Monitoring and Evaluation Guidance for School Health

Part 1

Eight Core Indicators to Support FRESH

Draft for Review

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Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
AIR	American Institutes for Research
EFA	Education for All
FRESH	Focusing Resources on Effective School Health
HIV	Human immunodeficiency virus
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and evaluation
PCD	The Partnership for Child Development
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WFP	United Nations World Food Programme
WHO	World Health Organization

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Introduction

Ensuring that children are healthy so that they can learn and are able to acquire healthy behaviors is essential for an effective education system.

At the World Education Forum in Dakar in 2000, international agencies agreed on a common framework for school health – FRESH (Focusing Resources on Effective School Health). FRESH supports efficient, realistic and results-oriented implementation of school health programs to make schools healthier for children to learn and where children learn to be healthy. These programs help ensure that children enroll and stay in schools, learn more while in school and develop skills, knowledge and healthy behaviors that protect themselves and their future children from disease. School health programs contribute to the Education for All (EFA) goals to improve the quality of education and learning outcomes, while also indirectly contributing to the major health and development goals by promoting healthy behaviors amongst schoolchildren and the broader community in which they live.

Over the years, a growing number of governments and international agencies have begun implementing school health. A survey of 36 countries in sub-Saharan Africa in 2000 and then in 2007 showed an increase in implementation of school health programming meeting a minimum criteria of equity and effectiveness from 8 to 44 per cent. It also showed that school health programs are becoming more comprehensive and thus, more reflective of the FRESH framework[1]. Despite the huge growth in the implementation of FRESH at country- and project-level, no internationally agreed guidance on how to monitor and evaluate school health programs exist. While many guidelines focus on particular school health issues, no guideline as yet has recommended indicators to assess progress in implementing FRESH or pooled all school health-related indicators into one document for the purposes of comprehensive monitoring and evaluation (M&E) of school health.

This document is based on the internationally agreed FRESH framework and draws on a wide range of school health-related M&E guidance from all health fields. It was developed between 2008 and 2012 by FRESH partners (the FRESH M&E Coordinating Group and thematic experts, overseen by a broader FRESH M&E Advisory Board) representing 12 international agencies. Three meetings of FRESH partners were held during this period to review progress and next steps: the first hosted by the World Health Organization (WHO) in September 2008, the second hosted by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in November 2010, and the third hosted by The Partnership for Child Development (PCD) in October 2011.

This document is Part 1 of the broader FRESH M&E guidance to support governments and organizations in monitoring and evaluating school health programs. The eight Core Indicators presented in this Guidance document focus on national-level efforts to implement comprehensive school heath programs as defined in the international FRESH framework. Eight data collection tools are available separately to support the collection and compilation of these eight Core Indicators (see Annex A).

Part 2 of the FRESH M&E guidance (available separately) is focused on program-level M&E of school health. It contains a menu of around 150 thematic indicators, largely drawn from existing M&E guidance or developed by thematic expert groups, covering 15 school health topics for researchers and program staff to choose from.

[1] PCD (2007). *Directory of Support to School-Based Health and Nutrition Programs. London, PCD.*

The FRESH Framework

The FRESH framework, an intersectoral partnership for Focusing Resources on Effective School Health, was launched at the World Education Forum in Dakar in 2000. It highlights the importance of school health for the achievement of the education Millennium Development Goals and provides the context for developing effective school health programs. FRESH recommends the four following components (program pillars) to be addressed in all schools:

1. Equitable school health policies[2].
2. Safe learning environment[3].
3. Skills-based health education.
4. School-based health and nutrition services.

Equitable School Health Policies

National- and local (school)-level school health policies are necessary to promote effective school health programming:

- ***At school-level:*** School health-related policies set priorities, objectives, standards and rules to protect and promote the health and safety of students and staff. School health policies should address physical safety issues such as ensuring that the school has adequate water and sanitation facilities as well as a safe environment to protect students and staff from abuse, sexual harassment, discrimination, and bullying. School health policies should respond to local priorities and needs of all, including marginalized children. For example, where teenage pregnancy is common, a school health policy may focus on the inclusion of pregnant school girls and young mothers; and where road traffic accidents are a particular danger, a school health policy may prioritize the protection of children from the road. Policies regarding the health-related practices of teachers and students can reinforce health education: teachers can act as positive role models for their students, for example, by not smoking in school. The process of developing and agreeing upon policies draws attention to these issues.
- ***At national-level:*** School-level health policies are most effective when supported by a national-level policy framework that articulates expectations for schools across the country. For example, the national school health policy may recommend that all schools have safe and separate water and sanitation facilities for girls and boys, that all children are dewormed at least once a year, and that child health clubs are set up in every school to improve child participation in school health. Both national- and school-level policies are best developed by involving as many stakeholders as possible, for example, involving teachers, students, health care providers and the community.

Safe Learning Environment

The school environment refers to both the physical and psychosocial environment, or aspects of the school or learning space that affects both the physical and psychosocial well-being of students.

- ***The physical environment:*** the school should be a place where students are free from danger, disease, physical harm or injury; where sufficient water and sanitation facilities are provided and where physical structures (buildings, courtyards, paths and latrines) are sound, welcoming and secure. The school environment can potentially damage the health and development of students, particularly if it increases their exposure to hazards such as infectious diseases carried by an unsafe water supply, lack of hand washing facilities or unsanitary latrines. Clean water and adequate sanitation facilities also help reinforce the health and hygiene education in school allowing students to practice what they learn. They also make the school more welcoming and can increase school attendance and retention, especially amongst girls who require the privacy of single sex toilets (particularly during their menses).
- ***The psychosocial environment:*** the school should be a place where all students are free from fear, exploitation, and where codes against misconduct exist and are enforced. When students do not feel safe inside or on their way to school because they are subject to violence, abuse or neglect, the consequences for children, staff, the school and the wider community are many: vandalism against school and community property increase, abusive behavior toward school staff escalates, conflict among peer groups heightens and, in general, children are unable to learn, less likely to attend and more likely to eventually drop out of school. Preventing and stopping all forms of aggression (physical, sexual and verbal) is a first step to making children feel safe in school. Having clear rules and procedures for responding to aggressive acts and ensuring that students, staff and parents are aware of and enforce these rules and procedures are essential.

[2] Originally referred to as 'health-related school policies'. The word 'equitable' was included to ensure that health-related school policies address issues of all children, including disadvantaged minorities.

[3] Originally referred to as 'safe water and sanitation'. This was broadened to a 'safe learning environment' to include psychosocial aspects of the learning environment and other physical safety issues besides water and sanitation.

Skills-Based Health Education

Skills-based health education uses participatory exercises to assist students to acquire knowledge and develop the attitudes and skills required to adopt healthy behaviors. The skills developed can include cognitive skills such as problem solving, creative and critical thinking, and decision-making; personal skills such as self-awareness, anger management and emotional coping; and interpersonal skills such as communication, cooperation and negotiation skills. For example, skills-based health education can clarify students perceptions of risk and vulnerability, which can help them avoid situations of increased risk of becoming infected with HIV, malaria or other diseases, increase their understanding of the importance of washing hands after going to the latrine or before eating, or realize their own role in the use of resources and their impact on the environment. Skills-based health education thus, has the potential to empower individuals to protect and improve their own and others' health, safety and well-being, which can in turn lead to better health and educational outcomes for children and their communities now and in the future.

School-Based Health and Nutrition Services

Many common health problems which students face in school can be managed effectively, simply, and inexpensively through school-based health and nutrition services. Treatment services such as deworming and micronutrient supplementation are simple, easy, safe and cheap to administer by teachers and can immediately improve children's health and nutritional status and consequently their ability to concentrate and learn in school. School-based counseling services can help identify and support children and young people during difficult times and prevent school absenteeism and dropout. A strong referral system with health service providers, child protection services and community support groups are also essential to ensure that children with a more serious health problem which cannot be dealt with at school are referred to the appropriate services. While the school system is rarely universal, coverage is often superior to health systems, and it has an extensive skilled workforce with daily contact with children and the community. It is therefore, in a unique position to address common health problems which are preventing children from attending and participating in schools in a prompt and cost-effective manner.

Cross-Cutting Themes

1. *Effective partnership between health and education sectors:* The health sector retains the responsibility for the health of children while the education sector retains responsibility for implementing and often funding school-based interventions. However, both of these sectors need to identify their responsibilities and present a coordinated action to improve the health and education outcomes of children. The starting point is usually the establishment of cross-sectoral working groups or steering committees at national-, district- and local-level to coordinate actions and decision-making.

2. *Community participation and ownership:* This is achieved through effective community mobilization strategies and strong partnerships between relevant stakeholders, which engender a sense of collaboration, commitment and communal ownership and build public awareness and strengthen demand. The community includes the private sector; women's, men's, and youth groups; school management committees; parent-teacher associations; local health care providers; village and religious leaders; and any community group interested in and committed to improving the lives and futures of children in the community. These partnerships work together to make schools healthier and more child-friendly by jointly identifying health issues that need to be addressed through the school and then designing and managing activities to address such issues. Effective partnerships between the school system and community have the power to improve the effectiveness, relevance and sustainability of the school health program.

3. *Child participation:* The right to participate is one of the guiding principles of the Conventions of the Rights of the Child. Article 12 of the Convention states that children have the right to participate in decision-making processes that may be relevant in their lives and to influence decisions taken in their regard – within the family, the school or the community. Child participation means that children have the opportunity to express a view, influence decision-making and achieve change. It must be integral to every activity, from planning to implementing to evaluating activities at school-, district- and national-level and a way of working to be practiced by all stakeholders (teachers, health care providers, parents and community members). It must therefore, be addressed in every training and orientation. When children participate in activities, they also acquire the knowledge, and develop the attitudes, values and skills needed to adopt healthy lifestyles and become more active citizens. Child health clubs and governments, child suggestion boxes and active teaching methods are some ways of ensuring that children's views and concerns are considered.

FRESH Core Indicators

The main purpose of the FRESH Core Indicators is to assess and monitor national-level progress in implementing a comprehensive school health program, specifically the four FRESH pillars recommended in the internationally agreed FRESH framework. They attempt to answer the following question:

To what extent are the four FRESH pillars of school health implemented in your country?

Collecting the FRESH Core Indicators will allow countries to identify the strengths and weaknesses of their school health programming and to use the information to strengthen policy and implementation and monitor progress towards meeting the FRESH framework 'standards' over time.

There are eight Core Indicators, two per FRESH pillar. For each pillar, there is a national-level Core Indicator and a school-level Core Indicator:

- *National-Level Core Indicators* assess the existence and quality of national-level documentation to support the implementation of that FRESH pillar, e.g. water and sanitation standards to guide WASH (water, sanitation and hygiene) improvements or the health education curriculum to support skills-based health education. This indicator is collected through a desk review of relevant documents (national policies, strategies, standards, and curriculums, etc.).
- *School-Level Core Indicators* assess the level to which elements of the pillar is implemented in schools: To what extent do schools have a safe school environment? What proportion of schools implement regular skills-based health education? These indicators are collected through a survey in a sample of schools representative of all schools in the country (pre-school, primary and secondary; private and public; different geographical areas; and ethnic groups).

Eight checklists have been developed to support the collection of the eight Core Indicators along with data collection guidance. These are available separately and will be pilot tested in 2013 (see Annex A).

Part 2 of the FRESH M&E guidance focuses on program-level M&E. It includes around 150 ***thematic school health indicators***, drawn largely from existing M&E guidance and organized by health topic (or thematic area) to support the selection of program specific indicators. Each thematic indicator page includes a short introduction to the health topic with a rationale for addressing this health issue in schools, recommended strategies and interventions and a list of references for more information. A list of M&E indicators relating specifically to each health issue is then provided. These are drawn either from existing documents or were developed by thematic expert groups. The health themes covered are:

WASH	**Immunization**
Worms	**Violence in Schools**
Food and Nutrition	**Injury Prevention and Response**
Physical Activity	**HIV and AIDS**
Malaria	**Sexual and Reproductive Health**
Oral Health	**Substance Use**
Eye Health	**Disaster Risk Reduction and Sustainable Development**
Hearing	

The FRESH Core Indicator data collection tools and guidance and part 2 of the FRESH M&E guidance will be available online at the UNESCO HIV and Health Education website and through FRESH M&E Coordinating Group members, listed in the Acknowledgments section of this document.

FRESH Core Indicators: Summary

FRESH Pillars	Level	CORE INDICATORS	Definition
A. EQUITABLE SCHOOL HEALTH POLICIES	NATIONAL	1. Existence, quality and dissemination of a comprehensive national-level school health policy.	Using **FRESH checklist 1**, this indicator is measured by reviewing national policies and strategies, situation analyses and other relevant documents to determine: • If a national-level school health policy exists and has been disseminated. • The extent to which the policy addresses priority health problems of all population groups. • The extent to which the policy addresses all aspects of each of the four FRESH pillars.
	SCHOOL	2. Percentage of schools that have comprehensive health-related school policies.	Using **FRESH checklist 2**, this indicator is assessed through a survey in a representative sample of schools to determine: • The extent to which health-related policies exist in schools, along with procedures to monitor and enforce the policies. • The extent to which health-related policies that exist in schools address priority health concerns (both national- and community-level). • The extent to which health-related policies that exist in schools address the other three FRESH pillars. • The extent to which students, parents and community leaders are aware of, and contribute to the policy.
B. SAFE LEARNING ENVIRONMENT	NATIONAL	3. Existence of national school safety standards addressing both the physical and psychosocial school environment.	Using **FRESH checklist 3**, this indicator is measured by reviewing national policies, strategies and standards for schools to determine: • Whether national standards exist to guide and assess the physical school environment. • Whether national standards exist to guide and assess the psychosocial school environment. • The quality of the above standards.
	SCHOOL	4. Percentage of schools that meet the national school safety standards.	Using **FRESH checklist 4**, this indicator is assessed through a survey in a representative sample of schools to determine: • The extent to which schools meet the safe learning environment standards (physical and psychosocial). • The extent to which the school leadership and staff are aware of and enforce the national standards for a safe learning environment (physical and psychosocial). • Student, parent and community perceptions of the school providing a safe learning environment (physical and psychosocial).
C. SKILLS-BASED HEALTH EDUCATION	NATIONAL	5. Priority health content and skills-based pedagogy are present in national guidance for school curricula, teacher training and learning assessments.	Using **FRESH checklist 5**, this indicator is measured by analyzing the content of the school curricula, teacher training manuals, student materials, and school examination guidelines to determine: • The extent to which priority health information is accurately and (age-) appropriately expressed in the school curricula and student materials. • The extent to which curricula for school health includes specific skills-based pedagogical components. • The existence and quality of teacher training and guidance to support participative, skills-based health education in schools. • The existence and quality of skills-based assessment rubrics and priority health content questions in national school leaving examinations.
	SCHOOL	6. Percentage of schools that provide regular skills-based health education sessions, as recommended in the national guidance.	Using **FRESH checklist 6**, this indicator is assessed through a survey in a representative sample of schools to determine: • The extent to which health generally and specific health topics (as per national guidance) are taught across school grades. • The extent to which teachers have received the appropriate training and have access to necessary tools to help them teach the health topics using appropriate teaching approaches. • The extent to which teachers are using participative, skills-based teaching approaches to teach health in schools.
D. SCHOOL-BASED HEALTH AND NUTRITION SERVICES	NATIONAL	7. A minimum package of school-based health and nutrition services has been defined at national-level based on local health priorities and cost-effectiveness.	Using **FRESH checklist 7**, this indicator is measured by reviewing national policies and strategies to determine: • Whether a package of school-based health and nutrition services has been defined and recommended at national-level. • The extent to which the recommended package of school-based health and nutrition services is based on national and regional health priorities and needs. • The extent to which the recommended package of school-based health and nutrition services is cost-effective.
	SCHOOL	8. Percentage of schools where the minimum package of school-based health and nutrition services (as defined at program-/national-level) is provided.	Using **FRESH checklist 8**, this indicator is assessed through a survey in a representative sample of schools to determine: • The extent to which the minimum recommended package of school-based health and nutrition services and each element within the package are provided in schools. • Capacity within schools to deliver a minimum package of school-based health and nutrition services. • Students, parents, and other community members views on the provision of school-based health and nutrition services.

A. EQUITABLE SCHOOL HEALTH POLICIES

National-Level

Core Indicator 1: Existence, quality and dissemination of a comprehensive national-level school health policy[4].

PURPOSE	To determine: **1) If a national-level school health policy exists and has been disseminated.** • Does a school health-related strategy[5] or policy exist, either as part of a broader health, education or poverty reduction policy or strategy or as a stand-alone document? • Has the school health policy or strategy been disseminated nationally? **2) The extent to which the policy addresses priority health problems of all population groups.** • Has there been a comprehensive situational analysis of the health needs and priorities of school-age children as a whole and has that informed the national school health policy? • Does the national policy on school health reflect the findings and recommendations in the situational analysis? **3) The extent to which the policy addresses all aspects of each of the four FRESH pillars.** • Does the national school health policy recommend local-/school-level adaptation or development of the school health policy? • Does the national school health policy recommend a safe learning environment (physical and psychosocial)? • Does the national school health policy recommend skills-based health education? • Does the national school health policy recommend a package of school-based health and nutrition services?
RATIONALE	A school health policy is defined here in its broadest sense. It refers to any national government endorsed document which outlines the rules and principles for school health programming nationwide. It may be included within a wider education or health policy or strategy, or stand-alone. The purpose of a school health policy is to provide a common goal, strategy and a set of recommended interventions for all schools and implementing partners across the country. Without a guiding policy, school health is less likely to be prioritized by the government, schools, the health system and development partners; programming may be patchy; driven by confounding priorities; not evidence-based and uncoordinated. A weak policy may be even more harmful. It is essential that the policy is based on a rigorous situation analysis and multi-stakeholder consultations to ensure that it addresses the health priorities of all school-age children (girls and boys, minority groups, urban and rural, from pre-school to secondary schools); and that it addresses all aspects of the four FRESH pillars (equitable school health policies, a safe learning environment, skills-based health education, and school-based health and nutrition services). This indicator assesses whether a school health policy exists and the quality of that policy.
DATA COLLECTION METHOD	This indicator is assessed by conducting a review of national policies and strategies (education, health and other relevant documents), situation analyses and relevant meeting reports to assess the three sub-indicators described in the Purpose above (see data collection guidance for more details).
MEASUREMENT TOOLS	The FRESH checklist 1 can be used to review the above documents. The checklist is organized into three sections, each section responding to one of the three sub-indicators listed in the Purpose above and the overall Core Indicator 1. A score for each section and a total is calculated by adding up the responses to the list of questions to show the level to which Core Indicator 1 is addressed.

4 A school health policy is defined here as a set of principles and rules governing school activities and operations for the protection and promotion of children's health and well-being at school.

5 A school health strategy sets out how a specific set of activities is to be implemented within a given time frame.

A. EQUITABLE SCHOOL HEALTH POLICIES

School-Level

Core Indicator 2: Percentage of schools that have comprehensive health-related school policies[6].

PURPOSE	To determine: **1) The extent to which health-related policies exist in schools, along with procedures to monitor and enforce the policies.** • Does the school have written school health-related policies? • Are procedures in place to monitor and enforce the school health-related policy at school-level? **2) The extent to which health-related policies that exist in schools address priority health concerns (both national- and community-level).** **3) The extent to which health-related policies that exist in schools address the other three FRESH pillars.** • To what extent are national health priorities known and reflected in the school health-related policy? • Does the school health-related policy include a section on providing a safe learning environment for students? • Does the school health-related policy include guidance on teaching skills-based health education? • Does the school health-related policy include a section on the provision of school-based health and nutrition services? **4) The extent to which students, parents and community leaders are aware of, and contribute to the policy.**
RATIONALE	Most schools around the world have school policies, defined here as a set of rules and principles that guide school-related activities and operations. School leadership, management committees, staff, parents and students are all expected to agree, abide by and act upon these policies to ensure the school operates effectively and achieves its goal(s). Since children's health and well-being (physical and psychosocial) are an integral part of quality education, health-related policies are necessary to protect and promote children's health and well-being at school. School health-related policies should reflect both the national school health policy (if present) and priorities, and the local health priorities which may differ between schools. For example, a school located near a busy road may include a policy which focuses on protecting schoolchildren from traffic accidents, whereas a remote rural school may focus on addressing short-term hunger as children walk long distances to school. This indicator assesses the extent to which schools have health-related policies, whether these policies address both national and local health priorities and whether they address all aspects of the three other FRESH pillars. The extent to which school health-related policies address local health priorities will depend in part on the level of participation from different stakeholders, particularly children (girls, boys and minority groups) when developing the policy.
DATA COLLECTION METHOD	This indicator is assessed through a survey in a sample of schools representative of all schools in the country (see data collection guidance for more details).
MEASUREMENT TOOLS	The FRESH checklist 2 can be used to collect information on school-level health-related policies. It must be adapted to each context to reflect the national school health policy (if present) and priorities. The tool will inform the four sub-indicators listed in the Purpose above and the overall Core Indicator 2. Checklists for schools will need to be aggregated to generate the overall Core Indicator 2 and sub-indicators. These can then be disaggregated by district, school-level (primary and secondary) and type of school (private and public), and used to identify higher and lower performing schools.

6 A school health-related policy is defined here as a set of principles and rules governing school activities and operations for the protection and promotion of children's health and well-being at school.

B. SAFE LEARNING ENVIRONMENT

National-Level

Core Indicator 3: Existence of national school safety standards[7] addressing both the physical and psychosocial school environment.

PURPOSE	To determine: **1) Whether national standards exist to guide and assess the physical school environment.** • Are there national standards to guide and assess the water and sanitation situation in schools; the safety of school buildings and structures; and child protection from external hazards? **2) Whether national standards exist to guide and assess the psychosocial school environment.** • Are there national rules, procedures and codes of conduct to prevent and address violence in schools and standards for ensuring schools are welcoming? **3) The quality of the above standards.** • Are the standards based on evidence of priority health needs and issues in schools? • Do they reflect the distinct needs of different groups of children? • Are the standards user-friendly and accessible?
RATIONALE	While schools have a huge capacity to improve the health of schoolchildren, they can also be harmful if the school environment is not safe and supportive. A safe school environment should protect and promote both physical and psychosocial well-being. It should be free from violence, abuse, drugs, alcohol, bullying and discrimination; it should be free of dangerous objects, have a safe structure and be secure from neighboring hazards (roads and bars, etc.); and it should provide potable drinking water, safe sanitation facilities for girls and boys with hand washing facilities to prevent the spread of diseases. School safety standards provide: a common understanding of what a safe school environment means; benchmarks for assessing school environment safety; and guidance on how to improve the school environment e.g. how to address issues of violence, discrimination and ensure children are protected or how to construct/improve the water and sanitation facilities. This indicator assesses whether national standards (or guidelines) exist on the safety of the school environment (physical and psychosocial) and the quality of these standards.
DATA COLLECTION METHOD	This indicator can be evaluated by conducting a review of national (or program) policies, strategies and standards (education, health, water and sanitation, and child protection, etc.) for schools to assess the three sub-indicators described in the Purpose above (see data collection guidance for more details).
MEASUREMENT TOOLS	The FRESH checklist 3 can be used to review the above documents. The checklist is organized into two sections, each section responding to one of the three sub-indicators listed in the Purpose above and the overall Core Indicator 3. A score for each section and a total is calculated by adding up the responses to the list of questions showing the level to which Core Indicator 3 is addressed.

7 School safety standards are defined here as the norms for ensuring a safe school environment.

B. SAFE LEARNING ENVIRONMENT

School-Level

Core Indicator 4: Percentage of schools that meet the national school safety standards.

PURPOSE	To determine: **1) The extent to which schools meet the safe learning environment standards (physical and psychosocial).** • Are sufficient numbers of latrines provided and maintained and are they used by/do they meet the needs of girls and boys? • Are there protocols to deal with bullying (by staff and students) and are they well understood and implemented? • Looking at the complete list of minimum standards (physical and psychosocial), how many does the school comply with? **2) The extent to which the school leadership and staff are aware of and enforce the national standards for a safe learning environment (physical and psychosocial).** • Can staff describe the standards for a safe physical and psychosocial learning environment? • Do staff receive training to develop their awareness of the safe physical and psychosocial standards and where relevant, how to implement and/or develop the standards? • Are staff and/or other partners actively supporting, maintaining and enforcing the standards for a safe physical and psychosocial learning environment? **3) Student, parent and community perceptions of the school providing a safe learning environment (physical and psychosocial).**
RATIONALE	While national standards may exist to guide schools and the education system on how to ensure children are safe and protected at school, this does not mean that the standards will be reflected in schools across the country. In many cases, some aspects will be addressed and others not. Schools and the education system's ability to meet the standards depend on a number of factors, including staff and school leadership awareness of the standards, their commitment and capacity to implement the standards, which in turn depends on the education system, community or other partner's support (financial and technical) to help schools meet those standards. Where national standards do not exist, international standards can be used to assess the safety of the school environment and guide schools and the education system more generally on improving the safety of children at school. This indicator assesses the extent to which schools have a safe learning environment, from both a physical and psychosocial perspective.
DATA COLLECTION METHOD	This indicator is assessed through a survey in a sample of schools representative of all schools in the country (see data collection guidance for more details).
MEASUREMENT TOOLS	The FRESH checklist 4 can be used to collect information on the safety of the school environment and inform the three sub-indicators in the Purpose above and the overall Core Indicator 4. It covers both the physical and psychosocial aspects of the school environment and should be adapted to each context to reflect the national standards and program goals. Checklists collected in each surveyed school will need to be aggregated to generate the overall Core Indicator 4 and sub-indicators. These can then be disaggregated by district, school-level (primary and secondary) and type of school (private and public), and used to identify higher and lower performing schools.

C. SKILLS-BASED HEALTH EDUCATION

National-Level

Core Indicator 5: Priority health content and skills-based pedagogy[8] are present in national guidance for school curricula, teacher training and learning assessments.

PURPOSE

To determine:

1) **The extent to which priority health information (based on national health priorities) is accurately and (age-) appropriately expressed in the school curricula and student materials.**
   - Is there a clear 'scope and sequence'[9] that develops the depth and breadth of health topics in the national primary and secondary school curricula?
   - Are the health topics included in the curriculum for primary and secondary schools selected on the basis of national health priorities?
2) **The extent to which curricula for school health includes specific skills-based pedagogical components.**
   - Does the national curricula guidance on school health at primary- and secondary-level feature specific skills-based development and/or the use of child-centered participatory approaches?
3) **The existence and quality of teacher training and guidance to support participative, skills-based health education in schools.**
   - Does the pre-service teacher education curricula/modules include the pedagogy of teaching skills-based health education?
   - Does the in-service teacher education curricula/modules include staff development linked to teaching skills-based health education or improving the quality of skills-based health education in specific topic areas (such as sexual and reproductive health)?
   - Is there a curricula or guidance for the professional development of teacher educators to develop the capacity and motivation of teachers to deliver skills-based health education in schools?
4) **The existence and quality of skills-based assessment rubrics and priority health content questions in national school leaving examinations.**
   - Does the primary leaving examinations feature the key health topics recommended in the curriculum?
   - Do the specific questions asked of students in the external assessments at primary- and secondary-level include questions on health promoting skills and behaviors they might use in their daily lives vs. knowledge?
   - Within the assessment guidance on school health, is there additional guidance on how to recognize and assess student achievement and activity in health promotion within the school and from the school to the home and community?

RATIONALE

The education system is one of the most cost-effective systems through which to bring long-term behavior change in a population. However, its ability to bring about these changes depends on the way health education is delivered in schools: the frequency, relevance and accuracy of the health information provided; the extent to which participative, skills-based teaching approaches are used to teach these topics; and the scope and sequence in which they are delivered (progressively building on previous health lessons). This in turn depends on teachers' capacity and motivation to teach health topics using these methodologies, which requires that:

1. Relevant health topics are prioritized in the national school curricula and examinations, which motivates teachers to teach these health topics.
2. Participative, skills-based teaching approaches focused on health are adequately covered in pre- and in-service teacher trainings.
3. Teachers have the necessary tools (teacher guidance and student materials) to help them teach the recommended health topics using appropriate teaching approaches and assess student achievement in health promotion in the school and community.

[8] For the pedagogy to be skills-based means that by the end of a specific component of learning (such as a lessons or lesson series) students should be able perform certain actions as a result of this learning that they were not able to do prior to their learning.

[9] 'Scope and sequence' means that the topics are set out in a logical sequence and as the students develop, they repeat the topic but, in more depth.

C. SKILLS-BASED HEALTH EDUCATION

National-Level

Core Indicator 5: Priority health content and skills-based pedagogy are present in national guidance for school curricula, teacher training and learning assessments.

<table>
<tr><td>DATA COLLECTION METHOD</td><td>The three points listed in the Rationale can be assessed by conducting a rigorous content analysis of the following documents:
• Primary and secondary school curricula, where subjects and learning objectives are defined by grade.
• Pre- and in-service teacher training manuals and materials.
• Teacher guidance and student materials for subject areas where health topics are included.
• The national school examination guidelines and past school examination papers.
(See data collection guidance for more details).</td></tr>
<tr><td>MEASUREMENT TOOLS</td><td>The FRESH checklist 5 can be used to conduct the content analysis of the above documents. The checklist is organized into five sections, with each section responding to one of the four sub-indicators listed in the Purpose above and the overall Core Indicator 5. The checklist includes a suggested list of health topics which must be adapted to each country context. A score for each section and a total is calculated by adding up the responses to the list of questions showing the level to which Core Indicator 5 is addressed.</td></tr>
</table>

C. SKILLS-BASED HEALTH EDUCATION

School-Level

Core Indicator 6: Percentage of schools that provide regular skills-based health education sessions, as recommended in the national guidance.

<table>
<tr><td>PURPOSE</td><td>To determine:
1) The extent to which health generally and specific health topics (as per national guidance) are taught across school grades.
• How many distinct health lessons[10] does the school teach during the school-term and how many are infused into other lessons (such as math, language, and art, etc.)?
• How many health-related topics are being addressed in non-classroom school time every term?
• Which of the recommended health topics (as per national guidance) are being taught this school year? Are all recommended health topics taught or are some topics left out?
• Was the selection of health topics OR the actual lesson content linked to the topic adapted by the teacher to fit LOCAL conditions and challenges and was it adapted to fit students ideas about the problems and challenges they face?

2) The extent to which teachers have received the appropriate training and have access to necessary tools to help them teach the health topics using appropriate teaching approaches (such as recommended teacher guidance and student materials).
• Which of the recommended textbooks or curriculum guidelines are present and used in schools?
• How many teachers in the schools have received the recommended training to teach skills-based health education?

3) The extent to which teachers are using participative, skills-based teaching approaches to teach health in schools.
• Are teachers focusing on developing students' skills during the health lessons?
• Do teachers write down the skill(s) they wish to develop or strengthen in their students as a result of each health lesson in their lesson plans?
• Do teachers ask the students open questions (i.e. questions you do not know the answers to) and/or give them an activity to do to practice a skill in most of their health lessons?</td></tr>
<tr><td>RATIONALE</td><td>Skills-based health education can influence health behavior by equipping students with the knowledge, attitudes and skills they need to stay safe and healthy. Skills-based health education can clarify students' perceptions of risk and vulnerability to help them avoid situations of increased risk and empower individuals to protect and improve their own and others' health, safety and well-being, which can in turn lead to better educational outcomes. This indicator assesses the extent to which skills-based health education is being provided in schools.</td></tr>
<tr><td>DATA COLLECTION METHOD</td><td>This indicator is assessed through a survey in a sample of schools representative of all schools in the country (see data collection guidance for more details).</td></tr>
<tr><td>MEASUREMENT TOOLS</td><td>The FRESH checklist 6 can be used to assess the three sub-indicators listed in the Purpose above and the overall Core Indicator 6. These will be assessed through discussion with teachers and students in each surveyed school. Checklists from each school will need to be aggregated to generate the overall Core Indicator 6 and sub-indicators. These can then be disaggregated by district, school-level (primary and secondary) and type of school (private and public), and used to identify higher and lower performing schools.</td></tr>
</table>

[10] Please note the distinction between lessons and topics. Several lessons can be used to teach a topic.

D. SCHOOL-BASED HEALTH AND NUTRITION SERVICES

National-Level

Core Indicator 7: A minimum package of school-based health and nutrition services has been defined at national-level based on local health priorities and cost-effectiveness.

PURPOSE	To determine: **1) Whether a package of school-based health and nutrition services has been defined and recommended at national-level (within a national strategy or policy).** **2) The extent to which the recommended package of school-based health and nutrition services is based on national and regional health priorities and needs.** • Is the recommended package of health and nutrition services based on a rigorous assessment of the health and nutrition needs of school-age children across the country? • Does the package address the needs of different groups of children (ethnic minorities, younger children, adolescents, girls, orphans and vulnerable children, etc)? **3) The extent to which the recommended package of school-based health and nutrition services is cost-effective.** • Are they affordable and easy to administer through the education system? Do they address priority health problems that affect a large number of children, and is there evidence to suggest that the interventions will improve children's health and education outcomes?
RATIONALE	The education system provides a highly effective system through which to provide key health and nutrition services to school-age children and address health and nutrition problems which affect their participation and learning in school. Which services should be provided in schools depends on the national and sub-national health and nutrition priorities in this age group, and the relative cost and ease of administration of the services through the education system. There is a large evidence base for a number of school-based health and nutrition services including deworming, iron supplementation and school feeding highlighting their relative cost-effectiveness in different contexts, but less evidence for other equally popular services like school pharmacies or first aid kits, physical screening or school counseling. Defining the package of school-based health and nutrition services relies on a clear understanding of the health and nutrition priorities within each context (national and sub-national), the relative cost of delivering the service through schools and expected benefits for children. A rigorous situation analysis (with a review of survey reports and studies) should help identify the health and nutrition priorities, information gaps and existing experience and evidence in the country. An additional survey may be required however, to confirm prevalence of specific health and nutrition problems in different parts of the country and confirm the service provision protocol.
DATA COLLECTION METHOD	The three sub-indicators in the Purpose above can be evaluated by conducting a review of national (or program) policies, strategies and reports (see data collection guidance for more details).
MEASUREMENT TOOLS	The FRESH checklist 7 can be used to review the above documents. The checklist is organized into four sections, each section responding to one of the three sub-indicators listed in the Purpose above and the overall Core Indicator 7.

D. SCHOOL-BASED HEALTH AND NUTRITION SERVICES

School-Level

Core Indicator 8: Percentage of schools where the minimum package of school-based health and nutrition services (as defined at program-/national-level) is provided.

PURPOSE	To determine: **1) The extent to which the minimum recommended package of school-based health and nutrition services and each element within the package are provided in schools.** • Is the full recommended package of health and nutrition services available at the school? • Which elements of the recommended package of health and nutrition services are available at the school? **2) Capacity within schools to deliver a minimum package of school-based health and nutrition services.** • Have staff been trained to deliver school-based health and nutrition services (delivery including referrals)? • Are staff who are involved in the delivery of school-based health and nutrition services sufficiently supported by the health system? **3) Students, parents, and other community members views on the provision of school-based health and nutrition services.** • Do the school-based health and nutrition services meet the physical health needs of students? • Do the school-based health and nutrition services meet the psychosocial health needs of students?
RATIONALE	This indicator assesses the extent to which the minimum package of school-based health and nutrition services (defined either at national- or program-level) is being provided in schools. The recommended package of school-based health and nutrition services may be determined at national-level (within the national school health policy) or at program-level. In either case, the package of school-based health and nutrition services should address national (and or local) health and nutrition priorities and be cost-effective. The package may include a range of services addressing both physical and psychosocial health problems affecting schoolchildren and their participation and learning in school. Examples of school-based health and nutrition services include mass deworming and micronutrient supplementation as recommended by WHO in areas where prevalence of worms or anemia are high; school meals or snacks to address short-term hunger and improve attendance; school pharmacies or first aid kits; vaccinations (usually boosters); counseling of children and an effective referral system for more serious health problems. The services may be administered by teachers and/or health professionals, but are school-based, rather than health center- or community-based.
DATA COLLECTION METHOD	This indicator is assessed through a survey in a sample of schools representative of all schools in the country (see data collection guidance for more details).
MEASUREMENT TOOLS	The FRESH checklist 8 can be used to collect information on school-based health and nutrition service provision and inform the three sub-indicators listed in the Purpose above and the overall Core Indicator 8. It must be adapted to each context to reflect the recommended minimum package of school-based health and nutrition services (as determined at program- or national-level). Minimum standards for each school-based health and nutrition service should be provided alongside the checklist to clarify what a school should consider 'provision of a health and nutrition service'. Checklists from each school will need to be aggregated to generate the overall Core Indicator 8 and sub-indicators. These can then be disaggregated by district, school-level (primary and secondary) and type of school (private and public), and used to identify higher and lower performing schools.

ANNEX A:
Data Collection Guidance on Using the FRESH Core Indicator Checklists

Eight checklists have been developed to support the collection of the eight Core Indicators along with data collection guidance. Four focus on national-level and four focus on school-level – one for each of the four FRESH pillars. Each checklist has a section at the top summarizing the methodology to administer that specific checklist. Here is an introduction to, and general guidelines on, setting up the surveys and using the checklists.

The checklists are available separately and will be pilot tested in 2013. These checklists can be accessed on the UNESCO HIV and Health Education webpages and from the FRESH M&E Coordinating Group members.

National-Level Checklists

Checklists 1, 3, 5 and 7 are the four national-level checklists. They assess the extent to which a comprehensive school health policy is in place and that systems and standards exist to support the effective implementation of a comprehensive school health program.

Personnel selected to complete the national-level checklists will have a research background or experience with undertaking desk reviews. There is a degree of subjectivity linked to the task and the task is best carried out by a team of two or more people.

School-Level Checklists

Checklists 2, 4, 6 and 8 are the four school-level checklists. They assess the extent to which the four pillars of FRESH are being implemented at school-level. Surveyors may focus on one or more of the checklists.

The school-level checklists include questions for teachers, pupils and, in some cases, their parents and community members to ensure that the views of all stakeholders, particularly the main beneficiaries of the program, children, are considered. Personnel selected to complete the school-level checklists will need to have skills to conduct surveys including focus group discussions. They must also be familiar between the differences in children and adults especially when conducting focus group discussions. It is therefore, best for members of the survey team to have had experience working with children and/or to have the necessary skills to develop a rapport with children.

The four school-level checklists can be administered by:

- A local survey team such as personnel from the education and health ministries.
- An external survey team such as researchers from an academic institution.

For further information, please contact the
FRESH partner organizations through
info-iatt@unesco.org

www.unesco.org/new/health-education