The Common Approach to Sponsorship-funded Programming

School Health and Nutrition Module

Revised November 2010

Save the Children®

Contents

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Acronyms used in this module:

AD	Adolescent Development
BE	Basic Education
CAC	Community Action Cycle
CM	Community Mobilization
CO	Country Office
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
DM&E	Design, Monitoring and Evaluation
ECCD	Early Childhood Care and Development
EFA	Education for All
FGD	Focus Group Discussions
FRESH	Focusing Resources on Effective School Health
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disorders
IR	Intermediate Result
MoE	Ministry of Education
MoH	Ministry of Health
M&E	Monitoring and Evaluation
NGO	Non-governmental Organization
NTD	Neglected Tropical Diseases
OVC	Orphans and Vulnerable Children
PIT	Process Indicator Tool
PTA	Parent-Teacher Association
RIPT	Results Indicator Planning Tool
SHN	School Health and Nutrition
SMC	School Management Committee
STWG	Sponsorship Technical Working Group
SO	Strategic Objective
STH	Soil-transmitted Helminths
TA	Technical Assistance
VAD	Vitamin A Deficiency
WASH	Water, Sanitation and Hygiene

Introduction to the Common Approach School Health and Nutrition Module

About the Common Approach to Sponsorship-funded Programming

Funds raised through marketing sponsorship products (e.g. individual and representative child sponsorship) are allocated to specific country offices (COs) to implement sponsorship-funded programs. These programs aim to ensure that children are educated and healthy through the use of a proven approach to design, implementation and measurement, known as "The Common Approach to Sponsorship-funded Programming" or "the Common Approach."[1]

The goal of the Common Approach is for country offices to successfully design, implement, monitor and evaluate their sponsorship-funded programs. The Common Approach framework has seven key components:

1. A focus on select programs in which Save the Children has extensive experience and expertise, and that coincide with the age range of sponsored children. These are called the sponsorship "core programs"[2] and consist of:
    a. Early Childhood Care and Development (ECCD)
    b. Basic Education (BE)
    c. School Health and Nutrition (SHN)
    d. Adolescent Development (AD)
2. Guidance and tools for each of these programs documented in core program modules, including this one.
3. Standard supporting guidance and tools for design, monitoring and evaluation (DM&E), which are summarized in this module (detailed guidance can be found in the Common Approach DM&E Module).
4. Adherence to a common program cycle.
5. The provision of consistent, quality program technical assistance (TA) by the members of the Sponsorship Technical Working Group (STWG).
6. Mechanisms through which we can learn from experience and use this information to make program improvement.
7. Use of a proven approach for mobilizing communities, documented in the Sponsorship Community Mobilization Compendium: Mobilizing Communities for Education, Health and Social Change.

This module draws on all seven of these components and provides guidance on how to design, implement, monitor and evaluate your sponsorship-funded SHN program.

[1] The acronym "CASP" is sometimes also used to refer to The Common Approach to Sponsorship-funded Programming.
[2] Country offices must invest a minimum of 75 percent of their sponsorship program resources in one or more of these core program areas.

Sponsorship-funded Programs and Innovation

At the heart of the Common Approach framework is the implementation of quality, evidence-based programs. However, there is flexibility within the framework to allow for innovation. Sponsorship funds can be used to pilot and evaluate cost-efficient innovative interventions and/or approaches that seek to best address children's positive growth and development. Successful innovations can then be shared with other Save the Children COs, and scaled up through hand-over to the government, additional donor funds or partnership with others. The implementation of any innovation should be done in close coordination with the program's STWG TA provider.

How to Use this Module

The module is divided into two main sections:

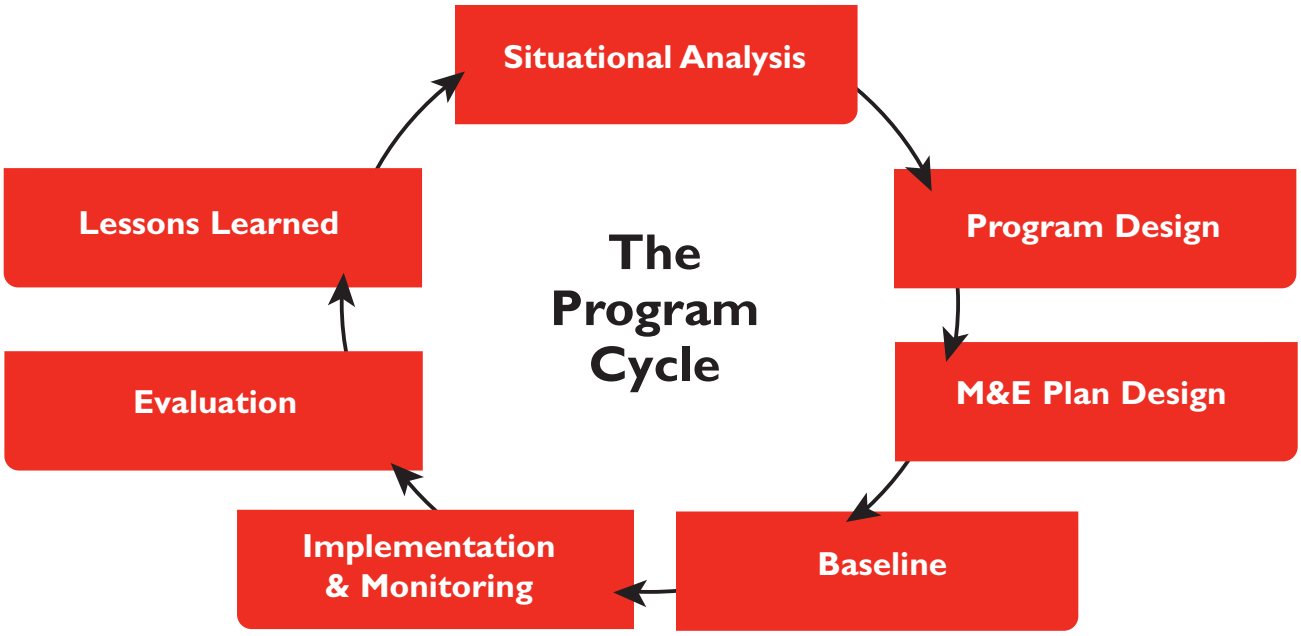
1. **About School Health and Nutrition Programs:** This section provides the rationale for SHN and introduces the Focusing Resources on Effective School Health (FRESH) international framework for SHN programming. It also includes Save the Children's experience and approach to SHN programming; outlines key principles that should guide all Save the Children SHN programs; and highlights the important links SHN programs must make with Save the Children's other sponsorship-funded programs as well as programs outside Save the Children.
2. **The Common Approach to School Health and Nutrition Programming:** This second section walks you through each of the seven steps of the Common Approach program cycle (see Figure 1), with SHN-specific guidance provided for each step. Particular emphasis is placed on the situational analysis and program design steps. The seven steps are summarized below:

   - **Step 1: Situational Analysis.** A situational analysis must be conducted prior to designing an SHN program in an impact area. It involves collecting and analyzing information to identify and define key problems that can be addressed by an SHN program.
   - **Step 2: Program Design.** Once information on the needs and resources of the target communities are available from the situational analysis, this information should then be used to design an SHN program. To help design the SHN program, the SHN results framework in this module can be used to help determine the end results you seek from SHN programming in your country context. Once you've identified the results you seek, you'll need to select the strategies (interventions) for achieving those results. The Key Strategies Matrix in this module will help you weigh options and choose the interventions appropriate for your country context. As a last step to completing the program design, a Summary Implementation Plan must be prepared.
   - **Step 3 & 4: Monitoring and Evaluation (M&E) Plan Design and Baseline Data Collection.** Prior to implementation, draft an M&E plan based on the program design, identify key indicators to measure program progress over the life of the program, and document your Impact Area Presence Plan. Collect baseline data and produce a comprehensive baseline report.
   - **Step 5: Implementation and Monitoring.** In this step you will undertake all activities required to implement and monitor the SHN program. A Results Review should be organized every six months so that program staff and implementing partners can discuss program progress, identify gaps and plan next steps to improve the program accordingly. Key references are provided to help you with this step.

- **Step 6 & 7: Evaluation and Lessons Learned.** Midway through the program, and close to the end of the planned presence in the impact area, a program evaluation must be conducted to assess if the program has been effective in improving the health, nutritional and educational outcomes of children. Every program follows a different timeline for when evaluations take place; however, every three to four years is recommended for most SHN programs. A Lessons Learned workshop should be conducted after each evaluation at least, and most importantly, close to the end of the program, prior to phase-in to a new impact area. A Lessons Learned workshop provides all stakeholders associated with the program the opportunity to discuss program results, identify key successes and challenges faced during the life of the program, as well as strategies that worked well and should be continued.

This module is intended to serve as a reference and guide for CO program technical staff and is to be supplemented by technical assistance from the CO's STWG TA providers. In addition, the Common Approach DM&E Module and the Sponsorship Community Mobilization Compendium should be read alongside this core program module. The DM&E Module contains many helpful tools and in-depth explanations about each step of the program cycle, with a particular emphasis on the steps that follow the situational analysis and program design. The Sponsorship Community Mobilization Compendium provides detailed guidance on how to implement the Community Action Cycle (CAC). The phases of the CAC, and how they relate to each program cycle step, are presented in abbreviated form in this core program module.

Figure 1: *The Common Approach Program Cycle*



The Common Approach emphasizes that programs must be designed, monitored and evaluated according to a standard process. This process is guided by adherence to a standardized program cycle.

About School Health and Nutrition Programs

What are School Health and Nutrition Programs?

School Health and Nutrition programs are health and nutrition interventions that are implemented through schools and targeted at school-age children (approximately five to 12 years) so that they improve their health and nutritional status, behaviors and skills, and are able to participate in and complete their education.

Why invest in School Health and Nutrition Programs?

1. To improve children's health, their learning in school and educational outcomes.

School-age children are often thought of as healthy, but studies have shown that they face high levels of illness and malnutrition as they go through these crucial growing years. In some of the neediest countries, school-age children face high morbidity from preventable diseases, which decrease their cognitive development, intellectual capacity, and overall growth (see Box 1 on the burden of ill-health in school-age children). Children are sometimes too weak or sick to go to school and often cannot pay attention during a full schedule of classes. Many perform poorly on school tests, repeat grades or drop out of school altogether, failing to attain the basic skills that may help them lead healthier and more productive lives in the future. The World Declaration on Education for All identifies poor health and malnutrition as one of the key challenges to promoting quality primary education for all children.

Maintaining children's health is therefore essential for their cognitive development, growth, and learning, and for ensuring quality Education for All. Research has shown that school-based health and nutrition programs improve children's health and nutrition, in turn leading to increased enrollment, attendance, reduced class repetition and increased educational attainment. For example, micronutrient supplementation and deworming have been shown to improve school performance and restore intelligence quotient (IQ) losses of up to 21 points. Hygiene and sanitation promotion in schools is known to improve children's health, boost school attendance and improve gender equity.[3]

2. To meet children's basic rights to education and health.

SHN programs support the basic human rights included in the Convention on the Rights of the Child (CRC), especially those related to the highest attainable standard of health (Article 24) and the right to education for the development of children to their fullest potential (Articles 28 and 29). Children have rights to information, education and services; to the highest attainable standard of physical and mental health; and to formal and non-formal education about population and health issues, including sexual and reproductive health issues. Access to clean water and adequate sanitation facilities is also a fundamental right to safeguard health and human dignity. SHN programs offer a unique opportunity to help meet these rights. Effective SHN programs ensure that schools are safe and protected (free from abuse, corporal punishment and harassment) and ensure children's participation in education at all levels.

[3] Jukes, M C H., *et al* (2008). *School Health, Nutrition and Education for All: Levelling the Playing Field.* Home Grown School Feeding. Download from: http://www.hgsf-global.org/en/policy.

3. To meet new opportunities and unfulfilled needs.

Global and national initiatives to improve child survival and achieve universal access to basic education mean that more children now have the opportunity to go to school. As a result, schools are now a key setting where the education and health sectors can jointly take action to improve and sustain the health, nutrition and education of children previously not reached, especially girls.

4. To enhance equity in education.

Children who begin school with the worst health status have the most to gain from health and nutrition programs. They also have the most to gain educationally, since they show the greatest improvement in cognition as a result of health interventions. Thus, SHN programs particularly benefit the poor and the disadvantaged. These children are increasingly accessible through schools as a result of universal education strategies.

Although girls are more disadvantaged than boys in terms of school enrollment and completion, more girls attend schools than ever before. School-based health interventions have the capacity to reach more girls than are being reached through existing health services thus improving their health. Moreover, education in general protects girls from risky behaviors, delays their pregnancy, prevents HIV/AIDS and improves their overall health, and SHN programs ensure that they are able to complete schooling and improve educational performance. Similarly, improvements to sanitation facilities in schools, such as separate latrines for girls, attract more girls to school since schools are perceived as safer and more adapted to their needs, encouraging parents to enroll and keep their daughters in school.

5. To build on investments in early childhood.

An increasing number of countries have recognized the need to ensure good health and development during the most vulnerable early years of life. Integrated management of childhood illness, early childhood development, and growth monitoring and promotion programs all help to ensure that a child enters school fit, well and ready to learn. But the school-age child continues to be at risk of ill health, and the health of children often deteriorates during the school years. SHN programs ensure that children remain healthy during the years that are critical for education.

6. To promote adolescent development.

Children form attitudes and beliefs early in life and are more likely to practice healthy behaviors if they are established as habits at an early age. Schools offer the best venue to reach young children and youth with age-appropriate messages on healthy behaviors in order to tackle some major problems of adolescence: violence, substance abuse, teenage pregnancy and sexually transmitted diseases, including HIV/AIDS. As primary education enrollment rates rise, schools are also an effective venue for communicating messages which can be disseminated throughout the entire community.

7. To invest cost-effectively in health and education.

SHN programs help link the resources of the health, education, nutrition and sanitation sectors in an infrastructure – the school – that is usually already in place. The school system's coverage is extensive and it has a skilled workforce that already works closely with communities. The existence of this infrastructure means program costs can be low, and if well-designed, SHN programs can be amongst the most cost-effective of public health interventions. Generalized treatment approaches such as mass deworming or micronutrient supplementations, which do not rely on selective treatment based on individual diagnosis, are particularly cheap: annual deworming is estimated to cost only US$0.20-$0.30 per child per year; vitamin A supplementation, US$0.04; and a course of iron folate supplements only US$0.10.

Box 1: Burden of ill-health in school-age children

- 53 percent of school-age children suffer from Iron Deficiency Anemia (IDA), the major health consequences of which are impaired physical and cognitive development, as well as increased morbidity from infectious diseases.[4]
- 60 million or five percent of all school-age children suffer from iodine deficiency. [5] Iodine Deficiency Disorders (IDD) can start before birth and jeopardize children's mental health as well as their survival. Often, IDDs can lead to less visible, yet pervasive, mental impairment that reduces intellectual capacity at home, school and work.
- Approximately 85 million or seven percent of all school-age children lack sufficient vitamin A.[6] Long-term vitamin A deficiency (VAD) negatively impacts growth, impairs learning ability, and those who have VAD are at risk of blindness, malnutrition (anemia), infections (e.g. parasitic worms, malaria) and death.
- The prevalence of stunting and underweight school children, two key indicators for malnutrition, is high in low-income countries, ranging from 48 to 56 percent for stunting and 34 to 62 percent for underweight children.[7] Poor health and nutrition can have a magnified impact on the next generation, especially school-age girls. Malnourished girls become mothers who face high levels of maternal mortality and bear low birth-weight babies at greater risk of infant mortality.
- 25 to 35 percent of school-age children are infected with one or more of the major helminth species.[8] This translates to an estimated 320 million school-age children who are infected with roundworm, 233 million with whipworm and 239 million with hookworm. As a result, children suffer from diarrhea, abdominal pain, general malaise and weakness that affect working and learning capacities, nutrition and physical growth.
- Malaria accounts for 50 percent (or 214,000) of all deaths among African school-age children per year. 20 to 50 percent of African school-age children living in high transmission areas experience clinical attacks annually, causing 4-10 million days of school-absenteeism per year.[9] Due to anemia and neurological consequences of cerebral malaria, cognition, learning and educational achievement are all affected.
- Though HIV prevalence is lowest among school-age children, an estimated 2.1 million children under 15 years are living with HIV. Also, young people account for around 40 percent of all new adult (15+ years) HIV infections worldwide.[10] Out-of-school girls have a higher risk of contracting HIV than girls in school.
- Children lose 272 million school days each year due to diarrhea. More than half of all primary schools in the developing countries with available data do not have adequate water facilities and nearly two-thirds lack adequate sanitation. [11]

4 Jukes, M C H., et al (2008).
5 Jukes, M C H., et al (2008).
6 Jukes, M C H., et al (2008).
7 Jukes, M C H., et al (2008).
8 Jukes, M C H., et al (2008).
9 Brooker, S. (2009). *Malaria Control in Schools: A toolkit on effective education sector responses to malaria in Africa.* Download from: http://www.schoolsandhealth.org/Documents/Malaria%20Toolkit%20for%20Schools%202009.pdf.
10 UNAIDS, *Report on the global AIDS epidemic, Geneva, 2008.*
11 Care, Dubai Cares, Emory University Center for Global Safe Water, IRC International Water and Sanitation Centre, Save the Children, UNICEF, Water Advocates, WaterAid, Water For People, WHO (2010). *Raising Clean Hands. Advancing Learning, Health and Participation through WASH in School*, retrieve at. http://www.washinschools.com.

The International Framework for School Health and Nutrition Programs

In view of the evidence and arguments in support of SHN programs, international organizations including the WHO, UNICEF, UNESCO, and the World Bank agreed at the Dakar World Education Forum in 2000 that SHN was essential to reaching the global Education for All (EFA) Goals. The Focusing Resources on Effective School Health (FRESH) framework was developed to outline an initial set of four core activities, called pillars, which need to be comprehensively implemented in all schools in order to meet the health needs of school-age children and to ensure that programs go to scale. The FRESH pillars capture the best practices from program experiences and should be the starting point for designing effective SHN programs and the basis for scaling up country programming. The four pillars of the FRESH framework are:

1. **Safe school environment:** This includes the provision of safe water, adequate sanitation and promotion of hygienic practices for a safe and healthy school environment.
2. **School health and nutrition policy:** This includes advocacy, support and promotion of national and school-level SHN policies.
3. **School-based delivery of health services:** Examples of these services are micronutrient supplementation, deworming, vision and hearing screening, school-based management of minor illnesses and injuries.
4. **Skills-based health education:** This component is centered on a behavior change approach to the promotion of good health, nutrition and hygiene and prevention of HIV.

In addition, the success of the program and sustainability of its achievements hinges on some key supporting strategies:

- Effective partnerships between teachers and health workers, and between the education and health sectors.
- Effective community partnerships.
- Pupil awareness and participation.

Save the Children's Approach to School Health and Nutrition

In 2009, over 2 million children benefited from Save the Children's SHN programs in 20 countries across all global regions. Internationally, Save the Children is one of the leading non-governmental organizations (NGOs) in SHN. In many countries, Save the Children is the only international NGO implementing comprehensive SHN programs (as outlined in the FRESH framework) that combine skills-based health education with the promotion of clean water and sanitation, related health services, school-community partnerships and supporting policies at the school and national level.

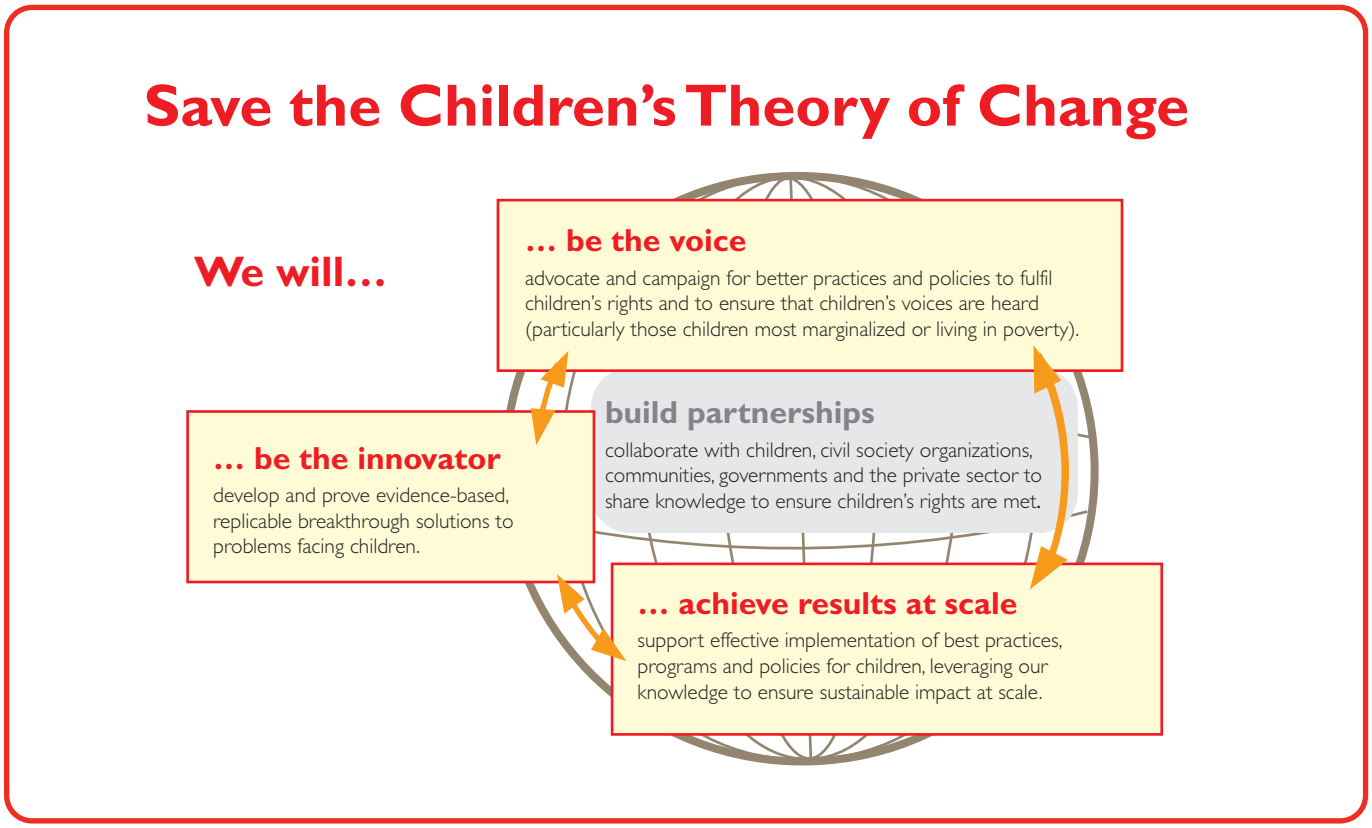
Save the Children works at various levels to address the health and nutrition problems of school-age children (ages 5-12), which align with Save the Children's Theory of Change (see Box 2 for more information on the theory of change):

- At the community level, Save the Children mobilizes and supports community and parent **partnerships** with schools for the delivery of school-based health and nutrition services and the promotion of healthy behaviors. SHN programming is delivered in areas where Save the Children has a pre-existing base often through its Basic Education program. This joint approach has created tremendous synergies, both in terms of resources expended, and in terms of education and health services working together to serve children. Save the Children also creates partnerships with governments, through memoranda of understanding with ministries of education and health, to

ensure cooperative work in schools. Partnerships with other national and international development agencies are also very important to promoting SHN and Save the Children contributes to the various working groups on SHN internationally and within program countries.

- In our program work with communities, Save the Children contributes to the **evidence base** for SHN by teaming up with researchers in public health and education to undertake operational research projects that help measure the impact of Save the Children's efforts (so we are accountable for results) and identify and test innovative approaches to programming. As a result, Save the Children continues to innovate and refine its approaches to improve program effectiveness within each context. For example, based on the evidence, deworming followed by vitamin A and iron supplementation is now provided across all of our programs as a means to reduce worm burden as well as associated anemia in school children. Through regular assessments and monitoring and evaluation, SHN programs also demonstrate how investments and interventions are contributing to improvements in outcomes.

Box 2: *The Theory of Change*



- Save the Children's Theory of Change describes how we will work to create impact for children. The schematic above describes the four elements to the Theory of Change, which should help guide the planning and implementation of all sponsorship-funded programs.
- At the national level, Save the Children uses the evidence from its model of delivering SHN through community and formal schools to **advocate** for the establishment of policies for a

national SHN program. Depending on the context, policies may also include the introduction of new SHN interventions on a wider scale; modernization of existing SHN programs; integration of other programs with SHN; or giving support to school children and/or SHN through a financing scheme. For example, in Nepal Save the Children worked closely with the ministries of health and education to provide technical assistance for the development of a coherent national SHN strategy. Save the Children is also the current rotating coordinator of the national SHN network in Nepal, comprised of government ministries, donors and other NGOs, which advocates for the scale up of SHN programs nationally.

- Over the years, Save the Children's SHN programs have contributed to reaching **results at scale** both within countries and globally. Over the past five years, the number of children who have benefited from our SHN programs has grown five fold, from nearly 400,000 children annually in 2004 to over 2 million in 2009. Many more children have benefited indirectly from the establishment of national or sub-national SHN programs by governments following Save the Children's advocacy and partnership.

Key Principles of School Health and Nutrition Programming

There are several key principles that guide and are evident in Save the Children's approach to SHN programs described above. Several have already been discussed in the previous sections, and are summarized again below. A star (*) identifies the principles that are being introduced in this module for the first time.

- ***SHN programs mobilize communities.** Community mobilization (CM) is an essential part of sponsorship-funded program development, planning, implementation, monitoring and evaluation, and it is necessary for long-term sustainability of activities and their impact once programs phase out. A sound community mobilization approach means not only consulting with communities and schools, but creating an environment in which individuals and the community are empowered to take collective action towards education and/or health goals. Key elements of community mobilization include participation, ownership, equality, sustainability, community and dialogue of knowledge.

  Community mobilization is also one of the three key cross-cutting strategies within the international FRESH framework. Save the Children's SHN programs promote the meaningful participation of not only children but also their families and communities in the process of learning and the organization of the school. Programs are family-focused, working to enable parents to support both their children's individual education as well as the overall school. Programs are community-based, encouraging local partnership in education through local school boards, parent-teacher associations or school management committees (SMC) acting in the best interests of children.

- ***SHN programs are sustainable.** It is critical that local governments, communities and other stakeholders continue to maintain and expand SHN programs beyond Save the Children's intervention. From the beginning, programs are developed in line with government standards and norms. Programs are designed with time and resource limits, and develop strategies to ensure that communities and institutions do not become exclusively dependent on Save the Children and its resources. A key strategy to ensuring that communities maintain program ownership is to involve them in the program throughout, as outlined in the community action cycle.

- ***SHN programs are flexible, relevant and appropriate.** While the state-of-the-art is documented in the Common Approach core program modules, programs are flexible and should be adjusted to ensure they are relevant to children's needs and country contexts, now and for the future. Programs should derive strategies from local culture. This involves identifying positive

practices and determining acceptable ways to introduce new activities and practices.

- ***SHN programs are participatory.** It is important that SHN programs are child-centered and promote children's meaningful participation in all aspects of the program. Children should be included from situation analysis, to program design, to monitoring and evaluation of programs. SHN programs must promote and enable children to be agents of change.
- **SHN programs are gender sensitive and inclusive of all children.** SHN programs promote gender equity in enrollment and achievement, eliminate gender stereotypes, and promote girl-friendly facilities. SHN programs do not exclude or discriminate on the basis of difference. Instead, all children are welcomed, treated equitably and given equal opportunities.
- **SHN programs are safe and protective of children.** SHN programs ensure healthy and safe learning environments with adequate water and sanitation facilities. Programs promote the healthy physical, social and emotional development of children in environments (including on the way to and from school) that are free from abuse, corporal punishment, and harassment.
- **SHN programs are accountable for results.** Through regular assessment, monitoring and evaluation, SHN programs demonstrate how investments and interventions are contributing to improvements in health, learning, inclusion, safety and protection.
- **SHN programs are innovative.** SHN programs develop, test and refine new and/or better ways to address the key health, educational and developmental needs of children. Investing in innovation and documentation is critical to achieving positive, lasting change at scale.
- **SHN programs are integrated across sectors.** SHN interventions are not implemented in isolation but are linked as appropriate to other programs and sectors. In particular, SHN programs should be linked to existing BE programs.
- **SHN programs collaborate and partner.** Programs work with governments at the local and national level, as well as other partners to ensure that they complement and strengthen the government system and are not offered merely as substitutes.
- **SHN programs are cost-effective.** SHN programs identify and prioritize interventions that produce the greatest impact for the least amount of resources. That is, program outcomes justify the level of expenditure necessary to achieve them. This includes applying relevant evidence-based strategies and conducting operations research to compare and test different approaches. Cost effective programming is a key element in program sustainability.
- **SHN programs seek to scale up.** Programs will test, monitor, evaluate, document and disseminate lessons learned and best practices in SHN programming in preparation to scale-up through partners and/or other funding sources. Replication and expansion of quality programs and/or interventions will be a priority to increase coverage and reach more children.
- **SHN programs advocate for change.** Based on evidence and the unmet needs in countries, SHN program advocate for changes in national level policies as well as local level implementation of programs, so that the health needs of children are met in the most appropriate and cost-effective way possible.

School Health and Nutrition and Links to Other Programs

Given the target age-group of five to 12 year olds, SHN programs normally operate within Save the Children's **Basic Education** programs as a key component of ensuring quality basic education. However, in order to extend the health, nutritional and education benefits to children who are both under and above this age

bracket, opportunities should be sought for creating stronger links with our programs in Early Childhood Care and Development and Adolescent Development. There are also opportunities for SHN programs to link more closely with national health programs as they are key contributors to implementing the health strategies and achieving health targets. In countries where natural or man-made emergencies are common, schools also have a role in emergency response. These are discussed in more detail below:

1. Links with Early Childhood Care and Development

Given the school-based delivery model, our SHN experience is primarily relevant to early childhood care and development (ECCD) services that are provided through ECCD centers[12] such as preschools that typically reach children of ages three to five years. Examples of interventions that SHN programs could extend to ECCD centers are as follows:

- In terms of health services, deworming would be relevant to preschoolers where the worm prevalence is greater than 20 percent (a recommendation by WHO). Deworming and vitamin A is often provided to children under five years by the health sector during child health days, but if not, these could be provided by trained ECCD teachers or local health nurses. Micronutrient supplementation can also be added to deworming. Iron is particularly important since the prevalence and consequences of anemia amongst preschoolers are high. Delivery strategies must be adapted to the younger child, for example, to prevent choking when providing tablets. Simple screening tests for health concerns such as hearing could also be done in ECCD centers to help identify children who need special medical attention.
- SHN programs can promote a safe environment in ECCD centers by ensuring toilets and hand-washing facilities are child-friendly. Latrine holes should be small so they aren't intimidating; latrines could have a hand-rail to hold on to if children are squatting or lower toilet bowls for sitting. Hand-washing stands/sinks need to be low enough and not too wide for small children to reach. Similarly, all handles and locks need to be within reach and easy to open.
- SHN programs can start providing simple and age-appropriate health and hygiene education to younger children in ECCD centers. A focus on proper latrine use and hand-washing would be an ideal place to start. A greater focus on complementary parent education will be needed as the children may not understand some of the health messages or lack the ability to act on them. Parenting education also offers an opportunity to improve caring practices amongst the younger siblings/children (zero to three years). Another consideration is the education level and capacity of ECCD teachers/facilitators, since they may be volunteers who have less training than primary school teachers with which the SHN program usually works.
- SHN programs can also involve parents and communities in addressing health concerns of younger children. For example, parent-teacher associations (PTA) could be involved in ECCD center site selection to ensure that it has adequate water, sanitation and hygiene facilities for the children. PTAs can also help to develop and enforce health policies at the center, such as a policy restricting tobacco use near the ECCD center.

2. Links with Adolescent Development Programming and HIV/AIDS Prevention

Adolescent Development (AD) is another sponsorship-funded core program, focusing on the life-skills, values, education and livelihoods development of in- and out-of-school youth aged ten to eighteen. AD includes Adolescent Reproductive and Sexual Health (ARSH) as well as non-formal education and adolescent

[12] ECCD centers are just one ECCD approach; other more community based interventions or those focused on children 0-3 years may benefit more from interventions that are a part of Child Health and/or Maternal and Newborn Health programs.

livelihoods development programming. Clearly there are some programmatic overlaps between AD and SHN given the multi-dimensional (physical, social and emotional) changes in young adolescents, especially those 10-12 years of age – a common target group for both programs. Young people who have the information and resources to deal with these changes before puberty will be better prepared for this transition. SHN programs can contribute to AD in the following ways:

- SHN interventions such as skills-based health education aim at promoting skills in relation to overall health and hygiene, of which sexual and reproductive health is an element. As the age of sexual maturity is well under 12 years of age in many countries now, for young people who may not attend beyond school primary school, skills-based health education may be the only opportunity they have to learn about protecting themselves from risky sexual practices. Therefore, when developing health education activities, be it curriculum or peer-based, it is important that SHN program managers ensure sexual and reproductive health concerns are addressed adequately and in an open and age-appropriate manner. Activities on gender, sexuality, sexually transmitted infections and HIV/AIDS prevention should a) answer young people's questions about body changes, b) reduce teasing and encourage boys to respect girls as their bodies mature, c) remove misconceptions about HIV and discriminatory attitudes towards people living with HIV and d) plant seeds for positive and responsible sexual health behavior as children move into adolescence. Program managers should seek input from their AD colleagues and STWG TA providers to help ensure this takes place.
- Girls are more vulnerable to absenteeism and drop out, partly due to their reluctance to attend school during menstruation, particularly when latrines and washing facilities are not private, safe or are simply not available. While establishing latrines in schools, SHN interventions should ensure separate latrines for girls with washstands to ensure menstrual hygiene, so that they feel comfortable and encouraged to continue to attend school when they would otherwise stay home. Health education should also cover menstrual hygiene information and support for girls so that they will be able to manage the challenges and fears associated with menstruation.
- In places where iron deficiency anemia is an endemic problem and can compromise the health of adolescent girls of reproductive age, iron supplementation to these girls can be provided as part of SHN's extended support to secondary schools (where applicable), in cooperation with the AD program.

3. Links with existing national health programs

SHN programs play a key role in implementing the strategies outlined by national health programs and in helping them meet their targets. It is therefore important that Save the Children is seen as a key partner and our efforts in SHN are counted towards the national program:

- National neglected tropical disease (NTD) programs are seeking alternative delivery systems for achieving mass coverage for the most common NTDs (trachoma, soil-transmitted helminths or STH, schistosomiasis, lymphatic filariasis, onchocerciasis) and the education system offers a highly cost-effective system to reaching school-age children (which often represent one-third of the overall population) and promoting treatment in the community. Specifically, the WHO has set a target for all national deworming programs for STH and schistosomiasis to reach at least 75 percent of school-age children in endemic areas with regular deworming. Given that school-based deworming contributes to this coverage target, SHN programs must coordinate with the government while deworming and subsequently report program coverage to the ministry of health (MoH) annually.

- UNAIDS has recognized curriculum-based HIV prevention education and peer education as key strategies for national HIV/AIDS control programs. Given Save the Children's efforts in providing skills-based health and HIV prevention education in and outside classrooms, SHN programs should forge stronger links with national AIDS control programs.
- Schools can play a key role in achieving the national malaria program goals, particularly in promoting bed net use amongst the school-age population, and through them, the wider community. An increasing number of countries are moving toward universal coverage of bed nets, which includes school-age children who are both the population group that is the most likely to be infected with malaria and least likely to use a bed net.
- Similarly, SHN programs should also link with national health programs that contribute to the control of other health problems (e.g. malnutrition), which are also addressed by Save the Children. Creating these links is important to maximize synergy with national efforts, especially in places where resources are limited.

4. Links with emergency response programs

In countries where human-induced and/or natural emergencies are common, schools and SHN programs can play a role in the different stages of disaster risk reduction.

- In terms of disaster prevention and mitigation, specific standards for school infrastructures are being put into place to ensure the safety and security of school children and their teachers during disasters. SHN programs may contribute to a safe school by teaching children about ways to avoid death and mitigate injuries during emergencies such as fire, floods, earthquakes and typhoons/hurricanes/cyclones. These messages can be provided using a peer-to-peer approach to reach out-of-school children who may be more severely affected.
- Schools are often used as evacuation centers for displaced families and populations to ensure their well-being as they await further humanitarian response efforts. Knowing that facilities may be used in emergency situations, SHN programs could, as a disaster preparedness measure, plan facilities so that water and toilet facilities in schools are adequate and user-friendly.
- During emergency response, SHN programs could link up with makeshift schools or Child Friendly Spaces to introduce health and nutrition interventions to ensure that children remain healthy and well-nourished during their displacement.

This is the end of the first section. The next section leads you through the steps of the Common Approach program cycle.

The Common Approach to School Health and Nurition Programming

The following section provides step-by-step guidance on how to design, implement, monitor and evaluate your sponsorship-funded SHN program. The section is organized around the seven steps of the program cycle, with SHN-specific guidance provided at each step. Particular emphasis is placed on the situational analysis and program design steps. As noted above, additional guidance can and should be obtained from the Common Approach DM&E Module and the Sponsorship Community Mobilization Compendium, as well as from your STWG TA provider.

Step 1: Situational Analysis

Goal of this step:

Identify problems and needs in the sponsorship impact area to inform program design.

What you will need:

- This module
- The DM&E module

The outputs of this step will be:

- A situation analysis report
- Completed Situational Analysis Summary Tool

The purpose of a situational analysis

Save the Children believes no one model works well everywhere, since values, expectations, needs and realities vary considerably in different locations. Thus, despite being structured around the four FRESH pillars, SHN programs vary in nature based on specific needs and strengths in a community. Some programs may emphasize mitigation of arsenic in drinking water as part of ensuring a safe school environment, while in others provision of gender segregated latrines may be a top priority. Understanding the child rearing, health and education beliefs, practices, and concerns of a community is critical for truly effective programming.

Before planning an SHN program, program staff must ask questions that will inform the specific content, breadth and depth of such an effort in a particular context. This is more broadly the purpose of the situational analysis. The situation analysis helps identify priority problems in each context and also considers the underlying dynamics with a view toward identifying potential points of intervention. It focuses on capacities and identifies not only current policies and relevant services but current and potential stakeholders as well. The information gathered and analyzed is used to facilitate the process of planning systematic, strategic and integrated collaborative responses that successfully address the health and nutritional needs and rights of all children in the impact area.

When designing a program, it is very easy to make assumptions on the problems in the community. A situational analysis ensures that the community communicates their needs. The situational analysis is a critical step in establishing a relationship with the community based on mutual understanding, and in promoting the involvement of community members in the planning and management of any program. Aside from community involvement, inquiry into local SHN needs and options should be conducted in tandem with national educators, health personnel, social welfare officers and others who have information regarding the local issues that may influence the provision of services.

How to do a situational analysis

Step 1: Review the questions in the Situational Analysis Matrix

In the Situational Analysis Matrix below, you will find a list of questions which the situation analysis should

address. For each question, information sources and data collection methods are suggested to help you gather information to complete the situation analysis. Review the matrix first and select the questions, data sources and methods that seem most relevant to your impact area and program needs. Make a plan for the data collection and a report outline. As you undertake this step, keep in mind that the situational analysis should be conducted in collaboration with the other core program teams; it should not be done separately.

Step 2: Gather information

Gather the information you will need to answer the questions you identified in Step 1 from the suggested sources of information. The main data sources include:

- **Review of secondary data:** A review of documents – including reports, policies, communiqués, and surveys such as the demographic and health surveys (DHS) – and published papers specific to your country and issues. These documents can be obtained from from government agencies in your country (including district and national levels), such as the ministry of education (MoE) or the ministry of health (MoH) and development partners (e.g. UNICEF, WHO, UNDP, USAID, World Bank).
- **Key informant interviews:** Conducted at the national and district levels, these will include interviews with national level experts, national program managers and development partners involved in SHN related activities (such as deworming/NTD control, HIV/AIDS prevention, nutrition, malaria, trachoma, etc.), in addition to Save the Children program staff. The choice of key informants will vary by country and will depend on the program focus and existing connections with Save the Children. Key informant interviews should also be used to create and strengthen connections with partners, make sure they are aware of Save the Children's activities, identify possible links and gather recommendations for Save the Children's program focus (e.g. what role should Save the Children play to contribute to the national SHN – or other – strategy?).
- **Primary data collection at school and community level using participatory methods, including focus group discussions (FGD) and in-depth interviews:** A small number of schools/communities (five to eight maximum) should be selected for primary data collection to allow more time to gain a better understanding of the needs and issues at the school and community level in each community within Save the Children's impact area. The main data collection method will be focus group discussions with children (separately for girls and boys as well as younger and older children); parents (mothers and fathers separately); school management committees and other community associations; and in-depth interviews with key community/school members, including teachers, school directors, community leaders, health extension workers and local government health and education officials.

Assistance from a qualitative research expert may be needed to help gather and analyze the primary data at school and community level. However, the key informant interviews and review of secondary data should ideally be conducted by Save the Children staff to strengthen our relationships with partners and awareness of SHN-related documents in-country. Box 3 below outlines some important considerations for data collection and management.

Box 3: Important considerations for data collection and management

There are some important considerations when carrying out your situational analysis. Being aware of these will help you produce a much more valid, complete study:

- **Gender:** Be mindful of collecting data of both males and females, making distinctions between the roles they carry and the status they have in their communities. For example, it is important to collect data from fathers, since there is a tendency to rely exclusively on mothers for data on children. In many cultural contexts it is useful to separate the groups.
- **Diversity of informants:** Collecting information from a variety of informants, instead of relying on just one or just a few is very important for data validity. For example, try to collect data from multiple, different parents, instead of relying on one parent only.
- **Geographical diversity in sampling:** When collecting data, be sure to include people and information from different geographical locations. Do not gather only data from a specific street, block or part of the community, but rather collect information on different locations within the community.
- **Diversity in age groups:** Be mindful of diversity in ages when collecting data. Young children, for example, have different needs than those who are adolescents. Some community members have a different viewpoint on public issues since they might have lived longer and have witnessed more of the history of the community. Keep in mind that collecting data from different age groups will make your information more valid.
- **Inclusion of children:** Children offer very valuable information and their points of view are essential. By taking children into account when collecting data, you will gain information not only from what they have to say, but also by observing them, how they behave and how they relate to others.
- **Triangulation of information:** Do not rely exclusively on one method of data collection, but rather use several methods. This ensures that your data is more valid. Relying on one method, such as observations or surveys, will give you incomplete information. In addition, be sure that information is collected by a team, and not by an individual. This will avoid personal biases and will ensure that the data is more valid as it is being managed by different persons with various points of view.

Step 3: Process the information and summarize findings in a report

The information gathered must be processed and summarized into a report. Findings from the review of secondary data, key informant interviews and primary data collection should be reported under separate sections and then pulled together in the conclusion with programmatic recommendations. A suggested outline of a situational analysis report can be found in Annex 1. The Situational Analysis Summary Tool in the Common Approach DM&E module can be used to prioritize the important findings from the situation analysis and to begin to identify appropriate strategies and interventions to address these findings.

Step 4: Share findings and use for program design

The final and most important step is to share the findings of the situational analysis with Save the Children staff and district level partners and use those results to guide the program design and baseline. Some of the key decisions that need to be made as a result are as follows:

a. Can all the concerns that have been identified be addressed under the four FRESH pillars? If not, what additional areas need to be considered?

b. What are the cross-cutting issues/concerns (e.g. motivation of the SMC and teachers) that need to be addressed more generally in the SHN program? Are these issues in the other core programs, and can resources be pooled in addressing them jointly? Specifically, what are the key issues for community mobilization that need to be considered during program design?

c. Which key SHN concerns have been identified and can be addressed by Save the Children's SHN strategies (see Step 2 above)? Which SHN concerns have not been elaborated in Save the Children's SHN strategies as outlined in this module, and which SHN concerns require additional guidance/TA support?

d. For which SHN concerns are there either insufficient local data or a need for school/local level data to be collected through the baseline study?

Key questions to guide a situational analysis

This section contains a set of guiding questions divided up by six broad topics, which are presented in the matrix below. The first five topics correspond to the results framework you will construct in the next step of the Common Approach process. The sixth topic examines Save the Children's capacity to implement an SHN program in your impact area.

You should select the guiding questions from each topic that are most relevant to your impact area. Some questions listed below may not be relevant for you, and you may decide to include other questions based on your experience and understanding of the local context.

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
The education situation *SHN's goal is to improve education. It is therefore essential to understand the wider issues facing the education system and the part that health plays within the broader educational context.* *Note: The situational analysis should be coordinated across all sponsorship-funded programs. Data related to education should not be collected twice*	**Methods** • Review of secondary data and published papers • Key informant interviews • School/community level FGDs **Sources of information** • ECCD and BE data (avoid duplicating data collection) • MoE statistics (national and district level) • Education reports published and unpublished (MoE and partners) • Interviews with MoE personnel at district and regional level • School level statistics in sample schools • FGDs with children, teachers, school management committees and parents	**Secondary Data** a) Do schools suffer from low enrollment, high absenteeism, high repetition and drop out, and/or low school performance? How does this break down by age, sex and other socio-demographic determinants? Provide national and district level data if available, and show how district level statistics compare to national level. • Enrollment rate by sex • Retention/completion rate by sex and age/grade • School attendance/absenteeism by sex and age/grade • Drop out rates by grade • Transition rate to secondary school • Teacher/student ratio (include the range) • Percent of orphans and vulnerable children (OVC) attending/not attending school b) What are the main factors contributing to low enrollment rates, low retention rates, high repetition rates etc. Do these factors vary by sex, age, ethnicity and other socio-demographic determinants? • Are schools accessible to most of the school-age population? If not, what are the main factors preventing some children from attending school (e.g. long distances from home; social, cultural, health or economic reasons)? • Are certain children more likely to drop out of school than others (e.g. girls)? If so, why and what is being done to address this (at national and district level)? c) Are children safe at and on their way to school? • Is corporal punishment common practice? • Are other types of violence, including bullying and sexual abuse common between students, and/or students and teachers? • How are these affecting children's school participation (attendance and learning)? • Are certain children more likely to be targeted by abuse (e.g. girls, OVCs, younger/older children, certain ethnic groups, poorer children)? **Key informant interview** As above (especially c) since it will be difficult to obtain answers to these questions using secondary data. **Community/school level FGDs** As above (especially c) since it will be difficult to find in secondary data.	**Goal**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
The health and nutritional status of school children *What are the most significant health and nutrition problems facing school-age children and are these affecting their ability to attend and learn in school?*	**Methods** • Secondary data • Key informant interviews • FGD with children, teachers and community members • Baseline survey can confirm findings and fill missing gaps in info **Sources of information** • Published papers (search websites such as: http://www.ncbi.nlm.nih.gov/sites/entrez) • MoH statistics, DHS, agency reports and unpublished survey reports • Interviews with national level experts (nutritionists, parasitologists, malaria etc.), development partners and academics working in the field • Interviews with regional, district and community level health workers • FGDs with teachers, parents, school management committees and children	**Secondary Data** a) What is the prevalence of key health problems among school-age children and other age groups, nationally and at the district level, if available. Are certain children more likely to be affected than others (age, sex, social/ethnic status)? Specifically, what is: • The prevalence of worms (soil-transmitted helminths and schistosomiasis)? • The prevalence of malaria, trachoma and other infectious diseases? For malaria also note the peak season for transmission and infection. • The prevalence of HIV/AIDS among all age groups? • The prevalence of micronutrient deficiencies: anemia, vitamin A and iodine deficiency? • The prevalence of general malnutrition: stunting, underweight, wasting? • The prevalence of other health problems: dental caries, vision and hearing problems? • Mortality rate amongst school children and the main causes of mortality? Report differences between the sexes, age groups and other socio-demographic determinants, if available. If no information is available for school-age children, report findings from other age groups (e.g. under fives, pregnant women), and use as an indicator of likely health problems amongst school-age children. Note the gaps in information which can be completed during the baseline survey. b) Is there any country level evidence of the impact/associations between health and education? **Key informant interview** As above and below. **Community/school level FGDs** What are the most common health problems faced by school children and are they affecting their ability to attend and participate in school? How do these manifest themselves at the school level? Are deaths common amongst school children? What are the most common causes of death?	**Goal**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
School children's access to and use of health services *Do school-age children have access to basic health services to address the most common health problems identified? Are any of these health services provided at school? Are these services being used?*	**Methods** • Secondary data • Interviews with key informants • FGD with school and community members **Sources of information** • School health policy/strategy document and program reports • NTD program strategy and report and other national programs which include a school-based element • School health statistics if available • Interview with national program coordinators: SHN, NTD/Schisto or STH control • Review of school level SHN statistics (if available) • FGDs with teachers, parents, school management committees and children	**Secondary Data** a) What school-based health services are being provided in schools nationally and at district level (e.g. deworming, micronutrient supplements, school feeding, vaccinations, first aid kits, counseling, etc.)? Specifically list: • Agencies/ministries (MoH, MoE, NGOs, UN) supporting these interventions and districts targeted. • Coverage rates of these interventions by sex and grade if available (e.g. percentage of children dewormed by sex), or number of schools included in the national deworming program. b) What other health services are available to school children? • Community or health center based health campaigns targeting school-age children, such as deworming, vaccination, voluntary counseling and testing for HIV/AIDS, insecticide-treated bed net distributions, malaria treatment • Other health services such as sexual and reproductive health services **Key informant interview** a) What school-based health services are being provided in schools nationally and at the district level? • What are the main successes and challenges faced with the implementation of school-based health services at school, community, district and national level? • Do all school-age children use these services or are certain children less likely to use them (e.g. girls, younger/older children, children from certain socio-economic groups)? • Are out of school children also targeted? If so how are they targeted? **Community/school level FGDs** As above, plus the following: • Check school level statistics for data on use coverage/use of health service by sex and grade. • Are children using and benefiting from these services? If not, why not? Are certain groups of children less likely to use them (children living far from service delivery; girls/boys; younger/older children; children from certain socio-economic groups; OVCs)?	**Strategic Objective (SO), Intermediate Result (IR)**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
The health and safety of the school environment *Are schools safe and healthy or are aspects of the school environment contributing to children's health problems or their participation in school?*	**Methods** • Review secondary data available • Interviews with key informants • FGD with school and community members **Sources of information** • MoE statistics and/or SHN statistics • Reports (qualitative and quantitative) on water and sanitation and hygiene (WASH) in schools (e.g. WASH in school reports) • Reports on school safety (e.g. violence in schools, road safety) • Interview with SHN coordinator and water and sanitation experts at national and district level • Interview with partner agencies focusing on school safety and WASH (e.g. UNICEF) • School observation • FGDs with students, teachers, school management committees and parents	**Secondary Data** a) What proportion of schools have basic water and sanitation facilities nationally and at district level? Check statistics available and find out the: • Percent of schools with separate latrines for girls and boys • Percent of schools with safe drinking water • Percent of schools with hand-washing These statistics are likely to be reported differently in each country, so include what is available. It's also useful to know what indicators are tracked through the education M&E system. b) Do national standards exist for school safety and for water and sanitation? If so, what do they include/not include? c) Is child safety at and on their way to school an issue and if so, is it preventing children (particularly girls) attending and participating in school? Safety can relate to physical, sexual or mental violence by a range of people including teachers and fellow students. It can also relate to environmental safety linked to road traffic or other hazards near or on the way to schools. Summarize any findings of reports (qualitative or quantitative) found on the health and safety of school environments at national or district level. **Key informant interview** As above, plus the following: a) To what extent do schools meet the national standards for safety and water and sanitation? What are the main challenges faced by schools in meeting these standards? b) Are schools safe for all children at school or on their way to school? Are certain children (girls, OVCs, children from certain ethnic groups, etc.) less likely to be safe at school? If so, why? What are the main risks faced and what is currently being done (or should be done) to address these issues? c) Are the water and sanitation facilities in schools child-friendly (e.g. adapted to younger children's and girls' needs)? Are they conducive to health, or on the contrary, contributing to the transmission of disease (e.g. Are soap and water available and are the latrines cleaned daily? Is the drinking water potable?) How is the water kept clean? d) How are the water and sanitation facilities managed at the school level? What are the main challenges faced in ensuring well maintained and user-friendly facilities at all times? **Community/school level FGDs** As above, plus the following: • Observe the school environment (using a checklist) to assess safety and quality of water and sanitation facilities.	**IR 2**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
The health knowledge, skills, attitudes and behaviors of school children and their communities *Are children practicing the key health behaviors to ensure that they stay healthy? What are schools doing/not doing to provide children with the knowledge, skills and attitudes needed to practice these behaviors?*	**Methods** • Secondary data review • Key informant interviews • FGDs with school and community members **Sources of information** • Reports of health behavioral studies, including DHS • School curriculum and information education and communication materials (including by development partners) used in schools • Interviews with national level experts (malaria, HIV/AIDS, hygiene, nutrition) and development partners • FGDs with student, teachers, school management committees and community members	**Secondary Data** • Focusing on each disease separately, what behaviors are contributing to these diseases? What are the known (documented) barriers and motivations for practicing the recommended health behaviors? Identify gaps in information for further research. • What health topics does the existing health curriculum include? Through which subject(s) are these health topics addressed? What health messages are being transmitted and how? Are the health messages clear? Are the lessons participative, adapted to the context and skills-based? What are the main gaps in the existing school curriculum, in terms of health subjects covered and teaching approach? • What other health materials exist/are being used in schools to support the curriculum? What other extra curricular activities are schools encouraged to organize to promote healthy behaviors? • How much HIV/AIDS and sexual health is included in the current curriculum? In which grade are these subjects taught? **Key informant interview** As above if there is insufficient information from the secondary data, plus: • What are the strengths and weaknesses of the existing school curriculum and system in promoting healthy behaviors amongst school children, including HIV/AIDS prevention? What effort is being made to improve it or add extra curricular health promoting activities to the school-agenda? • Are teachers trained in skills-based health education, particularly sexual education and HIV/AIDS prevention? Is it included in the pre- or in-service teacher training? What are the plans or needs for improving teachers' capacity to provide skills-based health education? **Community/school level FGDs** • Do children, teachers and community members know what health behaviors they should practice to stay healthy (e.g. to avoid getting HIV/AIDS, malaria, diarrhea)? • Are children learning how to prevent these diseases in schools? Is it effective or could schools (and school children and teachers) do more to promote healthy behaviors? If so, what support do they need? • Do teachers feel they have enough training and materials to promote healthy behaviors, including sexual health? If not, what do they need?	**SO, IR 3**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
Community support and school health policy *Without a supportive community and school health policies (from national to school level), none of the other elements of school health can be sustained. This section focuses on national level school health-related policies, as well as school level policies and community support for school health.*	**Methods** • Review secondary data • Key informant interviews • FGDs with teachers, the school management committees, children and parents **Sources of information** • National SHN policy or strategy document or other related documents (meeting reports, draft documents, etc.) • National program strategies (10 year plans) for malaria, HIV/AIDS, NTDs, water and sanitation • Interviews with national program coordinators (SHN, Malaria, NTDs, HIV/AIDS) • Interviews with development partners involved in the development of the national SHN strategy • FGDs with students, teachers and parents	**Secondary Data** • Does a national school health policy or strategy exist? If so, what are the main elements of this policy and what are the gaps? Use the international FRESH Framework and/or Save the Children's results framework as a reference point. Check whether the policy addresses all the key health problems identified in the previous sections. • Are school-based strategies included in other national program strategies (e.g. malaria, HIV/AIDS, NTD, water and sanitation)? If so, summarize the recommended strategies listed in each one. • What is the coordinating mechanism for the national SHN strategy at national, regional, district and school level? Have the roles of each stakeholder been clearly defined? Have the communities role been defined and a mechanism identified to engage communities? **Key informant interview** ***National level:*** • If there is a national SHN policy/strategy, what elements of this strategy are being implemented by the government (or other partners) at scale? What is the history to developing this policy/strategy? Which ministry has led this effort and which partners have been involved? What is the main funding source for implementing the strategy? What are the main strengths and the gaps of this strategy? What is preventing the strategy (or some of its elements) from being implemented? • If there is no SHN policy/strategy, is there an effort to draft one? Which ministries and partners are involved in this effort, and what are the next steps? • Has the national SHN policy been disseminated to the district and schools? If not, why not? If so, is it being used by the schools, and how? What have been the main challenges with implementing a SHN policy in schools? • What is the community's role in supporting the school health strategy and how is their participation being encouraged? What have been the main challenges? • What could be Save the Children role in supporting the implementation of the national SHN strategy (e.g. drafting of strategy, coordinating partners, conducting operational research, build capacity at national, regional, district and school leve1? ***District level:*** • Has the national SHN strategy/policy been disseminated at district level? Do district level health and education partners know the main elements of the SHN strategy and their role in implementing it? Has training been provided for district health and education staff? What elements of the national SHN strategy have been implemented at district level? Which ones haven't and why? What are the main challenges faced?	**IR 4**

Situational Analysis Matrix			
Broader Topic	**Data Collection Methods & Sources of Information**	**Guiding Questions**	**Result(s) Addressed**
		School/community level: • Has the community ever worked with the school on health issues before? Which issues? What were the results? What links does the community have with the school and to external political systems outside of the community (e.g. health system)? • What is the level of capacity/skills for supporting health activities in school (any participation or experience with assessing, planning, action, monitoring/evaluation, decision-making)? • What policies or school rules exist within the schools (e.g. anti-bullying, anti-smoking, etc.)? How and by whom are these developed? How are they disseminated and enforced? What difference do these policies/rules make? What are the main challenges in enforcing them? • What is the role of communities in supporting school health activities? At what stages are they involved (planning, implementation, monitoring, supervision and evaluation of activities)? What are the main successes and challenges in involving community members? • What is the role of students supporting school health activities? Do they participate in the planning, implementation and monitoring of activities? What are the main benefits and challenges in ensuring student participation in all activities?	**IR 4**
Save the Children's Capacity *An awareness of Save the Children's capacity and experiences in the specific context can help plan effectively using existing resources.*	**Methods:** Interviews with Save the Children staff and document revision. **Key Informants:** Save the Children staff and other documents that record the organization's experiences in the community.	• Has Save the Children already implemented SHN in the country? Does the capacity (staff) still exist? • Does Save the Children support education projects with SHN elements that this program can learn from? • Are there existing programs or potential partners who Save the Children can work with? • How can sponsorship-funded SHN activities link with other core programs? • Does Save the Children staff have adequate training in SHN as well as in health, nutrition and education, and an understanding of the other core programs? • Does Save the Children staff have adequate training and capacity to work with government officials and stakeholders to advocate for policy change and to collaborate with national governments and stakeholders? • What is Save the Children's capacity to mobilize the community? Are relationships with community actors strong?	

Community Mobilization Action!

Effective community mobilization is integral to program success. Throughout this module, a summary of each phase of the Community Action Cycle will be presented alongside the corresponding step in the program cycle, beginning here with the Situational Analysis. For a full explanation of each phase of the CAC, please refer to the Sponsorship Community Mobilization Compendium.

Remember that during the time of the Situational Analysis there is work to be done within your own team, and partners to prepare the way for mobilizing communities around the sponsorship-funded core program. In particular you will need to develop a community mobilization team composed of key staff and partners and ensure they are prepared with the skills and abilities to mobilize communities using empowering community approaches. This is also the time to pave the way for greater understanding of the communities you will be working with. It will be important to gather key information about how communities are organized, existing social networks and groups with which we might work, key leaders and stakeholders, and how community decisions are made.

Additional detail on the key community mobilization steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Prepare to Mobilize* phase. These key steps include:

Step 1: Put together a community mobilization team.
Step 2: Develop your community mobilization team.
Step 3: Gather information about community resources and constraints.
Step 4 in this phase is undertaken during program design (please see below).

Step 2: Program Design

Goal of this step:

Understand the Save the Children SHN results framework and document your own. Choose strategies that will best address the needs you identified in your situational analysis and enable the program to achieve the desired results. Develop a summary implementation plan.

What you will need:

- This module
- The DM&E module
- The situational analysis report

The outputs of this step will be:

- A results framework for your program
- A summary and/or detailed implementation plan

Now that you've gathered information about the needs and context of your impact area, you are ready to begin using that information to design your program. The two central elements of this are documenting your results framework and selecting the strategies that best address the gaps between what you found in your situational analysis and what you are seeking to achieve as reflected in the results framework.

What is a results framework?

The program design process begins with documenting your results framework (RF). A RF is a diagram which shows how a program will reach its goal of bringing about positive change for children, by identifying its long-term or strategic objectives (SO) and intermediate results (IRs).

The RF helps your team build consensus around the expected outcomes of the program and communicate those ideas to partners. As you implement your program, the RF will also help you gauge your progress towards the expected outcomes and adjust activities that are not producing the results you hoped for. It is therefore important that the expected outcomes of the program, as outlined in the RF, do not change significantly over the life of the program.

The four major pieces in an RF, from top to bottom are outlined below and in the SHN Results Framework diagram displayed in Figure 2. Save the Children's "generic" SHN Results Framework is consistent with the international FRESH framework and is widely used across all of Save the Children's SHN programs. That said, programs can adjust the framework depending on local needs and priorities on the ground. Annex 2 presents an example from a country office where the RF integrates the SHN and BE program into one diagram.

1. **The Goal:** At the top of the RF, the goal is the "big picture" positive change you want. The broad goal for most SHN programs is usually an overall improvement in the health and educational status of school-age children.
2. **Strategic Objective:** The strategic objective is the measurable behavior change that is needed to reach your goal. For an SHN program, a general strategic objective is to ensure improved use of key school-based health and nutrition services and practices/behaviors.

3. **Intermediate Results:** Intermediate results are measurable, lower-level results that must occur in order to reach the Strategic Objective. The four main IRs identified by Save the Children's SHN program are as follows:

   IR 1 – Increased availability of school-based health, hygiene and nutrition services.

   IR 2 – Improved quality of the school environment.

   IR 3 – Improved knowledge, attitudes and interest towards using health services and health-protective behaviors.

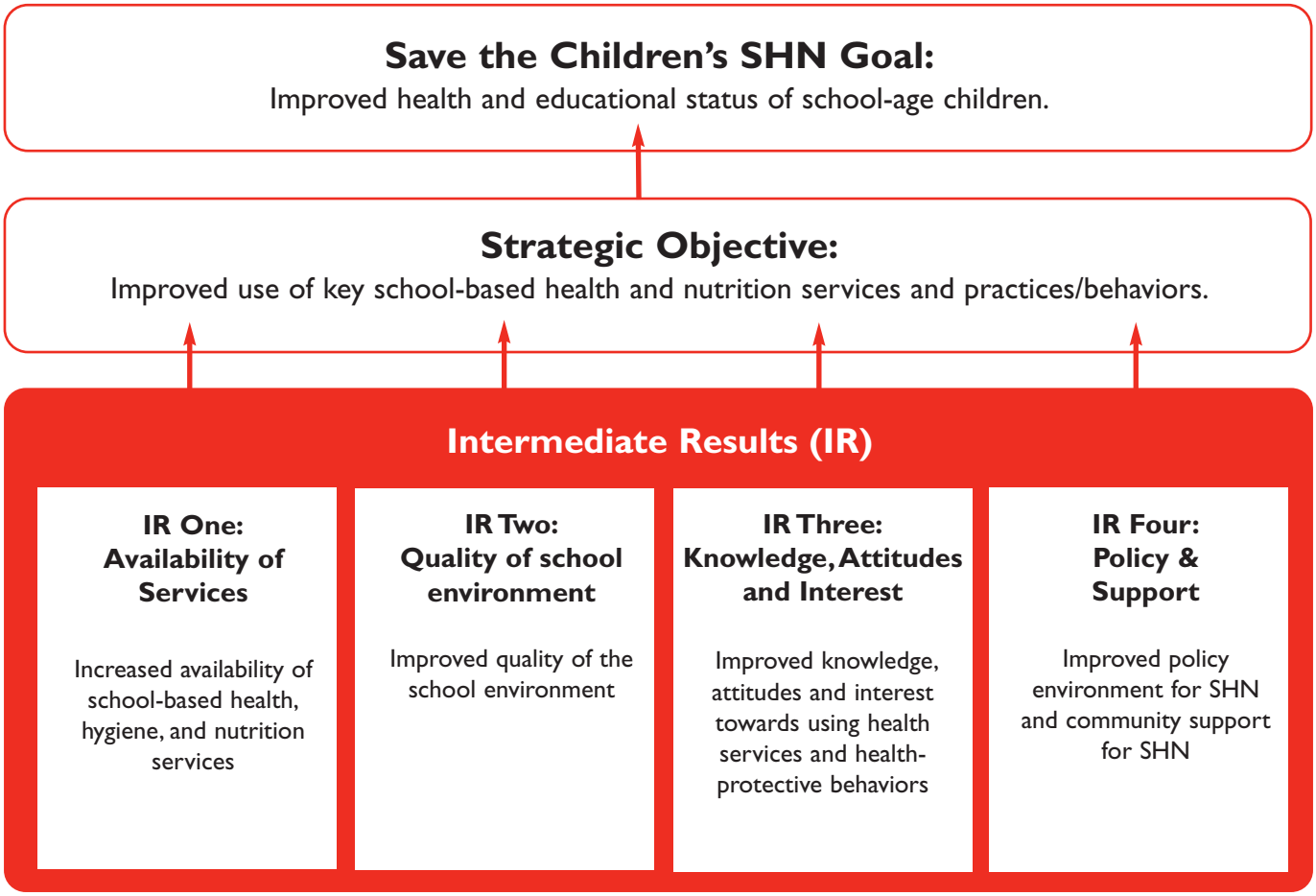
   IR 4 – Improved policy environment for SHN and community support for SHN.

You will notice that the situational analysis matrix shows which result(s) is addressed by each category of questions. This should help you begin to consider the findings of your situational analysis and choose strategies/interventions for each IR that best match the needs and resources of your impact area.

4. **Indicators:** Indicators are measures used to assess progress made towards achieving the goal, strategic objective and IRs. The indicators, however, are not displayed in the SHN Results Framework below. A list of recommended results-level indicators for SHN programs can be found in Annex 3 of this module.

On the pages following the results framework diagram, you will find a more detailed description of each IR and the kinds of strategies that are recommended to achieve each IR. The strategies that are selected must address the unique contexts, issues and needs of your impact area.

Figure 2: *School Health and Nutrition Results Framework*



About Intermediate Result One: Availability of services

The first intermediate result ensures there is an increase in the availability of school-based health, hygiene and nutrition services. The services that are provided will be directly linked to the situational analysis findings of health problems. The simplest and most cost-effective services that teachers can administer include mass deworming to treat worm infections and micronutrient supplementation (e.g. vitamin A and iron) to improve children's health and nutritional status. These must only be done if the prevalence of worms and anemia is high enough to warrant such an intervention (see WHO recommendations in key strategies matrix). Deworming is inexpensive and has an immediate impact on children's health and nutritional status and consequently their ability to concentrate and learn in school. Micronutrient supplementation should be provided a week or so after deworming so that intestinal absorption of nutrients is effective. Usually vitamin A supplementation is provided a week after deworming, followed by weekly or twice weekly iron supplementation for a period of twelve to sixteen weeks. Other services that are provided through schools could include iodine supplementation if absolutely necessary; treatment of health problems such as malaria and injuries using first aid kits; vision and hearing screening; and psychosocial counseling. For more information on these strategies refer to the Key Strategies Matrix in Annex 4. SHN also works to link the health system to schools to improve health services to school children by the health system.

Strategies for IR 1 may include:

- Mass supplementation of iron, vitamin A or multiple micronutrients.
- Routine mass treatment of soil-transmitted helminths and schistosomiasis, which make up four of the seven most common NTDs.
- Screening and classroom remediation for vision and hearing impairments.
- School-based access to sexual/reproductive health and HIV counseling.
- Distribution of long lasting insecticide impregnated nets (LLINs) and/or school-based malaria treatment.

Issues related to IR 1 include:

- For many of these activities, effort should be made to reach all school-age children regardless of whether or not they are enrolled in school. Many of these activities (e.g. deworming) are more effective when more children participate.
- Some activities may target specific children who need additional services such as psychosocial support for children affected by HIV/AIDS or conflict and emergencies.

About Intermediate Result Two: Quality of the school environment

A quality school environment significantly reduces hygiene-related disease, increases student attendance and learning achievement, and contributes to dignity and gender equality. It depends on the availability of safe water for drinking and hand-washing as well as access to sanitary latrines and hand-washing facilities. Safe drinking water is water which does not contain harmful pathogens and which does not contain chemicals above the recommended dose for safety. A sanitary latrine is a latrine where human excrement is disposed into a closed space which does not come in contact with open air or contaminate the environment. There should be an adequate number of separate child-friendly latrines for girls and boys, and separate facilities for teachers in schools. An appropriate hand-washing facility is easily accessible to children, has proper drainage of water and includes soap, ash or similar cleansing agent.

In addition, a safe school environment should be clean, secure and free from risks or dangers, and conducive to learning. Waste must be safely disposed; and the environment should protect children from abuse and exclusion.

Strategies for IR 2 may include:

- Provision of appropriate hand-washing facilities.
- Separate child-friendly and sanitary latrines for girls and boys, and separate facilities for teachers.
- Provision of potable water in schools.
- Solid waste and environment management to prevent diseases such as dengue.

Issues related to IR 2 include:

- The success of these strategies relies on the development of a system (e.g. school hygiene committees) for maintaining SHN facilities (see IR 4 in Annex 4), and the promotion of hygiene practices (see IR 3 in Annex 4).

About Intermediate Result Three: Knowledge, Attitudes and Interest

Improvements in knowledge, attitudes and interest towards using health services and health-protective behaviors can be brought about through skills-based health education. Classroom-based health education sessions should be designed such that health information for children is incorporated or linked to existing grade-specific curriculum. The education should be behavior and child-centered; so that as a result school children are motivated to change their attitudes and practices towards personal hygiene, water and sanitation, food and nutrition, first aid treatment and HIV/AIDS. Schools offer the best venue for reaching large numbers of young children and youth with accurate HIV/AIDS and sexual and reproductive health information. Children form attitudes and beliefs early in life and are more likely to practice healthy behaviors if they learn them before they have already adopted unhealthy ones.

In addition to in-class health education, peer education could also take place in primary schools. Peer education involves students in peer groups demonstrating and promoting healthy practices among themselves in order to support healthy behaviors in the school and in the community. The child-to-child approach, which follows the same principals, encourages school children to take responsibility for their own health and that of their community and find solutions to address the health problems. With these approaches, students learn from each other and share their knowledge and awareness with their non-school peers, families and other community members, while developing a range of essential skills (critical and creative thinking, decision making, problem solving, communication, leadership, etc.). Peer education creates a bridging relationship between schools and the community, increasing the value of the school within the broader goal of community development.

Strategies for IR 3 may include:

- In-class skills-based health education to enable children to stay healthy and avoid risky behaviors.
- Peer education to encourage children's participation in health education.
- Teacher training on skills-based health and nutrition education, including HIV/AIDS prevention and sexual and reproductive health.
- Training of health workers and community participants on the different elements of SHN services.
- Parental education.

These strategies may happen in combination and are therefore jointly discussed in the Key Strategies Matrix.

Issues related to IR 3 include:

- There are four elements that lead to behavior change which is the goal of health education. First, it is important that children have the knowledge of health concerns, services and health-protective behaviors. Second, we know that changes in knowledge do not always translate into changes in practice, therefore, building knowledge should be accompanied by efforts to build children's skills so that they can take action for their own health. Third, children should feel inspired or motivated to act on the information or skills they have acquired. So creativity is required in designing health education programs. Fourth, there should be an enabling environment – not just in terms of the physical infrastructure – but also an environment where adults respect children and provide them the support they need to resolve health problems.
- Programs must develop comprehensive behavior-centered strategies, based on a sound understanding of the target population. Formative research on attitudes and practices in relation to healthy behaviors can help in developing an appropriate behavior change strategy. It is difficult to measure behavior change in a short period of time. Monitoring and evaluation methods and tools should therefore be reliable and consistent to be able to measure behavioral change.
- Save the Children's skills-based health education activities should support national level efforts in strengthening the curriculum. Program staff should collaborate with the MoE and partners regarding their roles and responsibilities in strengthening the curriculum.

About Intermediate Result Four: Policy & Community Support

As an NGO, one of Save the Children's roles is to advocate and facilitate the development of a national SHN policy that can inform SHN programs throughout the country. Save the Children should participate in the national SHN working group and present evidence from its program in order to inform policy and for the development of a long-term strategic plan. The SHN program manager should participate in policy development and review workshops in order to voice and address the concerns of communities, NGOs and other district level implementers.

Once the national SHN policy and the strategic plan are developed, Save the Children should support the district level to disseminate and implement the policy at both the district and school levels. We should be part of the district level SHN committee, which is responsible for ensuring the implementation of the SHN program in the district, partnering with NGOs and safeguarding the welfare of school-age children. Save the Children must also support effective partnerships between the education (e.g. teachers), health (e.g. health workers) and water (e.g. engineers) sectors; engage the community in the program; and encourage pupil participation in the program.

Strategies for IR 4 may include:

- Advocating for and supporting the development and implementation of SHN policies at national, district and school levels in order to scale-up to national-level SHN programming or modernize or upgrade an existing SHN program. This includes participating in coordinating meetings between education and health officials from the community up to the national level, through SHN working groups and otherwise, to ensure effective program management, increased sustainability, and an environment favorable to meeting the health and nutrition needs of school-age children.
- Capacity building of the school structures, including the teachers, parent-teachers associations and school management committees, to ensure ongoing support for SHN activities.

Issues related to IR 4 include:

- It is critical to work with stakeholders in the formal schooling system (official, government schools) and in non-formal schools (community-based and -managed), if both exist in your impact area.
- Efforts to scale-up programs often take many months and years so results may be difficult to observe.
- Certain policies may prove to be controversial or difficult to advocate (e.g. policies on reproductive health, corporal punishment, sexual harassment and allowing pregnant students to attend school).

Sponsorship-funded programs and advocacy

Save the Children's firsthand experience through our work on the ground positions us well to advocate for change. In order to increase the reach and sustainability of our work, we must endeavor to develop and document program interventions that can be implemented and sustained at scale by local and national governments and partners. In areas where we come across policy barriers that hinder our work and Save the Children believes that government policy is inadequate or not being effectively applied, we may decide to advocate if we assess that we are well-placed to do so and see a chance for success. In these cases, the program team should identify an advocacy objective(s) and a strategy to achieve the objective. The advocacy strategy should be informed by results from our sponsorship-funded programs and the evidence base we create through their implementation.

Selecting strategies for your program

After documenting the results framework, the next step in designing your program will be selecting the strategies that best address the gaps between what you found in your situational analysis and what you are seeking to achieve as reflected in the results framework. Ideally, you will select strategies that address all four IRs in a holistic way. When this is not possible, your team should work with technical staff in your country office, regional office or in headquarters to choose strategies based on available resources and community needs.

Some possible strategies that could be used to address the problems related to each IR have already been presented above in the Results Framework section, however, a menu of strategies, called the Key Strategies Matrix is also presented in Annex 4. This matrix lists many of the key strategies that have been found to be effective when implementing SHN programs, but it is not comprehensive. The information included in the matrix will help you assess the applicability of strategies to your context by giving you some basic rationale, as well as information about the costs, frequencies, and issues related to each strategy.

Not all strategies listed in the matrix will be appropriate for your impact area. Remember to base your strategy choices on the results of your situational analysis, as well as the resources available, while keeping in mind the goal of SHN programming and each of the four IRs. For more information on individual strategies described in the matrix, please contact your STWG SHN TA provider.

Completing the Summary Implementation Plan

Once you have chosen the strategies that will best address the objectives of your program and the needs of adolescents in your impact area, within the context of your sponsorship program budget, record your choices in the Summary Implementation Plan (SIP), which you will find in the DM&E Module. Where countries use a Detailed Implementation Plan (DIP) for planning purposes, this can be substituted for the SIP as long as all of the information in the SIP is included. The implementation plan should be reviewed and updated on an annual basis.

Community Mobilization Action!
Program Design

During the time of program design, a community mobilization plan for Save the Children staff and partners will provide a needed roadmap for beginning work with selected communities. The community mobilization plan is a description of *how* your CM team intends to mobilize communities around the core program goal in the designated area you will be working. As such, the community mobilization plan should serve as a detailed roadmap for you and your team. Note: this is not a community action plan, which will be developed by communities themselves later in the process.

Your team's mobilization plan should focus on the overall core program goal and objectives and identify a process that will help interested communities achieve them. As you create this plan, you should always keep the two overriding goals of community mobilization in your mind:

1. **To achieve the core program goal of the community, including those *most affected* by the issue.**
2. **To improve the community's capacity to address the issues and sustain their effort over time.**

Developing a community mobilization plan provides an opportunity to harmonize efforts between sponsorship operations and program staff so that communities are not bombarded by multiple meetings for similar purposes. The mobilization plan should be widely shared to see if community-based efforts might be integrated. For example, if other core programs are being newly initiated, coordinating community orientation meetings could be time-saving (and appreciated by communities).

Additional detail on the key CM step to be undertaken during this time can be found in the Sponsorship CM Compendium in Step 4 of the *Prepare to Mobilize* phase: Develop a CM Plan.

STWG review needed!

Before moving on to the next steps in the program cycle, it is critical to seek a technical review of what you have developed in Step 2 of this module (program design). Do not move on to the next step of designing your M&E plan before sharing your results framework and Summary Implementation Plan with your STWG TA provider for their review and input.

Step 3: Monitoring and Evaluation Plan Design

Goal of this step:

Develop a monitoring and evaluation plan after careful selection of SHN indicators.

What you will need:

- This module
- The DM&E module
- The completed Results Framework
- The Summary Implementation Plan
- The Common Approach SHN Indicator Reference Sheets

The outputs of this step will be:

- A Results Indicator Planning Tool (RIPT) for your program
- A completed Process Indicator Tool (PIT)

It is now time to design a monitoring and evaluation (M&E) plan for your SHN program, determining which process and results indicators you will track.

Process indicators measure progress in program implementation, to assess whether activities are being implemented as planned. Process indicators and targets are set every year, based on your implementation plans, and are documented and submitted annually with the Country Annual Plan (CAP) using the Process Indicator Tool (PIT). Process indicators relate to program inputs (materials, goods or actions to carry out the program) and outputs (services provided). For SHN programs, process indicators typically include:

- Supplies data (e.g. number of tablets, SHN manuals, first aid kits, vision and hearing materials)
- Services data (e.g. number of schools providing deworming)
- School level data (e.g. percentage of schools with latrines, hand-washing facilities, water supplies, functional SMC)
- Child level data (e.g. percentage of children dewormed, supplemented or screened)

Results indicators measure higher-level changes that we believe our program activities contribute to. Results indicators should be the same from year to year: they are established when a program or new intervention is designed. The Results Indicator Planning Tool (RIPT) is the template for sponsorship results indicator planning, and includes the information usually contained in a monitoring and evaluation plan. It contains the definition for the indicator and how it is calculated, as well as the source, data collection tool, the frequency of data collection and a target. It also names who is responsible for ensuring that the data are collected. When you are filling out the RIPT, it is important to consult the SHN Indicator Reference Sheets in Annex 3 of this module, which contain the recommended indicators for Common Approach SHN programs.

Most results indicators should be tracked on an annual basis, although some (e.g. those related to behavior change) may be tracked less frequently. SHN indicators should be recorded annually in a document which allows program staff and STWG TA providers to view the trend in results year after year. These data should link into the agency global monitoring and data collection efforts. More guidance on selecting results and

process indicators and reporting on them, as well as the tools used for M&E planning, can be found in the Common Approach DM&E module.

Beyond the process and results indicators described above, it is important to consider the evaluation design and plan for your program. The minimum requirement for all sponsorship-funded programs is a baseline to endline evaluation. In addition to this, there are other possible approaches that program teams can consider in light of their evaluation capacity, available resources, and evaluation objectives. In all cases, technical assistance must be sought.

Community Mobilization Action!
M&E Plan Design

During or around the time the M&E plan is being developed your team can formally approach the community and invite their participation in the core program(s). If the steps in this phase of the Community Action Cycle are undertaken prior to the baseline, community members can be involved and assist in data collection efforts, analysis and dissemination of results. Remember: sharing the outcomes of the situational analysis with communities will help build interest and participation in the core program.

Key to communities getting organized around the core program is ensuring that communities are fully oriented to Save the Children and our partners and understand the core program issue and how sponsorship-funded programming works. Inviting those most affected and interested in the core program to participate, and ensuring they will have a central role, voice and will benefit, is also critical.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Organize the Community for Action* phase. These key steps are:

Step 1: Orient the community.

Step 2: Build relationships, trust, credibility and a sense of ownership with the community.

Step 3: Invite community participation.

Step 4: Develop a core group from the community.

Time to document the Impact Area Presence Plan!

Once you have completed the first three steps in the program cycle, it's time to document your long-term plan for sponsorship-funded programs in your designated impact area. This includes: the rationale for program implementation; the program design (including the results framework(s) and key strategies); the M&E plan design; your community mobilization plan; as well as the exit strategy. The plan should be submitted to your STWG TA providers before moving on to the baseline step. For more information about this plan, please see the DM&E module.

Step 4: Baseline Data Collection

Goal of this step:

Gather baseline data on the health status of school-age children and schools in the impact area.

What you will need:

- This module
- The DM&E module
- The completed Results Indicator Planning Tool
- *Monitoring School Health and Nutrition Programs: Guidelines for program managers*
- Save the Children's *Model Knowledge, Attitude and Practice (KAP) questionnaire*

The outputs of this step will be:

- A baseline survey report

Baseline data are the first measures of indicators prior to the implementation of the SHN program and will act as the main point of comparison to measure program progress over the life of the program. Since sponsorship-funded programs run for an average of ten years in one impact area, it is crucial to have a high quality baseline which can be referred to throughout the life of the program until phase out. It is also important you collect these data because they:

- **Identify and/or confirm the health problems of school children in the local area.**
- **Determine the coverage of services prior to the SHN program.**
- **Confirm the interventions needed for the SHN program.**

The baseline data needs to be accurate and the methods and tools used for collecting the information need to be well documented, as these same methods and tools will need to be applied to collect data in future. As a first step, use the completed RIPT and PIT (see Step 3 above) to identify sources and tools to collect baseline data. Generally there are two types of data collection methods: 1) annual monitoring data, which is gathered during program activities, such as percentage of pupils receiving vitamin A, or from schools at the end or start of the school year (enrollment, repetition and drop out rates); and 2) survey-based data which is collected every three to four years (baseline, mid-term and endline). In both cases, data collection forms should remain the same from baseline throughout the life of the program to ensure findings at different points in time are comparable (this does not preclude the program from adding new indicators over the course of program implementation – e.g. related to an innovation). For sample data collection forms and analysis guidance, refer to *Monitoring School Health and Nutrition Programs: Guidelines for program managers.* In order to evaluate the knowledge, attitudes, and practices of children in relation to the SHN program in your country, please use the KAP model questionnaire as a resource (see list of resources). It contains model questions for the many topic areas that SHN programs address around the world. These will need to be adapted to your local context.

For survey-based data, you will need to design the survey to fit with the overall evaluation plan for the program (developed in the M&E Plan). You will need to seek assistance for this from Save the Children's national or regional monitoring and evaluation advisors and STWG TA providers. The methodology applied will

comprise of:

- Determining the evaluation design for the overall program, namely whether/how a comparison group is needed to strengthen the rigor of the results.
- Determining the number of schools to be sampled and school children within each school to be surveyed.
- Determining the data collection methodology and tools required; developing and testing survey questionnaires; identifying a survey team and supervisor, data analyst and report writer.

Typically the SHN data that you will collect and the data collection methods that you will use during a baseline survey could be as follows:

- **Anthropometric data:** Measurements of body weight, height and mid-upper arm circumferences to assess the percentage of children that are malnourished (stunted, underweight and with a low Body Mass Index (BMI) for age).
- **Hemoglobin (Hb) levels:** Blood samples by finger pricks to measure Hb concentration, to assess the percentage of children who are anemic.
- **Iodized salt:** Salt samples to measure the prevalence of iodized salt.
- **Vitamin A deficiency:** Eye exams to assess presence of clinical signs of vitamin A deficiency (e.g. Bitot's spots). Because Bitot's spots only represent advanced stages of the disease, it is not an appropriate indicator for measuring program impact but can be used to confirm the need. This must be carried out by a trained ophthalmologist.
- **Iodine deficiency:** Palpation of the goiter. This must be carried out by a trained individual; however, goiters are not an accurate or reliable indicator for recent iodine deficiency and therefore must be interpreted with care.
- **Parasitic infections:** Urine samples for the presence of blood and to count the number of eggs for schistosomiasis. Stool samples to count the number and types of intestinal worms found.
- **Child interviews:** Individual interviews with children to assess their Knowledge, Attitude and Practice of key health practices.
- **School observation:** Observation of the school environment, the overall safety of the school, and assessment of the presence and quality of water and sanitation facilities.
- **School Director and SMC interview:** Interviews with the School Director and SMC members to assess the school and SMC functionality, awareness of SHN issues and key challenges.

As with the situational analysis, plan and conduct the SHN baseline survey along with the other sponsorship-funded programs. A report should be written following baseline data collection that includes all the sponsorship-funded programs being planned for. The report should include the following information:

- **Introduction:** A summary description of the planned programs.
- **Methodology:** A description of the overall evaluation approach, how the data was collected, the sampling method, and the tools applied to generate the results.
- **Results Indicator Planning Tool:** The RIPT(s) can be annexed to show data sources and how indicators were calculated.

- **Findings:** A detailed description of the results presented in tables showing results by sex, age group and geographical area. Include sample size (n), means and percentages with standard deviations for each result.
- **Conclusions and recommendations:** The interpretation of the results and recommendations for future programming.

Community Mobilization Action!
Baseline

Around the time of the baseline activities, the *Explore and Set Priorities* phase of the Community Action Cycle is undertaken by community members. The *Explore* phase aims to help community members, explore *their own* knowledge, beliefs, and practices related to the core program issue and the perspectives of the broader community. The community *core group*, which was formed earlier, learns how to carry out participatory activities that will better inform them and the community about the core program issue in order to help them set their priorities. The *Explore* phase can be easily integrated into the baseline study, especially if qualitative data is being collected.

Helping communities analyze the underlying issues affecting change, local barriers and strengths, and set their own priorities is key to engaging communities in actions that are relevant to their reality. What should you do if communities do not prioritize issues that might in be in the core program design? Remember: core programs will have some overall strategies that are best addressed at the national/district levels and others that are best addressed at community level. Therefore, aspects of each core program may *not always* be community-based and might be achieved through work with partners at different levels.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Explore and Set Priorities* phase. These key steps are:

Step 1: Explore the core program issue(s) with the community core group.

Step 2: With the community core group, explore the core program issue with the broader community.

Step 3: Analyze the information.

Step 4: Set priorities.

Step 5: Implementation and Monitoring

Goal of this step:

Implement program activities and regularly monitor the progress of the program.

What you will need:

- This module
- The DM&E module
- Your Summary Implementation Plan
- Your Process Indicator Tool
- Your Results Indicator Planning Tool
- SHN Program Implementation Guides
- *Monitoring School Health and Nutrition Programs: Guidelines for program managers*

The outputs of this step will be:

- A Results and Process Indicator Report (RPIR) and Progress Narrative
- A report(s)/action plan(s) from the Results Review meeting(s)

Implementing your program

You are now ready to implement the SHN program. For more guidance on how to implement the various interventions and recommended strategies, refer to the strategies matrix and the list of resources organized by each IR in Annex 5. The Bangladesh and Malawi country offices have developed the following program implementation guides for their SHN program. These serve as a ready reference for information on how to implement SHN interventions and strategies used, and can be accessed at the following links or from the STWG:

Save the Children (2010). *School Health and Nutrition Manual: A guide for program planning and implementation in Bangladesh.*
http://www.schoolsandhealth.org/Documents/Bangladesh%20SHN%20Operational%20Manual%20final.pdf

Save the Children (2010). *School Health and Nutrition Manual: A guide on how to implement programs in Malawi.*
http://www.schoolsandhealth.org/Documents/Malawi%20SHN%20Operartional%20Manual%20final.pdf

Monitoring and reporting on your progress

During implementation, you will regularly monitor both process and results indicators, according to the plans and timeframes set out in your PIT and RIPT. All SHN indicators should be tracked in a program database and should be reported on in a summary document which allows program staff and STWG TA providers to view current values and trends over time. A Results Review should be held at least every six months to discuss if the program is on track and to identify areas for improvement.

The Results Review offers the opportunity to examine questions such as:

- **Do you need to adopt different strategies to more effectively achieve your objectives? Do the strategies complement each other in achieving your results?**
- **Are there barriers to achieving results that are not addressed in the program design, which must be addressed to make the program successful?**
- **Do you need to reorganize the field team or make other changes to Save the Children/partner implementation to better achieve targets? For example, are there adequate supervision and quality assurance mechanisms?**

Detailed guidance on how to conduct a Results Review can be found in the Common Approach DM&E module.

Both process and results indicators are reported through the Country Annual Report (CAR) once a year using a Results and Process Indicator Report (RPIR) along with an explanation of the findings, which is called the Progress Narrative. Please note that results level indicators for ECCD, BE and SHN are reported through the global indicator reporting mechanism, rather than through the RPIR, so as to avoid duplication of effort. The Progress Narrative and process indicators are still reported through the RPIR.

Community Mobilization Action!
Implementation

Communities take part in the implementation of core programs in many ways based on the overall core program design. One important way communities participate is through the development of their own action plan, implementing their planned strategies and activities, and monitoring their own success. The *Plan Together* phase of the Community Action Cycle helps the community core group develop their community action plan to address the core program issue. It is important to ensure that those most affected by the core program issue have a central role and voice in developing the community action plan.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Plan Together* phase. These key steps are:

Step 1: Determine who will be involved in planning and their roles and responsibilities.

Step 2: Design the planning session.

Step 3: Facilitate the planning session to create a community action plan.

The *Act Together* phase of the CAC also takes place during implementation, and helps communities implement their community action plans. The role of the sponsorship CM team is now to strengthen community capacity in areas necessary to effectively carry out the strategies and activities the community core group defined in their action plans. These may include skills in leadership, planning, conflict resolution/decision-making, resource mobilization and management. At this point, there are often volunteers and community groups working together to carry out activities. Helping communities monitor their own progress and using data for decision-making is essential in motivating ongoing collective action.

Additional detail on the key CM steps to be undertaken during the *Act Together* phase can be found in the Sponsorship CM Compendium. These key steps are:

Step 1: Define the CM team's role in accompanying community action.

Step 2: Strengthen the community's capacity to carryout its action plan.

Step 3: Monitor community progress.

Step 4: Problem-solve, troubleshoot, advise and mediate conflicts.

Step 6: Evaluation

Goal of this step:

Evaluate the program to assess its effectiveness.

What you will need:

- This module
- The DM&E module
- Guidance from your STWG TA provider and an M&E specialist

The outputs of this step will be:

- An evaluation report

The minimum requirement for the evaluation of a sponsorship-funded program is baseline to endline, including a mid-term evaluation, with annual monitoring of key indicators. Other evaluation designs may also be considered. For example, evaluations may seek to examine both program processes (the quality of implementation) and impact (what changes result from the program). When you enter into a new impact area, you will need to establish your approach to evaluation as you design the program, so that the methodology and baseline allow for a strong evaluation. Generally speaking, program results should be evaluated at three to four-year intervals (baseline, mid-term and endline).

Evaluations allow implementers to observe any changes that have occurred throughout the course of implementation and in some cases to assess whether this change was a result of Save the Children programming. For SHN evaluations we are particularly interested in the following questions:

- **Are children healthier than at baseline/versus comparison group?**
- **Have children's school performance/literacy rates improved since baseline/versus comparison group?**
- **Are more children reporting practicing healthier behaviors than at baseline/versus comparison group?**
- **Do more schools have adequate water, hand-washing and latrine facilities in the area covered by the program/versus in comparison group?**
- **Are communities and parents more involved in and supportive of their children's health and education than at baseline/versus comparison group?**
- **Has Save the Children contributed to changes in broader policies and guidelines for SHN?**

Alternatively, you may wish to evaluate the impact of particular interventions as you design and test new and innovative approaches. This may be done at a different interval from the impact area evaluation cycle. In this case, we recommend working closely with a researcher and/or your STWG TA provider to come up with the best evaluation design possible. The evaluation design should be tailored to help you answer specific questions and to generate the evidence needed for advocacy and replication of the approach. Conducting a longitudinal study, which tracks a cohort(s) of children over time, is another evaluation option that sponsorship-funded programs can consider undertaking.

Community Mobilization Action!
Evaluation

The evaluation of core program(s) provides a unique opportunity for communities to learn about the success of their collective action as well as what work remains to be undertaken. The *Evaluate Together* phase provides an opportunity for community members to participate in the evaluation process, learn how to evaluate, analyze results, share results with the community, and apply lessons learned to future program efforts.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Evaluate Together* phase. These key steps are:

Step 1: Form a representative evaluation team with community members and other interested parties.

Step 2: Determine what participants want to learn from the evaluation.

Step 3: Develop an evaluation plan and evaluation instruments.

Step 4: Conduct the participatory evaluation.

Step 5: Analyze the results with the evaluation team members.

Step 6: Document lessons learned and provide feedback to the community.

Step 7: Lessons Learned

Goal of this step:

To reflect and learn from program implementation and evaluation, in order to inform future programming and improve effectiveness.

What you will need:

- This module
- The Lessons Learned guidance in the DM&E module

The outputs of this step will be:

- Documented Lessons Learned

Sponsorship-funded programming constantly generates learning that is relevant to future implementation and to other non-sponsorship programs. This learning may be technical – for example, which strategies are most effective to accomplish an objective – or they may be related to partnering or reaching a particular target population. It is critical to take the time to reflect on and document this learning, so that it can feed into future programming.

In order to document and use this information, you should undertake a Lessons Learned process after each evaluation (i.e. mid-term, endline), at least.[13] Here, Save the Children staff, government officials, program participants and donors have the opportunity to reflect on past programming and provide feedback to inform future work. This review should look at both the strengths of the program and areas that need improvement. By the end of the session, there should be a common understanding of and agreement on the lessons learned. Lessons should be clearly documented and widely shared, so that they can be used to improve current and future programming. Documenting and sharing evaluation results and lessons learned enable sponsorship-funded programs and innovative practice to be leveraged to achieve impact at a larger scale. More information for conducting a Lessons Learned workshop can be found in the Common Approach DM&E Module.

Community Mobilization Action!

Lessons Learned

Communities have a unique role to play in sharing lessons learned. In particular, community-to-community sharing of promising practices (and lessons learned) provides important learning between and amongst communities themselves. The ability for communities to share and see each other's work, innovation and success generates rapid uptake of approaches and strategies. Analyzing and documenting lessons learned also provide important guidance on how best to scale-up approaches.

Additional detail on the key CM steps to be undertaken during this time can be found in the Sponsorship CM Compendium in the *Prepare to Scale-up* phase. These key steps are:

Step 1: Identify communities of promising practice.
Step 2: Provide opportunities for community-to-community exchange and learning.
Step 3: Utilize lessons learned to consolidate and refine the approach to prepare for scale-up.
Step 4: Develop a scale up plan including roles and responsibilities of implementing partners.

[13] A Lessons Learned exercise can be undertaken at other stages as well, depending on the situation. For example, it can be very useful to undertake a Lesson Learned exercise prior to a final evaluation when a CO is phasing over into a new impact area, if the phase-in is to take place before the final evaluation in the "old" impact area. In this case, conducting the lessons learned "early" would ensure that these lessons learned from the old impact area inform the program design and implementation in the new area from the outset.

Annexes

Annex 1: Suggested Outline for a Situational Analysis Report

The following is a suggested outline for an integrated situational analysis report covering all core sponsorship-funded programs:

Executive Summary: A two to three page summary providing a brief background on Save the Children's sponsorship program in country, the objective of the situational analysis, methodology used, key findings relevant to each core program, along with conclusions and recommendations for each core program.

Background: Brief background on Save the Children's sponsorship program so far in the country (e.g. phase-over from the old impact area and why the new impact area was selected).

Objectives: Brief statements on the key topics to be assessed during the situational analysis under each core program.

Methodology: An overview of the how secondary and primary data was collected and analyzed. This can include information on how geographic areas, schools, key informants were selected in order to provide a representative view of the situation.

Findings: The findings can be divided by key sub-headings, and then within each sub-heading data collected from different methods (e.g. secondary data; national and district level key informant interviews; and local/ school-level information) should be presented separately. The key sub-headings can be:

A) **The general context:** To include geographical location (location versus key cities, terrain, climate), socio-political and socio-economic situation (poverty levels, rural-urban mix, occupations, housing and shelter, political situation, other key societal concerns), and demographics (population density, size, age structure, numbers of men versus women).

B) **Early Childhood Care and Development:** To include information on the ECCD system in the country and impact area, covering all government, informal, private, and NGO sectors. The key health, development, and other early childhood concerns can also be included here.

C) **Basic Education and School Health and Nutrition:** To include details on the education and health system for school-age children in the country/impact area. Secondary data (e.g. on education performance, and health knowledge, attitude, behavior and status indicators) should also be presented as must information from key informant interviews that provide an understanding of the education and SHN situation.

D) **Adolescent Development:** To include details on the key health, development, livelihoods development concerns for adolescents. Information on the key players, and the situation/system for adolescent development needs.

E) **Policy environment and coordination at different levels (from national to local):** To include information on the relevant policies that are either in draft or complete form, that need to be advocated, amended, or disseminated. Also includes the structures in place to allow coordination between various stakeholders. This sub-heading could also be covered under sub-headings B, C and D above.

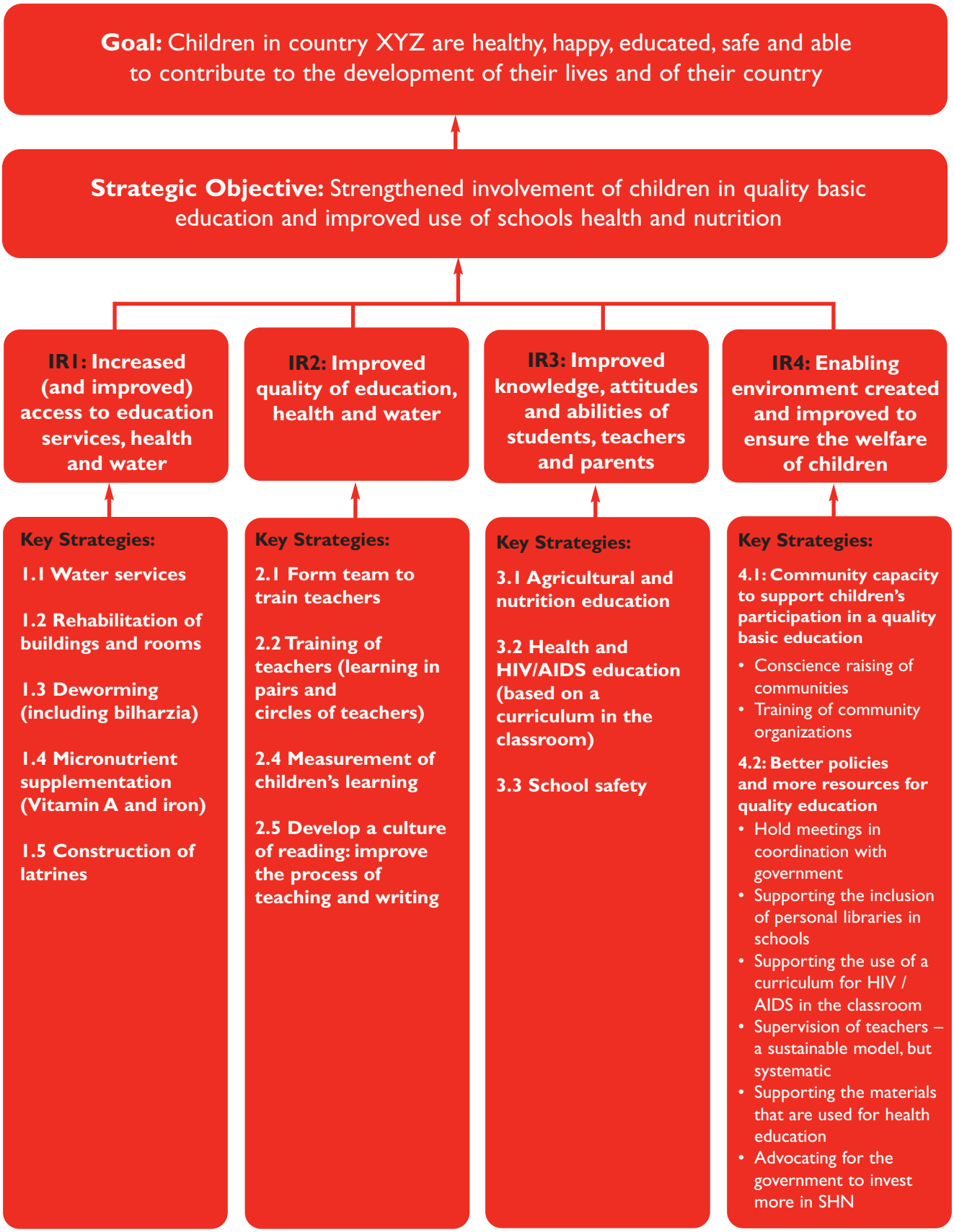
F) **Save the Children Capacity:** To include the human (technical, managerial and support), financial, and other material capacity that exists in order for Save the Children to implement its core programs.

G) **Other cross-cutting areas:** Other issues not covered under the above areas can be addressed here. They can include teacher's capacity, school infrastructure, functionality of the SMC and partnership between health, education and other relevant social sectors.

Conclusions and programmatic recommendations: Conclusions should synthesize the information from the different data collection methods to provide an overview of the overall situation and it should be followed by specific recommendations. This section can include a sub-heading for each of the core programs-ECCD, BE, SHN and AD. The overall situation under each core program should focus on the strengths and the areas for improvement/gaps to be filled. Under SHN, information can be presented under the six broad topics identified for collecting data.

Annex 2: Example of a Results Framework that Integrates SHN and BE

Please note that this is an example from a country office; it is not a "model" integrated results framework.



Annex 3: SHN Indicator Reference Sheet

SHN programs should select indicators from this SHN indicator reference sheet based on what is most relevant for the program. Given that one of SHN's fundamental contributions is to improve education outcomes, it is recommended that at least two education indicators be selected. In addition, appropriate indicators should be selected for each level of health and nutrition result. Please note the indicators are a sub-set of Save the Children's Global Education Indicators.

Table 1: *Education indicators*[1]

Result	Indicator name	Definition		Means of verification			Notes
		Description	Calculation	Source	Tool	Frequency	
Goal	**Cognitive ability**	Cognitive ability is a direct impact measure of SHN interventions and is important to measure. Please consult with your STWG TA provider for assistance on the appropriate methodology to use.					
Goal	**Children's learning outcomes**	Children's mastery of literacy at the basic education/ primary level.	(# of BE students in a representative sample of schools/sites supported by sponsorship that achieve mastery on a reliable criterion-referenced test of literacy in the language of instruction) X 100 divided by (# of BE students in a representative sample schools/sites supported by sponsorship that take a reliable criterion-referenced test of literacy in the language of instruction)	Assessment with sample of schools and children.	Save the Children assessment tool (to be determined)	Annual, at the end of school year	Work with the sponsorship Basic Education team to obtain this data. Please note that it is necessary for the BE team to obtain technical assistance to measure this indicator. *The latest indicator guidance issued from the EGI should be followed (the information here is current as of November 2010).*
Goal	**Student attendance rate**	The ratio of students present in school on a given number of days during the year (determined by head counts) to the number of children enrolled, disaggregated by sex.	(Total number of girls or boys observed in the classroom on given day) X 100 divided by (Total number of girls or boys enrolled in program on that day)	Spot check/head count of children in each class during an unannounced visit. If attendance records at the school match precisely the observed head count for one year, attendance records can be used for two of the three spot checks each year.	Spot check form	Three times a year (indicator is the average of these three spot checks), spaced throughout the year	Work with the sponsorship Basic Education team to obtain this data. Spot checks should be conducted via program staff visits or special data collection forms administered on a pre-selected number of specific days that take into account weekends, holidays, and seasonal and other factors affecting regular attendance. Reported number is average of three surprise spot checks on non-consecutive days throughout the year (note denominator may change as children transfer in or out), i.e. (% day 1 + % day 2 + % day 3)/ 3. If percentages vary by factors greater than 2, verify that there are no exceptional circumstances, e.g. disease epidemic or festival. The spot-check days should be distributed throughout the year. Days for count visits must be random, and advance warning to school authorities should not be given. You may be able to use a sample of schools for the spot check: consult with your STWG TA provider.

[1] Where there are similarities between the Education Global Initiative (EGI) and these sponsorship Common Approach indicators, the information in this table will be adjusted to ensure harmonization of the two monitoring and evaluation systems. *This information is current as of November 2010.*

Result	Indicator name	Definition		Means of verification			Notes
		Description	Calculation	Source	Tool	Frequency	
Goal	**Children reaching grade five**	Proportion of children enrolled in the first grade of primary school who reach grade 5 (disaggregated by sex).	(Total number of students enrolled in grade five of primary school) x 100 divided by (Total number of children who entered first grade with this group of children)	School Records and/or MoE records: current year and data from four years ago.	School profile form	Annual (use enrollment numbers from the beginning of each year)	Work with the sponsorship Basic Education team to obtain this data. For non-formal programs, count the % of children who complete the entire cycle of non-formal education that is provided by the project.
Goal	**Promotion rate** **Drop out rate** **Repetition rate**	For these indicators, please use the definition used by the national education system of your country. Be sure to document this definition in your RIPT/M&E plan. In addition, these indicators are most valuable when disaggregated (see notes).		School records	School profile form	Baseline, mid-term and endline	Work with the sponsorship Basic Education team to obtain this data. At a minimum, indicators should be disaggregated by grade. If possible, they should also be disaggregated according to other relevant demographic information such as sex, linguistic minorities, ethnic minorities etc. The data for each of these indicators should be collected and documented by school (vs. a whole district).
Goal	**Prevalence of anemia**	WHO defines anemia as follows: 5-11y: 115g hemoglobin/l 12-14y: 120 g hemoglobin/l girls 15y+: 120 g hemoglobin/l boys 15y+: 130 g hemoglobin/l (WHO, 2001) It is recommended to have a comparison group when evaluating SHN on anemia prevalence, because anemia prevalence tends to rise and fall seasonally, due to factors unrelated to Save the Children programming. A comparison group controls for these other factors and evaluates the impact of SHN only.	(Number of children who have anemia) x 100, divided by (Total number of children tested)	Survey ***Seek technical assistance***	Hemoglobin analysis using Blood Hemoglobin Photometer (Hemocue)	Baseline, (mid-term) and endline	

Table 2: *Health and nutrition indicators*

Result	Indicator name	Definition		Means of verification			Notes
		Description	Calculation	Source	Tool	Frequency	
Goal	**Prevalence of intestinal parasites and/or urinary schistosomiasis**	Infection by intestinal parasitic worms (geohelminths) is widespread throughout the world and affects millions of people, especially children. Three of the most common kinds of worms that infect children are roundworm (Ascaris lumbricoides), whipworm (Trichuris trichiura) and hookworm (Ancylostoma duodenale and Necator americanus). There are two types of schistosomiasis, the urinary type, caused by Schistosoma haematobium and the intestinal type, caused by Schistosoma mansoni. Schistosomes are small parasitic worms (flukes) that live in blood vessels around the bladder (urinary type) or intestine (intestinal type).	(Number of children who have parasites) x 100, divided by (Total number of children tested)	Survey ***Seek technical assistance***	Stool examination and/or Urine Analysis	Baseline, (mid-term) and endline	*The specific types of parasites should be noted and the intensity of infection.
Goal	**Prevalence of stunting (low height for age)**	Stunting (defined as less than two Height for Age Z-score (HAZ) from a reference population of the same age and sex – see EPINUT program for details) is a measure of chronic undernutrition. Although most stunting stems from early childhood undernutrition, anthropometric studies amongst school-age children suggest that children become more stunted, throughout their school years. SHN interventions can prevent children from become more stunted and there is evidence that suggests that it can be reversed.	(Number of children with HAZ <-2) x 100, divided by (Total number of children tested)	Survey ***Seek technical assistance***	Height measure (high quality that measures to the minimeter)	Baseline (mid-term) and endline	
Goal	**Prevalence of health and nutrition problems** (according to context and program focus)	Other indicators of health and nutrition status may be collected, which may vary according to the context (types of problems present in particular area) and the program focus. For example, if promotion of iodized salt is an important element of the program, prevalence of goitre or urinary iodine may be collected.	(Number of children with health problem) x 100, divided by (Total number of children tested)	Survey ***Seek technical assistance***	Will vary by health problem	Baseline (mid-term) and endline	
SO	**Percent of children dewormed or/and supplemented with micronutrients**	Efficacy of treatment increases when all children in the impact area regardless of their enrollment status are treated. For out-of-school children, the denominator should be all school-age children in the impact area. Intestinal parasites are treated with a single dose of either mebandazole or albendazole and schistosomiasis is treated with an individualized dose of praziquantel. Vitamin A and iron supplementation are often needed and in areas where iodized salt is unavailable supplementation of iodine is necessary.	(Number of children dewormed or supplemented with micronutrients) x 100, divided by (Total number of children enrolled in program schools)	Program records	SHN monitoring form	Annually	*Note the specific anti-parasitic medication or micronutrient used when reporting this result.

Result	Indicator name	Definition		Means of verification			Notes
		Description	Calculation	Source	Tool	Frequency	
SO	**Percent of school children reporting a specific behavior or observed practicing a specific behavior**	The behaviors that are measured should be addressed in the interventions (e.g. through the school health curriculum or other school-based health promotion activities). Specify the behavior(s).	(Number of children reporting a specific behavior OR observed practicing a specific behavior) x 100, divided by (Total number of children surveyed or observed)	Survey	SHN KAP questionnaire and/or observation sheet*	Baseline and endline; use qualitative tools to check progress	*All tools should be adapted to the local context and project needs and pre-tested.
IR1	**Percent of schools doing mass deworming and/or micronutrient supplementation**	Choose appropriate indicators to match project's interventions. Note the specific micronutrients or/and anti-parasitic available when reporting this result. If out-of-school children are targeted for the program service, the denominator should be all school-age children in the impact area or can be counted as a process indicator only.	(Number of schools doing mass deworming and/or micronutrient supplementation) x 100, divided by (Total number of schools within target area)	Program records	SHN monitoring form	Annually	
IR1	**Percent of schools doing vision and hearing screening treatment and/or malaria treatment kits and/or psycho-social counselling and/or other SHN related services**	Choose appropriate indicator to match project's interventions and specify the intervention.	(Number of schools providing vision and hearing screening or counselling or other SHN services) x 100, divided by (Total number of schools within target area)	Program records	SHN monitoring form	Annually	
IR2	**Percent of schools with access to potable water**	Quality of school environment is improved with increased access to water in schools.	(Number of schools with access to potable water) x 100, divided by (Total number of schools within target area)	Program records/school enrollment	SHN monitoring form	Annually	
IR 2	**Percent of schools with functioning latrines* and/or with hand-washing facilities**	Quality of school environment is improved with increased access to functioning latrines. Presence of hand-washing facilities with soap near the latrines is ideal. Note the importance of soap when assessing hand-washing facilities.	(Number of schools with a functioning latrine with hand-washing facilities) x 100, divided by (Total number of schools within target area)	Program Records/school enrollment	SHN monitoring form	Annually	* Specify what your CO considers "functioning" and use this to assess school latrines. Note these criteria when reporting your results.
IR3	**Percent of teachers trained to teach SHN curriculum using participatory methods (including child-to-child)**	Training may be conducted by SHN program directly or via partner organizations/government so the quality of training is key to the usefulness of this indicator. This is a process indicator that will lead to results indicator but it is a key indicator that can be monitored annually.	(Number of teachers trained) x 100, divided by (Total number of teachers in program schools)	Program records/school enrollment	SHN monitoring form	Annually	

Result	Indicator name	Definition		Means of verification			Notes
		Description	Calculation	Source	Tool	Frequency	
IR3	**Percent of children who know certain facts about health, hygiene, nutrition and /or HIV/AIDS prevention and have positive attitudes towards specific behaviors**	The knowledge and attitudes that are measured should be addressed directly in the interventions (e.g. through the school health curriculum or other school based health promotion activities). Specify the facts that should be known.	(Number of children who know certain facts) x 100, divided by (Number of children interviewed)	KAP survey	SHN KAP questionnaire*	Baseline and endline. Use qualitative tools to check progress.	*All tools should be adapted to the local context and project needs and pre-tested.
IR4	**Percent of schools with functioning SHN Committees**	Identify the criteria you will use to determine whether or not a Committee is "functioning" (i.e. number of times it meets, degree of involvement, etc.) before conducting the assessment. Its links to school management committees should be part of the definition of "functioning." Note these criteria when reporting your results.	(Number of schools in target area with functioning SHN Committees) x 100, divided by (Total number of schools in target area)	School management committee records	SHN forms	Baseline & annually	
IR4	**Change in policy environment related to SHN**	Examples of these types of supportive policy initiatives include governmental task-forces, regional/governmental initiatives, public-education campaigns, etc. For example, the establishment of food safety standards at schools.	During your situational analysis or baseline study, a 'baseline' should be established regarding the policy environment for SHN in the target area. Each year monitor the policy environment and record any changes that have taken place.	Information about resources may be found in government/ education departments, other NGO reports, local initiatives and/or universities	SHN forms	Baseline & annually	

Annex 4: Key Strategies Matrix

Please note: The majority of the strategies in the matrix below are tried and tested, and have become standard practice. Others still require some operational research and development. Please make note of this when assessing the applicability of these strategies to your program.

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Intermediate Result 1: Increased availability of school-based health, hygiene, and nutrition services			
Schistosomiasis (Bilharzia) – Mass treatment of school-age children (SAC) with praziquantel (dosage determined by height)	**When:** When there is a prevalence of parasites in the school-age population. Treatment frequency depends on prevalence (see below). **How often:** **1.** If schistosomiasis prevalence >=50% by parasitology (or >=30% by questionnaire for visible hematuria), treat all school-age children (enrolled/non-enrolled) once a year. **2.** If prevalence >=10% but <50% by parasitology (or <30% by questionnaire for visible hematuria), treat all school-age children (enrolled/non-enrolled) every 2 years. **3.** If prevalence <10% by parasitology, treat all school-age children (enrolled/non-enrolled) twice during primary schooling (e.g. once on entry and exit).	Costs between 20-71¢ per child including delivery costs. Less than 2¢ per actual treatment. Training and supervision costs are minimal for this mass treatment approach when dose poles are used.	• **Rationale:** 200 million people globally are infected with schistosomiasis; 120 million people suffer with symptoms (e.g. abdominal pain and swelling, diarrhea, blood in stools/urine). Most live in poor communities with poor WASH facilities and close to infested water bodies that harbor susceptible snails. Hygiene and play habits make children vulnerable to infection. In many areas mostly school-age children are infected, thus causing anemia, stunting and a reduced ability to learn. Regular treatment is safe, easy and cheap, and improves children's health and nutrition, in turn leading to increased enrollment, attendance, reduced class repetition, and increased educational attainment. Including treatment for soil-transmitted helminths, school-based deworming addresses more than half of all Neglected Tropical Diseases that are a priority concern for USAID and other major donors. • **Situational Analysis (SITAN) & baseline:** Maps of prevalence where available should be used for a rapid appraisal/SITAN. Refer to www.thiswormyworld.org for predictive prevalence maps. This should be followed by prevalence surveys that require technical assistance from laboratory technicians and others. • **Implementation: 1.** Drug procurement and distribution system needs to be coordinated with available, on-going systems for the intervention to be sustainable. **2.** Treatment needs to be linked to effective behavior change communications for prevention (see hygiene and other practices) to improve sustainability. **3.** Treatment-seeking behavior needs to be promoted especially when prevalence is too low for mass treatment. **4.** Dosage (depends on weight) can be determined using a dosage pole. **5.** Intervention needs to be linked to effective behavior change communications program for prevention of intestinal parasitic infection. **6.** Signed parental consent may be needed in some countries prior to the intervention. **References:** See List of Resources, Annex 5: 10 to 16 under Access to SHN.
Soil Transmitted Helminthiasis (intestinal worms) – Mass treatment of SAC with Albendazole (400mg) or Mebendazole (500mg).	**When to implement:** When there is a prevalence of parasites in the school-age population. Treatment frequency depends on prevalence (see below). **How often:** **1.** Twice a year, if prevalence rate > 50%. **2.** Once a year if prevalence is >20% and <50%. **3.** Mass treatment can be done when prevalence is lower if funding is available.	Costs 3-20¢ per year including delivery costs. Less than 2¢ per actual treatment. Training and supervision costs minimal for this mass treatment approach.	• **Rationale:** More than 807 million people are infected with roundworm, 604 million with whipworm, and 600 million with hookworm. Children are most heavily burdened. Symptoms include diarrhoea, abdominal pain, general malaise and weakness that affect working and learning capacities, nutrition (causing anemia) and physical growth. Controlling intestinal worms will help prevent 200 million years of lost primary schooling. Regular deworming is safe, easy and cheap and improves children's health and nutrition and in turn leads to increased enrollment and attendance, reduced class repetition, and increased educational attainment. Including treatment for soil-transmitted helminths, school-based deworming addresses more than half of all Neglected Tropical Diseases that are a priority concern for USAID and other major donors. • **SITAN & baseline:** Same as under SITAN & baseline for Schistosomiasis. • **Implementation:** Same as points 1, 2, 3, 5 and 6 under implementation for Schistosomiasis. Children under 12 months should not be treated. **References:** See List of Resources, Annex 5: 10 to 16 under Access to SHN

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Vitamin A deficiency – School-based mass distribution of vitamin A capsules.	**When:** When there are high-risk individuals (malnourished children, those with infectious diseases such as measles, those living close to children with clinical vitamin A deficiency, refugees without regular food sources, famine affected) and supplementation is feasible and cost-effective. **How often:** Every 6 months. Some governments have a strategy of every 4 months.	Costs 4¢/child including delivery. Less than 2¢ per actual treatment. Training and supervision costs minimal.	• **Rationale:** More than 125 million young children and 85 million school age children (or 7 percent of all school-age children) suffer from vitamin A deficiency. Long term vitamin A deficiency negatively impacts on growth, impairs learning ability, and those who have VAD are at risk of blindness, malnutrition (anemia), infections (e.g. parasitic worms, malaria) and death. Vitamin A capsules are inexpensive and can be given a week after deworming. • **SITAN & Baseline:** Measuring vitamin A status is problematic; currently no reliable, quick, and easy field methods. • **Implementation: 1.** Need to ensure that adolescent girls who might get pregnant do not receive supplementation. **2.** Vitamin A supplies for higher priority groups (under 5 year olds) should not be compromised. **3.** Needs to be linked to effective communication strategies focused on the nutritive importance of vitamin A to the body and dietary practices to prevent vitamin A deficiency. **References:** See List of Resources, Annex 5: 17-18 under Access to SHN.
Iodine deficiency – Schools as a mechanism for promoting and monitoring the use of iodized salt.	**When:** Anytime and anywhere-universal salt iodization has been endorsed by many governments. **How often:** Periodic.	Salt testing kits available from UNICEF or household testing method can also be used. Promotional materials. Training of teachers and students.	• **Rationale:** It is estimated that 37% of the school-age population of 285 million have insufficient iodine intake (median UI <100 _g/l). Iodine deficiency is the world's most prevalent yet preventable cause of brain damage. Iodine deficiency disorders (IDD), can start before birth, and often jeopardize children's mental health and survival. Of far greater significance is IDD's less visible, yet pervasive, mental impairment that reduces intellectual capacity. • **Implementation: 1.** Potentially an under-utilized opportunity for promoting consumption of iodized salt. **2.** Must include the promotional element and be linked to behavior change strategies if it is to contribute to alleviating the problem. **3.** Supply issues may require advocacy at different levels before promotion of consumption of iodized salt can be effective. **4.** May also include the promotion of consumption of iodine-rich foods which are locally available. **References:** See List of Resources, Annex 5: 19 under Access to SHN.
Iodine deficiency – School-based mass treatment with iodized oil capsules targeted at high risk groups where iodized salt is not available.	**When:** If populations live in severely endemic area without access to iodized salt; or median UI concentrations in SAC < 20 g/l. **How often:** Every 6-12 months depending on the severity of deficiency.	30-40¢ per child including delivery. Iodine capsules are more expensive than other micronutrients treatments. Training and supervision costs minimal.	• **Rationale:** Same as above. • **SITAN & baseline:** Measuring iodine status in field conditions is problematic. Total goiter rate is not accurate and inappropriate to measure program impact. • **Implementation: 1.** Should be second priority to promotion of iodized salt. **2.** Less attention given to the need for distribution of iodized oil with the advent of efforts to fortify salt with iodine. **3.** Need for continued promotion in areas of high risk not covered yet by salt fortification. **4.** Should not diminish supplies of iodized oil for higher priority groups. **5.** Salt testing of iodine can be part of class activity or part of peer education sessions.
Iodine deficiency anemia – School-based mass treatment of iron on a weekly or twice weekly basis to alleviate anemia. 400mg Ferrous Sulphate weekly or 200 mg twice weekly.	**When:** When the anemia is a severe public health problem, i.e. prevalence is above 40% (WHO); and when populations are at high risk of iron deficiency. **How often:** Once or twice a week for 10-15 weeks during high risk season. Number of weeks depends on funding and number of weeks in school term, as well as seasonal nutritional needs. Usually one or two periods per school year.	Low cost. Training and supervision costs more substantial to ensure compliance	• **Rationale:** Iron deficiency is the most common nutritional deficiency in the world – 2 billion people are anemic, many due to low iron. The major health consequences in children are impaired physical and cognitive development, and increased morbidity from infectious diseases. Weekly iron supplementation has been found to increase hemoglobin concentration in blood, reduce anemia and reinfections with worms. • **Implementation: 1.** Time from teaching must be evaluated and minimized in light of the length of treatment. **2.** Iron procurement and delivery system must be linked to available systems if programs are to be sustained. **3.** Needs to be linked to effective behavior change strategies that prevent iron deficiency through diet strategies. **4.** Should be linked to interventions that address other causes of iron deficiency-vitamin A supplementation, deworming, prevention of malaria, and avoidance of tea during iron-rich food intake, consumption of a source of vitamin C for iron absorption. **References:** See List of Resources, Annex 5: 20 and 21 under Access to SHN.

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Vision and hearing impairment – School-based screening for vision and hearing and classroom management.	**When:** For vision, before the age when a high prevalence of refractive errors are seen. For hearing, at school entry especially in areas with high chronic otitis media prevalence where follow up ear, nose throat (ENT) services are available. **How often:** Once per year.	Low to negligible cost for tools and teacher training. High costs for provision of glasses and hearing aids, making this impossible in most contexts.	• **Rationale:** *Vision* – Uncorrected refractive error is a leading cause of visual impairment of children worldwide. Reduced vision can impair the ability of a child to participate in class and to join in sports activities, affecting academic performance and impeding personal development. Vision screening is used widely in schools; however no randomized studies have taken place to evaluate the effectiveness of screening programs. *Hearing* – Chronic suppurative otitis media (CSOM) is a major cause of acquired hearing impairment in children, especially in developing countries. If resources are available for referring children with hearing impairment for treatment and hearing amplification, then the WHO recommends hearing screening programs among school children in areas of high CSOM prevalence. Screening helps avoid the unwanted impact on school and social performance of prolonged, unrelieved hearing loss. • **Implementation: 1.** Ensure that children who test positive for vision or hearing problems are not discriminated against or neglected by school teachers. **2.** Ensure that classroom management measures (e.g. move children to the front of class) are taken in the absence of other corrective actions. **3.** Ensure clear parent communication to follow-up on children with identified needs. **4.** Link with referral services that include the provision of eye glasses, medical or surgical treatment for ear infections and hearing aids. **5.** School clinic teacher should be trained and know where to refer if cases are serious.
Illnesses and injuries – School-based first aid service.	**When:** Routinely in schools, and especially during important events such as sports day. **How often:** As needed.	Recurrent costs to refill the first aid kit. Cost can be low to medium depending on the contents of the kit. Moderate cost for training in first aid.	• **Rationale:** Many health problems that children encounter at school, such as minor injuries, headache, fever or diarrhea, can be treated at school with a first aid kit. The child will receive immediate treatment at school to avoid walking long distances to a health center and missing school, or to be left untreated. It is also a way to identify more serious health problems, which should be referred to a health professional. However, research into the cost and sustainability of first aid is required. • **Implementation: 1.** SHN staff should organize first aid training for primary school head teachers and a class teacher. **2.** The program should provide a first aid kit to each school in order to initiate first aid activities. **3.** Teachers should inform the students about the availability of first aid at the school premises and the location of the first aid station. **4.** The school management committee should be responsible for raising funds for replenishing the first aid kit and for refilling supplies.
Trachoma – School-based trachoma treatment using antibiotic. One Azithromycin (oral) tablet or 1% tetracycline ointment (eye application) applied twice daily for 6 weeks.	**When:** When trachoma is known to be endemic in a district. **How often:** Depends on baseline prevalence of trachomatous inflammation-follicular (TF) in 1-9 yr olds. If >=10%, annually for 3 years; if >=5% but < 10% only facial cleanliness and environmental improvement needed; if < 5% no intervention.	Medium costs – Azithromycin is relatively expensive compared to tetracycline ointment. Comprehensive baseline survey costs are expensive; but a Trachoma Rapid Assessment is fast and cheap.	• **Rationale:** An estimated 6 million people are blind from Trachoma. The majority of Trachoma infections occur in children from ages 1-9 years. Repeated infections lead to scarring of the conjunctiva (eyelid), causing the eyelashes to turn inward and abrade the cornea. • **Implementation: 1.** Baseline and implementation should be planned at district level **2.** Intervention should be linked to the other strategies for trachoma control, namely surgery, facial cleanliness, and environmental improvement and effective health education should be provided to that effect. **3.** Teachers should be trained in health education for trachoma; and trachoma education should be part of the curriculum. **4.** Teachers should also be trained on providing Azithromycin; where tetracycline is used, significant teacher input is required for compliance. • **Note:** Please note that Save the Children does **not** have much experience in this; we need to work with others such as International Trachoma Initiative. **References:** See List of Resources, Annex 5: 9 under Access to SHN.

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Malaria – 1. School-based intermittent preventive treatment (IPT) of malaria using antimalarials (e.g. Fansidar, Artemisinin-based Combination Therapy- ACT), depending on the malarial parasite (e.g. Plasmodium falciparum, P. malariae, P. vivax, P. ovale), the country where infection was acquired, and potential resistance to a drug. For more information please consult your national MoH for the recommended treatment protocol. 2. Promotion of long-lasting insecticide treated bed-nets (LLINs).	**When:** In malaria endemic areas. **How often:** IPT- on a periodic basis (once or twice a year). LLINs – continuous.	Training of teachers and supply of malaria treatment. As part of the Cover the Bed Net Gap initiative WHO, UNICEF and partners recommend that LLINs should be distributed freely or be highly subsidized and used by all community members, including schoolchildren. www.malariaprogress.org Initial cost of LLINs is US$4-6.	• **Rationale:** Malaria accounts for 50% (or 214,000) of all deaths among African school-age children per year. 20% to 50% of African school children living in areas of stable high transmission experience clinical attacks annually, causing 4-10 million days of school-absenteeism per year. Due to anemia and neurological consequences of cerebral malaria, cognition, learning and educational achievement are all affected. Only two studies (in Kenya & Mali) have evaluated the impact of IPT among schoolchildren. Both studies found reduced rates of anemia and malaria. Though the WHO advises on promoting the use of LLINs among school-age children, there are few empirical examples of its impact. Thus, both these strategies need operational research. • **Implementation: 1.** Drug and net procurement and distribution need to be coordinated with ongoing systems. **2.** Parent commitment necessary if the program is to be sustained. **3.** IPT must include parasitological diagnosis before treatment, and the drug used must depend on national protocol. Diagnosis and treatment by teachers must be supervised by local health staff. **4.** Intervention needs to be linked to effective behavior change program for prevention of malaria infection, recognition of symptoms, and seeking of treatment. **5.** Policies on malaria control need to be closely monitored to inform the program. • **Note:** These are new interventions that need to be tested and Save the Children is leading the way. • Drugs for malaria treatment change and Save the Children should keep abreast of changing protocol for treatment in each country. For more information on the latest recommendation for malaria control through schools, please contact your SHN TA provider. **References:** See List of Resources, Annex 5: 1 and 8 under Access to SHN.
Sexual/reproductive health and HIV – School-based access to sexual/reproductive health and HIV counseling and psychosocial support.	**When:** During adolescence. **How often:** Continuous.	Heavy training of teachers, some counseling material.	• **Rationale:** There are an estimated 1.2 billion adolescents (1 in 5 people) in the world, with a majority (83%) in low-income countries. Adolescence is a period of great physical and psychological change. This is when sexual habits and decisions about risk and protection are formed. Some of the problems that adolescents are faced with that could affect their education include early pregnancy, unsafe abortions, sexually transmitted infections including HIV, and gender-based violence. • **Implementation: 1.** Trust of children, and parents for using counseling. **2.** Gender of the teacher/counselor will impact utilization. **3.** Time requirements may necessitate additional personnel. **4.** Need referral system for abuse and other problems identified during sessions. **5.** Should be linked to health education to encourage the formation of healthy sexual attitudes and practices. **6.** Teacher should be trained in counseling to ensure proper conduct and effectiveness. **References:** See List of Resources, Annex 5: 22-24 under Access to SHN.

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Intermediate Result 2: Improved quality of the school environment			
Unsafe water – In-school potable water provision, such as through tube wells; or water treatment, using chlorine; or water filters (ceramic and biosand), solar disinfection, flocculation-disinfection products.	**When:** At all times. **How often:** Continuous.	Low, depending on the technique for purification of existing water; high for new water sources (bore-holes, pumps). Moderate costs depending on the design.	• **Rationale:** 1.1 billion people globally, do not have access to improved water sources. Diseases due to inadequate water cause a huge burden in low-income countries. Children's ability to learn is affected in many ways. Roundworm infections affect children's physical and cognitive development; long-term exposure to lead and arsenic impairs learning; diarrhoeal diseases force children to be absent from school. Research evidence shows that WASH in schools improves children's health, boosts school attendance and achievement and promotes gender equity. • **Implementation: 1.** Requires mobilization and organization of the community to supply labor and on-going maintenance. **2.** Technologies for purification vary greatly. **3.** When a new water source is required, it means that the water is needed by everyone, not just school-age children. A method for sharing the water in the community is required. **4.** Should be implemented alongside hygiene and sanitation interventions. **5.** Water storage facilities are needed in areas where dry spells or drought is experienced. **6.** Water analysis will be required to ensure potability. **References:** See List of Resources, Annex 5: 1-11 under Quality of School Environment.
Poor hygiene – In-school hand-washing facilities with soap or ash. Options include: • A pitcher and basin • A small tank with a tap on a stand, filled using a bucket, with a basin to collect waste water • A tippy-tap made from a hollow gourd or plastic bottle	**When:** At all times. **How often:** Once, with ongoing maintenance.	Low to moderate, depending on type of facility. Ongoing provision of soap or ash.	• **Rationale:** 60% of the population (2.4 billion people) in low-income countries live in highly unsanitary conditions and have poor hygienic behaviors that increase their risk to infectious diseases. Children are particularly prone to worm infections and other diarrhoeal diseases which result in significant absenteeism from school. Research shows that hygiene and sanitation promotion in schools improves children's health, boosts school attendance and improves gender equity. • **Implementation: 1.** Technologies for hand-washing facilities vary greatly. They can be very cheap and simple or more sophisticated and expensive. Children may be involved in designing facilities. **2.** Needs to be linked to effective behavior change communications to promote use of water and soap, not just water. **3.** It is difficult to practice behavior modeled in schools when households do not have necessary environment, therefore, must work with communities to encourage household installation of hygiene facilities. **4.** Needs to be linked to provision of soap or other abrasive/cleansing materials for effectiveness of hand-washing. **5.** Should be emphasized in relation to common illnesses and also on emerging diseases (e.g., SARS, bird flu, H1N1). **6.** Facility needs to be located appropriately to act as visual cue and encourage use (i.e. near entrance to latrines). **References:** See List of Resources, Annex 5: 1-11 under Quality of School Environment.
Poor sanitation – In-school latrine construction. Options include: • basic pit latrine • pour flush latrines • eco-latrines and • ventilated improved pit (VIP) latrine (recommended over basic pit latrine)	**When:** Once with ongoing maintenance.	Moderate to high cost depending on the design.	• **Rationale:** same as above. • **Implementation: 1.** Requires mobilization and organization of the community to supply labor and ongoing maintenance. **2.** Needs to be linked to effective behavior change communications to promote use and care of these facilities. **3.** It is difficult to practice behavior modeled in schools when households do not have necessary environment, therefore, must work with communities to encourage household installation of sanitation facilities. **4.** May be a critical intervention to ensure enrollment and attendance of adolescent girls. **5.** Designs must be child-friendly. **6.** Latrines should conform to the policies and standards of the Education and Health Departments even if only at a minimum. **7.** Needs to be located appropriately to encourage use and to ensure child safety. **References:** See List of Resources, Annex 5: 1-11 under Quality of School Environment.
Poor waste management – Solid waste and environment management to prevent diseases such as dengue.	**When:** At all times. **How often:** On-going basis, e.g. weekly.	Low to moderate.	• **Rationale:** With proper waste disposal, the disease burden of vectors like dengue, which is highly prevalent in urban areas, is reduced. Also incidence of injuries in schools is reduced. Children are also able to learn more effectively in a clean environment. In the process, children also learn and practice life long healthy behaviors and promote a clean environment at home. • **Implementation:** The following points should be ensured: **1.** Classrooms and other teaching areas are regularly cleaned, to minimize dust and molds. **2.** All areas are free of sharp objects and other physical hazards.**3.** Solid waste from classrooms, kitchens and offices is collected daily and is disposed of safely. **4.** Wastewater is disposed of quickly and safely. **References:** See List of Resources, Annex 5: 1-11 under Quality of School Environment.

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Intermediate Result 3: Improved knowledge, attitudes and interest towards using health services and health-protective behaviors			
Poor knowledge, attitudes, skills and practices in relation to health and nutrition - Health education using in-class and peer-to-peer methods to address: • Inappropriate dietary practices that contribute to malnutrition • Unhealthy practices leading to intestinal and other parasitic diseases • High-risk behaviors among youth, e.g. unsafe and early initiation of sex, drug and alcohol use, etc. • Prevention of HIV/AIDS • Prevention of traffic and home accidents • Prevention of smoking • Oral health practices	**When:** Throughout school life. **How often:** Continuous.	High to medium initial cost for developing an appropriate behavior change strategy; for materials development or adaptation. Requires training and support to teachers and health workers. Requires awareness building of personnel and parents for their support for this activity.	• **Rationale:** Research has shown that effective health education helps students increase their health knowledge and improve their health skills and behaviors. Students who actively participate in an effective health education program engage in fewer of the risky behaviors targeted by the program. • **Implementation: 1.** Effective programs and materials demand a process that identifies ideal behaviors, current behaviors and opportunities, feasible behaviors, major barriers, and major motivations for practicing behaviors. **2.** A significant commitment both in financial and human resource terms must be made to implement the process. It requires time and a significant number of activities with the community and beneficiaries. If the process is short-changed, the communication program is unlikely to be effective. The cost is reduced drastically once the materials have been developed/adapted and the initial set of trainers and teachers have been trained. **3.** Effective health education programs that bring about long-term changes in behavior are critical to the sustainability of the benefits of other SHN interventions. **4.** Health education should focus on skills development. Broadly these include communication skills, decision making skills and coping skills in relation to a health issue. **5.** Health education should be curriculum-based and be led by an adult. It should use participatory teaching methods such as class discussions, demonstrations, role-play, story telling, debates and audio visual activities. Other approaches to health education include extra curricular activities using a peer-to-peer or child-to-child approach. **6.** Will need to have a focal person for SHN (e.g. School clinic teacher who will also be trained on health and nutrition messages. This teacher will also supervise the children.). **References:** See List of Resources, Annex 5: 1-6 under Knowledge, Attitudes and Interest.
Sexual reproductive health and HIV concerns • Parent-child communication guide.	**When:** Early adolescence to discuss various sexual, reproductive health and HIV related concerns. **How often:** Continuous.	Low costs for training for lead parents/ PTA/ school management committee members.	• **Rationale:** This is an innovative strategy which was adopted by the SHN program in Malawi based on research which showed that children trust their parents most for advice and support on sexual health but it usually comes too late or is given in a disciplinary way. A communication guide is a tool for parents to discuss sexual health and HIV with their children before they become sexually active. • **Implementation: 1.** Requires cascading of training and responsibility. **2.** Proper counseling and support of parents are essential to ensure the guides are used effectively. **3.** Geared towards community and not really school-based so not all children will benefit; only children of parents who take interest will benefit. **4.** A model guide is the "Cool Parent Guide" developed by the Malawi CO (see List of Resources, Annex 5). **References:** See List of Resources, Annex 5: 7 under Knowledge, Attitudes and Interest.

Health Concern – Key Strategy	When and How Often to Implement	Costs	Rationale/Issues/Comments
Intermediate Result 4: Improved policy environment for SHN and community support for SHN			
Lack of safe school policies – advocacy for development of national and local school policies or modification of existing policies.	**When:** When there is a lack of a safe school policy or the existing policy is inadequate. **How often:** Continuous till there is a policy change.	Medium costs for advocacy materials development, and cost of a research study done to inform policy recommendations. May also require significant staff time for follow up.	• **Rationale:** Policies provide an essential overarching structure for SHN programs. They add purpose, coherence, credibility and commitment to all SHN activities undertaken to improve student health and educational outcomes. Policies may help address issues such as: a) School commitment to equity, non-discrimination and human rights. b) Child protection from harassment or abuse on school grounds. c) Continued education of pregnant and parenting teens. d) A clear structure to a safe, protective, and inclusive school environment. e) Health-related practices of teachers and students; for example, not smoking in school. f) Ensuring health services are regularly provided. • **Implementation: 1.** To help develop a national SHN policy: a) The SHN program should present to decision makers key recommendations based on evidence from its SHN situation analysis, M&E and operational research activities. b) The SHN program manager should participate during policy development and review workshops in order to voice and address the concerns of communities. **2.** Once the national SHN policy and the strategic plan is developed, Save the Children should support the district level to disseminate and implement the program at both the district and school levels. **3.** Requires communities that are fully engaged and children are full participants, not just recipients of this activity. **4.** Policies developed with community and child participation should ensure security and safety in and around schools (e.g., no smoking; nutrition-promoting school canteens and cafeterias). **References:** See List of Resources, Annex 5: 1-4 under Community Support and Policy.
Capacity building for schools (e.g. training of teachers, parent-teacher associations or creation of groups for SHN such as a sub-committee on SHN in the School management committee).	**When:** Before the initiation of any SHN activities. **How often:** Periodically.	Low to medium – training needed for lead parents/ PTA/School management committee members.	• **Rationale:** Research shows that teachers require training to most effectively implement participatory learning experiences aimed at building skills for health, including HIV prevention. • **Implementation: 1.** Capacity building is generally required at a range of levels – community, local, district and national – for effective, sustained support of SHN. **2.** Based on a training needs assessment, a capacity building tree should be developed to describe how stakeholders at each level will be oriented and trained on the program. **References:** See List of Resources, Annex 5: 1-4 under Community Support and Policy.

Annex 5: List of Resources

General SHN Resources

1. Bundy, D.A.P., et al., Eds. (2006). *School-Based Health and Nutrition Programs. Disease Control Priorities in Developing Countries* (2nd Edition). New York: Oxford University Press. Download the chapter on SHN that appropriately summarizes need and issues from: http://files.dcp2.org/pdf/DCP/DCP58.pdf.
2. Government of Nepal, (2006), *National School Health and Nutrition Strategy, Nepal.*
3. Hall, Andrew et al. (2002). *A situation analysis of school health and nutrition in Ethiopia.* Save the Children USA. This situation analysis, carried out by SHN experts for Save the Children's program in Ethiopia, can be used as a model situation analysis.
4. Jukes, M C H., et al (2008). *School Health, Nutrition and Education for All: Levelling the Playing Field.* Home Grown School Feeding. Download from: http://www.hgsf-global.org/en/policy.
5. Partnership for Child Development (1999). *School Health & Nutrition: A Situation Analysis. A Participatory Approach to Building Programmes that Promote health, Nutrition and Learning in Schools.* Download from: http://www.schoolsandhealth.org/Documents/A%20Situation%20Analysis%20%20A%20Participatory%20Approach%20to%20Building%20Programmes1999.pdf.
6. Partnership for Child Development (2002). *School-age Children: Their Nutrition and Health.* Download from: http://www.schoolsandhealth.org/Documents/School-Age%20Children%20%20Their%20Nutrition%20and%20Health.pdf.
7. Save the Children (2008). *Monitoring School Health and Nutrition Programs: Guidelines for program managers.* Download from: http://savenet2.savechildren.org.
8. Save the Children (2010). *School Health and Nutrition Manual: A guide for program planning and implementation in Bangladesh.* Download from: http://www.schoolsandhealth.org/Documents/Bangladesh%20SHN%20Operational%20Manual%20final.pdf.
9. Save the Children (2010). *School Health and Nutrition Manual: A guide on how to implement programs in Malawi.* Download from: http://www.schoolsandhealth.org/Documents/Malawi%20SHN%20Operartional%20Manual%20final.pdf.
10. Save the Children (in draft). *School Health and Nutrition KAP Model Questionnaire.* Download from: https://savenet2.savechildren.org/op/ip/ps/Lists/PSDocuments/DispForm.aspx?ID=27.
11. Schools & Health, Download from: www.schoolsandhealth.org. The organization is run by the World Bank and Partnership for Child Development. General information on School Heath and Nutrition and Focusing Resources on Effective School Health (FRESH), updates on meetings and SHN programs by country. Links to other useful websites and a list of all publications on SHN related topics.
12. World Bank (2003). *School Health at a Glance.* World Bank-produced information sheets on school health; available in English, French, Portuguese and Russian. Download the English version from: http://siteresources.worldbank.org/INTPHAAG/Resources/AAGSchoolHealth.pdf. Download the full series and other languages from: http://www.worldbank.org/hnp.

Resources on Access to SHN

1. Brooker, S. (2009). *Malaria Control in Schools: A toolkit on effective education sector responses to malaria in Africa.* Download from: http://www.schoolsandhealth.org/Documents/Malaria%20Toolkit%20for%20Schools%202009.pdf.
2. Bundy, D.A.P. & Del Rosso, J.M. (1993). *Making nutrition improvements at low cost through parasite control.* Human Resources Development and Operations Policy World Bank Working Paper.
3. Global Network. Retrieve from www.globalnetwork.org. Contains many useful resources and background on neglected tropical disease control.
4. The International Council for the Control of Iodine Deficiency Disorders. Retrieve from www.iccidd.org. Provides basic information on Iodine Deficiency and statistics by country; a contact e-mail for questions regarding iodine deficiency is also included.
5. OVCsupport.net: A global hub on children and HIV. A collection of information and tools on supporting OVC living in a world with HIV/AIDS. Retrieve at www.ovcsupport.net.
6. Save the Children Afghanistan (2004). *Eating Good Food: Nutrition education activities for use with children.*

7. Save the Children (October 2006). *Position Paper on School-Feeding.* Download from: https://savenet2.savechildren.org/op/ip/ipl/pr2/Lists/PR2Documents/DispForm.aspx?ID=75&Source=https%3A%2F%2Fsavenet2%2Esavechildren%2Eorg%2Fop%2Fip%2Fipl%2Fpr2%2FLists%2FPR2Documents%2FAllItems%2Easpx. This document outlines the pros and cons of school feeding programs and Save the Children US and Save the Children UK's position regarding this controversial topic.

8. WHO (2010). Guidelines for the Treatment of Malaria. Second Edition. WHO. Download from: http://whqlibdoc.who.int/publications/2010/9789241547925_eng.pdf

9. World Bank (2009). *Rethinking School Feeding: Social Safety Nets, Child Development and the Education Sector.* A joint publication of the World Food Program and the World Bank Group providing a new analysis of school feeding programs. It explores how food procurement can help local economies, and emphasizes the centrality of the education sector in the policy dialogue on school feeding. Download from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099080042112/DID_School_Feeding.pdf.

10. International Trachoma Initiative. Retrieve from www.trachoma.org. The site includes basic information on trachoma and regular updates on related issues.

11. World Health Organization (2006). *Trachoma Control: A Guide for Program Managers.* Download from http://whqlibdoc.who.int/publications/2006/9241546905_eng.pdf.
Also visit http://www.who.int/blindness/causes/trachoma_documents/en/index.html.

12. World Health Organization (2006). *A Guide: Trachoma Prevention through School Health Curriculum.* Download from http://www.who.int/blindness/CHF%20GUIDE%20FINAL%20EN.pdf.

13. World Health Organization, Neglected Tropical Diseases. Retrieve from http://www.who.int/neglected_diseases/preventive_chemotherapy/databank/en/. This weblink presents two tools about the progress on implementation of preventive chemotherapy for NTD control globally. The first is a web-based interactive databank presenting historical data on treatment coverage for lymphatic filariasis, soil-transmitted helminthiasis, and schistosomiasis. The second is a country profile which provides background on the NTD and the strategy that is in place in the country.

14. World Health Organization (2006). *Preventive Chemotherapy in Human Helminthiasis.* Download from http://whqlibdoc.who.int/publications/2006/9241547103_eng.pdf. This document includes the latest WHO recommendations on dosage and duration of chemotherapy.

15. Global Atlas of Helminth Infections. Retrieve from www.thiswormyworld.org. This website contains links to predictive maps on the prevalence of worms in a country, which is based on existing survey data, and maps that include the treatment strategy for that country.

16. Global NGO Deworming Inventory. Retrieve from http://www.dewerminginventory.org/. This website provides information on the progress on implementation of preventive chemotherapy for NTD control by NGOs globally. This inventory complements the WHO Preventive Chemotherapy (PCT) databank which collects treatment data from governmental health agencies.

17. World Health Organization: Partners for Parasite Control. Retrieve from http://www.who.int/wormcontrol/documents/new/en/. *See How to Deworm School-age Children: Instructions for Teachers and Helminth Control in School-age Children: A guide for managers of control programs.*

18. WHO (January 2004). *Action Against Worms.* Partnership for Parasite Control (Issue 1). Download from: http://www.who.int/wormcontrol/newsletter/en/PPC4%20Newsletter.pdf. A step by step guide on how to set-up a deworming program.

19. World Bank (2003). *Deworming at a Glance.* Download from: http://siteresources.worldbank.org/INTPHAAG/Resources/AAGDewormingEng110603.pdf. World Bank-produced information sheets on deworming; available in English, French and Portuguese.

20. World Health Organization (2004). *How to add deworming to vitamin A distribution.* Download from: http://whqlibdoc.who.int/hq/2004/WHO_CDS_CPE_PVC_2004.11.pdf.

21. World Health Organization (1997). *Vitamin A supplements: A guide to their use in the treatment and prevention of vitamin A deficiency and xeropthalmia.* Download from: http://www.who.int/nutrition/publications/micronutrients/vitamin_a_deficieny/9241545062/en/index.html

22. World Health Organization (1995). *Vitamin A deficiency and its consequences. A field guide to detection and control.* Download from: http://www.who.int/nutrition/publications/micronutrients/vitamin_a_deficieny/en/.

23. World Health Organization (1994). I*odine and Health. Eliminating iodine deficiency disorders safely through salt iodization.* Download from: http://www.who.int/nutrition/publications/micronutrients/iodine_deficiency/WHO_NUT_94.4/en/index.html.

24. World Health Organization (2001) Iron Deficiency Anemia. Assessment, Prevention and Control. A guide for program managers. Download from: http://www.who.int/nutrition/publications/en/ida_assessment_prevention_control.pdf.

25. World Health Organization (2009). Weekly iron-folic acid supplementation (WIFS) in women of reproductive age: its role in promoting optimal maternal and child health. Download from: http://www.searo.who.int/LinkFiles/Nutrition_for_Health_and_Development_WHO_weekly_iron_folic_acid.pdf.

26. World Health Organization (2008). *Promoting adolescent sexual and reproductive health through schools in low income countries: an information brief.* Download from: http://www.who.int/child_adolescent_health/documents/who_fch_cah_adh_09_03/en/index.html.

27. World Health Organization (2002). Adolescent Friendly Health Services. Download from: http://www.who.int/child_adolescent_health/documents/fch_cah_02_14/en/.

28. World Health Organization (2001). Counseling skills training in adolescent sexuality and reproductive health. A facilitator's guide. Download from: http://whqlibdoc.who.int/hq/1993/who_adh_93.3.pdf.

Resources on Quality of School Environment: Water & Sanitation

1. Care, Dubai Cares, Emory University Center for Global Safe Water, IRC International Water and Sanitation Centre, Save the Children, UNICEF, Water Advocates, WaterAid, Water For People, WHO (2010). *Raising Clean Hands. Advancing Learning, Health and Participation through WASH in School*, retrieve at. http://www.washinschools.com. A joint advocacy brief calling for WASH in schools, with key action points. Visit for more information on Raising Clean Hands and links to IEC packs and other important WASH documents.

2. Conant, Jeff. (2005). *Sanitation and Cleanliness for a Healthy Environment.* Hesperian Foundation, New York.

3. Conant, Jeff. (2005). *Water for Life: Community Water Security.* Hesperian Foundation, New York.

4. Curtis, V. (1998). *Hygienic, healthy and happy: A manual for setting up hygiene promotion programmes.* UNICEF, New York.

5. International Water and Sanitation Centre, retrieve from www.irc.nl. Up to date news. Thematic Overview Papers combine recent experiences, expert opinions and foreseeable trends with links to the most informative information.

6. Zomerplaag J and Mooijman A (2004). *Child-Friendly Hygiene and Sanitation in Schools.* Available on the 'Strengthening SHN Programs' CD-Rom (PCD, 2005).

7. UNICEF, United for Children. Retrieve from www.unicef.org/wes/index_documents.html. A selection of technical, policy and advocacy documents produced by UNICEF on water, sanitation, hygiene and the environment. See *Towards Better Programming: A manual on school sanitation and hygiene.*

8. World Health Organization (2009). *Water, Sanitation and Hygiene Standards for Schools in Low-cost Settings.* This document provides the latest guidance on standards for WASH in schools in low-income countries.

9. World Bank, Water and Sanitation Program and UNICEF (2005). *Toolkit on Hygiene Sanitation and Water in Schools.* A CD-Rom. Download the summary booklet from: http://www.wsp.org/publications/TOOLKIT.pdf. CD can be requested from Whelpdesk@worldbank.org. Soon to be available in French.

10. UNESCO, Focusing Resources on Effective School Health (FRESH). Retrieve from www.unesco.org/education/fresh. UNESCO tools on water and sanitation in schools including:

    - *Water and Sanitation: A Checklist for the Environment and Supplies in Schools.* Strategies to ensure schools have adequate water, sanitation and hygiene facilities.
    - *Guidelines for the Provision of Safe Water and Sanitation Facilities in Schools.* Optimal and minimal acceptable standards for schools.
    - *Simple Technology for Filtering and Disinfecting Water at School.*
    - *Selecting an Appropriate Technology for Water Supply Projects.*

Resources for Knowledge, Attitudes and Interest: Health Education including HIV/AIDS Prevention

1. AIDSmark. Retrieve from www.aidsmark.org/intervention/bcc.html. Collection of HIV/AIDS materials for building effective Behavior Change Communications (BCC) programs.
2. Child-to-Child Trust. Retrieve from www.child-to-child.org. An educational process that links children's learning with action to promote health, wellbeing, and development.
3. International Bureau of Education. Retrieve from www.ibe.unesco.org/HIVAids.html. The website includes: Databank of HIV/AIDS and education documents by country; curriculum manual with tools for HIV/AIDS education and teacher training.
4. Safe Passages to Adulthood. Retrieve from www.safepassages.soton.ac.uk. A number of guides to good practice and research tools on sexual health for young people.
5. UNICEF: Life Skills. Retrieve from http://www.unicef.org/lifeskills/index.html. Background information on life skills education with links to resources on health and HIV prevention education.
6. World Health Organization (2004). *WHO Information Series on School Health: Teacher's Exercise Book for HIV Prevention.*
7. Save the Children (2008). *The Cool Parent Guide: Preventing HIV/AIDS in young children. Successes and lessons learned from Mangochi District, Malawi.* Download from: http://www.schoolsandhealth.org/Documents/The_Cool_Parent_Guide_Preventing_HIV_AIDS_in_Young_Children%20-%20Lessons_learned_from_Malawi.pdf.

Resources for Community Support and Policy

1. Howard-Grabman, L. and Snetro, G. (2004). *How To Mobilize Communities For Health and Social Change, A Field Guide.* Health Communication Partnership. Examples of community mobilization experiences in developing countries. Download from: http://www.hcpartnership.org/Publications/Field_Guides/Mobilize/pdf/
2. UNESCO: FRESH. Retrieve from www.unesco.org/education/fresh. UNESCO tools to download on every element of SHN including the following on school policy: *School Health Policy Development: Basic First Steps* (2004); *Basic Guidelines for the Development of School Policies, Governing Nutrition Interventions* (2004).
3. World Health Organization: Information Series on School Health. Retrieve from www.who.int/school_youth_health/resources/information_series/en/. The World Health Organization has developed an information series on different aspects of SHN, including the following WHO and UNESCO tools: *Creating an Environment for Emotional and Social Wellbeing, (2003); Steps to Becoming an Inclusive Learning-Friendly Environment (2004); Evaluating the Psycho-social Environment of Your School* (2004).
4. Save the Children (2003). *Partnership Defined Quality Manual*. Guidebook to the PDQ approach. Retrieve from: http://savenet2.savechildren.org.