

The FRESH M&E Framework

A Generic Framework for Monitoring and
Evaluation of School Health Interventions

DRAFT

Draft-Version

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Abbreviations and Acronyms

AIR	American Institutes for Research
AIDS	Acquired Immune Deficiency Syndrome
CFSs	Child Friendly Schools
ECD	Early Childhood Development
EMIS	Education Management Information System
FRESH	Focusing Resources on Effective School Health
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team on Education
IRS	Indoor residual spraying
ITN	Insecticide-treated net
LLIN	Long-lasting insecticidal net
MoE	Ministry of Education
MoH	Ministry of Health
NTD	Neglected Tropical Diseases
PCD	Partnership for Child Development
PTA	Parent Teachers Association
SCN	Standing Committee on Nutrition
SEL	Social and Emotional Learning
STI	Sexually Transmitted Infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drugs and Crime
UPC	Universal Primary Completion
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

Purpose of the M&E Framework

The purpose of the FRESH¹ monitoring and evaluation (M&E) framework is to provide guidance to countries or organizations implementing school health programmes in selecting indicators from internationally agreed sources to monitor and evaluate their programmes. By synthesising existing good examples of indicators and M&E guidance in one place, it is intended that the framework will serve as a ready reference for consistent guidance during programming. With its set of recommended indicators, it is intended that the framework will help programmes in low-income countries ensure their implementation is more standardized and evidence-based and will allow easier comparative benchmarking and monitoring across countries. Additionally, it is hoped that the framework will help lead to better coordination between programmes and the priorities they address (e.g. worms and micronutrient supplementation) and ultimately contribute to better health and education outcomes.

The guidance provided in the FRESH M&E framework document is generic – not a rigid blue print – and is intended to support and complement existing local standards and codes, not to modify or substitute for them. Thus where the framework defines standards for indicators (e.g. standards for a safe, sustainable, and accessible water supply for determining percentage of school with such a supply) it is strongly encouraged that the standards are adapted at the local level.

The framework is written for use by governments, NGOs, civil society and international (UN) agencies, education managers and planners implementing school health programs.

Background on the M&E framework

The development of a recommended set of indicators for the generic M&E framework for school health programs began in 2008 with a participative review to assess need for a generic framework and identify good practice and limitations in existing resources. The review findings were presented at a meeting of FRESH partners at WHO, Geneva, in September 2008, who endorsed the need to develop a framework. The process to coordinate its development included the formation of an advisory board, a smaller coordinating group that would liaise with the advisory board and direct the framework development, and thematic groups of experts that would work to develop specific thematic indicators in liaison with the coordinating group. Each thematic area received input from thematic experts/working groups to varying degrees.

In March of 2010, coordinating group members held a workshop to summarise a draft of thematic indicators, which led to the development of FRESH summary indicators for each of the four FRESH pillars. Subsequently, a first draft of the FRESH M&E framework was developed in September 2010 in consultation with coordinating group members and other outside experts. It is envisioned that the current draft of the M&E framework will go through additional iterations and peer review before it is ready for public dissemination.

FRESH and the M&E Framework Components

The FRESH framework calls for an initial set of four core activities (pillars) to be comprehensively implemented in all schools in order to meet the health needs of school-age children. The pillars capture the best practices from programme experiences and should be considered in designing an effective school-based health programmes. The four pillars include:

¹ FRESH or **F**ocusing **R**esources on **E**ffective **S**chool **H**ealth is a common framework of school health programmes which was internationally agreed upon in April 2000 at the World Education Forum in Dakar, Senegal. The FRESH partners include many international organizations including Child-to-Child Trust, EDC, Education International, FAO, IRC, PCD, RBM Partnership, Save the Children, UNAIDS, UNESCO, UNICEF, UNODC, WFP, WHO and the World Bank

- 1) *Policy*: health- and nutrition-related school policies that are non-discriminatory, protective, inclusive, and gender sensitive that promote the nutrition and physical and psychosocial health of staff, teachers and children;
- 2) *School environment*: access to safe water and provision of separate sanitation facilities for girls, boys, and teachers;
- 3) *Skills-Based Health Education*: life skills education, that address identified health, nutrition, and hygiene issues with knowledge, attitudes and skills that promote positive behaviours; and
- 4) *Services*: simple, safe, and familiar health and nutrition services that can be delivered cost-effectively in schools (such as deworming services, micronutrient supplements, and nutrition snacks that counter hunger) and increased access to youth-friendly clinics (World Bank 2000).

The FRESH M&E framework has two main components, summary indicators and thematic indicators.

Summary Indicators

Drawn from the menu of thematic indicators are a limited number of summary indicators, which are organized around the four FRESH pillars and are intended to enable international and programmatic measurement of countries' and programmes' progress towards implementing FRESH. While the below list is still a draft, it is expected these will be further condensed, based on whether they are SMART (see page 8), and can be reported upon even in resource-poor settings. Once finalised they are recommended for all organisations and countries to collect and report. Defining the outcomes and impacts of the summary indicators are currently in the process of revision, but for the time being they include: (1) reduction in morbidity and mortality prevalence, (2) improved capacity to concentrate and learn, (3) improvement in education performance indicators (e.g. attendance, retention and completion rates).

FRESH SUMMARY INDICATORS	
POLICY	
1.	Existence of a national level policy that addresses school health across all four components of FRESH
2.	Extent to which school health policy is implemented across the country
ENVIRONMENT	
3.	Existence of national level physical school environment (inspection) standards
4.	Percentage of schools implementing the physical school standards
5.	Existence of national level psychosocial school environment standards
6.	Percentage of schools implementing the psychosocial school standards
SERVICES	
7.	Percentage of schools that provide health and nutrition services with referral to treatment systems
SKILLS-BASED HEALTH EDUCATION	
8.	Life skills concepts and themes are addressed in the national level curricula for primary and secondary schools
9.	Life skills concepts and themes are explicitly assessed in national level school leaving examinations
10.	Life skills concepts and themes are addressed in the national level pre-service teacher training curricula
11.	Percentage of learners that have received life skills education the last academic year
12.	Percentage of teachers having received in-service training in life skills education the last academic year

- | | |
|-----|---|
| 13. | Percentage of women and men, aged 15 – 49 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (UNGASS #17) |
| 14. | Current school attendance among orphans and non orphans, aged 5 – 17 years (From Revised IATT, reformulation of UNGASS#12) |
| 15. | Percentage of women and men, aged 15 – 20 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (From Revised IATT, UNGASS #17) |

Thematic Indicators

FRESH Thematic Indicators present an extensive menu of school health indicators to monitor activities of interventions addressing different thematic areas. Thematic areas may be diseases (e.g. HIV/AIDS or malaria) or health concerns (e.g. sexual and reproductive health or substance abuse). The menu of thematic indicators addresses distinct health conditions and also groups health concerns together (oral health, vision and hearing). While thematic indicators are part of the M&E framework, once finalised they will not be recommended for collection and reporting by all organisations since they are an extended list of indicators which will need to be adapted and used based on the local thematic concerns.

Thematic indicators are designed to monitor the processes (activities, direct inputs and outputs) related to school health interventions. Higher-level outcomes (expected changes in knowledge, attitude, practice, behavior, health or education status) and impacts on health and education are mentioned but not directly measured, as those are depended on a number of interventions in society and cannot be attributed to a single cause. Indicators for the thematic indicators were developed with different levels of consultation with thematic experts. While some are more final than others, all of the thematic indicators will undergo further development in consultation with thematic experts. The list of thematic areas include: HIV/AIDS; deworming; hygiene, water and sanitation; malaria; nutrition; sustainable development; sexual and reproductive health; physical activity; oral health, vision and hearing; general life skills; substance abuse; disaster risk reduction/emergences violence against children; and first aid and general safety.

Background

Ensuring that children are healthy and able to learn is an essential component of an effective education system. This is especially relevant for efforts aiming to provide education for all in areas of poverty and deprivation where individuals are most in need. Supporting efforts to encourage enrolment, reduce absenteeism and dropout will enable more of the poorest and most disadvantaged children, many of whom are girls, to attend school. It is the children who are least healthy and most malnourished that have the most to gain educationally through school health-related interventions.

The past few decades have seen growth in the evidence for and planning of school-based health programmes globally. Experiences from the 1980s showed that such programs contributed to both health and education outcomes, particularly for girls and the poor. Throughout the 1990s, school health programmes were developed in many countries around the world, and better practices evolved from these experiences. The launch of the Focusing Resources on Effective School Health (FRESH) framework at the April 2000 World Education Forum in Dakar (UNESCO 2000) was a major step forward in international coordination of school-based health programs. Early partners of this consensus included UNESCO, UNICEF, WHO, the World Bank, Education International, EDC and PCD.

Common experiences in school health programming present an opportunity for concerted action by a partnership of agencies to now assist countries to make such school health programmes more effective, through evidence-based monitoring and evaluation.

FRESH Background

The FRESH framework describes three ways in which health relates to education: as an input and condition necessary for learning, as an outcome of effective quality education, and as a sector that must collaborate with education. For the effective implementation of health and nutrition services within school-based health programs, the FRESH framework calls for an initial set of four core activities (pillars) to be comprehensively implemented in all schools in order to meet the health needs of school-age children and to ensure that programmes go to scale. The pillars capture the best practices from programme experiences and should be considered in designing an effective school-based health programmes. The four pillars include the following:

- 1) *Policy*: health- and nutrition-related school policies that are non-discriminatory, protective, inclusive, and gender sensitive that promote the nutrition and physical and psychosocial health of staff, teachers and children;
- 2) *School environment*: access to safe water and provision of separate sanitation facilities for girls, boys, and teachers, and ensuring a safe, healthy, clean and emotionally supportive environment that fosters children's ability to attend school, pay attention and learn.
- 3) *Skills-Based Health Education*: life skills education, that address identified health, nutrition, and hygiene issues with knowledge, attitudes and skills that promote positive behaviours; and
- 4) *Services*: simple, safe, and familiar health and nutrition services that can be delivered cost-effectively in schools (such as deworming services, micronutrient supplements, and nutrition snacks that counter hunger) and increased access to youth-friendly clinics (World Bank 2000).

Strategic partnerships, between the education and health sectors (particularly teachers and health workers) and between schools and the community, are required for successful implementation of school-based health programs (World Bank 2002).

Improving the health and learning of school children through school-based health programmes is not a new concept. Many countries have overarching inter-ministerial school

health committees and policies, standards for learning environments, health, hygiene and nutrition education in formal curricula, and some also provide basic health, hygiene and nutrition through schools. Many development agencies recognize the importance of such comprehensive school health, hygiene and nutrition programmes for learning and development, and have decades of experience of supporting countries to plan and implement these.

INTERAGENCY INITIATIVE

The actions of FRESH also contribute to existing country and development agency initiatives. They are an essential component of child-friendly schooling promoted by UNICEF, the “health promoting schools” and the “nutrition-friendly schools” initiatives of WHO, the “Essential Package” of UNICEF/WFP, well as to global efforts by a number of other development agencies such as UNESCO and the World Bank to make schools effective as well as healthy, hygienic and safe. Overall, the inter-agency action is as Focusing Resources on Effective School Health, and giving a FRESH Start to improving the quality and equity of education.

Development of the M&E framework

Effective monitoring and evaluation (M&E) is essential if comprehensive school health programmes, as outlined by the FRESH framework, are to be scaled up and sustained. Many resources have been developed by organizations to assist the M&E of school health programmes in low-income countries and many more M&E resources exist within each health area (HIV/AIDS with the Inter-Agency Task Team on Education, nutrition, water and sanitation with WASH in Schools) with school aspects. The diversity of M&E resources that exists reflects the fact that school health programmes are contextual and no one size fits all. Over the past two years, however, FRESH partners have been working on a generic M&E framework for school health intervention, which brings together the various sets of M&E guidance into one document. The purpose of such a framework is to provide internationally agreed guidance to countries or organizations implementing school health programmes in selecting indicators to monitor and evaluate their programmes.

The development of a recommended set of indicators for the generic M&E framework for school health programs began in 2008 with a participative review to assess need for a generic framework and identify good practice and limitations in existing resources. The review findings were presented at a meeting of FRESH partners at WHO, Geneva, in September 2008, who endorsed the need to develop a framework. The process to coordinate its development included the formation of an advisory board, a smaller coordinating group that would liaise with the advisory board and direct the framework development, and thematic groups of experts that would work to develop specific thematic indicators in liaison with the coordinating group. Each thematic area received input from thematic experts/working groups to varying degrees.

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Case Study I: The Global Atlas of Helminth Infection: A free online database of prevalence maps for Worm Infection

The Global Atlas of Helminth Infection provides free online access to accurate and up-to-date maps about helminth (worm) prevalence in Africa. All visitors to the GAHI website are allowed and encouraged to freely download, reuse, reprint, modify, distribute, and/or copy all of the published maps for non-commercial use.

How does it work?

Users of the website can provide or download school/ community-level estimates of worm infections from helminth survey data. Eight key pieces of information are required on stool and urine samples for submission of survey data is to be submitted to the website. Once the information is submitted, the villages are “geolocated” using a GIS database. Only the school/community-level summary data summary are included in the database for the development of maps.

Why is it useful?

The maps are provided for managers of public health programmes to support them in the planning and implementation of deworming. The maps can be used to (1) define the numbers at risk of infection with each STH and schistosome species; (2) determine areas requiring mass treatment and provide estimates of target populations; (3) forecast drug needs and costs for albendazole and mebendazole (for STH) and praziquantel (for schistosomiasis);(4) and facilitate efficient allocation of scarce control resources.

How is it relevant to FRESH?

This website provides an example of how national and school level data from FRESH might be shared and used. For example, one might want to map the schools that have private toilets/latrines, potable water or distribute of long-lasting insecticidal nets (LLINs) to students. Mapping information like this may be useful for district health or education officers or as an advocacy tool.

Adapted from the Global Atlas of Helminth Infections,, <http://www.thiswormyworld.org/>

Core framework for action

Four components that should be made available together, in all schools

1. HEALTH-RELATED SCHOOL POLICIES

Health policies in schools, including skills-based health education and the provision of some health services, can help promote the overall health, hygiene and nutrition of children. But good health policies should go beyond this to ensure a safe and secure physical environment and a positive psychosocial environment, and should address issues such as abuse of students, sexual harassment, school violence, and bullying. By guaranteeing the further education of pregnant schoolgirls and young mothers, school health policies will help promote inclusion and equity in the school environment. Policies that help to prevent and reduce harassment by other students and even by teachers also help to fight against reasons that girls withdraw or are withdrawn from schools. 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. The policies are best developed by involving many levels, including the national level, a teachers, children, and parents

2. SAFE SCHOOL ENVIRONMENT

School environment refers to aspects of the school or learning space that affect children's emotional, psychological and physical well-being. The school should be a place where children are free from fear, anxiety, danger, disease, exploitation, harm or injury; where sufficient water, hygiene and sanitation are provided, where codes of conduct against violence exist and are enforced, and where physical structures (buildings, paths, latrines) are sound, welcoming and secure.

Provision of safe water and sanitation and supporting adequate hygiene practices are essential first steps towards a healthy physical, learning environment. The school environment can potentially damage the health and nutritional status of schoolchildren, particularly if it increases their exposure to hazards such as infectious disease carried by an unsafe water supply or helminths from unsanitary latrines. In order for hygiene education to be effective, clean water and adequate sanitation facilities must be made available. By providing these facilities, schools can reinforce the health and hygiene messages, and act as an example to both students and the wider community. The provision of adequate water and sanitation facilities makes the school environment safer, more welcoming and can increase school attendance. Single sex toilets make it easier for girls to enrol and remain in school particularly around the age of menses, when privacy is sacred.

3. LIFE SKILLS EDUCATION

Life skills education is a structured program of needs- and outcomes-based teaching and learning that uses participatory exercises to assist children and young people to develop precursors of behaviour or life skills that can help them deal with the challenges and demands of everyday life. The life skills covered can include cognitive skills such as problem-solving skills, creative and critical thinking, and decision-making, personal skills related to self-awareness, agency and coping, as well as inter-personal skills for communication and relationships. Life skills education can influence health behaviour by equipping learners with the knowledge, attitudes and skills they need to stay safe and healthy. For example, life skills education can clarify learners perceptions of risk and vulnerability, which can help them avoid situations of increased risk of becoming infected with HIV or Malaria, increase their understanding of the importance of washing hands after going to the latrine or before eating, or realize their own role in use of resources and their impact on the environment. Life skills education thus has the potential to empower individuals to protect and improve their own and others' physical, mental and social health, which can in turn lead to better educational outcomes.

4. SCHOOL BASED HEALTH AND NUTRITION SERVICES

Evidence indicates that many of the common conditions of ill health among school-age children 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. Also, schools have unparalleled access to the target group, and school-based services take advantage of an existing skilled workforce (teachers and administrators) that is already engaged with community providers of health and family services.

Case Study 2: School Deworming in Cambodia

The deworming coverage of school-age children in Cambodia is estimated at 84%. Thorough training, service delivery, and coordination between schools and the Cambodian Ministry of Health are key to the program's success.

Background: Cambodia's school-age children number approximately 2,880,000. The net enrolment rate is 88%. The total number of registered primary schools is 5,850. These schools are grouped into school clusters; each cluster is composed of 2 to 5 neighbouring schools. In the entire country there are 1,231 school cluster directors and 1,135 health centres, all were involved in the control programme.

Training: In 2003, all cluster directors attended provincial training workshops on drug administration and health education. Each province conducted, on average, three, one-day workshops. The cluster directors then disseminated information to schoolteachers during regularly held weekly meetings.

Service delivery: Drugs and materials for the deworming campaign were delivered to each peripheral health unit by the MoH's network of lorries used for its regularly scheduled deliveries. Once the mebendazole arrived to the health units, it was collected by each school cluster director who then distributed the appropriate number of tablets to each school for distribution. The teachers did not receive monetary allowances for administering the mebendazole tablets to the school children.

Costs: The cost for each treated child was USD 0.12. Most of this cost was due to the training activities. From 2004 onward, Cambodia's deworming campaigns have been repeated every 6-months at an estimated cost of 4 cents per child. The reduced costs were due to the fact that cluster directors were trained only the first year.

Adapted from (Sinuon et al, 2005, from WHO's upcoming book Helminths)

Cross Cutting Themes

In addition to the 4 FRESH pillars, there are also three cross cutting themes support programme implementation.

EFFECTIVE PARTNERSHIPS BETWEEN TEACHERS AND HEALTH WORKERS AND BETWEEN THE EDUCATION AND HEALTH SECTORS

The success of school health programmes demands an effective partnership between Ministries of Education and Health, and between teachers and health workers. The health sector retains the responsibility for the health of children, but the education sector is responsible for implementing, and often funding, the school based programmes. These sectors need to identify responsibilities and present a coordinated action to improve health and learning outcomes of children.

EFFECTIVE COMMUNITY PARTNERSHIPS

Promoting a positive interaction between the school and the community is fundamental to the success and sustainability of any school improvement process. Community partnerships engender a sense of collaboration, commitment and communal ownership. Such partnerships also build public awareness and strengthen demand. Within the school health component of such improvement processes, parental support and cooperation allows education about health to be shared and reinforced at home. The involvement of the broader community (the private sector, community organizations and women's groups) can enhance and reinforce school health promotion and resources. These partnerships, which should work together to make schools more child-friendly, can jointly identify health issues that need to be addressed through the school and then help design and manage activities to address such issues.

In the long run, school health programmes are most successful when supported by multiple endeavours that provide reinforcement for the expression of positive and adaptive behaviours through supportive social norms and collective behaviours. Neither schools, nor parents, or community service providers can achieve separately what can be achieved when all of these actors work together.

PUPIL AWARENESS AND PARTICIPATION

Children must be important participants in all aspects of school health programmes, and not simply the beneficiaries. Children who participate in: health policy development and implementation; efforts to create a safer and more sanitary environment; health promotion aimed at their parents, other children, and community members; and school health services, learn about health by doing. This is an effective way to help young people acquire the knowledge, attitudes, values and skills needed to adopt healthy lifestyles and to support health and Education for All.

Case Study 3: Community-based Monitoring and Programme Assessment System (COMPAS) Viet Nam, Child Friendly Schools

A major emphasis is placed on development and application of the Community-based Monitoring and Programme Assessment System (COMPAS) in Viet Nam. Addressing three priority areas of the project – monitoring and evaluation, school-based management and school-community partnership – COMPAS is a project-wide data collection system aimed at creating a centralized database. It is expected to be used on a regular basis to guide project implementation in Viet Nam.

COMPAS is being developed and promoted as a mechanism and a forum that:

- Introduces and advocates child rights and child-friendly schools;
- Enables school self-assessment and planning;
- Provides data that will complement provincial, district and local planning;
- Tracks children, particularly girls and poor children;
- Creates enabling conditions to further development of the child-friendly learning environment;
- Converges with key interventions and generates stronger community participation;
- Assists principals in managing the school in more effective, participatory ways.

COMPAS includes baseline surveys that are conducted in 200 schools twice annually, at the beginning and end of each academic year. It supports training for local officials in survey techniques and use of data in decision-making and management. COMPAS is intended to work as a forward-moving cycle: advocacy and data collection training -> field collection of data -> analysis -> school action planning -> child-friendly learning environment implementation -> further 'assessment of progress' data collection. The analysis is used both formatively at the local level for school improvement and as input for the central database of Viet Nam's Ministry of Education and Training for planning and resource allocation.

Adapted from UNICEF Child Friendly Schools Manual (2009)

Audience

The FRESH M&E framework is written for use by governments, NGOs, civil society and international (UN) agencies, education managers and planners. These groups are encouraged to work together to set relevant, achievable and sustainable national-level and school level targets for school health policies, services, environment and life skills.

The Framework

Purpose of the M&E framework

The purpose of the FRESH monitoring and evaluation (M&E) framework is to provide guidance to countries or organizations implementing school health programmes in selecting indicators from internationally agreed sources to monitor and evaluate their programmes. By synthesising existing good examples of indicators and M&E guidance in one place, it is intended that the framework will serve as a ready reference for consistent guidance during programming. With its set of recommended indicators, it is intended that the framework will help programmes in low-income countries ensure their implementation is more standardized and evidence-based and will allow easier comparative benchmarking and monitoring across countries. Additionally, it is hoped that the framework will help lead to better coordination between programmes and the priorities they address (e.g. worms and micronutrient supplementation) and ultimately contribute to better health and education outcomes.

The guidance provided in the FRESH M&E framework document is generic – not a rigid blue print – and is intended to support and complement existing local standards and codes, not to modify or substitute for them. Thus where the framework defines standards for indicators (e.g. standards for a safe, sustainable, and accessible water supply for determining percentage of school with such a supply) it is strongly encouraged that the standards are adapted at the local level.

The framework is written for use by governments, NGOs, civil society and international (UN) agencies, education managers and planners implementing school health programs.

Guiding principles

The framework provides guidance on key summary FRESH indicators, a limited set of indicators that are recommended for all organizations and countries and hopefully also schools to collect and report on. Secondly, it provides guidance on thematic indicators from existing international resources, which address specific health conditions or concerns (e.g. HIV, malaria, mental health) while monitoring and evaluating FRESH interventions.

The M&E Framework will enable the monitoring and evaluation of school health programmes across countries and organisations to become more consistent and systematic across school health programmes, and lead to more evidence-based programming. It may also allow the production of a global database that countries and organisations can feed in to, compare progress from and use for programme planning and implementation.

By having access to a common internationally agreed M&E framework that synergises existing M&E resources and guidelines, countries and organizations will be able to adapt to their local programme settings. This should help ensure that quality M&E is an integral part of all school health programmes (national and programme level).

Components of the framework

The FRESH M&E framework has two main components, thematic indicators and summary indicators.

Summary Indicators

Drawn from the menu of thematic indicators are a limited number of summary indicators, which are organized around the four FRESH pillars and are intended to enable international and programmatic measurement of countries' and programmes' progress towards implementing FRESH. Thus once finalised they are recommended for all organisations and countries to collect and report. Defining the outcomes and impacts of the summary indicators are currently in the process of revision, but for the time being they include: (1) reduction in morbidity and mortality prevalence, (2) improved capacity to concentrate and learn, (3) improvement in education performance indicators (e.g. attendance, retention and completion rates).

Thematic Indicators

FRESH Thematic Indicators present an extensive menu of school health indicators to monitor activities of interventions addressing different thematic areas. Thematic areas may be diseases (e.g. HIV/AIDS or malaria) or health concerns (e.g. sexual and reproductive health or substance abuse). The menu of thematic indicators addresses distinct health conditions and also groups health concerns together (oral health, vision and hearing). While thematic indicators are part of the M&E framework, once finalised they will not be recommended for collection and reporting by all organisations since they are an extended list of indicators which will need to be adapted and used based on the local thematic concerns.

Thematic indicators are designed to monitor the processes (activities, direct inputs and outputs) related to school health interventions. Higher-level outcomes (expected changes in knowledge, attitude, practice, behavior, health or education status) and impacts on health and education are mentioned but not directly measured, as those are depended on a number of interventions in society and cannot be attributed to a single cause. Indicators for the thematic indicators were developed with different levels of consultation with thematic experts. While some are more final than others, all of the thematic indicators will undergo further development in consultation with thematic experts. The list of thematic areas include: HIV/AIDS; deworming; hygiene, water and sanitation; malaria; nutrition; sustainable development; sexual and reproductive health; physical activity; oral health, vision and hearing; general life skills; substance abuse; disaster risk reduction/emergences violence against children; and first aid and general safety.

Tools and Methods

INDICATOR CONSTRUCTION

This framework includes detailed guidelines for the construction of each summary indicator and thematic indicators where they have been worked out. These guidelines include the purpose and background of the indicator, the frequency with which relevant data should be gathered, recommended measurement tools, recommended methods of measurement and a summary interpretation of the indicator.

PILLARS AND PROCESS INDICATORS

The indicators for each section are divided by the four FRESH Pillars- policy, environment, services and life skills. The majority of the indicators are process indicators and refer to the policies, activity, services, skills and education provided and are directly related to program coverage and quality. The indicators are mutually reinforcing and they (1) support an enabling community and policy environment; (2) increase the quality of facilities, services, supplies and information; (3) increase access and availability of school and clinic-based health services; and (4) encourage an increase in knowledge, skills, positive attitudes and interest in the application of health information.

OUTCOMES AND IMPACTS (Adapted from UNICEF CFS Manual)

Outcomes measure the extent to which the objectives have been achieved, what concrete changes have resulted from school health inputs and processes, and whether interventions have been able to influence the knowledge, attitudes and behaviour of students, school staff, community members and education system officials. Outcome indicators may include information on changes in enrolment, repetition and drop-out rates for boys and girls. Impact, the long term changes that result from the interventions, are presented as well. Impacts relate to health outcomes, such as a change in status, and education outcomes, such as increase in attendance, enrollment, and cognitive ability.

MEASUREMENT TOOLS AND DATA SOURCES (ADAPTED FROM UNGASS)

The measurement tools for the recommended indicators still need further development. However, measurement tools have been suggested in this draft and they vary from existing data sources, and ongoing routine data collection systems such as EMIS and HMIS, to school surveys; specially designed surveys and questionnaires, including surveys of specific groups

(headmasters, teachers and students) and scales. Civil society organizations are valuable sources of data for many indicators, especially those that relate to interventions where nongovernmental, faith-based and community-based organizations play an active role, including work with young people.

In most countries, the bulk of the data required for the recommended national-level indicators may not be available from existing sources and routine data collection system and therefore beg the adaptation of existing monitoring tools or the addition of specific surveys. Thus where countries that already capture information from schools, health facilities and employers, the necessary SHN data requirements will need to be added to the ongoing data collection process. Where countries conduct regular, nationally representative, population-based surveys such as the Demographic and Health Survey, which may be a source of relevant information, such as behavioural data on young people, adaptations may be required.

In situations where nationally representative service coverage data are not available from monitoring systems, countries may use data collected from interviews of key informants. Although the data collected using this approach are less accurate than data collected by monitoring systems, the approach can be implemented quickly and relatively inexpensively.

NUMERATORS AND DENOMINATORS

The guidelines include detailed instructions on how to measure each summary and thematic indicator. Most indicators use numerators and denominators to calculate the percentages that measure the current state of the national and school level implementation of SHN strategies and activities.

For a given indicator, it is important that the data collection period is consistent for all the information relevant to that indicator's numerator and denominator. If data are collected at different times for the numerator and denominator, the accuracy and validity of that information will be compromised. Countries are strongly encouraged to pay close attention to the dates attached to specific data when calculating an indicator.

FRESH Summary Indicators

The FRESH Summary Indicators are intended to provide assistance in measuring progress towards implementing comprehensive school health programmes at international and programmatic levels. The summary indicators are drawn from a menu of thematic indicators and are limited in number but wide in scope. It is foreseen that the summary indicators will be internationally recommended for reporting by all agencies/countries implementing school health interventions. While the below list is still a draft, it is expected these will be further condensed, based on whether they are SMART, and can be reported upon even in resource-poor settings.

FRESH SUMMARY INDICATORS	
POLICY	
1.	Existence of a national level policy that addresses school health across all four components of FRESH
2.	Extent to which school health policy is implemented across the country
ENVIRONMENT	
3.	Existence of national level physical school environment (inspection) standards
4.	Percentage of schools implementing the physical school standards
5.	Existence of national level psychosocial school environment standards
6.	Percentage of schools implementing the psychosocial school standards
SERVICES	
7.	Percentage of schools that provide health and nutrition services with referral to treatment systems
SKILLS-BASED HEALTH EDUCATION	
8.	Life skills concepts and themes are addressed in the national level curricula for primary and secondary schools
9.	Life skills concepts and themes are explicitly assessed in national level school leaving examinations
10.	Life skills concepts and themes are addressed in the national level pre-service teacher training curricula
11.	Percentage of learners that have received life skills education the last academic year
12.	Percentage of teachers having received in-service training in life skills education the last academic year
13.	Percentage of women and men, aged 15 – 49 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (UNGASS #17)
14.	Current school attendance among orphans and non orphans, aged 5 – 17 years (From Revised IATT, reformulation of UNGASS#12)
15.	Percentage of women and men, aged 15 – 20 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (From Revised IATT, UNGASS #17)

Policies

Why are school health policies important?

Good School Health Policies are at the foundation of effective school health programs. They show commitment to ensuring that students are physically, mentally and emotionally ready to learn. Effective policies are the backbone of legislation that guarantees children's right to quality education.

Health policies in schools, including skills-based health education and the provision of some health services, can help promote the overall health, hygiene and nutrition of children and support cognitive development and educational attainment. Good health policies should emphasize the importance of a safe and secure physical environment and an inclusive and respectful psychosocial climate as well as address issues such as abuse of students, sexual harassment, school violence, and bullying. Students are most receptive to learning when they feel physically and emotionally safe.

Policies should also strive towards inclusion and equality by guaranteeing education to pregnant schoolgirls and young mothers. Policies aimed at preventing and reducing harassment will help eliminate some of the issues causing girls to withdraw (or be withdrawn) from schools. 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. Policy development should involve many levels from the national level ministries to the schools, parents, children and communities.

School health and nutrition policies must be developed and supported by key stakeholders at all levels. At the national level, for example, this involves an accepted framework of responsibility, policies, and action among the key government ministries and other institutions and organizations with an input and responsibility for school health programming. At district and school levels, policies should be clearly understood, implemented, and supported by all those responsible for the education, health, and well being of the children. Policies should cover a broad spectrum of areas critical for the health and development of school-age children.

In the context of the FRESH Framework, policy is the demonstration of a country or school's commitment and ranking of its priorities for action. It is also an expression of the country or school's strategic intent towards where it moves. It is therefore important for any organization, including schools, to set policies and "policy" is therefore one of the four components of FRESH.

1. Existence of a national level policy that addresses school health across all four components of FRESH

PURPOSE	To assess progress in the development and implementation of national-level school health policy.
DATA COLLECTION FREQUENCY	Annually
MEASUREMENT TOOLS	Interview and/or review of school health policy with key personnel in the MoH and MoE (or other ministries involved).
METHOD OF MEASUREMENT	This indicator uses a simple yes/no question. ² Key question: Does a National Level School Health Policy exist in written format? Yes/No

INTERPRETATION

Developing supportive National Level School Health policies is an essential step towards establishing, encouraging and facilitating improved school health and nutrition. The National level school health policy should be comprehensive, context specific and recommend evidence-based cost effective strategies. A comprehensive policy is one that includes all the relevant thematic areas deemed necessary by stakeholders³ for their country context and is ideally jointly produced by country MoH and MoE. Different countries may require a different selection of thematic areas to include in their policies depending on their health and nutrition needs. Stakeholders should consult with health experts to determine which thematic areas to include in the policy. The thematic areas may be:

HIV/AIDS
Deworming NTD Control
Hygiene, water and sanitation
Malaria
Nutrition
Education for Sustainable Development
Sexual and Reproductive Health (SRH)
Physical Activity
Oral Health, Vision and Hearing
General Life Skills/Social and Emotional Learning
Substance Abuse
Disaster Risk Reduction/Emergences
Violence in the School Setting
Prevention and Response to Unintentional Injury
Children with Special Needs

Evidence-based cost effective strategies, services and/or activities that each policy recommends should have a proven record of improving the health and nutrition of school aged children at a reasonable cost. For example, in the thematic area “Deworming”, there should be a policy to prevent infection and treat infected students. A strategy for this policy should recommend that schools initiate activities that aim to decrease parasite infection. A specific activity/service for this policy would be to prevent infections and re-infections by ensuring that at least 75% of school children receive deworming services twice a year where the prevalence of soil-transmitted helminthes is >50%. The cost would be less than 2 cents a year per actual treatment (total between 3-20 cents a year).

² Another option for measuring this indicator that uses score method can be found in Annex X

³ Stakeholders include everyone involved in development of the national policy. Stakeholders could include: Members of the MoH and MoE (at the national, district, regional, zonal, etc. level), school communities (including teachers, students, staff, parent teacher associations, school management committees), religious leaders and others.

1.1 – 1.3: Indicator Components for Existence of National Level SHN Policy

1.1 NATIONAL SHN POLICY DRAFTED

Key question 1: Has the National SHN Policy been drafted? Y/N

Key Question 2: Was there collaboration between the health and education ministries? Y/N

1.2 NATIONAL SHN POLICY IMPLEMENTED

Key question: Has the SHN policy been implemented? Y/N

1.3 NATIONAL SHN POLICY IMPLEMENTED PARTIALLY/COMPLETELY

Key question: Has the National SHN policy been partially implemented? Y/N

Key question: Has the National SHN policy been completely implemented? Y/N

*We need to define what we mean by completely or partially.

Concerns/Comments about this section:

Need to define complete and partial implementation. Ideally countries should provide their own definition but it might be good if FRESH could provide an example

DRAFT

2. Extent to School Health Policy is Implemented Across the Country

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

Environment

Why is the school environment important?

School environment refers to aspects of the school or learning space that affect children's emotional, psychological and physical well-being. The school should be a place where children are free from fear, anxiety, danger, disease, exploitation, harm or injury; where sufficient water, hygiene and sanitation are provided, where codes of conduct against violence exist and are enforced, and where physical structures (buildings, paths, latrines) are sound, welcoming and secure.

The provision of safe water and appropriate sanitation facilities are the basic first steps in the creation of a healthy physical learning environment. Policies governing the construction of such facilities should address the important issues of gender access and privacy, and maintenance policies should be established to ensure that the facilities are cared for and used properly over time. By providing safe and appropriate sanitation facilities, schools can reinforce the health and hygiene messages delivered in education programmes, and serve as an example to both students and the wider community. This, in turn, may lead to a demand for similar facilities in other parts of the community.

Although there is an urgent need for speeding up the instalment of appropriate facilities, school sanitation deals with more than building child-friendly facilities. Experience shows clearly that the mere provision of services, be it within schools or at a household level, will not be sustainable. Facilities need to be maintained and in order to be maintained there must be a recognized need and demand for water as well as sanitation at schools. To improve the sanitation environment of schools and to ensure benefits from safe and clean facilities, behavioural change is needed, leading to a proper use of facilities as well as organized maintenance of the facilities and sanitation-related behaviours such as hand-washing.

Schools are an integral part of a community. Involvement of the local community in school sanitation and hygiene activities increases the effectiveness of the programs. It also promotes the sense of ownership within communities that is needed to sustain the school systems for operation and maintenance. Although school sanitation and hygiene promotion can bring benefits for the children and their family members who may improve their sanitation, it is clear that sanitation is a public good and that sanitation improvement has much greater benefit when it is achieved by a whole community. Experience shows that children can act as potential agents of change within their homes and communities through their knowledge and use of sanitation and hygiene practice learned at school.

Concerns/Comments about this section:

Need to write a bit more about the emotional and psychological wellbeing of children here.

3. Existence of national level school environment (inspection) standards

PURPOSE	To assess national progress setting standards on desired characteristics of schools
DATA COLLECTION FREQUENCY	Annually
MEASUREMENT TOOLS	To be determined
METHOD OF MEASUREMENT	
Calculation:	To be determined

INTERPRETATION:

A structure for learning (school) and its immediate environment (school grounds) must offer basic minimum standards to encourage and facilitate learning. The school must respond to the environmental and cultural context of its location. A universal, standardized approach does not respond to the unique characteristics of a place and culture and could result in detachment and alienation of the community.

Desired characteristics of school- such as safety, security and wellbeing, infrastructure, design and services should be defined at the national level. After characteristics are defined, the next step is to set standards – both national and local – for these characteristics. For instance, a desired characteristic may be spacious classrooms where children can move around, work in small groups or display their work, rather than cramped classrooms where children sit in fixed rows, facing the blackboard and listening to the teacher. Setting standards then requires specifying the minimum floor space (square feet per child) required.

In the same way, 'playtime' standards could be set according to guidelines on how much school time (hours or periods per week) should be devoted to recreational activities. Similarly, standards can be set for staffing by determining the basic courses (in- service and pre-service) required for teachers to become 'child-friendly- school trained' or by recommending a ratio of pupils to each 'child- friendly-school-trained' teacher. In all cases, setting standards is not meant to establish a rigid blueprint for implementation but to provide a quantifiable basis for estimating the costs of making schools child-friendly in a given education system.

Possible school characteristics are as follows:

Structure

The building is to be structurally stable, weatherproof according to local environmental conditions, climatically comfortable, easily exited in case of emergency and well integrated with the environmental and cultural context.

Administrative offices

Separate space for faculty/administrative personnel gives privacy to students and teachers and maximizes the use of classroom space, enabling staff to work separately from students. Proximity between classrooms and administrative offices is recommended to monitor students' activities and create 'safety through transparency'.

Safe water

Fresh potable water should be available to students within the school. Proper plumbing infrastructure allows for the distribution of safe water. If such a setup is not possible, a borehole/well should be included in the school compound. This can be augmented with a rainwater catchment system in the roof as appropriate.

Hygiene facilities

A separate space should be provided with water and soap or other cleaning agent for children to wash their hands.

Toilets/latrines

Separate toilets or latrines should be available for girls and boys. Privacy, cleanliness and safety are major considerations when planning location and design of facilities.

Light, air, sun, dust, glare, reflection, humidity, noise and odour

Classrooms need good fresh-air circulation to avoid heat and excessive humidity. To ensure adequate daylight, a minimum of 20 per cent of the classroom floor area should be window area. Electricity or another means of power is needed to provide light and to operate equipment. Classrooms must be sufficiently shaded from direct sunlight, glare (direct light) and reflection (indirect light). Schools should not be located close to sources of excessive noise (traffic, railways, industries, informal sector activities) or excessive pollution or odours (waste belts, abattoirs). When this is not possible, design measures should be used to minimize the impact of these problems.

Colour

Materials and finishes should be the light, natural colours of the materials themselves, selected in harmony with warm natural hues as accents (reds, oranges, maroons, ochres and linen/khaki/off- whites) dictated by local, cultural preferences. For example, timber may be finished using clear varnish to preserve the natural beauty and warmth of the material. Or brighter accents can be used for play corners, decks, corridors and furniture. Learning spaces should be light and relaxed in colour, not gloomy, dull or dark.

Power (electric or alternative)

The school should have a power source to provide light, connectivity for communication equipment (computers, radios, television) and other appliances (refrigerators, stoves). Alternative sources of energy (solar, wind and biogas) can be integrated into the design of schools where appropriate.

Safety provisions

Fire prevention and emergency evacuation plans must be part of the design process and built into the school programme. Combustible materials should not be used for structural purposes unless treated to resist fire. Construction materials should be free of components or elements that can be hazardous to children. When construction is finished, school sites should be free of all fluid, solid and gaseous wastes. Schools should not be located close to industrial or other hazards.

Health provisions

At a minimum, schools should have a first-aid kit or medicine cabinet for basic emergencies or accidents. Proximity to a clinic enables health personnel to visit the school periodically and permits children to be taken to the clinic for treatment of health problems. This proximity is accomplished in many developing countries through clustering the main social service facilities in the same location.

Library

A designated space where books and learning resources are available in a proper reading environment is central to learning and teaching activities. The library or resource room needs to be strategically located within the school for easy access, but away from noisy areas for a greater degree of quiet.

Landscaping

School grounds form an integrated, holistic unity with school buildings and their users, but in conventional school planning they are often neglected. Trees are vital for filtering sun, dust and noise and for beautifying the school. Indigenous trees, shrubs and flowers should be planted in the school compound along with edible plants meant to teach children food production and conservation. Trees also have a softening and calming effect on the learning environment and its users. Planning the school landscaping is a good way to involve children in the realization of a child-friendly school.

SOURCE:

UNIEF Child Friendly Schools Manual, http://www.unicef.org/publications/index_49574.html

Concerns/Comments about this section:

This indicator was added at the last stages. Definition needs to be clearer and calculation fleshed out. Discuss with UNICEF.

DRAFT

4. Percentage of schools implementing physical school standards

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

5. Existence of national level psychosocial school environment standards

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

6. Percentage of schools implementing the psychosocial school standards

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

Services

Why are school health and nutrition services important?

More children than ever before are now enrolled in basic education programs, and this situation provides governments and partners an opportunity to provide school-based health services to address common health problems which are preventing school children from attending, staying, learning and achieving in school.

The content of school health services largely depends on the local health and nutritional needs, i.e. the context. Thus the prevalence of health concerns and the factors (including causative agents) affecting them should be taken into consideration when designing a program. Typically in a low-income setting some of the school health services that can be provided include i) routine mass treatment (deworming) of soil transmitted helminths and schistosomiasis; ii) mass supplementation of vitamin A, iron or multiple micronutrients; iii) school feeding; iv) screening (and at least classroom remediation) of vision and hearing impairments; and dental health screening; v) physical activity (fitness and growth) monitoring; vi) distribution of long-lasting insecticide treated bed-net (LLINs); vii) diagnosis and treatment of malaria; viii) first aid services; ix) sexual and reproductive health counselling; and psycho-social and substance abuse related counselling.

DRAFT

7. Percentage of schools that provide health and nutrition services with referral to treatment systems

PURPOSE

DATA COLLECTION FREQUENCY

MEASUREMENT TOOLS

METHOD OF MEASUREMENT Calculation Calculation Example

INTERPRETATION

Each school should decide what services are context-specific and comprehensive to them. Participatory weighted checklists (Annex A) are one tool that can be used to help individual schools design a customized selection of services that meet their particular needs. School heads, students, teachers, parents, local health/education officials (either sub-district or district level) and interested groups can use and discuss the checklist together. It may be useful for each group (students/teachers/school head, etc. to initially work independently on their own checklist and then share their opinions and findings to all stakeholders for further discussion and selection.

This indicator should also collect numbers on the percentage of students who received school based health and nutrition services, disaggregated by type/age of student and type of service. All school services, such as deworming, micronutrient supplementation, malaria treatment, etc. are listed in the section on thematic areas.

Referral and treatment systems can address general health problems that are not treated at the school. General health problems that include malaria, poor vision (with eye glasses), hearing loss, poor oral health and others. Specific referrals may include 1) health centre for malaria, 2) optometrist for vision re-test and eye glasses, 3) health centre for hearing retest and treatment (e.g. wax removal), 4) dentist for tooth/mouth pain, etc. More issues may need to be added (such as treatment for worms) depending on context.

Referral and treatment systems can also provide specialized services. Issues requiring specialized services may include sexual reproductive health, psychosocial support for students and teachers (particularly those affected by HIV/AIDS), violence against children/domestic violence, and drug dependence treatment. Specialized issues will need to be defined locally.

Determining what is “accessible” will depend on the context and norms.

In order for a referral and treatment system to be effective, the ailment/problem/issue should be successfully treated, addressed or resolved. Good record keeping/tracking is required to assess whether problems are adequately resolved. For general health problems, effectiveness will be fairly straightforward, but for specialized health issues, determining effectiveness may be difficult. A child’s ability to cope with a sensitive personal issue such as sexual violence or drug addiction may require more than just an effective referral and treatment system.

Skills-Based Health Education

Why is skills-based health education important?

Skills-based health education, or life skills, is concerned with the development of the child as a person, as well as external concerns that impact on their development, such as health, social, environmental and economic issues. The need to decrease occurrence of unprotected sexual activity (to prevent HIV, STI and unplanned pregnancy), violence, drug, alcohol and tobacco use provides an impetus to develop life skills education.

Life skills education and accurate health information can significantly enhance a wide array of content areas that aim to influence human behaviour. The specific content needs to be established with the needs of the learners targeted in mind. This means that the content of life skills education varies from country to country, and in the best case from one local context to another.

When addressing a number of identified content areas together, such as various physical, social and emotional health concerns, and exploring inter-linkages between their social, economic and environmental dimensions, life skills education is in line with education for sustainable development. By addressing these concerns across the emergency spectrum (disaster risk reduction, response, and recovery), effective life skills education can contribute to averting future emergencies, promoting individual and community resilience and mitigating impact during and in the aftermath of an emergency.

DRAFT

8. Life skills concepts and themes are addressed in the national curricula for primary and secondary schools

PURPOSE	To assess progress towards incorporating life skills education into national curricula
DATA COLLECTION FREQUENCY	Annually (?)
MEASUREMENT TOOLS	National curriculum review. A yes/no checklist might be used to identify whether or not each theme was addressed in the primary and secondary school curricula
METHOD OF MEASUREMENT	
Numerator:	Number of life skills themes addressed in school curricula
Denominator:	Total number of life skills themes recommended for national curricula (12.1)

INTERPRETATION

Life skills-based education is an effective methodology that uses participatory exercises to teach behaviours to young people that help them deal with the challenges and demands of everyday life. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach young people how to cope with their emotions and causes of stress.

School curricula guidelines should identify specific life skills learning outcomes and measurement standards for each thematic area. Materials for teaching life skills in schools should be developed and/or made available. Materials may include curriculum documents, frameworks, plans; syllabi for use in schools and teacher training institutes; and teaching materials and teaching aids. *(To be completed)*

When adapted for a content specific theme, such as HIV education in schools, a life skills-based approach helps young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. When properly implemented, it can have a positive effect on behaviours, including delay in sexual debut and reduction in number of sexual partners.

Key themes of life skills education (with regard to school health, MDGs and SD) include:

1. Essential life skills (social and emotional learning)
2. Basic nutrition and healthy life styles (Nutrition and physical activity)
3. Basic health issues (Malaria, Helminths, Influenza outbreaks)
4. Basic safety issues (Road safety, Safety at home and at school, first aid, emergency preparedness)
5. Personal health and hygiene issues (hygiene, oral health, vision and hearing)
6. Physical, emotional and social development and sexual and reproductive health
7. HIV and AIDS
8. Substance abuse
9. Violence prevention
10. Sustainable development (Climate change, Resource management, Environmental protection, Disaster risk reduction)

Indicator Components for key life skills that are addressed in the national curricula for primary and secondary schools

TOTAL NUMBER OF LIFE SKILLS THEMES RECOMMENDED IN NATIONAL CURRICULA

NUMBER LIFE SKILLS EDUCATION THEMES ADDRESSED EXPLICITLY IN THE NATIONAL CURRICULA

FOR PRIMARY SCHOOLS

NUMBER LIFE SKILLS EDUCATION THEMES ADDRESSED EXPLICITLY IN THE NATIONAL CURRICULA
FOR SECONDARY SCHOOLS

Concerns/Comments about this section:

Is the number of life-skills themes sufficient as an indicator, or are there some basic “key” life skills, which that should be recommended for all? If so, what should they be? The number of themes alone will tell us much, as it is contextual.

DRAFT

9. Life skills concepts and themes are explicitly assessed in national examination systems at various levels of education

PURPOSE	To assess national commitment to life skills education
DATA COLLECTION FREQUENCY	Annually
MEASUREMENT TOOLS	A national examination review. A yes/no checklist might be used to identify whether or not each theme was assessed in the primary and secondary school exams.
METHOD OF MEASUREMENT	
Primary Schools	NUMERATOR: Number of life skills themes assessed in primary school examinations. DENOMINATOR: Total number of life skills themes in national curricula
Secondary Schools	NUMERATOR: Number of life skills themes assessed in secondary school examinations. DENOMINATOR: Total number of life skills themes in national curricula

INTERPRETATION

By assessing life skills in national exams, countries can begin to identify if exam results are consistent with national priorities and if the schooling is efficient. By having life skills on exams, schools may also be more motivated to address life skill themes in their curriculum and school activities (light versions for primary schools, more in depth versions for secondary schools).

Often national exams tend to emphasize academic skills such as language and mathematics rather than more practical skills such as psychosocial or interpersonal skills or health behaviour. National public examinations also tend to encourage students and teachers alike to emphasise the development of good examination-taking techniques rather than attaining knowledge, skills and understanding. (Furniss).

It is of essential importance that quality of exam is high so that the outcomes accurately reflect knowledge, skills and abilities of the students.

SOURCE

Furniss, Elaine. (2003). Assessing Learning Achievement. UNICEF New York
<http://www.unicef.org/lifeskills/files/AssessingLearningAchievement.doc>

10. Life skills concepts and themes are addressed in the pre-service teacher training curricula

PURPOSE	To assess commitment towards incorporating life skills education in teacher training
DATA COLLECTION FREQUENCY	Every 2 years (?)
MEASUREMENT TOOLS	Review of national teacher training curricula for primary and secondary school teachers. A yes/no checklist might be used to identify whether or not each theme was addressed.

METHOD OF MEASUREMENT

Pre-service teacher training curricula	NUMERATOR: Number of generic and content specific life skills themes addressed in the pre-service teacher training curricula (disaggregate by theme and primary school secondary school curricula) DENOMINATOR: Total number of life skills themes in national curricula
Percent of teachers trained	NUMERATOR: Number of teachers that have been trained in generic and content specific life skills themes (disaggregated by theme and primary and secondary school) DENOMINATOR: Total number of teachers surveyed

INTERPRETATION

Life skills teacher training should enhance teaching methodology, improve teacher confidence and change teachers' knowledge, attitudes and skills related to the specific life skills theme. Effectiveness of teaching methods is an outcome that can be assess via student outcomes (knowledge, attitudes, skills and practices) and satisfaction.

The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes, and skills (e.g., interpersonal communication, negotiation, decision-making, critical thinking and coping strategies) that assist young people in maintaining safe lifestyles. Wherever possible, the teacher training should have been done in accordance with the latest UNICEF and UNESCO Guidelines.

SOURCE

UNICEF, http://www.unicef.org/lifeskills/index_10489.html

11. Percentage of learners that have received life skills education in the last academic year

PURPOSE	To assess progress towards implementation of life-skills based education in all schools
DATA COLLECTION FREQUENCY	Reported every 2 years (but collected through an annual data collection process)
MEASUREMENT TOOLS	School based survey. This could also be structured as a question to include in the Annual School Census questionnaire.
METHOD OF MEASUREMENT	
Numerator:	Number of students that received life skills in the last academic year
Denominator:	(disaggregated by gender, rural/urban; ethnic groups, other) Number of students surveyed

INTERPRETATION

In addition to measuring the percentage of students who received life skills education, it would be useful to assess the knowledge, attitudes and skills gained by the students at the time of, or very soon after the educational activities are completed. The term "attitudes" is used here to encompass a wide range of concepts including: intentions, beliefs, feelings about self (confidence) and others (discrimination), values, thoughts, social, religious and cultural tenets, morals and ethics. The term "skills" is used here to refer to life skills: psychosocial and interpersonal skills that can be applied to AIDS prevention and related issues. These skills are important because they can facilitate and may lead to behaviour change, when supported in comprehensive ways. The facilitator/teacher of the life skills course would be most suited to collect this information.

Soon after the life skills course/intervention, one might assess short term behavioural outcomes. For example, behaviours following an HIV/AIDS life skills course may include use of a condom during last sexual intercourse or reduction in number of sex partners.

SOURCE

UNICEF, http://www.unicef.org/lifeskills/index_10489.html

12. Percentage of teachers having received in-service training in life skills education in the last academic year

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

13. Percentage of women and men, aged 15 – 49 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (UNGASS #17)

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

14. Current school attendance among orphans and non orphans, aged 5 – 17 years (From Revised IATT, reformulation of UNGASS#12)

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

INTERPRETATION

DRAFT

15. Percentage of women and men, aged 15 – 20 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (From Revised IATT,UNGASS #17)

PURPOSE

**DATA COLLECTION
FREQUENCY**

MEASUREMENT TOOLS

METHOD OF MEASUREMENT
 Calculation
 Calculation Example

DRAFT

FRESH Thematic Indicators

FRESH Thematic Indicators present an extensive menu of school health indicators to monitor activities of interventions addressing different thematic areas. Thematic areas may be diseases (e.g. HIV/AIDS or malaria) or health concerns (e.g. sexual and reproductive health or substance abuse). The menu of thematic indicators addresses distinct health conditions and also groups health concerns together (oral health, vision and hearing). While thematic indicators are part of the M&E framework, once finalised they will not be recommended for collection and reporting by all organisations since they are an extended list of indicators which will need to be adapted and used based on the local thematic concerns.

Thematic indicators are designed to monitor the processes (activities, direct inputs and outputs) related to school health interventions. Higher-level outcomes (expected changes in knowledge, attitude, practice, behavior, health or education status) and impacts on health and education are mentioned but not directly measured, as those are depended on a number of interventions in society and cannot be attributed to a single cause. Indicators for the thematic indicators were developed with different levels of consultation with thematic experts. While some are more final than others, all of the thematic indicators will undergo further development in consultation with thematic experts. The list of thematic areas include: HIV/AIDS; deworming; hygiene, water and sanitation; malaria; nutrition; sustainable development; sexual and reproductive health; physical activity; oral health, vision and hearing; general life skills; substance abuse; disaster risk reduction/emergences violence against children; and first aid and general safety.

Thematic Indicator 1: HIV/AIDS

Over the past decade the education sector has played an increasingly important role in the multi-sectoral response to HIV & AIDS. The priority placed on the education sector's response is based on the evidence that education contributes to knowledge and personal skills essential for HIV prevention and that it protects individuals, communities and nations from the impact of AIDS. However, as resources for multi-sectoral responses to HIV become ever more limited, it becomes crucial that the education sector is able to show evidence of the impact of its responses to the HIV epidemic.

Life skills-based education is an effective methodology that uses participatory exercises to teach behaviours to young people that help them deal with the challenges and demands of everyday life. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach young people how to cope with their emotions and causes of stress. When adapted specifically for HIV education in schools, a life skills-based approach helps young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. When properly implemented, it can have a positive effect on behaviours, including delay in sexual debut and reduction in number of sexual partners.

HIV/AIDS Indicators Table

HIV/AIDS: Selected by IATT for education M&E Working Group

<p>POLICY</p> <ol style="list-style-type: none"> 1. Percentage of schools that have adopted and communicated a code of conduct related to physical safety, stigma and discrimination and sexual harassment/abuse. (From Revised IATT) 2. National Composite Policy Index (NCPI) (From Revised IATT)
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 3. Percentage of education personnel reached by a comprehensive workplace programme during the last academic year
<p>SERVICES</p> <ol style="list-style-type: none"> 4. Percent of schools with accessible and effective referral and treatment systems (Voluntary Counselling and Testing) 5. Percentage of schools with psychosocial support services provided by appropriately trained personnel 6. Percentage of orphaned and vulnerable children, aged 5-17 years, who receive free basic support through school
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 7. Percentage of schools that provided life skills-based HIV education, including sexuality education, within the curriculum, in the last academic year (Adapted for FRESH From Revised IATT) 8. Percentage of schools that provided co- or extra- curricular life skills based HIV education, including sexuality education, within the last academic year (From Revised IATT) 9. Percentage of schools with teachers who have both received training to teach life skills based HIV and sexuality education and who taught the subject as part of the curriculum within the last academic year (From Revised IATT) 10. Percentage of schools providing an orientation process for parents regarding life skills based HIV education, including sexuality education, programmes in schools (From Revised IATT)
<p>OUTCOME INDICATORS</p> <ol style="list-style-type: none"> 1. Percentage of young people, aged 10 – 24 years, who demonstrate desired levels of knowledge on transmission of HIV and reject major misconceptions about HIV transmission (From Revised IATT) 2. Percentage of young people, aged 10-24 years, who demonstrate desired levels of knowledge on transmission of HIV and reject major misconceptions about HIV transmission”.

IMPACT INDICATORS

3. Percentage of young people, aged 15-24, who have had sexual intercourse before the age of 15 years (From Revised IATT)
4. Percentage of young people, aged 15-24, who have had sexual intercourse before the age of 15 years (From Revised IATT)
5. Percentage of women and men, aged 15 – 49 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (UNGASS #17)
6. Current school attendance among orphans and non orphans, aged 5 – 17 years (From Revised IATT, reformulation of UNGASS#12)
7. Percentage of women and men, aged 15 – 20 years, who had more than one partner in the past 12 months who used a condom during their last sexual intercourse (From Revised IATT, UNGASS #17)

Indicator Components for HIV/AIDS**HIV/AIDS 1: PERCENTAGE OF SCHOOLS THAT PROVIDED LIFE SKILLS-BASED HIV EDUCATION, INCLUDING SEXUALITY EDUCATION, WITHIN THE CURRICULUM, IN THE LAST ACADEMIC YEAR**

DATA COLLECTION FREQUENCY: Reported every 2 years (but collected through an annual data collection process)

MEASUREMENT TOOLS: School based survey. This could also be structured as a set of questions to include in the Annual School Census questionnaire

METHOD OF MEASUREMENT: Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on what constitutes a code of conduct and what it means to adopt and communicate the code of conduct. They are then asked the following questions.

Key Question: Does your school have a code of conduct that deals with physical safety, zero tolerance for discrimination and stigma and sexual harassment and abuse? (The code of conduct must cover all the aspects)
If yes, has this code of conduct been adopted?
If yes, has the code of conduct been communicated to all stakeholders?

NUMERATOR: Number of schools who responded yes to question about the code of conduct, yes to having adopted the code of conduct and yes to having communicated the code of conduct (Positive response to all 3 aspects)
DENOMINATOR: Number of schools sampled

Purpose and Rational for Inclusion

This indicator is useful in assessing progress towards establishing safe and enabling environments in schools. This indicator provides a measure of the development, adoption and shared, legal frameworks that encourage school safety and schools as workplaces that reduce stigma, discrimination and sexual harassment.

Interpretation

It is important that schools are considered to be safe places and also offer an enabling environment for those who work there and attend schooling. Schools are required to adopt code of conducts that protect all who work and attend school there. The code of conduct should cover the critical areas of school safety (zones with no guns, drugs and alcohol); zero tolerance for any form of stigma and discrimination and no acceptance of any type of sexual harassment or abuse. The code of conduct should provide guidance and points of referrals should there be any form of transgression. The schools need the backing of education authorities and general legislature to ensure that the code of conduct can be enforced.

The indicator provides useful information on trends in the coverage of the codes of conduct – adding that these should be adopted formally and communicated with all stake holders.

Complementary strategies that measure the incidence of sexual harassment/abuse and cases of stigma and discrimination will need to be included in countries with high prevalence and low enrolment rates.

Strengths and Limitations

<p>Strengths:</p> <ul style="list-style-type: none"> •The method of calculation of the indicator is simple •The indicator allows for easy comparison over time •The indicator will raise awareness for the need of legislative frameworks to support schools 	<p>Limitations:</p> <ul style="list-style-type: none"> •The responses do not reflect on the number of cases found at school level •The indicator attempts to measure the steps taken to protect schools and those who work there
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HIV/AIDS 2: PERCENT OF SCHOOLS WITH ACCESSIBLE AND EFFECTIVE REFERRAL AND TREATMENT SYSTEMS (VOLUNTARY COUNSELLING AND TESTING)
(To be completed)

HIV/AIDS 3: PERCENTAGE OF SCHOOLS THAT PROVIDED LIFE SKILLS-BASED HIV EDUCATION, INCLUDING SEXUALITY EDUCATION, WITHIN THE CURRICULUM, IN THE LAST ACADEMIC YEAR
(To be completed)

HIV/AIDS 4: PERCENTAGE OF SCHOOLS THAT PROVIDED CO- OR EXTRA- CURRICULAR LIFE SKILLS BASED HIV EDUCATION, INCLUDING SEXUALITY EDUCATION, WITHIN THE LAST ACADEMIC YEAR
(To be completed)

HIV/AIDS 4: PERCENTAGE OF SCHOOLS WITH TEACHERS WHO HAVE BOTH RECEIVED TRAINING TO TEACH LIFE SKILLS BASED HIV AND SEXUALITY EDUCATION AND WHO TAUGHT THE SUBJECT AS PART OF THE CURRICULUM WITHIN THE LAST ACADEMIC YEAR
(To be completed)

Comments and Concerns:

This is a sample of how one indicator could be presented. This comes directly from a DRAFT of Proposed Indicators for the Global HIV M&E HIV/AIDS indicators 3,4,5 plus of the Impact REVISED HIV IATT Indicators can be presented like this if desired. EDUCAIDS framework contains all of this information

Thematic Indicator 2: Deworming (Neglected Tropical Diseases-Controlled)

Soil-transmitted helminths, commonly known as intestinal worms, and schistosomiasis affects hundreds of millions school-age children worldwide, with the greatest number of infections in sub-Saharan Africa and southeast Asia. Infection is caused by ingestion of eggs from contaminated soil (roundworm and whipworm) or by active penetration of the skin by larvae in the soil (hookworms).

Symptoms of worm infections can include stomach pain, coughing, fever, vomiting, diarrhoea, loss of appetite, a swollen belly, blood in stools or urine, and fatigue and listlessness. Worms can limit nutrient absorption and cause internal bleeding, leading to anaemia and malnutrition.

The infection of children aged 5 to 14—ages when they should be undergoing intense physical and intellectual growth—has negative effects on growth, nutritional status (particularly levels of iron and vitamin A), physical activity, cognitive development, concentration, and school performance. Adolescent girls are particularly at risk of anaemia that is aggravated by parasitic infections and ‘iron stress’. The impact on girls may also be worse in situations of poverty where girls may experience poorer nutritional status because boys are often favoured when food is scarce.

Although relatively few deaths are estimated to be directly attributable to worms, the significance of these infections for school children lies in their chronic effects on health and nutrition. They cause absenteeism from school and interfere with learning, and therefore limit the ability to overcome the cycle of poverty.

Deworming Indicators Table

DEWORMING	
POLICY	<ol style="list-style-type: none"> 1. Existence of National Level policy for school deworming 2. Percent of schools with written policies on deworming 3. Percent of schools with a deworming policy focusing on infection prevention and treatment of infected students. 4. Percent of schools that have assigned a head teacher to implement, monitor and review deworming policies
ENVIRONMENT	<ol style="list-style-type: none"> 5. Percent of children who attend schools with safe water supply, well maintained and cleaned school latrines; hand washing facilities; as well as safe collection and disposal of human waste (review after writing hygiene, water and sanitation thematic area)
SERVICES	<ol style="list-style-type: none"> 6. Percent of children who attend schools that initiated parasite screening in the past year 7. Percent of schools that provide treatment for worms once in the past 12 months 8. Percent of school-aged children who received treatment for worms once in the past 12 months 9. Percent of schools that conducted deworming health education activities to enrolled and non-enrolled school-aged children in the past 12 months 10. Percent of school-aged children who participated in deworming health education activities conducted by schools once in the past 12 months 11. Percent of schools that provide a standard supply of iron tablets (to enrolled and not enrolled students) 12. Percent of schools that provide vitamin A supplementation in the past year (to enrolled and not enrolled students)
SKILLS-BASED HEALTH EDUCATION	<ol style="list-style-type: none"> 13. Percent of schools that provide life skills education on prevention of parasites, including worms 14. Percent of students who received life skills education on prevention of parasites, including worms 15. Percent of schools that provide hygiene education for schoolchildren as part of the school curriculum 16. Percent of students who received hygiene education for schoolchildren as part of the school curriculum 17. Percent of schools that provide life skills education on symptoms of parasitic infections and the importance of seeking health care 18. Percent of students who received life skills education on symptoms of parasitic infections and the importance of seeking health care 19. Percent of primary schools that provide opportunities for teacher training on key themes of parasite prevention 20. Percent of secondary schools that provide opportunities for teacher training on key themes of parasite prevention 21. Percent of schools that promote positive hygiene behaviours, including mandatory correct use and maintenance of facilities that are systematically promoted among staff and schoolchildren. 22. Percentage of teachers who have ever received training in Deworming life skills education
OUTCOME INDICATORS	<ol style="list-style-type: none"> 1. Percent of school children and teachers who are aware of the symptoms of parasitic infections like intestinal worms 2. Percent of school children and teachers who know specific facts about parasite infections (e.g. washing hands after going to the latrine is one way of preventing worms) 3. Percent of school children and teachers who have positive attitudes towards specific behaviours that help prevent becoming infected with worms

4. Percent of students and teachers who show necessary skills and behavioural intent to apply learned behaviours that help prevent becoming affected with worms
5. Percent of students and teachers who understand treatment options for infections
6. Percent of students and teachers who wash hands after going to the toilet
7. Percent of students and teachers who sought medical care for parasite infection

IMPACT INDICATORS

8. Percent decrease of the density of worms in schoolchildren
9. Percent decrease in the incidents of anaemia in school children

STANDARDS

1. 75% of children are dewormed twice a year where the prevalence of soil-transmitted helminths is >50%
2. 75% of at risk children are de-wormed once a year where the prevalence of soil-transmitted helminths is 20-50%
3. Children are considered at risk if they live in an area where the STH prevalence is over 20%.

Indicator Components for Deworming

DEWORMING 1: EXISTENCE OF NATIONAL LEVEL POLICY FOR SCHOOL DEWORMING

Key question: Is there a National Level Policy for School Deworming? Yes/No

DEWORMING 2: PERCENT OF SCHOOLS WITH WRITTEN POLICIES ON DEWORMING

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/interview

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key Question:

Does your school have a written policy on deworming? Yes/No

NUMERATOR: Total number of schools with a policy on school deworming

DENOMINATOR: Total number of schools surveyed

DEWORMING 3: PERCENT OF SCHOOLS WITH DEWORMING POLICIES FOCUSING ON INFECTION PREVENTION AND TREATMENT OF INFECTED STUDENTS

DEWORMING 3.1 PERCENT OF SCHOOLS WITH DEWORMING POLICIES FOCUSING ON INFECTION PREVENTION

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/Interview during which school policy is reviewed

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Does your school deworming policy focus on infection prevention? Yes/No deworming?

NUMERATOR: Total number of schools with a policy on school deworming focusing on infection prevention (*the numerator should be the same or less than the numerator for Deworming 2*)

DENOMINATOR: Total number of schools surveyed

DEWORMING 3.2 PERCENT OF SCHOOLS WITH DEWORMING POLICIES FOCUSING ON TREATMENT OF INFECTED STUDENTS

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/Interview during which school policy is reviewed

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Does your school deworming policy focus on treatment of infected students? Yes/No

NUMERATOR: Total number of schools with a policy on school deworming focusing on treatment of infected students

(*The numerator should be the same or less than the numerator for Deworming 2*)

DENOMINATOR: Total number of schools surveyed

DEWORMING 4: PERCENT OF SCHOOLS THAT HAVE ASSIGNED A HEAD TEACHER TO IMPLEMENT, MONITOR AND REVIEW DEWORMING POLICIES

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/Interview during which school policy is reviewed

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Does your school have a head teacher to implement, monitor and review deworming policies? Yes/No

NUMERATOR: Total number of schools with a head teacher assigned to implement, monitor and review deworming policies

(*The numerator should be the same or less than the numerator for Deworming 2*)

DENOMINATOR: Total number of schools surveyed

DEWORMING 5: ENVIRONMENT (TBC)

DEWORMING 6: PERCENT OF SCHOOLS THAT INITIATED PARASITE SCREENING IN THE PAST YEAR

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools).

Key question: Did your school initiate parasite screening for worms in the past year? Yes/No

NUMERATOR: Total number of schools providing parasite screening for worms

DENOMINATOR: Total number of schools surveyed

DEWORMING 7: PERCENT OF SCHOOLS THAT PROVIDE TREATMENT FOR WORMS ONCE IN THE PAST 12 MONTHS ALL SCHOOL-AGED CHILDREN (ENROLLED)

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/Interview during which school policy is reviewed

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Did your school provide treatment for worms to all enrolled school-aged children in the last 12 months? Yes/No

NUMERATOR: Total number of schools that provided treatment to all enrolled school-aged children in the last 12 months

DENOMINATOR: Total number of schools surveyed in at risk areas

DEWORMING 8: PERCENT OF SCHOOLS THAT PROVIDE TREATMENT FOR WORMS ONCE IN THE PAST 12 MONTHS ALL SCHOOL-AGED CHILDREN (NOT ENROLLED)

(Same as Deworming 7, but for non-enrolled school-aged children)

DEWORMING 9: PERCENT OF SCHOOLS THAT CONDUCTED DE-WORMING HEALTH EDUCATION ACTIVITIES ONCE IN THE PAST 12 MONTHS FOR ALL SCHOOL-AGED CHILDREN (ENROLLED)

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/Interview during which school policy is reviewed

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Does your school have a head teacher to implement, monitor and review deworming policies? Yes/No

NUMERATOR: Total number of schools with a head teacher assigned to implement, monitor and review deworming policies

DENOMINATOR: Total number of schools surveyed in at risk areas

Health education activities should coincide with treatment services

DEWORMING 10: PERCENT OF SCHOOLS THAT CONDUCTED DE-WORMING HEALTH EDUCATION ACTIVITIES ONCE IN THE PAST 12 MONTHS FOR ALL SCHOOL-AGED CHILDREN (NON ENROLLED)

(Same as Deworming 7, but for non-enrolled school-aged children)

DEWORMING 11: PERCENT OF SCHOOLS THAT PROVIDE A STANDARD SUPPLY OF IRON TABLETS
(To be completed)

*School Children receive weekly iron tablets for at least 12 weeks in a year

DEWORMING 12: PERCENT OF SCHOOLS THAT PROVIDED VITAMIN A SUPPLEMENTATION IN THE PAST YEAR

(SEE NUTRITION 5- INDICATOR IS THE SAME)

DEWORMING 13: PERCENT OF SCHOOLS THAT PROVIDE LIFE SKILLS EDUCATION ON PREVENTION OF PARASITES, INCLUDING WORMS

(To be completed)

DEWORMING 14: PERCENT OF SCHOOLS THAT PROVIDE LIFE SKILLS EDUCATION ON SYMPTOMS OF PARASITIC INFECTIONS AND THE IMPORTANCE OF SEEKING HEALTH CARE
(To be completed)

DEWORMING 15: PERCENT OF PRIMARY SCHOOLS THAT PROVIDE OPPORTUNITIES FOR TEACHER TRAINING ON KEY THEMES OF PARASITE PREVENTION
(To be completed)

DEWORMING 16: PERCENT OF SECONDARY SCHOOLS THAT PROVIDE OPPORTUNITIES FOR TEACHER TRAINING ON KEY THEMES OF PARASITE PREVENTION
(To be completed)

Notes: Training should include teaching methods and resources to build knowledge and awareness of parasite prevention. Opportunities for further teacher training may include workshops and seminars available to teachers at their schools.

DEWORMING 17: PERCENT OF SECONDARY SCHOOLS THAT PROVIDE OPPORTUNITIES FOR TEACHER TRAINING ON KEY THEMES OF PARASITE PREVENTION
(To be completed)

DEWORMING 18: PERCENT OF SCHOOLS THAT PROMOTE POSITIVE HYGIENE BEHAVIORS, INCLUDING MANDATORY CORRECT USE AND MAINTENANCE OF FACILITIES THAT ARE SYSTEMATICALLY PROMOTED AMONG STAFF AND SCHOOLCHILDREN.
(To be completed)

SOURCES

IRC (2007). *Towards Effective Programming for WASH in Schools: A manual on scaling up programmes for water, sanitation and hygiene in schools*. Delft, The Netherlands, IRC International Water and Sanitation Centre. (TP series; no. 48). 93 p.

WHO Programs on Intestinal Worms, http://www.who.int/intestinal_worms/en/
Water, Sanitation and Hygiene (WASH) program standards

Baseline survey -- as outlined in the Guidelines for the evaluation of soil transmitted helminthiasis and schistosomiasis at community level (WHO/CTD/SIP/98.1).

WHO Information Series on School Health - Strengthening Interventions to Reduce Helminth Infections: An Entry Point for the Development of Health-Promoting Schools. Geneva: WHO

http://www.who.int/wormcontrol/documents/publications/en/99_3.pdf

<http://www.freshschools.org/Pages/HealthRelatedSchoolPolicies.aspx>

www.dewormtheworld.org

<http://www.dewormtheworld.org/pdf/SchoolDewormingataglance.pdf>

<http://heapro.oxfordjournals.org/cgi/content/full/15/3/197>

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2657832/>

Comments and Concerns:

Are we specifying a national policy on school deworming specifically or deworming as a component of the national school health and nutrition policy?

Thematic Indicator 3: Hygiene, Water Supply and Sanitation

Many schools serve communities that have a high prevalence of diseases related to inadequate water supply, sanitation and hygiene (particularly lack of handwashing), and where child malnutrition and other underlying health problems are common. Schools, particularly those in rural areas, often completely lack drinking water and sanitation facilities, or have facilities that are inadequate in both quality and quantity.

Girls and boys, including those with disabilities, are likely to be affected in different ways by inadequate water, sanitation and hygiene conditions in schools, and this may contribute to unequal learning opportunities. For example, lack of adequate, separate private and secure toilets and washing facilities may discourage parents from sending girls to school. In addition, lack of adequate facilities for menstrual hygiene can contribute to girls missing days at school; this can even lead girls to drop out of education altogether at puberty. Toilets that are inaccessible often mean that a disabled child does not eat or drink all day to avoid needing the toilet, leading to health problems and eventually to their dropping out of school altogether.

Children who have adequate water, sanitation and hygiene conditions at school are more able to integrate hygiene education into their daily lives, and can be effective messengers and agents for change in their families and the wider community. Conversely, communities in which schoolchildren are exposed to disease risk because of inadequate water supply, sanitation and hygiene at school are themselves more at risk. Families bear the burden of their children's illness due to bad conditions at school.

The hygiene behaviours that children learn at school — made possible through a combination of hygiene education and suitable water, sanitation and hygiene-enabling facilities — are skills that they are likely to maintain as adults and pass on to their own children.

(Introduction entirely adapted from sections *Water, sanitation and hygiene standards for schools in low-cost settings*. Edited by John Adams, Jamie Bartram, Yves Chartier, Jackie Sims)

Hygiene, Water and Sanitation Indicators Table

HYGIENE, WATER SUPPLY AND SANITATION
<p>POLICY</p> <ol style="list-style-type: none"> 1. Minimum Standards for Water, Sanitation and Hygiene Education (WASH) in Schools are defined at the national level 2. Percentage of schools that meet their national standards for WASH
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 3. Percent of schools with a safe, sustainable and accessible water supply 4. Percent of schools with sufficient, accessible, private, secure, clean and culturally appropriate toilets/latrines for schoolchildren and staff 5. Percent of schools where the school environment is kept safe through regular cleaning and waste disposal.
<p>SERVICES</p>
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 6. Percent of schools that provide hygiene education for schoolchildren as part of the school curriculum 7. Percent of students who received hygiene education for schoolchildren as part of the school curriculum 8. Percent of schools that promote positive hygiene behaviours, including mandatory correct use and maintenance of facilities that are systematically promoted among staff and schoolchildren (same as life skills 23 for Deworming). 9. Percent of schools that provide soap for handwashing (where there enough soap for children to wash their hands more than about 80% of the time- or 4 out of 5 days a week) 10. Facilities and resources enable staff and schoolchildren to practice behaviours that control disease transmission in an easy and timely way. 11. Percentage of teachers who have ever received training in hygiene, water and sanitation life skills education
<p>OUTCOME INDICATORS</p> <ol style="list-style-type: none"> 1. Percentage of students who know and understand specific facts about hygiene and menstruation 2. Percentage of students who have positive attitudes towards specific behaviours that ensure good personal hygiene
<p>IMPACT</p> <ol style="list-style-type: none"> 3. Reduction in diarrheal diseases 4. Increased enrolment 5. Increased attendance 6. Improved cognitive development 7. Gender equity in access to education increased

Indicator Components for Hygiene, Water Supply and Sanitation

Policy Notes:

Standard suggested is – a local set of targets, policies and procedures for implementing WASH in Schools national standards and/or guidelines determined

Water notes:

Water accessibility: Water for drinking, personal hygiene, food preparation, cleaning and laundry require that a functional and reliable water point is available (with soap/ash within school- esp. toilets and kitchens); a reliable drinking-water point is accessible; one shower is available for 20 users in boarding schools (including separate sex showers and showers for people with disabilities); and Laundry facilities with soap/detergent and hot water/chlorine solution are provided in boarding schools.

A functional water point is one that is available at or near the school that provides a sufficient quantity of water for the needs of school, is safe for drinking, and is accessible to children with disabilities.

Water potability and quality: Water safety should be measured against potability, as it is the highest potential end use of the water supply. To ensure safety of the water supply, the microbiological quality of drinking water must be sufficient (*Escherichia coli* or thermotolerant coliform bacteria are not detectable in any 100- ml sample). Drinking water must be treated if from unprotected source (treated to ensure microbiological safety), and chemical and radiological quality of drinking water must be sufficient (meeting WHO Guidelines for drinking-water quality, or national standards concerning chemical and radiological parameters). Drinking water must also be acceptable (there are no tastes, odours or colours that would discourage consumption of the water).

Water for other purposes must be clearly marked. Water that is not of drinking water quality can be used for cleaning, laundry and sanitation, but water for handwashing, bathing and dishwashing should be of drinking water quality.

Water supply is sufficient: Basic quantities of water are required for day schools, boarding schools and non-residential students and staff. For day schools, 5 litres per person per day is required for all schoolchildren and staff. For boarding schools, 20 litres per person per day is required. For all residential schoolchildren and staff 5 litres per person per day is required. Additional quantities of water required for flushing toilets, pour-flush toilets and anal washing. For flushing toilets, 10–20 litres per person per day is needed for conventional flushing toilets. For pour-flush toilets, 1.5–3.0 litres per person per day is needed. For anal washing, 1–2 litres per person per day is required. It is important that supply is sufficient to supply all needs at all times. Sustainability of the water supply may have to be addressed if some schools cannot meet their water supply needs.

Hygiene notes:

Handwashing facilities can be a standard tap with running water or a special handwashing station such as a container with a tap, a bucket with a dipper and basin, or any other device that provides about 1/2 litre of water each time a child wants to wash his or her hands. In schools, the critical times for handwashing is after defecation and before eating. If the school provides meals for children, food handlers should also have and use handwashing facilities.

In some schools, handwashing stations are located close to or within toilet blocks that are exclusively for girls or boys. In such cases, please fill in the numbers as exclusive for girls and for boys. For handwashing stations that can be used by both girls and boys (such as a tap and sink in a classroom) please fill in the numbers as communal.

Hygiene education can be provided through special sessions, as part of life skills training modules or as part of the regular curriculum. Hygiene education may include all aspects of personal hygiene, but should include at least some specific information and training about handwashing with soap.

Toilet/Latrine Notes:

Countries should define their own standards and definitions of sufficient, accessible, private, secure, clean and culturally appropriate based on their own beliefs and norms.

A toilet compartment is an individual stall/seat/squat plate where a single child can defecate in private. A toilet can be a pit latrine, an improved pit latrine, a flush toilet, a pour-flush toilet, or a composting toilet.

International standards for toilets/latrines for schoolchildren and staff are as follows: Sufficient toilets should be available where there is one per 25 girls and one for female staff; one toilet plus one urinal (or 50 cm of urinal wall) per 50 boys, and one for male staff. Toilets should be easily accessible to all, including staff and children with disabilities and be no more than 30 m from all users. Male and female toilets are completely separated. Toilets should provide privacy and security and be appropriate to local cultural and social conditions. Toilets should be age and gender appropriate and accessible for children with disabilities or suffering from chronic diseases (i.e. toilets are child friendly).

Toilets should also be hygienic to use and easy to clean and have convenient handwashing facilities close by. A cleaning and maintenance routine should be in operation, and ensures that clean and functioning toilets are available at all times.

Examples of interventions needed/inputs:

- Teachers, schoolchildren, families and other local stakeholders are mobilized to achieve and sustain a healthy school environment
- Definition on how to reach targets, implement policies and procedures for WASH in Schools defined
- Funding for improvement for WASH in Schools standards secured
- Mechanism to monitor WASH in Schools progress in schools established

Notes:

Examples of interventions needed/inputs:

- Hygiene education actually provided
- Hygiene promoted systematically
- Schoolchildren participate actively in maintaining hygiene
- Staff provide positive role models for hygiene behaviours
- School facilities maintained so as to be easy to use hygienically
- Children shown how to correctly use the toilet and water point, and how to wash their hands correctly

Notes for impact indicators

1. Percentage of learners who know and understand specific facts about hygiene and menstruation (i.e. how washing hands with soap before eating, after using a latrine/toilet and handling refuse is related to preventing disease, washing face daily to also avoid eye infections, girls need to know the significance of menstruation in relation to reproduction and the importance of menstrual hygiene and know how to care for and clean themselves when they are menstruating. Boys should also learn about menstruation and be aware of girls' particular hygiene needs.)
2. Percentage of learners who have positive attitudes towards specific behaviours that ensure good personal hygiene (e.g. washing hands and face with soap, and taking care of one's hygiene during menstruation). - show necessary skills and behavioural intent to apply learned behaviours and skills that ensure good personal hygiene

Sources

WHO (World Health Organization) (2009). *Water, sanitation and hygiene standards for schools in low-cost settings*. Edited by John Adams, Jamie Bartram, Yves Chartier, Jackie Sims)

UNICEF East Asia and the Pacific, WASH in Schools Monitoring Package (2010) (DRAFT-NOT PUBLISHED)

Comments and Concerns:

Alot to do here. Hopefully new WASH monitoring framework (to come out soon) can help with this.

Thematic Indicator 4: Malaria

Malaria is one of the major problems confronting school children, resulting in morbidity that affects school attendance and impairs cognition, learning and school performance. A child infected with malaria suffers with a high-grade fever and other potential symptoms such as convulsions, headaches, pains in the extremities, anorexia, complete exhaustion, nausea, diarrhoea and vomiting (WHO, 2007). Up to 50% of all deaths among African school age children can be accounted for by malaria (Brooker, 2009). In pregnancy, malaria is a major cause of low birth weight and maternal anaemia and can even result in maternal death. In Mozambique, for example, 27% of deaths in adolescent pregnant girls were caused by malaria (Brooker, 2009).

Schools are in an excellent position to help prevent and cure malaria by providing information on prevention and treatment through school-wide activities and curriculum based education, distribution and instruction on use of insecticide treated nets or long-lasting insecticidal nets, appropriate treatment and referrals for infected students, and more.

Malaria Indicators Table

MALARIA
<p>POLICY</p> <ol style="list-style-type: none"> 1. Existence of National Level policy for Malaria. 2. Percent of schools with a written policy, plan or guide to prevent and control malaria 3. Percent of schools that have assigned a head teacher to implement, monitor and review Malaria policies
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 4. Percent of schools that have been sprayed by indoor residual spraying in the past year
<p>SERVICES</p> <ol style="list-style-type: none"> 5. Percent of schools that distribute insecticide treated nets (ITNs) or long-lasting insecticidal nets (LLINs) to students 6. Percent of children who received insecticide treated nets (ITNs) or long-lasting insecticidal nets (LLINs) 7. Percent of schools promoting malaria diagnosis and prompt referral to community health facilities 8. Percent of students who received promoting malaria diagnosis and prompt referral to community health facilities 9. Percent of schools that initiated parasite screening in the last year (same indicator as DEWORMING 6) 10. Percent of students who received parasite screening in the last year 11. Percent of schools that provide access to prompt treatment with effective antimalarials.
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 12. Percent of schools with curriculum that includes 3 lessons on how to prevent and treat malaria 13. Percent of schools that provide education on malaria prevention 14. Percent of schools that provide education on how to properly diagnose malaria and when to seek medical advice 15. Percent of schools that provide education on malaria treatment (use of a full course of medication and follow treatment instructions religiously) 16. Percentage of teachers who have ever received training in Malaria life skills education
<p>OUTCOMES</p> <ol style="list-style-type: none"> 1. Percent of students who know and understand specific facts about Malaria and how to prevent becoming infected (students know that malaria is transmitted through the bites of some

mosquitoes, Sleeping under an insecticide-treated mosquito net is the best way to prevent mosquito bites)

2. Percent of students that know how to properly diagnose malaria and when to seek medical advice
3. Percent of students who can properly diagnose malaria
4. Percent of students that know when to seek medical advice for malaria
5. Percent of students that know how to use insecticide treated nets
6. Percent of students that know about the importance of a full course of medication for treatment of malaria using ACTs

IMPACT

7. Malaria-related absenteeism of students and staff reduced
8. Malaria infections (the presence of malaria parasites in the blood) among students and staff decreased
9. Malaria cases (fever and parasites) among students
10. Malaria death among students and staff decreased
11. Anaemia reduced among students in malaria high burden countries
12. Percent of children who have positive attitudes towards specific behaviours that help prevent becoming infected with Malaria

Indicator Components for Malaria

MALARIA 1: EXISTENCE OF NATIONAL LEVEL POLICY FOR MALARIA

Key question: Is there a National Level Policy for Malaria? Yes/No

MALARIA 2: PERCENT OF SCHOOLS WITH A WRITTEN POLICY, PLAN OR GUIDE TO PREVENT AND CONTROL MALARIA

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/interview

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Does your school have a written policy, plan or guide on malaria? Yes/No

NUMERATOR: Total number of schools with a written policy, plan or guide on malaria

DENOMINATOR: Total number of schools surveyed

MALARIA 3: PERCENT OF SCHOOLS THAT HAVE ASSIGNED A HEAD TEACHER TO IMPLEMENT, MONITOR AND REVIEW MALARIA POLICY, PLAN OR GUIDE

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey/Interview during which school policy is reviewed

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Does your school have a head teacher to implement, monitor and review the malaria policy, plan or guide?, Yes/No

NUMERATOR: Total number of schools with a head teacher assigned to implement, monitor and review malaria policy/plan/guide

DENOMINATOR: Total number of schools surveyed

MALARIA 4: PERCENT OF SCHOOLS THAT HAVE BEEN SPRAYED BY INDOOR RESIDUAL SPRAYING IN THE PAST YEAR

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Has your school been sprayed by indoor residual spraying in the past year? Yes/No

NUMERATOR: Total number of schools that were sprayed with a residual insecticide during an IRS campaign in the last year

DENOMINATOR: Total number of schools surveyed

INTERPRETATION:

All schools and other public buildings on the school grounds should be sprayed with insecticides. Dormitories of boarding schools should also be sprayed. While IRS is an effective measure to control vectors, the logistics of regular implementation is challenging. Therefore IRS should be viewed as one option for vector control rather than a definite solution (Brooker, 2009). Indoor residual spraying (IRS) is the indoor application of long-lasting (6-12 months) chemical insecticides to kill malarious mosquitoes.

MALARIA 5: PERCENT OF SCHOOLS THAT DISTRIBUTE INSECTICIDE TREATED NETS (ITNs) OR LONG-LASTING INSECTICIDAL NETS (LLINs) TO STUDENTS

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey

METHOD OF MEASUREMENT: Nationally-representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools)

Key question: Has your school distributed ITNs or LLNs to students in the past year? Yes/No

NUMERATOR: Total number of schools sprayed in the past year

DENOMINATOR: Total number of schools surveyed

INTERPRETATION:

ITNs are mosquito nets treated with an insecticide. The insecticide adds a chemical barrier to the physical barrier provided by the net. When the net is washed, the insecticide loses potency and must be retreated in order to remain effective. LLINs provide an alternative to ITNs because they don't require treatment and are thus more sustainable in the long run. Upfront cost of LLIN is higher than ITNs but becomes more cost effective after two years of use.

MALARIA 6: PERCENT OF SCHOOLS PROMOTING MALARIA DIAGNOSIS AND PROMPT REFERRAL TO COMMUNITY HEALTH FACILITIES

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools). Two-step process, which requires the calculation of a school level indicator, and a national-level indicator

School level:

NUMERATOR: Number of school children who were referred to community health facilities in the previous two weeks with a fever accompanied by malaria symptoms

DENOMINATOR: Total number of school children surveyed

Fever refers to: oral temperature ≥ 37.5 degrees C and symptoms are headache, muscle/joint pains

National Level:

NUMERATOR: Number of schools that referred children to community health facilities in the previous two weeks for malaria treatment

DENOMINATOR: Total number of schools surveyed

MALARIA 7: PERCENT OF SCHOOLS THAT INITIATED PARASITE SCREENING IN THE PAST YEAR

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools).

Key question: Did your school initiate parasite screening for malaria in the past year?
Yes/No

NUMERATOR: Total number of schools providing parasite screening for malaria

DENOMINATOR: Total number of schools surveyed

MALARIA 8: PERCENT OF SCHOOLS THAT PROVIDE ACCESS TO PROMPT TREATMENT WITH EFFECTIVE ANTIMALARIALS

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools).

Key question: Does your school provide access to prompt treatment services with effective antimalarials? Yes/No

NUMERATOR: Total number of schools providing prompt treatment with effective antimalarials

DENOMINATOR: Total number of schools providing parasite screening for malaria

INTERPRETATION:

Effective antimalarials are those such as Artemisinin-based Combination Therapies (ACTs). WHO recommends that all countries experiencing resistance to conventional monotherapies, such as chloroquine, amodiaquine or sulfadoxine-pyrimethamine, should use combination therapies, preferably those containing artemisinin derivatives, or ACTs. ACTs are treatments for uncomplicated falciparum malaria and are now the recommended first line of treatment for malaria in most countries in Africa

MALARIA 9: PERCENT OF SCHOOLS WITH CURRICULUM THAT INCLUDES 3 LESSONS ON HOW TO

PREVENT AND TREAT MALARIA

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: Interview with programme coordinator and teachers.

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools).

Key question: Does your school curriculum include 3 lessons on how to treat malaria?, Yes/No

NUMERATOR: Total number of schools with curriculum that includes 3 lessons on malaria

DENOMINATOR: Total number of schools surveyed

MALARIA 10: PERCENT OF SCHOOLS THAT PROVIDE EDUCATION ON MALARIA PREVENTION

To be completed

Education on malaria prevention should include use of insecticide treated nets (such as: how long to use it before replacing or re-treating it, what to do if one is not available, etc);

MALARIA 11: PERCENT OF SCHOOLS THAT PROVIDE EDUCATION ON HOW TO PROPERLY DIAGNOSE MALARIA AND WHEN TO SEEK MEDICAL ADVICE

To be completed

MALARIA 12: PERCENT OF SCHOOLS THAT PROVIDE EDUCATION ON MALARIA TREATMENT (USE OF A FULL COURSE OF MEDICATION AND FOLLOW TREATMENT INSTRUCTIONS RELIGIOUSLY)

To be completed

MALARIA 13: PERCENTAGE OF TEACHERS WHO HAVE EVER RECEIVED TRAINING IN MALARIA LIFE SKILLS EDUCATION

To be completed

MALARIA IMPACT INDICATORS: (TO BE COMPLETED)

SOURCES:

Brooker, Simon, et. Al. (2009) Malaria Control in Schools, A toolkit on effective education sector responses to malaria in Africa.

WHO (2007) Malaria Prevention and Control: An important responsibility of a Health-Promoting School. WHO Information Series on School Health.

Roll Back Malaria, Guidelines for Core Population-Based Indicators

Comments and Concerns:

Need to define "prompt"--within 24 or 48 hours after onset of fever?

Thematic Indicator 5: Nutrition

School-based nutrition interventions come in many forms including school gardens, nutrition education, micronutrient supplementation, school nutrition policies, and school feeding programs.

Micronutrient supplementation programs address the “hidden hunger” of micronutrient deficiencies. Iron deficiency anaemia is one of the most common micronutrient deficiencies amongst school age children, affecting around 50% of school age children worldwide (Jukes, m et al. 2008) and reducing children’s ability to participate and learn in school. Micronutrient deficiencies are caused by a variety of problems including parasitic infections such as worms and malaria, and poor quality of diet. Micronutrient supplementation is typically given after deworming and in the case of iron, the supplementation can last long periods e.g. one or two iron tablets a week for 10-15 weeks. (Adapted from Levelling the Playing Field/UNICEF)

Food For Education (FFE) programs typically provide school meals; snacks or take-home rations and can contribute to both improved educational and nutritional outcomes. They can help increase school enrolment and attendance (especially with girls through take-home rations), improve cognitive abilities and educational attainment. School meals have shown to produce a small but significant effect on weight gain and also help reduce micronutrient deficiencies through the use of fortified foods (Kristjansson, et al. 2008). By addressing short-term hunger and micronutrient deficiencies through fortified foods, feeding programs impact the immediate effects of poor nutrition. School feeding programs can also provide an income transfer to households by freeing up some of the money normally allocated to food to invest in other areas.

Nutrition education programs can help combat undernutrition and obesity as well as address micronutrient deficiencies by helping children and their families adopt healthy lifestyles through improved nutrition knowledge, attitudes and behaviours. Nutrition education interventions can address the burden of non-communicable diseases improve dietary habits and patterns of physical activity and nutrition-related decisions in the short and long term.

Nutrition Indicators Table

NUTRITION
<p>POLICY</p> <ol style="list-style-type: none"> 1. Existence of a national school nutrition policy 2. Existence of national-level curriculum standards for health education with focus on diet and physical activity
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 3. Percentage of schools where food for schoolchildren and staff is stored and prepared so as to minimize the risk of disease transmission—
<p>SERVICES</p> <p><i>Micronutrient supplementation</i></p> <ol style="list-style-type: none"> 4. Percent of schools providing micronutrient supplementation in the past year 5. Percentage of children (by sex) supplemented with micronutrients <p><i>Note: Define the type and course of micronutrients provided and adapt indicator as needed e.g. Percentage of schools which provided two iron tablets per week to all school children for 15 weeks</i></p> <p><i>School feeding</i></p> <ol style="list-style-type: none"> 6. Percentage of children receiving WFP food assistance as a percentage of planned beneficiaries by project category, age group, sex in the past year 7. Percent of schools providing Food For Education in the past year

SKILLS-BASED HEALTH EDUCATION

8. Total number of health education sessions focusing on healthy diet and physical activity per year within the national curriculum
9. Percent of schools that provided life skills-based nutrition education awareness programs
10. Percentage of learners who know specific facts about nutrition and healthy life styles related to balanced diet and how to ensure food and water are safe to be consumed
11. Percentage of learners who have positive attitudes towards healthy eating habits and exercise
12. Percent of learners who show necessary skills and behavioural intent to apply behaviours and skills that ensure healthy life style such as healthy eating habits and exercise
13. Percentage of teachers who have ever received training in Nutrition life skills education

IMPACT

1. Prevalence of thinness/wasting (low BMI for age)
2. Prevalence of Anaemia
3. Have positive attitudes towards specific behaviours
4. Improved capacity to concentrate and learn

Indicator Components for Nutrition**NUTRITION 1: EXISTENCE OF A NATIONAL SCHOOL NUTRITION POLICY**

To be completed

NUTRITION 2: EXISTENCE OF NATIONAL-LEVEL CURRICULUM STANDARDS FOR HEALTH EDUCATION WITH FOCUS ON DIET AND PHYSICAL ACTIVITY

To be completed

NUTRITION 3: PERCENT OF SCHOOLS WHERE FOOD FOR SCHOOLCHILDREN AND STAFF IS STORED AND PREPARED SO AS TO MINIMIZE THE RISK OF DISEASE TRANSMISSION

To be completed

Interpretation:

1. Food is handled and prepared with utmost cleanliness (hand are washed before preparing food).
2. Contact between raw foodstuffs and cooked food is avoided.
3. Food is cooked thoroughly.
4. Food kept at safe temperatures.
5. Safe water and safe raw ingredients are used.

Examples of interventions needed/inputs:

1. Food storage and preparation areas designed and built so as to be easy to keep clean
2. A handwashing station provided in the kitchen area

NUTRITION 4: PERCENTAGE OF SCHOOLS PROVIDING MICRONUTRIENT SUPPLEMENTATION IN THE PAST YEAR (DEFINE TYPE AND COURSE OF SUPPLEMENTATION)

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School activity reports

METHOD OF MEASUREMENT: All schools targeted by the program (disaggregated by primary and secondary schools and type of school).

Key question: Has your school provided micronutrient supplements to schoolchildren in the past year? Yes/No

NUMERATOR: Total number of schools that provided micronutrient supplementation in the past year

DENOMINATOR: Total number of schools targeted by the program

NUTRITION 5. PERCENT OF CHILDREN (BY SEX) SUPPLEMENTED WITH MICRONUTRIENTS IN THE PAST YEAR

DATA COLLECTION FREQUENCY: Annually or after each supplementation

MEASUREMENT TOOLS: Supplementation monitoring forms

METHOD OF MEASUREMENT: All schools targeted by the program (disaggregated by primary and secondary schools and type of school).

Key question: How many boys and girls were supplemented with micronutrients (define minimum course required) in the past year ?

NUMERATOR: Total number of boys and girls that were supplemented in the past year in the program schools

DENOMINATOR: Total number of boys and girls enrolled in the program schools

THE INDICATORS BELOW ON MICRONUTRIENTS ARE EXAMPLES OF HOW PROGRAMS MIGHT ADAPT THE INDICATORS TO A SPECIFIC MICRONUTRIENT

NUTRITION 5.1: PERCENT OF SCHOOLCHILDREN WHO RECEIVED WEEKLY IRON TABLETS FOR AT LEAST 12 WEEKS IN THE PAST YEAR

Key question: How many children have received iron supplements the past year?

NUMERATOR: Number of children who have received iron supplements in the past year

DENOMINATOR: Total number of children enrolled in school

NUTRITION 5.2: PERCENT OF SCHOOLS PROVIDING VITAMIN A IN THE PAST YEAR

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School survey, program records and/or SCHOOL HEALTH monitoring forms

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools).

Key question: Has your school provided Vitamin A supplementation to schoolchildren in the past year? Yes/No

NUMERATOR: Total number of schools that provided vitamin A supplementation in the past year

DENOMINATOR: Total number of schools surveyed

NUTRITION 5.3: PERCENT OF SCHOOLCHILDREN WHO HAVE RECEIVED 6 MONTHLY VITAMIN A SUPPLEMENTS IN THE PAST YEAR

NUMERATOR: Number of children who have received vitamin A supplements in the past year

DENOMINATOR: Total number of children enrolled in school

NUTRITION 6: PERCENTAGE OF CHILDREN RECEIVING WFP FOOD ASSISTANCE AS A PERCENTAGE OF PLANNED BENEFICIARIES BY PROJECT CATEGORY, AGE GROUP, SEX

To be completed

NUTRITION 7: PERCENT OF SCHOOLS PROVIDING FOOD FOR EDUCATION IN THE PAST YEAR

To be completed

NUTRITION 8: TOTAL NUMBER OF HEALTH EDUCATION SESSIONS FOCUSING ON HEALTHY DIET AND PHYSICAL ACTIVITY PER YEAR WITHIN THE NATIONAL CURRICULUM

To be completed

NUTRITION 9: PERCENT OF SCHOOLS THAT PROVIDED LIFE SKILLS-BASED NUTRITION EDUCATION AWARENESS PROGRAMS

DATA COLLECTION FREQUENCY: Annually

MEASUREMENT TOOLS: School activity reports

METHOD OF MEASUREMENT: All schools targeted by the program (disaggregated by primary and secondary schools, and type of school).

Key question: Does your school provide nutrition education and awareness programs? Yes/No

NUMERATOR: Total number of schools that provided nutrition education and awareness programs

DENOMINATOR: Total number of schools in the program

NUTRITION 10: PERCENTAGE OF CHILDREN WHO KNOW CERTAIN FACTS ABOUT NUTRITION AND HAVE POSITIVE ATTITUDES TOWARDS SPECIFIC BEHAVIOURS

To be completed

INTERPRETATION:

Facts about nutrition may include the following

- Raw food should be washed or cooked and cooked food should be eaten straight away; all water that people drink and use should come from a safe source or be purified;
- Containers for carrying and storing water need to be kept clean inside and outside and covered to keep the water clean;
- Where necessary, home-based water treatment, such as boiling, filtering, adding chlorine or disinfecting with sunlight, should be used to purify the water,
- Food, utensils and preparation surfaces should be kept clean and away from animals;
- Food should be stored in covered containers, safe disposal of all household refuse helps to keep the living environment clean and healthy and avoid illness.).

NUTRITION 11: PERCENT OF LEARNERS WHO SHOW NECESSARY SKILLS AND BEHAVIORAL INTENT TO APPLY BEHAVIORS AND SKILLS THAT ENSURE HEALTHY LIFE STYLE SUCH AS HEALTHY EATING HABITS AND EXERCISE

To be completed (unclear about what skills and behaviours would be...)

NUTRITION 12: PERCENT OF LEARNERS WHO SHOW NECESSARY SKILLS AND BEHAVIOURAL INTENT TO APPLY BEHAVIOURS AND SKILLS THAT ENSURE HEALTHY LIFE STYLE SUCH AS HEALTHY EATING HABITS AND EXERCISE

TO BE COMPLETED

NUTRITION 13: PERCENTAGE OF TEACHERS WHO HAVE EVER RECEIVED TRAINING IN NUTRITION LIFE SKILLS EDUCATION

To be completed

IMPACT *To be completed*

1. Prevalence of thinness/wasting (low BMI for age)
2. Prevalence of Anaemia
3. Have positive attitudes towards specific behaviours
4. Improved capacity to concentrate and learn

Notes on Anaemia:

The prevalence of anaemia is defined as the proportion (%) of the population surveyed with haemoglobin (Hb) concentration (g/L) below a certain cut-off level. The six cut-off levels: 70, 100, 110, 115, 120 and 130 g/L are the ones most frequently used.

General recommendations for younger school-age children: Intervention needed when anaemia prevalence is above 40% among school age children (above 60 months of age)

SOURCES:

Monitoring School Health and Nutrition Programs, Save the Children/US, (2008).

Ramage, A. Indicators for School-based Nutrition Interventions: A Review of Existing Resources on Micronutrient Supplementation, Food for Education and Nutrition Education, Save the Children/US (2010).

Kristjansson, EA, et al. "School Feeding for improving the physical and psychosocial health of disadvantaged students (Review)." *The Cochrane Library* (John Wiley & Sons, Ltd), no. 4 (2008).

Comments and Concerns:

Need to include facts about good foods to eat, as well as food hygiene. E.g. % of children who know the national dietary recommendations for a healthy lifestyle e.g. eat 5 portions of fruit and veg a day (UK one, would be nice to have one from a developing country)

DRAFT

Thematic Indicator 6: Education for Sustainable Development

Education for sustainable development develops and strengthens the capacity of individuals, groups, communities, organizations and countries to make judgements and choices in favour of sustainable development. It can promote a shift in people's mindsets and in so doing enable them to make our world safer, healthier and more prosperous, thereby improving the quality of life. Education for sustainable development can provide critical reflection and greater awareness and empowerment so that new visions and concepts can be explored and new methods and tools developed. (Taken from UNECE Strategy for Education for Sustainable Development).

Education for Sustainable Development Indicators Table

EDUCATION FOR SUSTAINABLE DEVELOPMENT
<p>POLICY</p> <ol style="list-style-type: none"> 1. Percent of schools with policies concerning: water usage, quality of food and water, waste management, reducing consumption patterns 2. Percent of schools adopt a "whole-institution approach" to Sustainable Development (SD)/ Education for Sustainable Development (ESD)
<p>ENVIRONMENT</p>
<p>SERVICES</p> <p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 1. The topic of environmental health addressed in the formal curriculum in primary school 2. Sustainable development is integrated in pre-service teacher training 3. Sustainable development is integrated in in-service teacher training 4. Learning outcomes (skills, attitudes and values) that support Environment and Sustainable development (ESD) are addressed explicitly in the curriculum programme of study at various levels of formal education?" 5. ESD methods and instruments for non-formal and informal learning are in place to assess changes in knowledge, attitude and practice. 6. ESD learning is addressed by quality assessment/enhancement systems (examinations) 7. ESD is included in the training of educators: <ul style="list-style-type: none"> - ESD is part of the initial educators' training - ESD is part of the educators' in-service training - ESD is part of training of leaders and administrators of educational institutions 8. Learners know and understand (knowledge): <ul style="list-style-type: none"> - analytical questions/critical thinking - complexity/systemic thinking - how to overcome obstacles/problem-solving - how to manage change/problem-setting - creative thinking/future-oriented thinking - interrelationships across disciplines/holistic approach - ESD key themes and their impact on individuals and society: Peace studies; Ethics and philosophy; Citizenship, democracy and governance; Human rights; Poverty alleviation; Cultural diversity; Biological and landscape diversity; Environmental Protection; Ecological principles/ecosystem approach; Natural resource management; Climate change; Personal and family health (e.g. HIV/AIDS, drug abuse, ...); Environmental health (e.g. food and drinking; water quality; pollution); Corporate social responsibility; Production and/or consumption patterns; Economics; Rural/urban development 9. Learners are someone who (attitudes): <ul style="list-style-type: none"> - is self-confident - shows self-expression and communication - copes under stress - identifies and clarifies values 10. Learners are able to (skills):

- act with responsibility (locally and globally)
- act with self-respect
- act with respect for others
- act with determination- identify stakeholders and their interests
- collaborate/work in teams
- participate in democratic decision making
- negotiate and build consensus
- distribute responsibilities
- apply learning in a variety of life-wide contexts
- make decisions, including in situations of uncertainty
- deal with crises and risks

Key themes of SD to be explicitly addressed in the primary and secondary school curriculum include: Peace studies; Ethics and philosophy; Citizenship, democracy and governance; Human rights; Poverty alleviation; Cultural diversity; Biological and landscape diversity; Environmental Protection; Ecological principles/ecosystem approach; Natural resource management; Climate change; Personal and family health (e.g. HIV/AIDS, drug abuse) Environmental health (e.g. food and drinking; water quality; pollution); Corporate social responsibility; Production and/or consumption patterns; Economics; Rural/urban development

Impact Indicators

1. Percentage of learners who know and understand that environmental, social, and economic spheres are interrelated
2. Percentage of learners who know that our world is in constant change and in an emergency continuum and that existing knowledge might be later found to be irrelevant, wrong or incomplete
3. Percentage of learners who know about environmental protection and concepts pertaining to reusing, recycling and conserving environmental resources
4. Percentage of learners who know about the negative impact of environmental pollution and degradation on development
5. Percentage of learners who know about environmental risks and emergency preparedness.
6. Percentage of learners who have positive attitudes towards the need for transformation towards development that aims for the advancement of quality of livelihood, solidarity and environmental sustainability
7. Percentage of learners that realize own role in use of resources and in solving environmental problems; value the natural environment, and responsible use of available environmental resources to ensure environmental sustainability
8. Percentage of learners that are aware of environmental hazards and risks
9. Percentage of learners who know that show necessary skills and behavioural intent to: envision and make informed decision with regard to long-term consequences of decisions and actions; use resources responsibly and solve environmental problems; advocate for preserving the natural environment; participate in environmental preservation and disaster management; reduce own and others' risks during natural and manmade disasters.

Indicator Components for Sustainable Development

To be completed

SOURCES

Good Practices in Education for Sustainable Development, UNICEF

<http://www.unece.org/env/esd/GoodPractices/list.html>

UNECE Expert Group on Indicators

<http://www.unece.org/env/esd/SC.EGI.htm>

UN Economic and Social Council

<http://www.unece.org/env/documents/2009/ECE/CEP/AC.13/ece.cep.ac.13.2009.5.e.pdf>

Comments and Concerns: UNICEF Expert Group in Competences in ESD to meet they are meeting 25-27 Oct 2010 to review the indicators. Indicators are to be finalized by January and printed in April.

Thematic Indicator 7: Sexual and Reproductive Health

Introduction and importance of topic *(To be completed)*

Sexual and Reproductive Health Indicators Table

SEXUAL AND REPRODUCTIVE HEALTH
<p>POLICY</p> <ol style="list-style-type: none"> 1. Policies that prohibit discrimination on basis of gender identity, sexual orientation or physical & intellectual disability 2. Policies that prohibit bullying, sexual harassment and sexual violence
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 3. Percent of female learners who have onsite access to sanitary products during menstruation
<p>SERVICES</p>
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 4. Percentage of learners who have received sexuality education 5. Percentage of learners who have talked with a parents or trusted adult re any sexual and reproductive health matters in the last year 6. Percentage of schools who have access to school-based or school-linked SRH counselling and/or services 7. Percentage of teachers who have ever received training in SRH life skills education
<p>IMPACT</p> <ol style="list-style-type: none"> 1. Percentage of learners who have taken measures to avoid adverse SRH outcomes (e.g., used contraception- including condoms, or chosen not to be sexually active) 2. Percentage of learners 15-19 years with unintended pregnancy 3. Percentage of learners whose peer group knows about and supports contraceptive use 4. Percentage of learners who feel confident abstaining from sex or using contraception (incl condom) 5. Percent of learners who have positive values and attitudes towards sexuality 6. Percent of learners who are respectful of differences and confident to manage negative norms and peer influence and make informed decisions with regard to sexual behaviour 7. Percent of learners who show necessary skills and behavioural intent to take measures to avoid adverse SRH outcomes (e.g., used contraception, incl condom, or chosen not to be sexually active) 8. Percent of learners who show necessary skills and behavioural intent to take measures to avoid adverse SRH outcomes to constructively use communication and negotiations with a parents or trusted adults re any sexual and reproductive health matters; Finding help and support) 9. Percent of learners who know and understand specific facts about Sexual Behaviour (Sex, Sexuality and the Sexual Life Cycle, Sexual Behaviour and Sexual Response) 10. Percent of learners who know and understand specific facts about Reproductive Health (Pregnancy Prevention, Understanding, Recognizing and Reducing the Risk of STIs, including HIV, HIV and AIDS Stigma, Care, Treatment and Support)

Indicator Components for Sexual and Reproductive health

To be completed

Thematic Indicator 8: Physical Activity

Current physical activity recommendations for children and adolescents include at least **60 minutes of moderate activity in total each day, with vigorous activity included at least twice a week** in order to build bone density, muscle strength and flexibility. (WHO).

Schools provide an excellent opportunity to enable students to acquire knowledge and skills and increase activity levels.

(To be completed)

Physical Activity Indicators Table

PHYSICAL ACTIVITY
<p>POLICY</p> <ol style="list-style-type: none"> 1. Schools with a policy, plan or guide to promote physical activity 2. Percent of schools that have assigned a head teacher to implement, monitor and review the policy, plan or guide. <p>Notes:</p> <ul style="list-style-type: none"> - Does the school have unwritten or informal policies on physical activity? - Are physical activity programmes offered from preschool to secondary school? - Are resources designated to support physical activity programmes? - What do administrators, teachers, community people, students and parents think of the policies?
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 3. Percent of schools providing education time for PE, PE expertise, facilities and space available for students to engage in a variety of physical activity, including provision of access to community resources when insufficient resources in schools prevents students from activity <p>Notes:</p> <p>Environment components: Ensure safe walking and cycling on the way to school. Provide bike storage facilities. Provide facilities and equipment for physical activity. Ensure safety for active transport to and from school. Ensure adequate safety precautions to prevent physical activity injuries and illness.</p> <ul style="list-style-type: none"> - Are physical activity facilities, equipment and space available during recess and at other times? - Are safety precautions being followed during curricular and extracurricular physical activities? - Can schools offer physical activity opportunities in extreme weather conditions?
<p>SERVICES</p> <ol style="list-style-type: none"> 4. Schools monitoring students' fitness, height and weight, including the collection of students' health and risk behaviour relating to physical activity <p>Notes:</p> <p>Monitor and assess physical activity levels and fitness. Collect medical information from students and parents that are relevant to participation in physical activity. Make recommendations on physical activity for students with disorders or disabilities. Are students, teachers and parents satisfied with the support provided by school health services for physical activity?</p> <ul style="list-style-type: none"> - Do school health services provide screening, counselling and other services related to physical activity? - Are first aid and other health services readily available to treat injuries that may occur during the performance of physical activity?
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 5. Training of teachers to implement skills-based health education including student led activities to promote physical activity through environmental changes 6. Percent of learners who show necessary skills and behavioural intent to apply behaviours and skills that ensure healthy life style such as healthy eating habits and exercise (Same as indicator 10 for nutrition) 7. Percentage of teachers who have ever received training in physical activity life skills education

8. Percent of schools that provide knowledge about the relationship of physical activity and health, its positive benefits for physical, psychological and social well-being and the long- and short-term consequences of sedentary lifestyles, such as obesity and risk of chronic diseases.
9. Percent of schools that help students develop positive attitudes about physical activity by emphasising the enjoyment rather than competitiveness of physical activity.
10. Percent of schools that encourage students to develop physical fitness, i.e. high levels of flexibility, strength, endurance and coordination, including motor skills.

IMPACT

To what extent have knowledge, attitudes, skills and practices of students and staff changed? (Use specific questions tailored to the objectives and activities of physical activity conducted at school.)

Indicator Components for Physical Activity

To be completed

SOURCE

Reference: WHO Series on School Health, Document 12. Promoting Physical Activity in Schools

DRAFT

Thematic Indicator 9: Oral Health, Vision and Hearing

Introduction and importance of topic *(To be completed)*

Oral Health, Vision and Hearing Indicators Table

ORAL HEALTH, VISION AND HEARING	
POLICY	1. Schools with a policy, plan or guide to promote oral health promotion, including the assignment of a head teacher to implement, monitor and review the policy, plan or guide
ENVIRONMENT	2. Supply of healthy food and drinks by school canteen, tuck shop and vending machines (if not covered by the Healthy Eating Thematic Area)
SERVICES	3. Schools implementing oral health services, including screening, treatment and preventing services such as scaling and fluoride application 4. Number and % schools doing vision screening 5. Number and % schools doing hearing screening 6. Number of children screened for vision problems 7. Number of children screened for hearing problems
SKILLS-BASED HEALTH EDUCATION	8. Students exposed to oral health education, including training for teachers to implement skills-based health education
IMPACT	1. Percentage of learners who know and understand specific facts about oral health 2. Reduction in children affected by tooth decay

Indicator Components for Oral Health, Vision and Hearing

To be completed

Thematic Indicator 10: Social Emotional Learning/Generic Life Skills

Introduction and importance of topic (*To be completed*)

Social Emotional Learning/Generic Life Skills Indicators Table

SOCIAL EMOTIONAL LEARNING/GENERIC LIFE SKILLS
<p>POLICY</p> <ol style="list-style-type: none"> 1. Percent of schools with strong leadership structure (same as Summary Indicator 1) 2. Percent of schools where students are encouraged to participate and engage in school-decision making and are given opportunities for leadership roles
<p>ENVIRONMENT</p> <ol style="list-style-type: none"> 3. Percent of schools conducive to social and emotional learning (same as Summary Indicator 8) 4. Percent of schools that have a supportive physical environment (same as Summary Indicator 9)
<p>SERVICES</p> <ol style="list-style-type: none"> 5. Percent of schools where Community Participation is sufficient
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 6. Percent of schools where teachers receive a sufficient level of professional support 7. Percent of schools where pedagogy is child centred
<p>IMPACT</p> <ol style="list-style-type: none"> 1. Percentage of learners who know and understand critical thinking and problem solving for responsible decision-making 2. Percentage of learners who know have personal skills for awareness and drive (are self-confident, and motivated) and self management (acknowledge and respect own and others' feelings, cope well under stress / are resilient) 3. Percentage of learners who know show necessary inter-personal skills and behavioural intent for communication, negotiation, cooperation and teamwork as well as for inclusion, empathy and advocacy 4. Percentage of learner who know and understand specific facts about relationships; culture society and human rights; human development; 5. Percentage of learners with improved skills in critical thinking, systemic thinking, problem-solving, problem-setting, future-oriented thinking, decision-making, dealing with crises and risks, collaboration and team work, negotiation and consensus building, participation in democratic decision making, self-expression and communication) 6. Percentage of learners with the capacity for self-confidence, coping under stress, acting with responsibility for self and others

Indicator Components for Generic Life Skills

To be completed

Notes for Policy:

Recommends use of child participation scales.

Child Participation (CP) scale measures the level of student participation and engagement in school decision-making, as perceived by teachers. Child Participation II (CP-II) scale measures the extent to which students in the school are given opportunities for leadership roles, making decisions, and collaborating with peers.

Notes for services:

Recommends use of the Family and Community Participation scale: The Family and Community Participation scale measures the extent teachers perceive partnerships between schools and parents and other local community members have been formed. Specifically, this scale taps teachers' perceptions of whether parents support their children's school by becoming involved in school events and whether school officials encourage and welcome the input of parents and community members.

Notes for Life skills:

Recommends use of the Support for Teacher Development and Pedagogy: The Support for Teacher Development and Pedagogy scale measures the level of professional support, such as feedback on teaching methods, resources to plan lessons and materials to implement the curriculum, and access to development opportunities, such as workshops, seminars and trainings, available to teachers at their schools.

Recommends use of the The Child-centered Pedagogy scale: The Child-centered Pedagogy scale measures different aspects of teaching and classroom management techniques, including the teacher's use of child-centered teaching strategies, preparation of organized lesson plans, and the manner in which the teacher communicates and interacts with students.

IMPACT

Percentage of learners who know and understand specific facts about:

- Relationships (Families, Friendship, Love and Romantic Relationships, Tolerance and Respect, Long-term Commitment, Marriage and Parenting);
- Culture, Society and Human Rights (Sexuality, Culture and Human Rights, Sexuality and the Media, The Social Construction of Gender, Gender-Based Violence including Sexual Abuse, Exploitation and Harmful Practices);
- Human Development (Sexual and Reproductive Anatomy and Physiology, Reproduction, Puberty, Body Image, Privacy and Bodily Integrity);

Thematic Indicator 11: Substance Abuse

Drugs in school include tobacco, alcohol, illicit (illegal or unlawful) drugs, prescription drugs and over-the-counter medicines.

It is the primary role of the school to teach skills, to impart knowledge and to establish a sound values base in relation to health and drug use, not to change behaviours that may be determined by factors beyond the influence of the school. (UNODC, 2004)

Educational programmes for the prevention of drug abuse should be responsive and inclusive and should take into account levels of drug use among individuals and in society, risk and protective factors, gender, ethnicity, culture, language, developmental level, ability level, religion and sexual orientation. Interacting with students in a way that acknowledges the reality of their backgrounds and experiences creates opportunities for meaningful student input into education for drug abuse prevention programmes. Students react positively when their individual needs and the needs of users and non-users are acknowledged and communication channels are kept open without drug use being condoned. (UNODC, 2004)

Substance Abuse Indicators Table

SUBSTANCE ABUSE
<p>POLICY</p> <ol style="list-style-type: none"> 1. Percent of schools with non-punitive policies addressing substance use in schools by both, students and staff with a strong referral component
<p>ENVIRONMENT</p>
<p>SERVICES</p>
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 2. Percent of schools that provide education on drugs (This indicator needs to be more specific) 3. Percentage of teachers who have ever received training in substance abuse life skills education
<p>IMPACT</p> <ol style="list-style-type: none"> 1. Percentage of learners who know and understand specific facts about different substances including tobacco, alcohol, illicit and prescription drugs, their short term and long terms effects, consequences of experimenting and use and actual real number of peers who have experimented or are using any substances to correct perceptions of use in peer group 2. Percentage of learners who have positive attitudes towards specific behaviours that help resist peer pressure, communicate their knowledge and opinion of substances and avoid situations where there is a risk of substance use 3. Percentage of learners who show necessary skills and behavioural intent to resist peer pressure to experiment and use substances, seek help and support, avoid situations and relationships where there is a risk of substance use, participate in other groups and activities and learn new skills.

Indicator Components for Substance Abuse

SUBSTANCE ABUSE 1: PERCENT OF SCHOOLS WITH NON-PUNITIVE POLICIES ADDRESSING SUBSTANCE USE IN SCHOOLS BY BOTH, STUDENTS AND STAFF WITH A STRONG REFERRAL COMPONENT

DATA COLLECTION FREQUENCY: Every 2 or 3 years

MEASUREMENT TOOLS: School survey administered to students and staff

METHOD OF MEASUREMENT: Nationally representative sample of schools (to include both private and public schools and disaggregated by primary and secondary schools). The indicator has two components

SUBSTANCE ABUSE 1.1: PERCENT OF SCHOOLS WITH NON-PUNITIVE POLICY ADDRESSING SUBSTANCE USE IN SCHOOLS BY BOTH, STUDENTS AND STAFF

Key question: Does your school have non-punitive policies addressing substance use in schools by both, students and staff? Yes/No

NUMERATOR: Total number of schools with non-punitive policies addressing substance use in schools

DENOMINATOR: Total number of schools surveyed

SUBSTANCE ABUSE 1.2: PERCENT OF SCHOOLS WITH A SUBSTANCE USE POLICY WITH A STRONG REFERRAL COMPONENT

Key question: Does your school substance policy have a strong referral component? Yes/No

NUMERATOR: Total number of schools with substance use policy with a strong referral component

DENOMINATOR: Total number of schools surveyed

INTERPRETATION:

Policies should be comprehensive and non-punitive (i.e. the policy should help and support the students to seek help when found using substances rather than punish them) and address substance use including tobacco, alcohol, illicit drugs and the illegal use of prescription drugs.

Some responses to drug use may marginalize and stigmatize students. Detection of drug use with a solely punitive outcome is not a productive strategy unless the health and safety of the school community is being compromised and could alienate students at risk from the only place where individuals and activities can support their efforts to change. (UNODC, 2004)

The decision to refer a student to a professional counsellor requires consideration of the needs of the person and the competence, confidence and context of the helper. Where issues are complex, referral should be made to a counsellor with experience to provide assessment and intervention. (UNODC, 2004)

SUBSTANCE ABUSE 2: PERCENT OF SCHOOLS THAT PROVIDE EDUCATION ON DRUGS

Notes: Notes:

Frequency: Every 2 years

Tools: School and teacher survey

- Present Unplugged curriculum by Eu-Dap- European Drug Addiction Prevention Trial as an example.

- Drug education based on life skills has been defined by UNODC (School prevention guidelines) and can be offered as a separate subject or as part of health or sports curriculum.

(To be completed)

SOURCE

UNODC (2004). School-Based Education for Drug Abuse Prevention Skills for Drug http://www.unodc.org/pdf/youthnet/handbook_school_english.pdf

Thematic Indicator 12: Disaster Risk Reduction and Emergencies

Introduction and importance of topic *(To be completed)*

Disaster Risk Reduction Indicators Table

DISASTER RISK REDUCTION AND EMERGENCIES	
POLICY	<ol style="list-style-type: none"> 1. Effective leadership is established for Education Cluster / Inter-Agency Coordination (with co-lead agency) with links to other cluster/sector coordination mechanisms on critical inter sectoral issues 2. Children, including girls and other excluded children, access quality education opportunities
ENVIRONMENT	<ol style="list-style-type: none"> 3. Safe and secure learning environments that promote the protection and well-being of learners is established
SERVICES	<ol style="list-style-type: none"> 4. Psychosocial and health services for children and teachers is integrated in educational response
SKILLS-BASED HEALTH EDUCATION	<ol style="list-style-type: none"> 5. Adolescents, young children and caregivers access life skills training, and information about the emergency and educational options for those who have missed out on schooling, especially adolescents 6. Percentage of teachers who have ever received training in life skills education for disaster risk reduction and emergencies
IMPACT	

Notes for Disaster Risk Reduction 1:

Benchmark 1: Coordination mechanism provides guidance to all partners on common standards, strategies and approaches, ensuring that all critical nutrition gaps and vulnerabilities are identified, and provides information on roles, responsibilities and accountability to ensure that all gaps are addressed without duplication.

Preparedness:

- Develop the capacity of education authorities in preparing the school system, at all levels, to respond to emergencies
- Clarify responsibilities and accountabilities of UNICEF for education in humanitarian situations, strengthen existing coordination mechanisms, or if not available, in collaboration with national authorities, create mechanisms to ensure that the humanitarian response is timely and coordinated and conforming to humanitarian principles and agreed standards and benchmarks
- Establish a multi-sectoral rapid assessment mechanism and format (including priority education information)
- Advocate for emergency component in education sector plans/budget, including preparedness plans, pre-position education kits or enter stand-by agreements with suppliers and stand-by agreements with partners

Response:

- Establish/activate transparent and inclusive education cluster/ coordination mechanisms, and assign staff to lead inter-agency coordination
- Revise/develop response framework, strategy and plan for action for education response, based on assessment findings; monitor implementation of program activities and ensure that capacity is in place at all levels to effectively respond to the crisis; ensure that education is integrated in flash appeals, donor briefings, the Central Emergency Response Fund and other funding proposals to ensure that the sector is given adequate attention

Early Recovery:

- Ensure education cluster coordination mechanism bridges with long-term vision and recovery planning; participate in, establish, or lead (as appropriate) early recovery coordination mechanism for education and supports the Early Recovery Cluster

Notes for Disaster Risk Reduction 2:

Benchmark 2: Schools re-opened and child-friendly and adolescent-friendly emergency non-formal programmes established for affected communities.

Preparedness:

- Support national authorities to plan for appropriate temporary learning spaces, establish codes of conduct to address all forms of violence, sexual exploitation, abuse and discrimination in learning situations and ensure joint preparedness planning with WASH and Protection cluster/partners. See also WASH and Protection CCCs

Response:

- Advocate for and support re-opening of schools and establishment of non-formal education and recreational programmes, provide appropriate basic education, early learning, and recreational materials and include special measures for children needing help to re-engaging in education e.g. girls and vulnerable and socially excluded children
- Address violence in and around learning spaces/schools including safety of children on the way to school, with focus on adolescent girls

Early Recovery:

- Ensure that education emergency response implementation includes principles of child-friendly approaches

Notes for Disaster Risk Reduction 3:

Benchmark 3: Schools are free from violence, and children, including girls, can safely move between home and school

Preparedness:

- Promote school emergency preparedness plans, advocate for safe school structures and include basic disaster risk reduction measures in school curriculum

Response:

- Set up safe temporary learning spaces for all age groups in consultation with communities, and establish community services around schools (such as water supply and sanitation) where appropriate, complemented by hygiene promotion

Early Recovery:

- Advocate and support the re-development of schools as safe, inclusive, equitable and child-friendly models, bringing in all children without discrimination and inclusive of school emergency preparedness measures.
- Advocate for and support development of sustainable and appropriate child-friendly and hazard-resistant standards/designs for reconstruction of schools"

Notes for Disaster Risk Reduction 4:

Benchmark 4: All education humanitarian response has psychosocial, health and nutrition integrated

Preparedness:

- Support national authorities to adjust the education system to respond to learners' psychosocial needs and increased vulnerabilities in situations of emergencies and agree on training packages and approaches to include psycho-social support, risk and vulnerability reduction and basic health, hygiene and nutrition promotion

Response

- Mobilize available psychosocial support for teachers and students and provide appropriate psychosocial support activities for teachers and students in temporary learning spaces, and in child-friendly spaces for young children and adolescents; establish initial links to basic health and nutrition services

Notes for Disaster Risk Reduction 5:

Benchmark 5: Relevant education programmes implemented, including for adolescents and young children

Preparedness:

- Agree with partners on education information and communication strategies and approaches including participation of adolescents using adapted existing materials

Response:

- Ensure development and implementation of context-relevant life skills programmes and learning content (e.g. basic health, nutrition and hygiene promotion) as well as prevention, protection, inclusion and support with regard to HIV and AIDS (also see HIV and AIDS CCCs), gender-based violence, conflict resolution, information about the situation (e.g. earthquake, armed conflict, etc.), involving affected population with a particular focus on adolescents and young people

Early recovery:

- Advocate for and support integration of life skills focused on disaster risk reduction into non formal/formal education
- Ensure that education interventions are based on a robust assessment and analysis of disaster risk
- Advocate for appropriate teacher/para-professional compensation mechanisms along agreed upon inter-agency guidelines.

Indicator Components for Disaster Risk Reduction and Emergencies

(To be completed)

Thematic Indicator 13: Violence In the School Setting

(extract from the World Report on Violence Against Children, 2006)

Children spend more time in the care of adults in pre-schools and schools than they do anywhere else outside of their homes. Like parents, the adults who oversee, manage and staff these places have a duty to provide safe and nurturing environments that support and promote children's education and development. They also have a duty to make sure such development prepares children for life as responsible adults, guided by values of non violence, gender equality, non discrimination, tolerance and mutual respect. These are the values that Governments embrace when they ratify the Convention on the Right of the Child (CRC) and other international human rights conventions.

Schools are uniquely placed to break the patterns of violence by giving children, their parents and communities the knowledge and skills to communicate, negotiate and resolve conflicts in more constructive ways. The forms of violence found in schools are both physical and psychological, and usually occur together. Violence perpetrated by teachers and other school staff include corporal punishment and other cruel and humiliating forms of punishment or treatment, sexual and gender-based violence, and bullying. Violence perpetrated by children include bullying, sexual and gender-based violence, schoolyard fighting, gang violence, and assault with weapons.

School based anti violence programs include: programs that develop better social skills, higher self-esteem and a greater sense of personal control over their lives, and also help students attain higher levels of academic achievement; the development and implementation of policies (or codes of conduct) governing the conduct and discipline of teachers and students and building community confidence in schools; good teacher recruitment and training; and involving parents and communities to monitor schools and intervene when necessary.

Violence in the School Setting Indicators Table

VIOLENCE IN THE SCHOOL SETTING
<p>POLICY</p> <ol style="list-style-type: none">1. Percent of schools with a policy or code of conduct on protection of learners and staff on physical and psychological punishment, drafted and disseminated2. Percent of schools with a policy or code of conduct on protection of learners and staff on discrimination and gender-based violence drafted and disseminated3. Percent of schools with a policy or code of conduct on protection of learners and staff on sexual and gender-based violence drafted and disseminated4. Percent of schools with a policy or code of conduct on protection of learners and staff on HIV and sexual violence drafted and disseminated5. Percent of schools with a policy or code of conduct on protection of learners and staff on bullying6. Percent of schools with a policy or code of conduct on protection of learners and staff on fighting, physical assault and gang activity drafted and disseminated7. Percent of schools with a policy or code of conduct on protection of learners and staff on homicides and serious injury drafted and disseminated8. Percent of schools with a policy or code of conduct on protection of learners and staff on weapons in schools drafted and disseminated9. Staff are aware of and apply the school policies and codes of conduct <p>Note: Method- review of school policy and headmaster interview. May also be useful to randomly survey students to check if they are aware of these policies, Perhaps make a checklist on existence, awareness and implementation/enforcement for schools, teachers and students.</p>
<p>ENVIRONMENT</p>

SERVICES

10. Percent of schools that provide a confidential referral system to physical health services for those experiencing physical and psychological punishment
11. Percent of schools that provide a confidential referral system to physical health services for those experiencing discrimination and gender-based violence
12. Percent of schools that provide a confidential referral system to physical health services for those experiencing sexual and gender-based violence
13. Percent of schools that provide a confidential referral system to physical health services for those experiencing HIV and sexual violence
14. Percent of schools that provide a confidential referral system to physical health services for those experiencing bullying
15. Percent of schools that provide a confidential referral system to physical health services for those experiencing fighting, physical assault and gang activity
16. Percent of schools that provide a confidential referral system to physical health services for those experiencing homicides and serious injury
17. Percent of schools that provide a confidential referral system to physical health services for those with weapons in schools
18. Perception of learners on whether or not the school provides confidential referral system to physical health services for those experiencing physical and psychological harm or violence (for each of the issues)
19. Perception of teachers and other school staff on whether or not the school provides confidential referral system to physical health services for those experiencing physical and psychological harm or violence (for each of the issues)
20. The school provides a confidential referral system to psychosocial and social services for those experiencing physical and psychological harm or violence (for each of the issues)
21. Perception of learners on whether or not the school provides confidential referral system to psychosocial and social services for those experiencing physical and psychological harm or violence (for each of the issues)
22. Perception of teachers and other school staff on whether or not the school provides confidential referral system to psychosocial and social services for those experiencing physical and psychological harm or violence (for each of the issues)

SKILLS-BASED HEALTH EDUCATION

24. Percent of schools with life skills education on the different forms of violence
25. Percent of schools with life skills education on physical and psychological punishment?
26. Percent of schools with life skills education on discrimination and gender-based violence
27. Percent of schools with life skills education on sexual and gender-based violence
28. Percent of schools with life skills education on HIV and sexual violence
29. Percent of schools with life skills education on bullying
30. Percent of schools with life skills education on fighting, physical assault and gang activity
31. Percent of schools with life skills education on homicides and serious injury
32. Percent of schools with life skills education on weapons in schools
33. Percent of schools with life skills education on how the different forms of violence and the impact on individuals, families, and society
34. Percent of schools with life skills education on the characteristics of aggressor, target, and bystander
35. Percent of schools with life skills education on factors that make one vulnerable to abuse and violence
36. Percent of schools with life skills education on the benefits of avoiding all forms of violence and aggression
37. Percent of schools with life skills education on importance of reducing all forms of discrimination (xenophobia, racism ethnicity etc)
38. Percentage of teachers who have ever received training in life skills education on violence against children

IMPACT

1. Percentage of learners who know and understand different forms of violence (physical and psychological punishment; discrimination and gender-based violence; sexual and gender-based violence; HIV and sexual violence; bullying; fighting, physical assault and gang activity; homicides and serious injury; weapons in schools)
2. Percentage of learners who know and understand how the different forms of violence impact on individuals, families, and society; the characteristics of aggressor, target, and bystander; factors that make one vulnerable to abuse and violence; the benefits of avoiding all forms of violence and aggression; and importance of reducing all forms of discrimination (xenophobia, racism ethnicity etc).
3. Percentage of learners who have positive attitudes towards respecting the rights of self and others and taking a stand against violence and abuse
4. Percentage of learners who show necessary skills and behavioural intent to: identify and reject/respond to inappropriate to sexually oriented touches, gestures and verbalizations; resolve conflict productively; treat others with respect; seek help; show empathy to victims of violence and abuse.

Indicator Components for Violence Against Children

(To be completed)

Notes and Concerns

The violence indicators came from the draft Violence Against Children indicators, and were revisited by members of UNICEF's education and protection sections. Stephanie Hodge (shodge@unicef.org) and Sarah Karmin (skarmin@unicef.org) were leading this work. Follow up needed.

Thematic Indicator 14: Prevention and Response to Unintentional Injuries

Introduction and importance of topic *(To be completed)*

Prevention and Response to Unintentional Injuries Indicators Table

PREVENTION AND RESPONSE TO UNINTENTIONAL INJURIES
<p>POLICY</p> <ol style="list-style-type: none"> 1. Existence of a national policy on first aid and basic safety in schools
<p>ENVIRONMENT</p>
<p>SERVICES</p> <ol style="list-style-type: none"> 2. Percentage of schools with a functional first aid kit (note: define 'functional') 3. Percent of schools with trained teacher(s) to monitor and administer first aid and basic safety 4. Percentage of teachers trained in the use of first aid kits 5. Number and Percentage of children treated with first aid kit
<p>SKILLS-BASED HEALTH EDUCATION</p> <ol style="list-style-type: none"> 6. Percentage of teachers who have ever received training in life skills education on first aid and basic safety 7. Percentage of learners who know and understand specific facts about first aid and risks: on or near roads; in or near water; with regard to fires, cooking stoves, hot liquids and foods, and exposed electric wires; with regard to medicines, poisons, insecticides, bleach, acids and liquid fertilizers and fuels; with regard to knives, scissors, sharp or pointed objects and broken glass. 8. Percentage of learners who have positive attitudes towards protecting themselves and others from risks. 9. Percentage of learners who show necessary skills and behavioural intent to practice: behaviours that reduce risks on the road, at home at school; during disasters; basic first aid techniques
<p>IMPACT</p>

Indicator Components for First AID and Basic Safety

(To be completed)

Notes and Concerns

For life skills 6 "Percentage of teachers who have ever received training in life skills education on first aid and basic safety"-- Is this to teach children about first aid?

Thematic Indicator 15: Children with Special Needs

CHILDREN WITH SPECIAL NEEDS
POLICY
ENVIRONMENT
SERVICES
SKILLS-BASED HEALTH EDUCATION
IMPACT

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Annex A

Participatory Weighted Checklists

Some FRESH summary indicators refer to a Participatory Weighted Checklists. Below is an explanation of how and why checklists are used, as well as calculation methods.

Why Participatory Weighted Checklists?

The process of using a weighted checklist is participatory but produces quantifiable results. The analysis of data collected does not require highly specialized statistical skills and the results can be publicly presented in a way that is easily understood. Participatory weighted checklists can be used among schoolchildren, school committees, ministries, school heads, teachers, parents and others to stimulate dialogue, gauge preferences and expectations and ensure active participation in decision-making related to school health.

Sample Checklist and Table for Policy Indicator

Comprehensiveness of National SHN Policy (*If policy does not currently exist and or is still in draft form, checklist may still be used to gauge expectations and positions of stakeholders.*)

The participatory weighted checklist below (Sample Instrument 1) is designed to help stakeholders, such as members of the Ministry of Health or Ministry of Education, determine if their SHN policy is comprehensive (according to their country and context). This assumes the list of thematic areas is complete. The thematic areas may need to be broken down in to specific subthemes. For example, a national policy might include HIV/AIDS as a topic but not explicitly mention the subthemes such as physical safety, zero tolerance for discrimination, stigma, etc. In order for a thematic-specific policy to be comprehensive, it should include the subthemes that stakeholders think are important/relevant to their context. None of the themes below are disaggregated into subthemes—this topic should be discussed in the October meeting. (If subthemes are to be included then the same weighted checklist can be used within subthemes).

The sample policy checklist instrument below is for an existing national SHN policy.

Sample Instrument 1: Individual respondent checklist for Existing National SHN Policy

* A necessary thematic area is one that respondents think their National SHN Policy cannot do without.

** A thematic area that is present is explicitly mentioned in the national level SHN Policy.

National Policy Thematic Areas	These thematic areas are:	
	Necessary* to have in your National level SHN policy (1=Yes or 0=No)	Present** in your National level SHN policy (1=Yes or 0=No)
HIV/AIDS		
Physical Environment/Sustainable Development		
Sexual and Reproductive Health (SRH)		
Physical Activity		
Deworming		
Malaria		
Oral Health		
Substance Abuse		
Child Participation		
Nutrition		
Hygiene, Water and Sanitation		
Disaster Risk Reduction/Emergences		
First Aid		
Social and emotional learning		

Violence against children		
Other (this will not be factored in scores but should be considered for discussion among stakeholders)		

Sample Table 1: Aggregated opinions and overall satisfaction of current policy

Once the opinions of respondents have been collected using sample instrument 1, they will be summarized in a table such as Sample Table 1 below. As an example, 90 individual opinions were received.

National Policy Thematic Areas	(a) # of respondents who think thematic area is necessary	(b) % of respondents who think thematic area is necessary	(c) # of respondents who think thematic area is present	(d) % of respondents who think thematic area is present	(e) Total number of respondents (N=90)	(f) Actual Raw Score = (a*c)	(g) Highest possible raw score = (a*e)
HIV/AIDS	75	83%	40	44%	90	3,000	6750
Physical Environment /Sustainable Development	61	68%	50	56%	90	3,050	5490
SRH	80	89%	42	47%	90	3,360	7200
Physical Activity	30	33%	75	83%	90	2,250	2700
Deworming	85	94%	50	56%	90	4,250	7650
Malaria	77	86%	65	72%	90	5,005	6930
Oral Health, vision and hearing	60	67%	32	36%	90	1,920	5400
Substance Abuse	40	44%	18	20%	90	720	3600
Child Participation	44	49%	29	32%	90	1,276	3960
Nutrition	87	97%	75	83%	90	6,525	7830
Hygiene, Water and Sanitation	90	100%	44	49%	90	3,960	8100
Disaster Risk Reduction/Emergences	60	67%	31	34%	90	1,860	5400
First Aid	56	62%	43	48%	90	2,408	5040
Social and emotional learning	20	22%	10	11%	90	200	1800
Violence against children	75	83%	60	67%	90	4,500	6750
Total Scores:						44,284	84,600
Overall Policy Agreement Score:					52%		

Policy Checklist Calculation, Uses and Discussion:

Once the responses have been collected, scores for individual respondents then can be calculated which describes *the relative importance of each thematic area*. These percentage figures are useful in themselves to show the distribution of preferences via bar charts or similar methods. There is also an Overall Policy Agreement Score, which shows the extent to which the policy reflects the interests and expectations of the stakeholders.

The score is calculated is as follows:

1. Multiply column (a) by column (c) each for each thematic area to get the actual raw score (e.g. for HIV/AIDS, the raw score is $75 \times 40 = 3,000$)
2. The sum of all the actual raw scores is the *total actual raw score* (column e)
3. Multiply column (a) column by column (e) (which is 90, the largest possible number of respondents that think the policy theme is present) for each thematic area (thematic area) to get the *highest possible raw score* (column g).
4. The sum of all *highest possible raw scores* is the *total highest possible raw score*
5. Divide the total summed scores (the sum of the actual raw scores and the sum of the highest possible raw scores) to get the **Overall Policy Agreement Score**. A high percentage= a high degree of agreement between expectations and what is actually present. In this example, the overall policy agreement is 52%. Stakeholders will have to determine what is an acceptable score if using this as a measure.

The Policy Checklist can help answer the following questions during the policy development process and during policy M&E:

◆ **How do you determine if a thematic area should be included in the policy?**

A thematic area that should be included in the National level SHN policy is one that 50% or more of the respondents think are necessary. This takes majority rather than a consensus approach. It is possible to change the number to over 50% if stakeholders wish.

According to this criterion, based on the percentages from column b in table 1 example above, all thematic areas except physical activity, substance abuse, child participation and social and emotional learning should be included in the policy. Decision to exclude thematic areas like these should not made *carte blanche*, as some thematic areas may be excluded for the wrong reasons. Stakeholders should discuss the scores—especially those that are very high or very low. Low scores may be due to lack of familiarity or understanding of the thematic area at hand. It will be important that all thematic areas are fully explained and understood by respondents before a checklist like this can be used. As far as possible, the assistance of health experts (especially in the thematic area) should be sought to understand the relevance of the thematic area to policy at national and local level. Health experts should be part of the discussion on scores between stakeholders.

◆ **What is a comprehensive policy?**

The national level SHN policy is comprehensive if the total # of thematic areas that 50% or more of the respondents think are necessary to have in policy equals the same and total # of thematic areas actually included (or are slated to be included) in the policy. Determining comprehensiveness involves taking the opinion of the majority.

◆ **What is the Overall Policy Agreement Score?**

As discussed above, this score looks at the overall level of policy agreement among all of the respondents in the checklist and can be used if stakeholders want to take more of a consensual approach to policy development or policy M&E. The score takes *total actual raw score* divided by the *total highest possible raw score*. A high percentage equals a high degree of agreement between expectations for the policy and what is actually present in the policy. In the checklist example in the discussion, the **Policy Agreement Score** is 52%. Stakeholders might want to set a particular threshold for the score based on the level of agreement they desire.

◆ **Are the overall interests and expectations of the stakeholders reflected in the**

policy?

This depends on the level of discussion and participation of stakeholders on selecting thematic areas for inclusion during policy development process as well as comprehensiveness of the policy and/or the Overall Policy Agreement Score. It would best to look at all three of these aspects well as ensuring continual consultation between stakeholders and health experts to determine if policy is on track or if it requires modification.

◆ Who should use the checklist?

Anyone who is affected by SHN policies should have the opportunity to participate in the ongoing policy monitoring process. This means teachers, school heads, school committees, students, parents and more. Teachers may use a checklist like this at times during school year during staff meetings to discuss, assess or familiarize themselves with school policies. The checklist could be used in classes to gauge student's opinions and familiarize them with their rights (and regulations).

For policy M&E

It is also possible to create another score that reflects what stakeholders think is necessary and what is actually present in the policy (by changing the meaning of the second column in the checklist). A score like this could be used at the end of the policy development process and throughout regular program monitoring.

Checklist Options

Another option for a checklist is ranking. Stakeholders could rank the themes in terms of their of relative importance from 0-3 (such as 0=no importance and 3=high importance). Importance could be defined as how much the policy is perceived to effect the student's health and nutrition outcomes. The weighting method will be the same as outlined in table 1 above. After the ranking, there can be follow-up discussions on the reasons for the variation (especially for attributes where opinions varied widely). These discussions could potentially lead to a convergence of views on priorities, increase the level of participation among stakeholder in policy development and help make stronger (and more comprehensive) policies.

Sample Checklist & Table for Service Indicator

Context-Specific SHN services are recommended national school health policy

Sample Table 2: Aggregated opinions and overall satisfaction of current School Health Services in National Policy

**A service that is a necessary is one that respondents think all schools in the country (or district/region) should have/offer and none should do without.*

*** A service that is present is explicitly mentioned in the national level SHN*

School Health and Nutrition Services	(a) # of respondents who think service is necessary	(b) % of respondents who think service is necessary	(c) # of respondents who think service is present	(d) % of respondents who think service is present	(e) Total number of respondents	(e) Actual Raw Score	(f) Highest Possible Raw Score
Deworming of all school children in endemic areas;							
Regular supplementation with micronutrients such as vit. A, iron, iodine in areas of deficiency;							
Screening for vision							
Screening for hearing							
Screening for oral health							
Screening for physical fitness							
First aid in schools							
ITN distribution;							
School meals where there is a food crisis							
Access to psychosocial counselling							
				Total Scores			
				Overall Agreement on School Health Services:			

Services Checklist Calculation, Uses and Discussion:

The services checklist can be calculated the same way as the policy checklist except that the overall score reflects a different outcome. In this instance, **The Overall Agreement on School Health Services** shows the extent to which the school services mentioned in the existing National SHN policy reflects the interests and expectations of stakeholders. Again, this checklist could be changed to reflect a planned rather than a completed national level SHN policy.

It might be useful for school heads, parents and school committees to fill out, review and

discuss the findings of the services checklist. Just as in the policy checklist, services that 50% or more of the respondents think are necessary for inclusion should be initially selected. However, it is also important to review the services that were excluded due to low scoring to ensure that there is mutual understanding and agreement for exclusion or potentially reconsidered for inclusion). As in the policy checklist, it is also useful to examine services that have scored particularly high as the score may reflect widely held health and nutrition related beliefs that may not reflect epidemiological reality. After the checklists have been reviewed and compiled, the outcomes should be shared and discussed with the MoH and MoE

The services checklist can help answer the following questions:

- ◆ How do you determine what specific school health services should be recommended in the National School Health Policy?
- ◆ How do you determine if the services recommended in the National SHN policy are comprehensive and context specific?

The inspiration and guidance for using these checklists comes from Rick Davis. His webpage on participatory weighted checklists can be found here:

<http://mande.co.uk/special-issues/weighted-checklists/>

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Annex B

AIR/ UNICEF Child Friendly School Scales

School Leadership Scale (Teacher Survey)

Reliability: The reliability statistic for this scale (α) is .79⁴

Question	Yes/No
1. At school, decisions are made based on what is best for students.	
2. I trust the principal (school director) will keep his or her word.	
3. The principal (school director) and other leaders in this school make good decisions.	
4. The principal (school director) looks out for the personal welfare of school staff members.	
5. I am satisfied with my involvement with decision-making at this school.	
6. When students break rules, they are treated fairly.	
7. School staff members have a lot of informal opportunities to influence what happens here.	
8. The work rules at this school make it easy for teachers to do their jobs well.	
9. School leadership provides teachers at this school with adequate support to continually improve their relationships with all types of students.	

The Emotionally Supportive Climate (ESC) scale (Student Survey)

No Reliability statistic provided

Question	Yes/No
1. I can talk with at least one adult at school about things that are bothering me.	
2. Teachers at this school really care about students like me.	
3. It is difficult for students like me to get extra help from teachers.	
4. This school does a good job teaching students what they really need to know in life.	
5. This school does not try to help students who are behind in their work to catch up.	
6. My teachers give me feedback on my assignments that help me to improve my work.	
7. This school does a good job in preparing students to continue on for more education after they graduate.	
8. Adults in this school are usually willing to give students extra help.	
9. Teachers notice if I am having difficulty with my lessons.	
10. Teachers give students opportunities to improve their work if they do poorly on an assignment.	
11. Students at this school have the materials they need to support their learning.	
12. I can talk to teachers or other adults at school if I am having problems in class.	
13. My family knows what goes on inside this school	
14. Families like mine are involved in making decisions that affect this school.	
15. Sometimes I am too hungry to pay attention in school.	

⁴ All of the scales have reliability statistics (Chronbach's alpha) of more than .70, which is typically the minimum desired reliability for a reporting scale.

The Safe, Inclusive and Respectful Climate (SIRC) scale (Teacher Survey)

Reliability: The reliability statistic for this scale (α) is .80

Question	Yes/No
1. I feel safe at my school.	
2. My students are safe at school.	
3. This school is being ruined by bullies.	
4. This school is badly affected by crime and violence in the community.	
5. Crime and violence are or should be major concerns at school.	
6. Both boys and girls have equal opportunities to succeed at this school.	
7. Some types of students at this school are treated better than others by teachers and school staff.	
8. This school is a welcoming place for all types of children.	
9. At this school, students and teachers get along really well.	
10. Students in this school help each other, even if they are not friends.	
11. Teachers and students treat each other with respect in this school.	
12. Teachers in this school treat each other with respect.	
13. Teachers at this school help each other.	
14. Teachers in this school trust each other.	
15. This school places a high value on understanding and respecting children's rights	

The Safe, Inclusive and Respectful Climate (SIRC) scale (Student Survey)

No Reliability statistic provided

Question	Yes/No
1. I feel safe at my school.	
2. I feel safe walking both to and from school.	
3. I sometimes stay home from school because I am worried about my safety.	
4. This school is badly affected by crime and violence in the community.	
5. Students at this school help each other, even if they're not friends.	
6. Students at this school treat each other with respect.	
7. If students see another student being picked on, they try to stop it.	
8. Students at this school like to put each other down.	
9. This school is being ruined by bullies.	
10. There are some students in this school who nobody talks to.	
11. There are some students at this school who everybody teases.	
12. Students at this school think it is okay to fight someone who insults them.	
13. Students at this school know how to disagree without starting a fight or an argument.	
14. My teachers treat me with respect.	
15. This school places a high value on understanding and respecting children's rights.	
16. Teachers at my school say unkind things to students.	
17. Sometimes I do not want to come to school because of how the teachers treat me.	
18. Teachers at this school are interested in what students like me have to say	
19. I think that this school respects families like mine.	
20. I look forward to coming to school.	
21. Some types of students at this school are treated better than others by teachers and school staff.	
22. Both boys and girls have equal opportunities to succeed at this school.	
23. This school is a welcoming place for all types of students.	
24. When students break rules, they are treated fairly.	
25. Adults in this school apply the same rules to all students equally.	
26. I wish I went to a different school.	
27. The school is a welcoming and inviting place for families like mine.	

Safe and Welcoming School Learning Environment scale (School Observation)

(GO= General Observation); IA= Indoor Areas; OA= Outdoor Areas)

Question	Yes/No
1. Students are protected from access by unauthorized adults while at school. (GO)	
2. Students are within sight or hearing of school staff at all times except for brief periods (e.g., when using the latrine). (GO)	
3. Students are not permitted to roam the hallways or school grounds when class is in session. (GO)	
4. Students are not permitted to leave school grounds without the knowledge and permission of school staff. (GO)	
5. Older students do not have unsupervised access to younger students while on school grounds (except siblings or other close family members). (GO)	
6. School buildings are in good structural condition. (GO)	
7. School buildings are in good physical condition (e.g., no peeling paint, broken windows, etc.) (GO)	
8. Students have adequate space to work and play without being disturbed by others (GO)	
9. Toxic materials (e.g., cleaning chemicals) are kept inaccessible to students at all times. (IA)	
10. The school keeps a stocked first aid kit accessible at all times. (IA)	
11. If the school is located near a road, there is a physical barrier between traffic and school grounds. (IA)	
12. School buildings and grounds have a welcoming appearance. (OA)	
13. Examples of student work or achievements are displayed in common areas. (OA)	
14. Outdoor play areas and equipment are safe and in good repair. (OA)	
15. Students are protected from the elements while using outdoor play areas (e.g., protected from excessive sun, dust, rain, or wind). (OA)	

Safe and Welcoming Classroom Environment (Classroom Observation)

Question	Yes/No
1. The classroom is protected from the elements (solid roof, walls, and floor).	
2. The classroom has adequate ventilation.	
3. The classroom is a comfortable temperature.	
4. The classroom lighting is adequate for students to work.	
5. The classroom is clean and orderly (the floor is clean, the tables are orderly, no garbage on the floor).	
6. Outside noise does not affect communication within the classroom. A7 Students each have sufficient space to work.	
7. Students each have a chair or bench to sit on while working.	
8. Furniture is of the right size for students to work comfortably.	
9. There is a blackboard/whiteboard in the classroom that all students can see clearly from their seats.	
10. Posters, artwork, or maps (commercially produced or handmade) appear on the walls of the classroom.	
11. There are examples of student work or projects visible in the classroom.	

Concerns and comments about this section:

Scales will all likely need to be modified and tested

SIRC student survey: The tools used should also measure student perceptions of issues of stigma and discrimination (particularly in regard to HIV & AIDS) and sexual harassment.

Annex C

Discussion with AIR on Use of Scales

Comments from conversation with David Osher, Vice President and Elizabeth Spier, Senior Research Analyst

How do you determine cut-off scores for the scales?

The key here is the purpose—surveillance, continuous improvement, or both

Option 1: Expert based approach.

If experts only develop standards, they may not resonate with the group they are trying to measure because they provide an outsider view that can have weak social validity.

Option 2: Practitioner based approach.

Practitioners may temper standards but may enhance their social validity.

Comment: There is a trade off between these two options in terms of accuracy and social validity. Ideally, there would be some sort of combination of both- an expert and a practitioner based approach to determining the cut-off scores. The standards and cutoff scores need to be explored further by experts across the world- this could possibly be done online using the Delphi method.

How often do you think the questionnaires for the scales can be used? Annually? Every two years?

Progress Monitoring/Continuous Improvement: To use the data for progress monitoring and continuous improvement, surveys should be conducted annually. Unpacking the items from the student surveys, developing strategies to improve outcomes and improving the ways in which students experience their environment is an iterative process will have the strongest impact on the students if done on an annual basis. If surveys are conducted during the spring and data is returned quickly, schools can discuss outcomes over the summer and make improvements for the following year. In order to get the data back quickly, one may need to use an automated system involving scanable surveys or other methods to get the data quickly back to the schools. With continuous improvement, it is important that the scores are correctly understood and interpreted- a lot of this may depend on technology and the amount of support given to schools.

Surveillance Monitoring: Conduct every other year to monitor promotive factors and risk factors for schools. Surveillance monitoring will have as much of an impact on the students, but is still better than having nothing at all. Timeliness of data analysis and feedback does not need to be as rushed as in annual monitoring, however it may make sense to conduct survey in year one, make changes in school environment in year two and conduct survey again in year three, make changes in school environment in year four, and so on.

How do you select schools for the survey? A nationally representative selection?

Stratified Random Sampling for surveillance. If the goal is to use the data for continuous improvement, sampling is not advised.

One may also need to consider specific factors that place young people at risk (such as region or ethnicity) to determine the sampling frame. Different regions and districts may have specific preferences for interventions- for example, schools with particular rough environments may require more attention and effort (regular surveying) than schools where the environment is more settled.

It may be a good idea to start off with a pilot school in each cluster/region and develop model programs. The model pilot school could be seen as a standard and serve as a basis of

comparison that could be used as standards and a basis for comparison with schools the surrounding area.

Potential model: In the city of Chicago, the development of a web-based tool to connect score reports with the schools helped people identify evidence based programs or strategies that matched their demographics.

How do you select students for the surveys? Do you focus on a particular age or year?

In the case of the UNICEF evaluation, AIR chose not to sample but to conduct the surveys on a census (population) basis. While this is an option, this is not a requirement, as a sampling frame (such as the school) can be used instead.

It would be possible to sample and stratify for a smaller number of students the numbers are high enough to make the sample representative. Alternatively, one could vary who gets what questionnaire (one child gets the SIRC questionnaire, the other gets the ESC questionnaire, etc.).

Literacy:

It is important to consider literacy of students when conducting the surveys. It may be best to assume that literacy is low and have the survey items read out loud to the students (if done this way, it is important that the person who reads the items is trained to read exactly what's there- and not explain and add examples which may unintentionally change the meaning of the question. It may also be possible to have the survey recorded on a high quality laser disk and played to the students so there is no risk of interference and embellishment by the reader).

Age/Grade:

Ideally, all students down to grade 2 should be surveyed. Items may need to be simplified for younger children—such as making the items and response choice be a basic yes/no/maybe.

In grades 5 and below, one must be very careful about asking questions that have the students evaluate adults, as this may be difficult for students to do accurately. It is important to have a high school version, a middle school and an elementary school version of the questionnaires that reflect the developmental and ecological differences of the students,

Teachers:

For the teacher surveys, it's important to address the questions to people who can provide answers that accurately reflect the reality (ie not just give their perceptions). One must have reason to believe that the teacher is in a position to know the information they are asked about (ie, ask the cooks about food quality, not the librarian). In regards to bullying for example, students give better and more core answers than teachers.

Are surveys self-administered or do they require an interviewer?

This depends entirely on the country and on the literacy level. It's safer to assume a low literacy level. Very important to provide pencils and erasers to students!

Who does the school and classroom observations?

Progress Monitoring/Continuous Improvement: Outside observer should be someone who is local and receives training on how to collect the data. While this may not give 100% accuracy, it does provide local ownership, which may be just as, if not more important.

Surveillance: Outside observer does not have to be local and may be someone with more expertise. Accuracy may be higher but local ownership will not be as strong.

Classroom Observation: Duration of observation does not seem to make a difference- staying in the classroom for 20 minutes provides just as much information as a 40 minute observation. Selecting classrooms for observations should be done randomly and the day the observer arrives (rather than in advance). This requires training and good protocol.

Triangulating data: Important to use more than one type of data source. Observations should be accompanied/compared with teacher and student surveys so that conclusions are based on all sources.

Confidentiality: It is very important to ensure that confidentiality is both real and perceived. For example, teachers should leave the room while students take the surveys, survey envelope should be sealed in front of everyone, observations should to be discussed in the classroom, etc.

Additional points: On the day of the survey or observation, it is important to ask the headmaster if anything different is going on that day (sick teachers, etc.) and if the day is a typical one (why or why not?). This can help account for some aberrations in the data. As mentioned earlier, it is also important to randomly select classes on the day of the visit.

Do you think it is feasible to use these scales for regular monitoring?

The more the surveys are connected to intervention and quality improvement, the more useful they will be. If people know that the data is going to be used to help them improve, they will be more likely to supply stronger data.

How do you suggest sharing the data from the surveys with schools after they have been analyzed?

- Focus at the scale level, provide a graphic sense of the overall big picture and disaggregate the data as much as possible. Even when differences are not found, the fact that different subgroups see things similarly is important in its own right.
- It's important to get back to people as quickly as possible and turn the data into something that is actionable.
- Identify areas of concern within the school and then show what those areas reveal in the survey
- Provide people with some human support to make sense of their own data (not just a guidebook or a tool)- provide training and capacity building.

Face validity of scales

1. During the CFS evaluations, the scales made sense to the surveyors who worked across the 6 countries where the CFS evaluations were conducted
2. AIR used the scales during subsequent work in to the Philippines and Thailand and were able to feed back the info they gathered from the scales to UNICEF and the MoE in these countries. Everyone who viewed the data seemed to agree that the information was accurate.
3. There are psychometric challenges that still need to be worked out with the scales if they going to be used regularly, even as it appeared to discriminate between schools and across countries.

Comment: In general, there are important and challenging psychometric issues that are worth addressing if one is willing to do the M&E work—and it won't always be easy and perfect.

General comments:

As part of implementation, the scales can be strategically modified and pruned. AIR could help narrow them down and identify areas where they could recommend more simplicity and also test them. Both David and Elizabeth feel that it important that these tools are strong and sustainable in the long run.

Annex D

Assessment Checklists for water, hygiene and sanitation

Assessment Checklist 1: Checklist for assessing water potability and water for cooking, personal hygiene, cleaning and laundry is safe for the purpose intended

Design and construction	Operation and maintenance
<ul style="list-style-type: none"> Is water from a safe source (free from faecal contamination)? Is water protected from contamination during transport from the source and at the school? 	<ul style="list-style-type: none"> Is the safety of the water system monitored regularly? Is the capacity of the water supply at the school monitored regularly? Are water storage containers or any feed lines at the school adequately maintained to avoid contamination of the water?
<ul style="list-style-type: none"> If necessary, can water be treated at the school? 	<ul style="list-style-type: none"> If water is treated at the school, is the treatment system operated effectively? Are there sufficient trained and adequately trained staff to carry out treatment?
<ul style="list-style-type: none"> Does the water supply meet WHO guidelines on chlorine disinfection or equivalent alternatives? 	<ul style="list-style-type: none"> If necessary, are resources available and appropriate to ensure chlorine disinfection at the school?
<ul style="list-style-type: none"> Is water acceptable (taste, appearance)? 	<ul style="list-style-type: none"> If the water is not acceptable to some of the school children and staff, do they use a safe alternative supply of water?
<ul style="list-style-type: none"> Is the school water supply designed to ensure that no-quality water comes to the distribution supply and contact is avoided? 	<ul style="list-style-type: none"> Are measures for avoiding contamination from the school followed consistently?

Assessment Checklist 2: Checklist for assessing sufficiency of water to meet all needs (for drinking, personal hygiene, food preparation, cleaning and laundry)

Design and construction	Operation and maintenance
<ul style="list-style-type: none"> Does the water supply have the capacity required? Is there a suitable distribution system to meet the need? 	<ul style="list-style-type: none"> Is a limited water supply available all times for all needs? Is the water supply protected and maintained to prevent wastage?

Assessment Checklist 3: Checklist for assessing that sufficient water-collection points and water-use facilities are available in the school to allow convenient access to, and use of, water for drinking, personal hygiene, food preparation, cleaning and laundry.

Design and construction	Operation and maintenance
1. Are there sufficient water points in the right places for a wide range of uses, including drinking, washing up, and dishes up, cleaning and cooking?	<ul style="list-style-type: none"> Is water accessible from several different points? Is there always water for a suitable quantity of washing up points?
2. Are there sufficient, clearly identified, safe drinking water points?	<ul style="list-style-type: none"> Are drinking water points properly used and adequately maintained? Are water points for disabled staff and children accessible, properly used and adequately maintained?
3. In washing areas, are there suitable drains or other points for collecting up?	Are drains properly used and adequately maintained?
4. In washing areas, are there suitable drying facilities?	Are drying facilities properly used and adequately maintained?

Assessment Checklist 4: Checklist for assessing if toilets are sufficient, accessible, private, secure, clean and culturally appropriate.

Design and construction	Operation and maintenance
1. Are there suitable facilities at the school for girls, boys and disabled?	Are there suitable facilities actually in use?
2. Are there separate blocks?	Are access routes both in good condition?
3. Do the blocks provide privacy and security?	Are there ceiling lights or the blocks cover the lighting?
4. Are the blocks appropriate to local culture and social conditions, gender and age of the staff and pupils?	Are the blocks being used as intended?
5. Are they appropriate and accessible for staff with a disability?	Are there suitable blocks for less able pupils, families etc. at door of disabled?
6. Are they secure, accessible to all and easy to clean?	<ul style="list-style-type: none"> Is anti-soiling paint in suitable condition? Are the blocks secure and locked to prevent theft? Are there any other needs considered?
7. Are there handwashing facilities close by?	Is there water and soap available?
8. Is there a cleaning and maintenance plan?	Is there a cleaning and maintenance schedule in operation?

Annex E

HIV/AIDS National Composite Policy Index

PURPOSE	To assess progress in the development and implementation of national level HIV and aids policies and strategies in all countries
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOLS	National Composite Policy Index (NCPI) questionnaire
METHOD OF MEASUREMENT	The composite index covers the following broad areas of policy, strategy and programme implementation: Part A 1. Strategic plan 2. Political support 3. Prevention 4. Treatment, care and support 5. Monitoring and evaluation Part B 1. Human rights 2. Civil society involvement 3. Prevention 4. Treatment, care and support
INTERPRETATION	It is important to analyse the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in (a) policy and strategy development and (b) implementation of policies and strategies, in order to tackle the country's HIV epidemic. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available.