the age of 10 years, than in adults. The patient may have:- Paralysis of arm and / or leg, on the same side of the body, Fits, Coma, sudden death that cannot be easily explained.

Crises: Sicklers may present with acute episode known generally as Crises . Crises can be divided into two types:

Anaemic Crises: - These are as a result of very low levels of haemoglobin in the blood, usually less than 5g /dl. The patient has symptoms of anaemia such as breathlessness at rest or on very mild exertion. It is the commonest cause of death in children who are sicklers.

Occlusive Crises:- These occur as a result of blockage of small blood vessels by the sickled red cells,. Blood flow to parts of the body supplied by these blood vessels is therefore reduced. Clinically, occlusive crises may be divided into two types:-

Painful crises: - These are by far the more frequent. The pains may affect the: Bones of the limb, bones of the back, ribs, and abdomen.

Painless Crises : - The patient may present with:-

Priapism (which can sometimes be painful), blood in the urine, stroke, and sudden visual impairment (usually in the haemoglobin SC patients).

3.2.5 Management of the Patient

Goals

1. To maintain the sickler in a steady state of health
2. To prevent sickle cell crises
3. To counsel the patient and parents on the disease, and promote in him a positive self-image.

Management in steady state prevent malaria:-

1. Advise on measures to prevent mosquito bites Give routine malaria prophylaxis.
2. Prevent secondary folate deficiency which will make anaemia worse. Give folic acid 5mg daily. Refer family to trained counsellor for counselling.
3. Management in painful crises:
4. Give analgesics: e.g Paracetamol or Aspirin should not be given to children (under 12 years).
5. The school health personnel should manage according to standing orders and refer.

Management in anaemic crises:

Bed rest, and refer to hospital in a reclining position Give oxygen by inhalation if breathless at rest.

3.2.6 Prevention of Complications & Health

Promotion

The school health personnel or counsellor should counsel the child or parents thus:

1. Prevent crises by avoiding trigger factors such as:-
    a. Strenuous physical exertion, e.g competitive sports, vigorous dancing, wrestling, etc.
    b. Infections especially malaria.
    c. Sudden change to a colder environment this should be avoided, or appropriate protective clothing should be worn.
    d. Any food or drink or condition known to induce crises in the individual.
2. The sickler should drink plenty of fluids.
3. He should visit the clinic, once in three months.
4. Patient or the parents should be encouraged to join a support group eg sickle cell club.

4.0 CONCLUSION

In this unit, you learnt about seizure disorders, the treatment of seizure disorders, and the side effects of the drugs. You have also realised that seizure disorder is a chronic ailment that can trigger on in school as an emergency, therefore the school personnel need to know how to assist a child to control it and emergency management of seizures. You also

learnt about sickle cell disorders, the causes, signs and symptoms, sickle cell crises and management, as well as management of complications. You should at this point be able to describe seizure disorders and to manage it. You should also be able to manage seizure disorders in a school child. You should also be able to counsel parents on prevention of sickle cell crisis in a school child.

5.0 SUMMARY

This unit has focused on seizure disorders a s a chronic disorder that occurs when clusters of nerve cells, or neurons, in the brain signal abnormally. In epilepsy, the normal pattern of neuronal activity becomes disturbed causing strange sensations, emotions and behaviour or sometime convulsions, muscle spasms, and loss of consciousness. Children with seizure disorders have challenges in the school and may develop behavioural and/or emotional problems from the stress and frustration of managing their seizures. Seizures can also affect learning, attention and memory and should be controlled by medication.

These children can develop school avoidance; therefore school staff should learn how to manage seizures among school children. The unit also focused on sickle cell disorders which are abnormal haemoglobin genotypes inherited from both parents. Complications of sickle cell anaemia, sickle cell crises prevention and management were also discussed.

6.0 TUTOR- MARKED ASSIGNMENT

State conditions when the case of a child with seizure should be considered as an emergency.

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UNIT 5 TREATMENT OF COMMON AILMENTS AMONG SCHOOL CHILDREN

CONTENTS

1.0 INTRODUCTION

Having gone through Emergency and Emergencies and First Aid Care in previous units, this unit will enable you acquire the understanding of minor ailments that are common among school children. But before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- discuss common health conditions among school children describe the signs and symptoms of the health conditions
- outline the management of the hea 9 lt 7 h conditions.

3.0 MAIN CONTENT

Common health conditions of school children

These include-Ascaris Lumbricoides, Malaria, Ringworm, Scabies, Pediculosis, Impetigo.

3.1 Ascaris Lumbriucoides (Roundworm)

This is a helminthic infection of the small intestines, characterised by irregular respiration, coughing, fever, worm excretion, etc. It occurs worldwide, especially in most tropical countries with low standards of sanitation. The reservoir of Ascariasis is man, while the intermediate sources of infection are salads and other foods (fruits) eaten raw.

The disease is not transferred directly from man to man, but by soil contaminated with the eggs of the helminth from human faeces and vomitus. Vegetables and other foods in contact with the contaminated soil also get contaminated and man gets infected by ingesting the contaminated food. The incubation period is two weeks.

3.1.1 Signs & Symptoms

Signs & symptoms of Ascariasis vary depending on the parasite burden. Mild infestation is accompanied by vague or almost absent signs, while heavy burden of infestation is characterised by digestive and

utritional disturbances, abdominal pain, vomiting, restlessness and disturbed sleep. It can affect respiratory s ys t e m leading to irregular respiration, spasms of coughing, fever, etc. Complications, especially in children include lower intestinal obstruction, occasional death due to adult worm migrating to liver, gall-bladder, peritoneal cavity or appendix, and in rare instances from intestinal perforation.

3.1.2 Management

A case of Ascariasis is managed using the standing orders.

Control/Prevention

Ascariasis is controlled by disposing faeces in most sanitary manner to prevent soil contamination by faeces. Families where Ascariasis exist should be investigated; and necessary, sanitary measures applied accordingly, People should be educated; including school children, food vendors, teachers etc on the use of toilet facilities, washing hands after

defecating and before eating and washing of food especially fruits which have been grown in soil to which compost has been added.

The school health team should embark on mass de-worming exercise possibly, every term.

3.2 Malaria

Malaria is the commonest cause of fever, which can be acute or chronic. It is caused by a single-celled parasite called plasmodium. The four species of plasmodium include:

- Plasmodium falciparum Plasmodium vivax Plasmodium ovale
- Plasmodium malariae

The falciparum type accounts for 80% of malaria in man and it is the most dangerous and devastating. Features of Malaria include: fever, weakness, loss of appetite, joint pains and enlarged spleen, especially in children. If untreated, may cause cerebral malaria, and anaemia.

3.2.1 Management

Treat malaria with Artemisinin Combination Therapy (ACT). (Refer to standing orders for details).

Treat fever as follows:

- undress the child and leave him uncovered
- Tepid-sponge gently to lower the body temperature Encourage him to drink plenty of water, or fruit juice.

Prevention& Control Measures includes:

Health education on environmental sanitation & elimination of breeding places of mosquitoes at home & the school premise, Use of insecticide, Larval control by spraying the breeding places of mosquito with larvicides, eliminating breeding places of mosquito, Window netting, Use of insecticide treated bed nets and the use of prophylactic drugs.

3.3 Ringworm

Ringworm is the term applied to mycotic or fungal disease of keratinised areas of the body (e.g hair, skin and nails). Ringworm is caused by various species of fungi known as the dermatophytes. The dermatomycoses are subdivided according to the sites of infections e.g

Ringworm of the scalp (Tinea capit 9 i 9 s), Ringworm of the body (Tinea corporis), ringworm of the foot (Tinea pedis), Ringworm of the Nails (Tinea Unguium), Tinea unguium various species of trichophyton.

Reservoir of infection is as follows:-

Tinea capitis man and animals like dogs, cats and cattle, Tinea corporis- man and animals, Tinea pedis man,]Tinea unguium man.

Mode of transmission:

Mode of transmission is by direct or indirect contact with lesion of infected persons, lesions and hairs of animals and contaminated

articles. This fungal disease occurs most commonly in children Three to nine years of age. All tinea infections are transmissible as long as the fungus is present in the infected area. Viable fungus may persist on contaminated material for long periods.

Incubation Period: The incubation period is 10 14 days. That of Tinea unguium is not known.

3.3.1 Signs and Symptoms of Ringworm

Tinea capitis begins as a small papule and spreads peripherally, leaving scaly patches of baldness. Infected hair is brittle and breaks easily.

Tinea corporis ringworm of the body. The periphery is reddish, vesicular or pustular and may be dry and scaly or moist and crusted.

Tinea pedis - scaling and cracking of the skin, especially between the toes. There could be blisters containing a thin watery fluid, usually called athletes foot.

Tinea unguium a chronic infectious disease involving one or morenails of hand of foot. The nail gradually thickens becomes discoloured and brittle nail becomes chalky and disintegrates. Period of communicability: As long as lesions are present and viable spores persist on contaminated materials.

3.3.2 Management: The Diseases should be Managed Using the Standing Orders

An antifungal ointment is typically applied to the skin for several weeks; occasionally oral antifungal medicine is prescribed.

Prevention / Control Measures:

Health education on the mode of spread of the infection and personal hygiene, Proper laundering or sterilization of clothing, towel and other articles that if shared can spread infection, examination of-school children, household contact and household pets and farm animals and treatment of infections, Concurrent disinfection of sock of infected individuals (for Tinea pedis), Personal hygiene.

Prevention Guidelines:

Keep the environment as clean, dry and cool as possible since ringworm fungi grow easily on moist warm surfaces. Students and staff should be discouraged from sharing ribbons, combs, and brushes.

3.4 Scabies

Scabies is an infection of the skin caused by the mite, sarcoptes scabies. The skin rash typically consists of small papules, vesicles and pustules characterised by intense pruritus and burrows which are superficial tunnels made by the adult mite. Scabies is caused by sacrcoptes scabies and m an is the r e se r v o i r of infection. The mode of infections is through direct contact, or indirectly contact through contaminated clothes. The incubation period is several days or even weeks before itching is noticed.

3.4.1 Signs and Symptoms

Signs and symptoms of scabies are characterized by visible papules or vesicles, tiny linear burrows containing the mites and their eggs. Lesions are prominent around finger webs, anterior surfaces of wrist and elbows, axillary folds, belt line, thighs and external genitalia in man. It also affects the nipple abdomen and lower portion of buttocks in women. Itching is intense especially at night.

3.4.2 Management

Scabies should be managed using the standing orders. Preventive & Control Measures:

Health education on the need for maintaining cleanliness on person, clothes and bed sheets, barring infected people from mixing with others until they are treated, Improvement of personal hygiene, and treatment of affected persons.

3.5 Pediculosis

Pediculosis is an infestation of the hair and clothing (especially along the seams of inner surfaces) with adult lice, nymphs, and nits (eggs) which results in severe itching or excoriation (abrasion) of the scalp, or both. Secondary inf ection ma 1 y 01 occur ensuring regional lymphadenitis (inflammation of the lymph nodes), especially cervical. Crab lice usually infest the pubic area they may also infest hair of the face (including eyelashes) axillae, and body surfaces. There are three types of lice 1) Pediculus humanus capitis are the head louse 2) Pediculus h corporis, the body louse and 3) phthrirus pubis, the crab louse.

3.5.1 Head Lice

Head lice are tiny insects that live in human hair and feed on human blood. They multiply rapidly laying little silvery coloured oval shaped eggs (called nits) that they glue to the base of the hair close to the scalp. Although it is hard to see head lice, a person can see the nits if they look closely. Nits are most often found in the hair behind the ears and at the back of the head and neck. Nits should not be confused with dandruff. Dandruff can easily be flicked of the hair; nits cannot because they are firmly attached to individual s hairs. One tell- tale sign of head lice is a persistent itching of the scalp which is caused by the bite of the louse, and that is sometimes accompanied by infection, scratch marks or what appear to be a rash. A secondary bac te rial infection c an occur, causing oozing or crusting. Swollen glands may also develop.

Anyone can get head lice. They are not a sign of being dirty and should not be considered a sign of an unclean house. Head lice are easily spread from person to person by direct contact and are often in school settings. Head lice do not spread disease. Head lice need human blood to survive. They are transmitted through direct contact with an infected person or with shared items such as combs, brushes, towels, pillowcases, hats, headphones, headgear, and clothing.

3.5.2 Treatment

The condition should be managed using the standing orders.

3.6 Impetigo

Impetigo is a common skin infection caused by streptococcal (strep) or staphylococcal (staph) bacteria. The first indication of infection may be discharges at an injured spot on the skin such as an insect bite, cut, or burn that can be spread easily by the individual s hands to other areas of

the skin. Impetigo most commonly occurs on the face. The red, rounded, and oozing rash may have a flat, honey colored crust and may be itchy. Impetigo sometimes causes blisters that break easily leaving raw, oozing skin exposed. In rare cases impetigo caused by strep bacteria may cause kidneys disease. Impetigo most commonly occurs during dry season.

A long as lesion from impetigo exists; bacteria can be spread to another person who has direct contact with the skin or a surface contaminated by the discharge or crust.

3.6.1 Treatment

Manage with standing orders: Wash with Tetmosol soap twice daily, especially the crusted lesions. Paint the open sores with gentian violet paint and give ampiclox for five days.

3.6.2 School Attendance Guidelines

Students and staff do not need to be sent home in the middle of the day if a suspected impetigo rash is noticed. Those who touch the rash should wash their hands immediately. The sores should be kept lightly covered until they have dried up completely.

4.0 CONCLUSION

In this unit you have learnt about common health conditions that could affect school children such as Ascaris Lumbricoides (Round Worms), Malaria fever, Ringworm, Scabies, Pediculosis, Impetigo. The unit discussed these health problems, their signs and symptoms and management.

5.0 SUMMARY

This unit has focused on the Common Health Conditions of School children such as Ascaris Lumbricoides,(Round worms), Malaria, Ringworm, Scabies, Pediculosis, Impetigo. The signs and symptoms, mode of transmission, management and prevention and control measures of conditions were discussed.

6.0 TUTOR-MARKED ASSIGNMENT

Discuss the prevention and control of malaria and worms.

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MODULE 4

UNIT 1 VACCINE PREVENTABLE DISEASES

CONTENTS

1.0 INTRODUCTION

Since you have gone through the previous unit you would have acquired the understanding of Common Health Conditions among school children. This will help you acquire basic understanding of vaccine preventable diseases. Before we do this, let us have a view of what you should learn in this unit, as indicated in the objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- discuss the vaccine preventable diseases
- state the signs and symptoms of the vaccine preventable diseases
- outline the management of the vaccine preventable diseases.

3.0 MAIN CONTENT

Vaccine Preventable diseases include- Tuberculosis, Hepatitis, Polio, Diphtheria, Measles, Pertussis, Yellow Fever, and Tetanus.

3.1 Tuberculosis

Tuberculosis (TB) is a bacterial disease caused by the tubercle bacilli Mycobacterium tuberculosis, Mycobacterium bovis and Mycobacterium Africana. It can affect any organ of the body, although the respiratory tract is most commonly involved . TB spreads through airborne transmission. If a person infected with TB coughs, sneezes, spits or sings and releases infected droplets of mucous, these may be picked up by a non- infected who then develop TB. These droplets remain viable and suspended in the air for several hours. TB is not spread by kissing or sharing utensils or other objects such as books or clothing. Young children with TB are less likely to infect others than are adults with TB because the concentration of bacilli is lower in the bronchial secretions and the cough is often not forceful enough to propel infectious particles. Two weeks after beginning anti –TB medications, most adults no longer transmit the organism.

TB infection is defined by a positive tuberculin skin test (PPD) in a person who has no physical findings of disease and a chest x ray that is either normal or reveals only granulomas or calcification in the lung or surrounding lymph nodes. TB „disease" is defined as a person with infection in whom signs symptoms and / or x –ray changes are apparent – disease may be limited to the lung and / or outside the lung. In adults this distinction between disease and infection is fairly clear, but it is less so in children. TB can lay dormant in the body for years before the disease becomes apparent. Adults and children who are more likely to progress from infection to disease include those with recent contact, immunosuppression, or

HIV infection. The most common symptoms is a cough, often one that last for weeks, and there may be blood in the mucous that is expectorated. The disease may also cause chest pain, fever weakness, loss of appetite and night sweating. Extra pulmonary symptoms reflect the area of the body that is involved with the disease.

Interpretation of the results depends on the size of the raised or indurate area at the site of the PPD test, typically the forearm. A reactive PPD develops a red, swollen area (indurations) at the approximate area of test administration, and occurs within 48 hours of test administration. A reactive area greater than or equal to 10 mm is considered positive for infection. For groups at high risk of infection indurations greater than or equal to 5 mm is considered positive. Groups at high risk for TB infections and disease include: Poor and indigent person especially in large cities, Person known to have or suspected of having HIV infection, Close contact of a person with infectious TB, Present and former residents of correctional institutions, Homeless person, Injecting drug users, Health care workers caring for high risk patient and Children exposed to high risk adults.

3.1.1 Treatment

Individuals with TB infection may be treated with oral anti-TB medication to prevent the infection from progressing to disease. Medications is usually taken once daily for 6 to 12 months.

3.1 2 School Attendance Guidelines

Students or staff diagnosed with suspected or confirmed TB disease should not attend or work in school until they have begun taking prescribed anti- TB medication and their health care provider states in writing that they are not contagious. Within two weeks, individuals taking such medications are generally not contagious.

3.2 Hepatitis A

Hepatitis A is an infection of the liver caused by the hepatitis A virus. Although the virus causes a total body illness, it is spread through the intestines and stool. The illness often occurs from two to eight weeks after the virus is ingested. Adults who have hepatitis A often suffer from fatigue, loss of appetite, nausea, abdominal pain, fever and jaundice (yellowing of the skin and whites of the eyes as well as dark brown urine and light coloured stools). These symptoms usually last from one to two weeks although some adults may be sick for several months. Most young children who catch the virus have only a mild flu like illness without jaundice or have no symptoms at all.

This virus is passed out of the body in the stool and is spread by stool to-mouth contact. It is found only briefly in the blood. Contact with stool contaminated food,

drink or environmental surfaces can also spread the infection. A person is most contagious during the two weeks before the illness begins. Because most young children with hepatitis A do not become ill, often the first sign of the infection is a jaundiced parent.

3.2.1 Treatment

Manage according to standing orders, however, treatment for hepatitis A focuses on relieving symptoms.

3.2.2 School Attendance Guidelines

Children and adults with acute hepatitis A should be excluded from school for one week after the onset of the illness and until jaundice has disappeared.

3.3 Poliomyelitis

Poliomyelitis is an acute viral disease which sometimes results in paralysis usually referred to as "infantile" paralysis. The causative agent of poliomyelitis are poliovirus types 1, 2 and 3, all types cause paralysis but type 1 has been most commonly involved. Reservoir of infection is man, especially children and adolescents. Modes of transmission are through eating food or drinking water contaminated with poliomyelitis virus and droplet infection (direct contact with pharyngeal secretion of infected person through close association).The incubation period is seven to 12 days. The sign and symptom of poliomyelitis are fever, headache, gastro –intro- intestinal disturbances, stiffness of neck and back with or without paralysis, found more in children and adolescents.

3.3.1 Management of Poliomyelitis

Poliomyelitis should be managed using the standing orders.

Preventive and control measures: Include active immunization of all susceptible persons with polio vaccine and education of the public on the advantages of immunization in early childhood, and on modes of spread. Control measures include early report to the local authority, Proper disposal of refuse including excreta, disinfection of throat discharges and articles soiled with discharges, treatment of infected persons, practical environmental and personal hygiene including, protection of food and water supplies.

3.4 Diphtheria

Diphtheria is an acute infectious disease of tonsils, pharynx, larynx or nose, occasionally of other mucus membrane or skin. It is a common endemic disease in childhood. The causative agent is a bacterial species known as corynebacterium diphtheria. The reservoir of infection is man. The mode of transmission is contact

with patient or carriers or rarely with articles soiled with discharges from lesions of infected person. Raw milk can also serve as a vehicle of infection. The incubation period is usually 2-5 days but may be longer.

3.4 1 Signs And Symptoms Include

Onset m a y be i n s i d i o u s without o b v i o u s f e v e r . But the pulse is rapid and there may be marked exhaustion and general malaise, Tonsils are covered by a greyish white membrane that makes the breath have a musty smell, enlargement of tonsillar glands in the neck, blood stained nasal discharge, Myocarditis which may lead to rapid pulse, fall in blood pressure and possibly death as well as paralysis of the nerves which leads to difficulty in breathing and swallowing.

3.4.2 Management

Diphtheria should be managed using the standing orders. Preventive and control measure: Immunisation of children with diphtheria toxoid People at risk -Doctors, laboratory staff, Nurses, other hospital personnel and teachers should be immunised, to be followed by a booster dose every 10 year.

3.5 Measles

Measles is a highly acute/ communicable viral infection characterised by fever, catarrhal symptoms, followed by a typical rash and is spread worldw ide. Measles is caused by a virus called Morbilli virus. The immediate reservoir of infection for measles is man. Mode of transmission is by droplet or direct contact with nasal or throat secretion of infected person. It is also transmitted indirectly by articles freshly soiled with secretions of nose and throat of an infected person. The incubation period is averagely 10 days but may be from eight to 14 days. The incubation period could however extend to 21 days exposure to people with passive protection.

3.5.1 Signs and Symptoms

The signs and symptoms of measles include fever, conjunctivitis, catarrhal conditions, bronchitis and koplik‟s spots in the buccal cavity. A characteristic reddish blotchy rash appears on the face; the rash is then generalised lasting 4- 6 days and then starts shedding. Malnutrition especially in children makes the disease severe. The rash spreads to different parts of the body including the limbs. Investigation of measles is based mostly on the signs and symptoms and is confirmed by the appearance of the koplik‟s spots which are tiny and whitish comparable to grains of salt in the mouth lasting 3- 4 days before the appearance of the rashes. Complications due to bacterial invasion could arise in the form of broncho –pneumonia, conjunctivitis, otitis media, kwashiorkor etc.

3.5.2 Management

Measles is Managed Using the Standing Orders

Control and Prevention: The child should be isolated and should therefore not be allowed to attend school, all that the child comes in contact with, should be disinfected, especially whatever has been spoiled by m o u t h and nasal discharges. All children should be immunized against measles in the first year of life.

3.6 Pertussis (Whooping Cough)

Pertussis (whooping cough) is a highly infectious respiratory tract infection caused by a bacterium. It is characterised by cold, fever, cough leading to a whoop. The causative agent of pertussis is a bacteria called Pertussis bacilli or Bordetella pertussis. The reservoir of infection for pertussis is man. The mode of transmission is through droplet infection by which the patient discharges sputum containing the bacillus, which are inhaled by a susceptible person within the immediate vicinity, who would in the process become infected. The incubation period for whooping cough is seven days but could extend to three weeks.

3.6.1 Signs and Symptom

It has a gradual onset with cold at first, then cough, and fever. The cough develops into a whoop about 2 weeks later, especially in the night. The whoop occurs as a result of the child‟s strong breathing after a series of prolonged coughing of 20 – 30 times. The whoop could be followed by vomiting. The sticky nature of the sputum prolongs the coughing and may result in the child‟s inability to eat.

3.6.2 Management

The management of pertussis or whooping cough is done using the standing orders:

Control Preventive Measures: The control of pertussis is effected by isolating the patient especially during the period of communicability, to reduce or prevent contact by other people, all sputum and other discharges from a patient should be disinfected and removed from the room in which he/she is, all possible contacts should
be traced and protected against the disease, the population at risk (mostly children) should be immunised with DPT vaccine for protection in the first ye a r of live, People should also be health educated on the disease, its cause, mode of spread, management and control.

3.7 Yellow Fever

Yellow fever is an acute febrile illness of the tropics caused by a virus known as yellow fever virus. The reservoir of infection is man and monkey. The mode of

transmission is through a bite by an infected mosquito. The incubation period in man is 3 -6 days and 9 -12 days in the mosquitoes.

3.7.1 Signs and Symptoms Include -

Fever for about five days and rarely more than seven, Headache, backache, prostration, Nausea, Vomiting, Slow and weakened pulse, Epistaxis, Gum bleeding, Jaundice. The immediate source of infection is- infected salivary secretion of infective mosquitoes.

3.7.2 Prevention and Control Measures

Isolation of clinically diagnosed cases in screened premises or under a mosquito bed net for at least five days since the virus almost invariably disappears from the peripheral blood after the expiration of this period, Blood samples should be taken for serological test, Contacts should be examined and placed under observation in screened quarters for six days from the last day of exposure, Efforts should be made to destroy potentially infected adult mosquitoes, The area in which the case was found should be sprayed with insecticides, All potential breeding places must be sought out and eliminated as rapidly as possible, Protect the population by inoculation with a live attenuated and modified virus, All immigrants to areas where the disease is endemic should be protected by vaccination, The use of insecticide treated bed nets should be encouraged in the school.

3.8 Tetanus (Lack)

Tetanus i s a disease caused by anaerobic bacteria called Clostridium tetani. The reservoir of infection is soil, and intestinal canals of animals, especially horses in which the organism is a harmless normal inhabitant, and also man. The mode of transmission of tetanus is introduction of tetanus spores into the body during injury usually puncture wound contaminated with soil, street dust, or animal and human faeces; infection can also be contacted through burns and unhealed umbilicus. The incubation period is four days to three weeks, depending on character, extent and location of the wound. Average is
10 days.

3.8.1 The Signs and Symptoms

Severe muscular spasms which usually start in the jaw muscles causing difficulty in opening the mouth as a result of rigidity of face and neck muscles; this is known as Lack jaw, Generalised muscular contractions, Rigidity of muscles and increase in muscle tone, Fever. The immediate source of infection are- Contaminated soil, Faeces of animals, contaminated surgical instruments.

3.8.2 Management of Tetanus-Manage Tetanus Using The Standing Orders

The preventive and control measures are-Active immunisation with tetanus toxoid for solid protection e.g. Childhood immunisation, Education on the need for routine immunisation with tetanus toxoid, In case of accidents, if there is any wound, remove all foreign matter from it by thorough cleansing, Sterilisation of all surgical instruments before use, Maintenance of asepsis of the umbilical stump of new-born infant, wearing of shoes always.

4.0 CONCLUSION

In this unit you have learnt about vaccine preventable communicable diseases such as Tuberculosis, Hepatitis, Polio, Diphtheria, Measles, Pertussis, Yellow Fever and Tetanus. You learnt the signs and symptoms of these diseases and their prevention and control measures.

5.0 SUMMARY

This unit focused on Vaccine Preventable Diseases such as Tuberculosis, Hepatitis, Polio, Diphtheria, Measles, Pertussis, Yellow Fever and Tetanus. The signs and symptoms of the diseases as well as their prevention and control measures were discussed. These are eight

of the infectious diseases that kill or disable children and the vaccines that can prevent them. The diseases are: Tuberculosis, Diphtheria, Pertusis , Tetanus, Poliomyelitis, Measles, Yellow fever and Hepatitis B.

6.0 TUTOR-MARKED ASSIGNMENT

1. (a) Outline the signs and symptoms of Tuberculosis and Measles.
   (b) Draw the immunization schedule.

7.0 REFERENCES / FURTHER READING

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Routine Immunisation Schedule

Vaccine/ Supplements	**No. Of Doses**	**Age**	**Minimum Interval between doses**	**Route of Administration**	**Dose**	**Vaccination site**
BCG	1	At birth as soon as possible afterbirth		Intra dermal	0.05ml	Upper left arm
OPV	4	At birth and at 6, 10 and 14 weeks of	4 weeks	Oral	2 drops	Mouth
DPT	3	At 6, 10 and 14 weeks of	4 weeks	Intra muscular	0.5ml	Outer part of left high
Hepatitis B	3	At Birth, 6 Weeks and 14 weeks of age	4 weeks	Intra muscular	0.5ml	Outer part of right high
Measles	1	At 9 months of age		Subcutaneous	0.5ml	Upper left arm
Yellow fever	1	At 9 months of age		Subcutaneous	0.5ml	Upper right arm
Vitamin A	2	At 9 months and 15 months of age	6 months	Oral	100,000IU 200,000IU	Mouth

UNIT 2 CONTROL OF COMMUNICABLE DISEASES

CONTENTS

1.0 INTRODUCTION

Having gone through the preceding units, you would have acquired the general overview of what this unit is about, how it links specifically to the course. This unit will help you acquire basic understanding of Communicable diseases that the school children can be exposed to in the School environment. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- discuss communicable diseases that school children are exposed to outline the signs and symptoms of communicable diseases
- describe the communicable diseases prevention and control measures.

3.0 MAIN CONTENT

3.1 Common Cold

Common cold is an acute viral and catarrhal infection of the upper respiratory tract characterized by coryza, lacrimation, and occurs worldwide and could be both endemic and epidemic. The incidence is high among children under five (5) years of age. There are numerous viruses responsible for common cold i.e rhinoviruses, parainfluenza viruses etc. The reservoir of infection for common cold is man. Common cold is transmitted by direct oral contact with an infected person, by droplet spread or could be indirectly by articles freshly soiled by discharges of nose and mouth of an infected person. The incubation period ranges between 12 – 72 hours but is usually 24 hours.

3.1.1 Signs and Symptoms

Common cold is characterized by coryza, lacrimation, irritated nasopharynx, chills and malaise lasting 2-7 days, fever is uncommon in both adults and children. Common cold predisposes people to bacterial complications like sinusitis, otitis media, laryngitis, tracheitis and bronchitis. Common cold is managed using the standing order.

3.1.2 Control / Prevention- In Controlling Common Cold

Concurrent disinfection of eating and drinking utensils, Sanitary
disposal of nose and mouth discharges, Isolation among children should be practiced, overcrowding should be avoided in schools, health
education in the schools on personal hygiene as is covering the mouth when coughing and sneezing and in sanitary disposal of discharges
from mouth and nose.

3.2 Influenza

Influenza is an acute viral disease of the respiratory tract that causes explosive epidemics that spread rapidly within the population. Influenza is caused by a virus called influenza virus classified into three (3) types A B and C with the „A" being the commonest, followed by the B and C which is not capable of causing outbreaks. The incubation period is short, ranging from 24 – 72 hours.

3.2.1 Signs and Symptoms

The disease starts with a sudden illness with fever, headaches muscle pains, prostration, coryza or runny nose and sore throat. The temperature rises to a peak and starts decreasing in a progressive manner. The catarrhal stage however remains pronounced throughout. Headaches and muscle pains could continue with loss of appetite. Recovery may come in a week.

Reservoir of Infection

Man is the main reservoir of infection but there are also other mammalian reservoir like swines, horses and avian species suspected as sources of new human strains. Transmission is by direct contact or through droplet infection or articles freshly soiled with discharges from the nose and throat of infected persons. It is most probably airborne among crowded population in enclosed spaces.

3.2.2 Control / Prevention

The health authority should be informed of any outbreak of influenza. The patient should be isolated to prevent the spread of the disease, Discharges from the nose and throat should be disinfected to destroy the virus, and health education on personal hygiene and avoidance of crowding; most people who get influenza feel too ill to go to school or work. The virus concentration in respiratory secretions is usually highest up to 7 days before a person develops symptoms of illness. Viruses continue to be present in respiratory secretions for two to three days after symptoms begins. As a result infected students and staff have already spread viruses before they begin to feel ill.

Treatment-Manage according to standing orders . Patient should have adequate rest and plenty of fluids.

3.3 Meningitis

Acute meningitis may be caused by a variety of organisms including viruses, bacteria, fungi, mycoplasma, and parasites. Viral or aseptic meningitis or meningoencephalitis is an acute inflammation of the meningitis that may or may not involve parts of the brain as well. The most common causative agents are enter viruses, but no cause is determined in the majority of cases. Severity of s y m p t o m s is determined by the extent of tissue involvement. Onset is generally gradual and may be preceded by a nonspecific febrile illness. Headaches and hyperesthesia are the most commonly reported symptoms in children and adolescents. Nausea, vomiting, leg pain, and photophobia are also common, stupor and seizure may be noted with high fever. Patients should be hospitalized and treated with antibiotics until a bacterial or other cause is ruled out. Treatment of aseptic meningitis is symptomatic and includes antipyretics and analgesics. Intravenous fluids may be necessary in cases of anorexia or vomiting.

Bacterial meningitis is one of the most potentially dangerous infections in children. The most common causative organisms in children two months to 12 years of age are S. pneumoniae, N. meningitides and H. influenza type B. Onset of symptoms is usually gradual and may be preceded by several days of upper respiratory symptoms. Increased lethargy and irritability follow. Bacteria called Neisseria meningococcal illnesses that are serious and sometimes fatal. People with this type of meningitis must be hospitalised immediately and receive intravenous

antibiotics.

3.3.1 Signs and Symptoms

The disease usually starts suddenly with fever chills, lethargy, and a rash of fine red freckles or purple splotches. Older children and adults may experience severe headache, neck pain, and stiffness. The bacteria are passed between people who are in close contact through coughing, sneezing, nasal discharge, saliva, and touching of infected secretions. It can be spread by sharing eating utensils, drinking cups, water bottles and kissing. While household contacts are at the highest risk of contracting this illness, others sharing these exposures are at risk as well.

3.3.2 Prevention and Control Measures

The best way to prevent spread of meningococcal disease is to alert everyone that a case has occurred so that appropriate preventive treatment can begin. Instruct significantly exposed staff and parents of significantly exposed student to contact their health care providers immediately. Anyone having close contact with the ill person (e.g. household members and friends sharing eating and drinking utensils, sharing water bottles or kissing) in the two weeks prior to the onset of symptoms should Inform parents and staff as antibiotics do not provide absolute protection against disease. Therefore a n y student or adult who develops symptoms such as fever or headaches requires prompt evaluation by a health care provider. Monitor the situation closely for two to three weeks. Make sure all students and staff are seen by their doctors and that the school is notified if another person develops meningococcal disease.

3.4 Varicella (Chicken Pox)

Chickenpox (primary varicella) is an acute generalised disease caused by varicella zoster virus, a member of the herpes virus group. The illness is characterised by a generalised, itchy blister like rash with mild fever and fatigue. The rash appears as red bumps which quickly become blistered ooze, and then crust over. New spots continue to appear for about three to four days. The spots will dry up and scab over before falling off. The disease is usually more serious in adults than in children. A variety of complications can occur with chickenpox. These include infections ranging from impetigo to severe skin infections with toxic shock syndrome. Secondary pneumonia can occur. Less common complications can involve the blood, joints, brain and kidney. Reyes Syndrome can follow chickenpox. Severe chickenpox can occur in new-born babies when their mothers develop chickenpox five days before or two days after birth.

Person with weakened immune systems or who are taking drugs that suppress their immune systems are at increased risk of developing severe chickenpox. Once a person has been infected with the varicella zoster virus and develops chickenpox the virus remains (without symptoms) in the body‟s nerve cells. In

some people, the virus reactivates later and is called shingles or zoster. With shingles, a red, often painful, or itchy, blistery rash appear, usually in a linear pattern that follow a nerve root. There is no fever. The virus shed in the blisters of the rash can cause chickenpox in a person who has not had it, if that person had direct contact with the infected shingles blister. Individuals with chickenpox are contagious from 1 to 2 days before the rash appears until 5 days after the rash begins. Chickenpox is transmitted from person to person by direct contact, droplet, or airborne spread of vesicle, fluid or secretions of the respiratory tract of chicken pox cases. Chickenpox spread is also transmitted by handling articles that are freshly soiled by the infected person‟s chickenpox lesions.

3.4.1 Treatment Management According to Standing Orders

Treat fever with paracetamol, prescribe anti-pruritic agent like calamine lotion, gentian violet if lesions are infected and encourage fluids.

3.4.2 School Attendance Guideline

There is need for isolation, especially in schools where children infected should be excluded during the period of communicability in the first one week of onset. Articles soiled by discharges from the nose and throat lesions should be concurrently disinfected. Students may return to school on the sixth day after the rash first appear (or when all blister are crusted over and dry). In mild cases with only a few blisters, students may return to school sooner if all lesions are crusted. Specific immune serum globulin from zoster convalescent patients (Zoster immune Globulin ZIG) may prevent or modify the disease in close contact. Students and staff with shingles carry the virus that causes chickenpox and could cause an outbreak. Therefore unless the shingle rash can be completely covered, it is advisable that individual with shingles stay home until the rash is crusted over and dry. The person with shingles must be very careful about personal hygiene.

3.5 Typhoid Fever

Typhoid fever is defined as a bacterial infection with a gradual onset characterised by continuous fever of about 104”(400c), abdominal discomfort and diarrhoea. It is a worldwide disease but endemic in areas of low standard of sanitation and personal hygiene. It is an enteric disease. The causative agent of typhoid fever is called typhoid bacillus or Salmonella typhi and there are different types of them.

The reservoir of infection for typhoid fever is man, including both patients and carriers, and sometimes family contacts. The transmission of this disease is through contaminated food and water, especially improperly cooked starchy foods , including fruits , vegetables , milk and their products. Contamination is done through hands, flies and entry by the organisms into canned food through leaks. The incubation period varies from 1-3 weeks with an average of two weeks.

3.5.1 Signs and Symptoms of Typhoid Fever

It starts with a gradual onset of headache and continuous fever of
104o F to the end of the first week, after which constipation and stomach discomfort and diarrhoea occur with the temperature still high. Constipation seems to be more usual than diarrhoea. In some cases, there is enlargement of the spleen.

Management

The management of this disease condition is done according to the standing orders.

3.5.2 Control / Prevention

The control of typhoid fever is through sanitary disposal of human excreta thereby getting rid of the salmonella typhi therein, water consumed by the School community should be thoroughly purified to destroy the causative agent that might have final access into it, the practice of personal and environmental hygiene and sanitation should be fully embraced, Carriers and contact should be kept under surveillance as much as possible and any article belonging to them should be disinfected, the School Food vendors should be frequently examined to ascertain their state of health, the susceptible people or those at risk should be immunised with typhoid vaccine.

4.0 CONCLUSION

In this unit you have learnt about Communicable diseases school children can be exposed to in the school environment, namely Common Cold, Influenza, Meningitis, Varicella (Chicken Pox) and Typhoid Fever. You looked at the signs and symptoms of the communicable diseases and their prevention and control measures.

5.0 SUMMARY

This unit has focused on *Communicable Diseases* that can affect the school children in the school environment including their signs and symptoms, incubation period and their period of communicability, as well as prevention and control measures.

6.0 TUTOR-MARKED ASSIGNMENT

State the school attendance guidelines for chicken pox and influenza.

7.0 REFERENCES / FURTHER READING

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UNIT 3 CHILD ABUSE

CONTENTS

1.0 INTRODUCTION

Having gone through the previous units, you would have acquired a general overview of what this unit is about, and its relevance in the School Health Programme. This unit will help you acquire an understanding of Child Abuse and Child Neglect. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define child abuse
- state the reasons for child abuse
- discuss how to assess for child abuse and neglect
- discuss how to intervene in cases of child abuse and neglect.

3.0 MAIN CONTENT

Child Abuse and Child Neglect

3.1 Definition of Child Abuse

Child abuse means physically hurting a child, sexually molesting a child, failing to provide proper care, or depriving a child of support and affection. Many children are at risk of, or suffer physical, emotional, or sexual abuse or neglect. The teacher or school health personnel may be the only adults outside the family who have contact with these children on a regular basis and, are professionally and legally obligated to intervene by reporting cases of suspected abuse to the appropriate authorities. For this reason it is important for all school personnel to be familiar with: Reasons for abuse, types of abuse and those at particular risk for abuse Resources available for the individual reporting the abuse and the individuals being subjected to the abuse.

3.1.1 Operational Definition of Abuse

3.1.1.1 Physical Abuse

Physical abuse is defined as any act, whether intentional or not, that causes harm to a child. Intentional physical injury usually is related to severe corporal punishment; however, physical abuse ranges from minor cuts and bruises to severe neurologic trauma and death.

3.1.1.2 Physical Neglect

Physical neglect occurs when caretakers do not provide for a child‟s physical survival needs (including adequate food, clothing, shelter, hygiene, supervision and medical and dental care) to the extent that the child‟ health or safety is endangered.

3.1.1.3 Sexual Abuse

Sexual abuse is defined as acts of sexual assault or sexual exploitation of minors. This category includes a wide spectrum of activities that may occur only once in a child‟s life or may occur over a period of several years. Specifically, sexual abuse includes the following sexual acts: incest, rape, intercourse, oral genital contact, fondling, sexual propositions or enticement, indecent exposure, child pornography, and child prostitution. Sexual abuse is most commonly carried out by someone a child knows and does not always involve violence. Males and females, infants, and adolescents are all subject to sexual abuse. The abuser may be an adult or another child.

3.1.1.4 Emotional Maltreatment

Emotional maltreatment is a pattern of acts by the child‟s caretaker that results in psychological or emotional harm to the child‟s physical health and development. Patterns of emotional maltreatment include rejection, intimidation, ignoring, ridiculing, threats or isolation.

3.2 Reasons for Abuse and Neglect

Child abuse and neglect are universal problems that occur across economic, cultural, and ethnic lines. Circumstances that put a child at high risk of abuse and neglect include:

Parent and others who have been abused or neglected as children may continue this pattern when raising or caring for children. Increase
family stress including marital, financial, and employment difficulty. Substance abuse in the home, Parents and child care providers who lack
the skill and knowledge for the role, Individuals inability to tolerate frustration and inability to control the impulse to act , or Family
members and others who feel isolated from family, friends and
community.

3.3 Assessing for Sign of Abuse and Neglect

Observation that should raise the suspicion of abuse:

Extensive bruises in various stages of healing, patterns of bruises caused by a particular instrument (belt buckle, wire, coat hangers), Burn patterns consistent with forced immersion in a hot liquid (distinct boundary line where the burn stops.), Pattern caused by a particular kind of implement (electric iron) or instrument (circular cigarette burn), Unexplained lacerations, Injuries inconsistent with information offered, Suspicious fractures in children less than three years old, Sprain and dislocation. Multiple, Frequent injuries, Skull fractures subdural haemorrhage, and hematoma. Human bites, Loosened or missing teeth accompanied by lacerated lips, Poisoning Child described as “different” in physical and emotional makeup, or Frequent UTTs, Genital bleeding, Anal bleeding, Pain with bowel movement, Vaginal discharge, Genital discomfort, Genital lesions, Ulcers, or sores, Experienced cruel treatment.

3.4 Child Abuse / Neglect

Child abuse can be one or two isolated incident or can occur over a prolonged period of time.

3.4.1 Behavioural Indicators of Abuse

Cannot recall how injuries occurred or offers an inconsistent explanation wary of adults. May cringe or flinch if touched unexpectedly. Infants may display a vacant stare. Extremely aggressive or extremely withdrawn. Indiscriminately seeks affection and / or Extremely compliant and or eager to please sexualised behaviour. Inappropriate knowledge of sexual terms or language.

3.4.2 Pattern that Indicate Abuse

Injuries that is not consistent with explanation.
Presence of several injuries that are in various stages of healing. Presence of various injuries over a period of time.
Facial injuries in infants and preschool children and / or
Injuries inconsistent with the child age and development phase.

3.5 Mental Abuse / Neglect

Emotional abuse includes all acts of omission or commission, which result in the absence of a nurturing environment for the child. It occurs when the caregiver continually treats the child in such a negative way that the child‟s concept of "self" is seriously impaired. Emotionally abusive behaviour by the caregiver can include constant yelling, demeaning remarks, rejecting, ignoring or isolating the child, or terrorising the child. Emotional abuse is the most difficult to identify and prove. There are a variety of behavioural child may exhibit as a result of mental abuse/ neglect. It is important when assessing for this types of abuse to examine specific behaviours of a child as well as develop an overall picture of the child‟s ability to interact and communicate with children and other adults.

The following lists particular behaviours and interaction styles that may be indicators of mental abuse or neglect:

Habit disorders (e.g biting, sucking, rocking, enuresis, over or under eating without physical cause).
Conduct disorders (e.g . withdrawal, antisocial behavior, such as destructiveness, cruelty, and stealing)
Neurotic traits (e.g. sleep disorders, speech disorder, inhibition of play)
Others (e.g. psychoneurotic traits, passive, and undemanding, extremely aggressive, demanding, or angry behaviour, over adaptive behaviours that are either inappropriately adult or infantile, delays in physical, emotional, and intellectual development, attempts at suicide, frequent comments and behaviour suggesting low self-esteem) Severe depression. Extreme attention seeking. Displays extreme inhibition in play.

3.5.1 Physical Indicators

Bed wetting that is non- medical in origin.
Frequent psychosomatic complaints headaches, nausea, abdominal pains. Child fails to thrive.

3.6 Neglect

The task of determining whether a child has been physically or emotionally abused is difficult. Even more of a dilemma occurs in trying to make judgment regarding maltreatment or neglect. Cultural norms must be considered though not used as an excuse or justification for maltreatment. Primary consideration must be for the health, welfare, and safety of the child.

Most caregivers do not intend to neglect their children. It usually results from ignorance about appropriate care for children or an ability to plan ahead. Neglect occurs when a caregiver fails to provide basic needs such as adequate food, sleep, safety, supervision, clothing, or medical treatment.

3.6.1 Physical Indicators

Poor hygiene.
Unattended physical problems or medical needs, Consistent lack of supervision.

3.7 Intervention

Usually child abuse is the result of a family crisis or series of crises with some triggering stressful event. Schools may foster communication, coordination and cooperation in the community to assist parents in learning how to deal with or resolve stress.

Crises Intervention may necessitate home visiting by the school health team. The resolution almost always involves counselling for the entire family, not just the abusive person. Treatment generall y requires team efforts, involving numerous professionals: primary health care workers, nurses, physicians, psychologists, social workers, educators, counsellors, attorneys, and child care workers, the clergy, etc.

4.0 CONCLUSION

In this unit you have learnt what child abuse are reasons for child abuse and child neglect, how to assess for signs of child abuse and neglect: physical indicators of abuse and intervention in cases of child abuse.

5.0 SUMMARY

This unit has focused on the definition of Child Abuse-which means: Physically

hurting a child, sexually molesting a child, failing to provide proper care, or depriving a child of support and affection. Children are vulnerable and as such many children are at risk of, or suffer physical, emotional, or sexual abuse or neglect. The teacher or school health personnel may be the only adults outside the family who have contact with these children on a regular basis and, are professionally and legally obligated to intervene by reporting cases of suspected abuse to the appropriate authorities. For this reason it is important for all school personnel to be familiar with:-Reasons for abuse, types of abuse and those at particular risk for abuse as well as indicators of child abuse and neglect.

6.0 TUTOR-MARKED ASSIGNMENT

State the operational definition of child abuse.

7.0 REFERENCES / FURTHER READING

The Sexual Assault Crisis Centre of Knoxville, T.N. (July 2001).
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UNIT 3 SEXUAL ABUSE CONTENTS

1.0 INTRODUCTION

Having gone through the previous units, you would have acquired a general overview of what this unit is about, and its relevance in the School Health Programme. This unit will help you acquire an understanding of child abuse and child neglect. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define child abuse
- state the reasons for child abuse
- discuss how to assess for child abuse and neglect
- discuss how to intervene in cases of child abuse and neglect.

3.0 MAIN CONTENT

Sexual Abuse

3.1 Definition

Sexual assault can be defined as:

Any unwanted sexual act committed or attempted against a person‟s will, forced sexual contact, an act motivated by the assailant‟s need for power and control, not a desire for sex, a traumatic event with long lasting effects. Sexual abuse can be physical, verbal or emotional and includes:

- sexual touching and fondling
- oral / genital contact
- exposing children to adult sexual activity or pornographic movies photographs
- having children pose, undress or perform in a sexual fashion on film or person peeping into bathrooms or bedrooms to spy on a child
- rape or attempted rape
- sexual interference
- an invitation to sexually touch
- parents or guardian procuring sexual activity from a child
- householder permitting sexual activity
- exposing genital to a child incest.

3. 2 An Abused Child

A child that has been a victim of sexual abuse, whether it is a single incident or a long term pattern of sexual abuse, is unlikely to reveal this information directly to an adult because the child:

- is afraid that when he/she reveals it, on one will believe
- believes he / she will get into trouble
- believes it is his /her fault
- is afraid of the perpetrator.

More than likely, a child will send signals to those around the child that something is wrong. School personnel need to be attuned to the types of clues that may indicate a child is in a sexual abusive situation. The signs may be physical or emotional and / or reflected in developmentally inappropriate behaviour by the child. Sexual abuse involves forcing, tricking, bribing, threatening, or pressuring a child into sexual awareness or activity. Because most children cannot or do not tell about being sexually abused, it is up to concerned adults to recognise signs of abuse.

The information below has been divided into two age groups, the younger child and the older child. The information of potential signs of sexual abuse is by no means a complete list of the possible behaviours a child might exhibit when involved in a sexual abuse / neglect situation. School personnel may refer to this list as a guideline for further exploration and to classify behaviour they might be seen in a child. It is strongly recommended that school personnel become
familiar with available resources.

3.2.1 Young Child

A young child (e.g toddlers, preschoolers, early elementary school age) may have difficulty verbalising their fears and concerns as well as the actual sexual abuse to which they are being subjected. This is especially true for children with disabilities. The following list summarises behavioural and physical signs that may be indicators of sexual abuse in the young child.

3.2.1.1 Behaviour Signs

Reports sexual abuse

Sleep disturbances such as fear of falling asleep and nightmares, sudden changes in behaviour and / or regressive behaviour, lack of inhibition of exhibiting body, detailed and age inappropriate understanding and verbalisation of sexual behaviour, highly sexualised play or sexual acting out with dolls, stuffed animals or other children and inappropriate behaviour with peers and adults that is seductive in nature.

3.2 1.2 Physical Signs: Stomach Aches

Dysuria (painful urination) or enuresis (involuntary urination after the age at which bladder control should have been established), encopresis (involuntary soiling with faeces after the age at which control of defecation should have been established), complaints of genital irritation, laceration, abrasion, bleeding, discharge or infection.(sexually transmitted infections should be considered in children with anal or genital infection, discharge or irritation.) and
a gagging response sore throat or mouth or throat lesions (as the result of oral genital contact) or other signs of physical abuse.

3.2.2 Older Child

Older children may be able to verbalise and label what is happening to them in a sexually abusive situation; however, feeling of embarrassment, humiliation, guilt, a sense of responsibility, and fear may prevent them from talking with anyone. In fact like young children, signs of sexual abuse in older children may emerge in regressive or sudden behavioural changes, physical signs of injury, or withdrawal. The following list summarises behavioural and physical signs that may be indicators of sexual abuse in the older child.

3.2.2.1 Behavioural Signs

Report of sexual abuse

Poor relationships with peers: This m a y take the form of w i t h d r a w a l from established relationships and inability to establish new relationships or aggressive /violent or sexually promiscuous behaviour, sexual abuse of younger children, poor self- esteem, genital feelings of shame or guilt, eating disorder (bulimia and anorexia), excessive concern about homosexuality (especially boys), deterioration in academic performance, role reversal with parent and overly concerned about younger sibling (s) running away and drugs abuse or moderate to severe anxiety or depression.

3.2.2.2 Physical Signs

Attempts at suicide, unexplained vaginal discharge, pregnancy and / or sexually transmitted infections, bruises and / or bleeding of external genital, vaginal, or anal areas and inner thighs, gagging response sore throat or mouth or throat lesions (as the result of oral genital contact) and difficulty sitting or walking or other signs of physical abuse.

3.3 Why Children Hide Abuse

Often children do not tell anyone about sexual abuse because they: Are afraid no one will believe them, worry about getting into trouble or getting a loved one into trouble, were threatened or bribed by the abuser to keep the abuse a secret blame themselves or believes the abuse is punishment for being “bad” are too younger to put what has happened into words, feel confused by attention and feelings accompanying the abuse, feel too ashamed or embarrassed to tell. silence enables sexual abuse to continue. silence protects sexual offenders and hurts children who are being abused.

3.4 Listening to Children

If a child trusts you enough to tell you about an incident of sexual abuse, you are in an important position to help that child recover.

3.5 Victims of Assault

As a victim of sexual assault, the student has a right to:

Be believed, regardless of the child relationship to the assailant Reassure child that the medical exam is not painful or overly traumatic If the child is under 18 years of age, may decide for him / her if he / she want a medical evidentiary exam.

3.6 Role of the School Health Team

The school may be instrumental in providing assistance to the family to prevent the abuse or neglect of children. Such prevention programs may be in the form of support groups and educational programs as well as students utilizing the many programs development for awareness and education of family problem and situations. Awareness of child abuse and neglect is a first step toward prevention and early intervention. The Worker should take a leading role in promoting awareness by providing training for staff members on early recognition of abuse and neglect, developing curricula for parenting or family life classes for students and working with other professionals and community organization to intervene in abusive families and to support research, prevention and follow –up activities.

It is school health personnel‟s professional responsibility to identify report, and follow-up on suspected cases of child abuse or neglect. As the school primary health care provider on site, the school health personnel is a resource and model for other staff members in the school who might suspect a case of child abuse or neglect.

It is the responsibility of the School Health Team to initiate participate and or cooperate in school and community activities designed to prevent, identify, and / or treat, the problem of child abuse and neglect in any form as well as to provide early intervention and follow-up of child .

3.6.1 Emotional Well-Being

Mental well-b eing is determined by the inter relationship of physical, environmental, social and psychological factors. Mental health issues have become critical and of concern in today‟s society. Mental health problems can negatively impact students‟ ability

to learn, function and interact within families, schools and communities and results in financial and social cost to society. School health personnel are members of the comprehensive team necessary to provide quality interventions for affected students. They work with students, parents, school personnel and medical and mental health communities to assess immediate and long term mental health needs, to initiate appropriate action to meet these needs, to assure follow-up and to provide ongoing support once a treatment plan is in place and students are in school.

The health worker provides a unique and essential contribution to the emotional climate within the educational environment. The health workers as member of the school interdisciplinary team that may involve counsellors, social workers, psychologists, and educators have the unique ability to address problems holistically, including physical emotional and social perspectives: The school health personnel works as a team member with the other school authorities to

understand student health care needs and implement care plans. He / she acts as a liaison to help link school and community programs and provide case management for students.

4.0 CONCLUSION

In this unit you have learnt the definition of sexual assault, An abused child, why children do not tell about abuse, victims of assault, the role of the school team and emotional well-being of abused children.

5.0 SUMMARY

This unit has focused on sexual assault- sexual assault can be defined as any unwanted sexual act committed or attempted against a person‟s will, forced sexual contact, an act motivated by the assailant‟s need for power and control, not a desire for sex or a traumatic event with long lasting effects. Sexual abuse involves forcing, tricking, bribing, threatening, or pressuring a child into sexual awareness or activity. Because most children cannot or do not tell about being sexually abuse, it is up to concerned adults to recognise signs of abuse. It is the responsibility of the School Health Team to initiate participate and or cooperate in school and community activities designed to prevent, identify, and / or treat, the problem of child abuse and neglect in any form as well as to provide early intervention and follow-up of child.

6.0 TUTOR-MARKED ASSIGNMENT

State the behavioural and physical signs in a young child that may give the suspicion of sexual abuse.

7.0 REFERENCES / FURTHER READING

The Sexual Assault Crisis Centre of Knoxville, TN. (July 2001).
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UNIT 5 HOME VISITING

CONTENTS

1.0 INTRODUCTION

In this unit you will learn about home visiting, its rationale in School Health Services Programme and how it can be organised in the community. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objectives below:

2.0 OBJECTIVES

At the end of this unit you should be able to:

- define home visiting.
- state the reason for home visiting,
- mention the advantages of home visiting,
- discuss how to conduct home visiting.

3.0 MAIN CONTENT

3.1 Definition of Home Visiting

For children who are unable to attend school, education should be available in an alternative setting such as rehabilitation centre, hospital or the home. Home visiting therefore is a method of reaching out to the family in order to help those school children with special problems.

3.2 The Reasons for Conducting Home Visit Are to

- find out how the home situation contributes to the child‟s problems.;
- teach some preventive measures to the parents;
- give the parents the opportunity to learnabout school health;
- see the family in their own environment and create rapport with them for effective management of health problems.

3.3 Role of the School Health Personnel

Home visiting had evolved from sanitary inspection of homes of
school children to what it has become today. The roles of school health personnel may include the following:

Serves as liaison between home and school regarding health concern keep home visits record, record health histories assess long term illnesses, implement case management within the school setting , participate in parent health personnel conferences, provide information and referral to community resources, involve with parent groups and provide activities for health promotion and education.

3.4 During Home Visits, School Health Personnel Can

Establish rapport with the student‟s family support system,
Assess family strength and needs, including limitations and barriers to the student achievement. The students need for community health resources, and the student‟s behaviour and reactions to home situations in partnership with the family, plan school health services that promote and support family goals to maximise functional capabilities, including the student‟s self- care independence, and future school attendance, and provide for family/ student participation in health promotion, maintenance, and restoration, including providing information needed to make decisions and choices about using health care resources.

3.4.1 How to Conduct Home Visiting

Select the families to be visited i.e. children with problems: Review available school and health records prior to home visits Review current health care plans, Identify objectives for the visit Contact student‟s health care provider, when appropriate for question and / or concerns, Plan time of visits to optimise safety and effectiveness, Make an appointment in advance of the visit

Log in and out at school office, noting the telephone number and address of the home to be visited, time of departure, and expected return, Avoid going alone to neighbourhoods known to be dangerous.

Wear identification (e.g name badge) and greet the family warmly and establish rapport ask relevant questions, observe the home and surrounding environment,

significant socio-cultural influences, and interactions of family member, identify health care needs/ problems, based on subjective and objective data, and involve the family members in the process, list problems in order of importance in accordance with family perceptions, counsel and educate them on matters affecting the child and the family. Any minor ailments discovered are treated according to standing orders while major conditions are referred for better management to appropriate health care providers.

Inspect the surroundings for any public nuisance and educate accordingly. Discuss alternative solutions and available community resources, Assist in the development of a plan for the appropriate interventions and establish a time to evaluate the effectiveness of the plan. Share the plan with appropriate persons involved in the health care of the student.

3.4.2 Materials Needed for Home Visiting

The materials needed for home visiting are: home visit bag
home based records, drugs like anti malarias, analgesic and haematinics, note book to write report, referral cards
standing orders.

3.4.3 After the Home Visit, School Health Personnel Should Record and Document

Subjective and objective data, problems identified, and plan of action including time line for achieving planned interventions and future plans and recommendations for home-visits. Write report on home visits stating: Condition of the home and family. How the home condition has affected the health of the child. Any illness treated or referred cases.

4.0 CONCLUSION

In this unit you have learnt about home visiting in School Health Programme, the reason for home visit, and the role of the school health personnel during home-visits, what to do during home-visits, the material needed for home visits and how to report home-visits.
You should at this point be able to state the reasons for home visiting in school health programme. You should also be able to describe how
to conduct home visits, including what to do during the visits as well as how to write the report of home visit.

5.0 SUMMARY

This unit has focused on Home Visiting in School Health Programme – as a method of reaching out to the family in order to help those school children with special problem. This is because a child‟s home environment can contribute to the child‟s problem.

Other reasons for home visiting can be to render preventive, curative and referral services. How to conduct and report home visits were also described.

6.0 TUTOR-MARKED ASSIGNMENT

Describe how to conduct a home visit to the home of a child that seems to be having emotional problems that have resulted in poor academic performance.

7.0 REFERENCES / FURTHER READING

Federal Ministry of Health and Human Services. (1992). School Health Session Plans. Training and Manpower D e v el o p me n t Division ,Lagos , Nigeria

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UNIT 6 EVALUATION OF SCHOOL HEALTH PROGRAMME

CONTENTS

1.0 INTRODUCTION

This unit will help you to acquire an understanding of evaluation of school health programme. Before we do this, let us have a view of what you should learn in this unit, as indicated in the unit objective.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe evaluation
- discuss the types of evaluation
- state the rationale for periodic evaluation
- mention the methods used in evaluation of school health. programme.

3.0 MAIN CONTENT

3.1 Evaluation

Evaluation is the collection of vital information to measure the relevance, progress, efficiency, effectiveness, and impact of a programme or projects against set objectives. In effect it is the assessment of the value of what one is doing or has done. There a r e many reasons why a programme should be evaluated:

- To find out the level of a achievement of the set objectives (Where are we?).

- To determine the problems encountered in the implementation phase, so that necessary corrections can be made to achieve set objectives (better management).
- To determine the lessons learnt which may be useful for the future projects or programmes (i.e sharing of experiences).
- To provide basis for the formulation of new objectives, policies, strategies to meet the needs of the population served.
- Evaluation of the school health programme is therefore essential-

- In order to determine how effectively schools meet the health needs of students and staff.
- The purpose of program evaluation is to assess whether goals and objectives have been met.
- Health laws and regulations change, professional standards change and the needs of students change. Program goals are adapted accordingly.
- Ongoing data collection and evaluation are key to promoting responsiveness in programs, staffing, funding and resources
- Results and recommendations developed during the evaluation process become input for subsequent planning.
- This feedback loop allows plans to be revised as needed, in order to keep programs appropriate, realistic and effective. It also provides the health team with measures of accountability.

3.1.1 Process Evaluation

Also called formative evaluation, this is an on-going process, occurring during the formative stage of a program. The goal of this evaluation is to improve the program or materials being designed. Process or formative evaluation begins with initial program design and continues through implementation, observation and revisions.

The first phase is a needs assessment, which establishes baseline data on the need for a services, program, curriculum or materials. It should occur before embarking on a project. During design, development and planning, the school health team should test instruments for comprehensibility, persuasiveness, user friendliness, appeal and other factors.

During field testing, the program or materials are tested for effectiveness. Data collected will help fine- tune materials, pinpoint any problems, aid in the revision process, and assist in the development of new materials. The programme designer should use different situations or settings to try out the program (reflective of the target audience), whether it be students, teachers and /or parents.

3.1.2 Outcome Evaluation

In contrast, outcome evaluation (also called summative evaluation) examines the success of the program in meeting specific objectives, such as whether there were changes in health behaviour or in the health status of students and/or staff. Did the program make a difference? For instance, as a result of a program to improve food habits of the students; did students eat less junk food? Should the program be continued? Outcome evaluations are designed to answer questions about the immediate changes that occur as a result of the program. Participant satisfaction, numbers served, and objective measures of change are common data collected for outcome evaluations.

3.1.3 Impact evaluation

Looks at longer-term changes that can help answer the question of overall program effectiveness. Some examples may include reducing costs, improvement in student health or productivity, or lower rates of school violence over an extended period of time. It may be helpful to consult a skilled external evaluator for outcome and impact evaluation; someone who is experienced in conducting evaluations, has some medical knowledge, and understands the mechanics behind day-to-day triage in a health service delivery. The basis of any good outcome evaluation is a good management information system for all children in the program. There should be periodic review and evaluation of the school health programme, to re- examine at each particular stage the school health needs and resources i.e the health problems and the means of getting those problems solved. This review should be carried out to see which of the objectives have been achieved and which ones have not been achieved.

3.2 Rationale for Periodic Review and Evaluation of School Health Needs and Resources to

- have a picture of the program at any point in time.
- determine the areas that requires more attention
- plan for more activities
- identify obstacles to the programme
- plan for intervention
- measure the achievement and impact.

3.3 Methods Used in the Review and Evaluation of School Health Programme

Teachers‟ interview

- Questions are designed and directed to the parents or teacher.
- The questions should cover all the objectives or needs of the program with the intention to find out the teachers‟ views and suggestions

- The interview is carried out by the health workers and each teacher is interviewed separately.
  Students‟ Questionnaires
- The questionnaire are designed and directed towards the students.
- They are usually set with many responses to be chosen from.
- The questionnaires are tested first before distributing them to the children.
- The children fill in the questionnaires by themselves
- After filling, they are returned to the teachers or health workers for compilation. School attendance Records
- A review of the school attendance register for that period will show the rate of absenteeism to sickness.
- A high rate or low rate shows the impact of the programme,
  and what health problems that need a more intensive intervention. Health Services / PHC Statistics • Statistics from the health facilities which give attendance record of school children at the clinic,and the types of conditions they present with are useful in reviewing the programme.
- Even the attendance of other members of the community at the clinic and reflect the impact of the school health program, depending on the type of school health project that the school children had carried out

4.0 CONCLUSION

In this unit you have learnt about evaluation of school health programme; the types of evaluation: process, outcome and impact evaluation, the rationale for periodic review and the methods that can be used to evaluate a school health programme.

5.0 SUMMARY

This unit has focused on the evaluation of school health programme- which is essential in order to determine how effectively the school health programme met the health needs of students and staff. The purpose of program evaluation is to assess whether goals and objectives have been met, identify obstacles and constraint to the achievement of the objective and the information obtained will be used to revise the programme.

6.0 TUTOR-MARKED ASSIGNMENT

What is the difference between process evaluation, outcome evaluation and impact evaluation?

7.0 REFERENCES / FURTHER READING

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