
CASP: THE COMMON APPROACH TO SPONSORSHIP-FUNDED PROGRAMMING

School Health & Nutrition Module

{Revised January 2007}



ACRONYMS

AD	Adolescent Development
BCC	Behavior Change Communications
BE	Basic Education
CASP	Common Approach to Sponsorship-Funded Programming
CO	Country Office (formerly “Field Office”)
DM&E	Design, Monitoring, and Evaluation
ECD	Early Childhood Development
IR	Intermediate Result
MOU	Memorandum of Understanding
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PDQ	Partnership Defined Quality
PTA	Parent-Teacher Association
RF	Results Framework
SC	Save the Children
SHN	School Health & Nutrition
SIP	Summary Implementation Plan
WHO	World Health Organization

ICONS

The following icons mark the locations of certain kinds of information in the text of this module:



Quick Instructions
Look for this icon to get a brief description about the page you are reading.



Emergencies & Conflicts
This icon marks key text for emergency and conflict situations.



HIV/AIDS
This icon marks key text for communities affected by HIV/AIDS.



Other vulnerabilities
This icon marks text addressing the needs of the most vulnerable children.

TABLE OF CONTENTS

Acronyms and icons.....	2
Introduction.....	4
Why invest in School Health & Nutrition?	4
About the CASP Process	4
How to use this module.....	5
About School Health & Nutrition.....	6
Overview of School Health & Nutrition.....	6
Trends in SHN at Save the Children	6
Step 1: Situational Analysis	8
Step 2: Results Framework.....	14
Step 3: Choose Strategies	18
Resources	25
Glossary	28

INTRODUCTION

Why invest in School Health & Nutrition?

In recent years, great progress has been made in improving child survival and increasing access to education for school-age children (ages 6–18) in the developing world. The percentage of children living past age five reached 92% in 2004, up from 80% in 1960. Over 85% of school-age children attend school.

Children aged 6–18 suffer lower mortality rates than younger children or adults. However, they continue to face high levels of illness and malnutrition as they go through their crucial growing years, decreasing their ability to pay attention and progress in school. If left untreated, these diseases can cause permanent impairment to their intellectual capacity, chronic illness, and poor growth. In some of the neediest countries, school-age children still face unacceptably high mortality rates from preventable diseases. Here are some key statistics:

- 210 million school-age children suffer from Iron Deficiency Anemia and 60 million school-age children suffer from iodine deficiency.
- 85 million children lack sufficient vitamin A.
- 320 million school-age children are infected with roundworm, 233 million with whipworm, and 239 million with hookworm .

Each of the above conditions diminishes learning capacity. Under-nourished children are sometimes too weak or sick to go to school and often cannot pay attention during a full schedule of classes. Many perform poorly on school tests, repeat grades, or drop out of school altogether, failing to attain the basic skills that may help them lead healthier and more productive lives in the future. Micro-nutrient supplementation and deworming have been shown to improve school performance and restore losses of up to 21 IQ points.

For school-age girls, low school attainment and poor health and nutrition can have a magnified impact on the next generation. Malnourished girls become mothers who face high levels of maternal mortality, and bear low birth-weight babies at greater risk of infant mortality. Out-of-school girls have a higher risk of contracting HIV than girls in school. In addition, the link between female educational attainment and lifetime health is clear. A better educated girl takes better care of herself and has fewer, healthier children.



Look for this icon throughout the module for quick instructions.

Learn more about the icons used in this document on Page 2.

About the CASP Process

Save the Children Country Offices (COs) that receive funding from Sponsorship must spend 75% of their Sponsorship funds in one or more of four “Core Program Areas” (Early Childhood Development; Basic Education; School Health and Nutrition; and Adolescent Development). The goal of the Common Approach to Sponsorship-funded Programming (CASP) is for Country Offices to successfully design, implement, monitor, and evaluate programs in these core areas.

Sponsorship funds are flexible enough to allow for, and even encourage, innovation. Programs designed through CASP can act as “field laboratories” for strategies that best address children’s positive growth and development. Successful smaller programs can then be scaled-up through hand-over to the government, additional donor funds, or partnership with others.

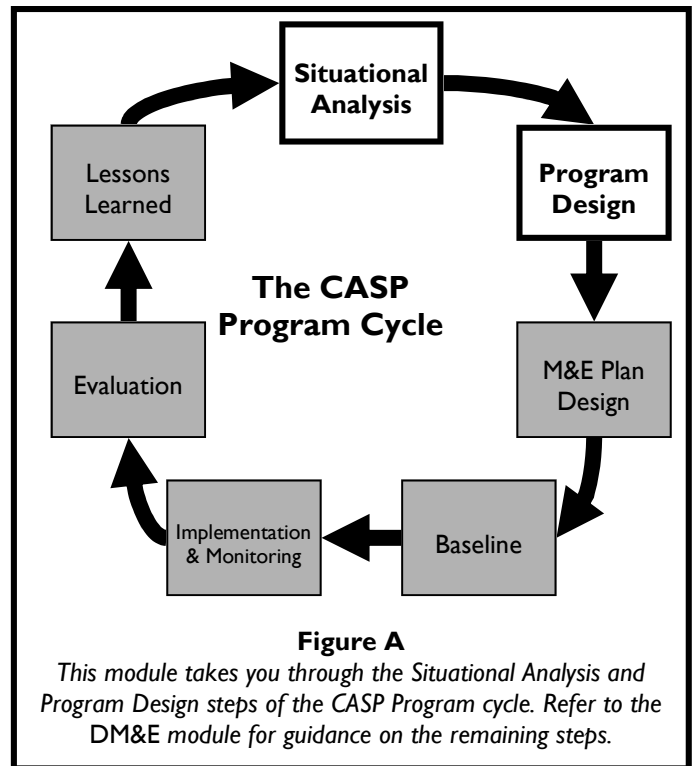
The CASP approach emphasizes that programs must be designed, monitored, and evaluated according to a standard process. This CASP module walks you through the design part of that process step-by-step. The module should facilitate communication among Country Offices, Area Offices, and Headquarters by simplifying and clearly defining the terms related to program design, monitoring, and evaluation.

The module describes state-of-the-art programming for School Health & Nutrition (SHN) and includes tools specific to this core program area.

How to Use this Module

This module is intended to provide you with **step-by-step guidance** in designing Sponsorship-funded programs in SHN. The module has several sections:

- **About School Health & Nutrition** This section provides some background in the state-of-the-art for SHN and describes some of the kinds of SHN programs Save the Children Country Offices have developed. This module assumes that you may have no background in SHN.
- **Step 1: Situational Analysis** Conducting a situational analysis is the first step in the planning process for a program. This section explains the importance of the situational analysis and gives you guidance specific to SHN.
- **Step 2: Results Framework** This section helps you think through the findings of the situational analysis and determine what results you seek from SHN programming.
- **Step 3: Key Strategies** Once you've identified the results you seek, you'll need to select strategies for achieving those results. The key strategy matrix will help you weigh options and choose the best strategies.



It is important to note that, throughout the CASP Program Cycle, you will also need to refer to the *Design, Monitoring, & Evaluation (DM&E) CASP Module*, which contains many helpful tools and in-depth explanations about each step of the process. Additionally, while the SHN module leads you through only two parts of the CASP Program Cycle, the *DM&E Module* leads you through all seven steps (see *Figure A*).

ABOUT SCHOOL HEALTH & NUTRITION

Overview of School Health & Nutrition

School Health & Nutrition addresses the critical health and nutrition factors that keep children out of school and inhibit their ability to learn. SHN is an integral part of education sector efforts to increase the access to and quality of basic education. SHN programs develop cost-effective models that identify and address priority health and nutrition problems among the school-age population, including adolescents. These models take advantage of school-based approaches to addressing issues including HIV/AIDS, early sexual debut, tobacco, and other challenges facing youth.

In 2006, Save the Children (SC) SHN programs reached around 900,000 school-age (6–18) children in nearly 1,800 schools in 16 countries across Africa, Asia, the Middle East, Latin America, and the Caribbean. Internationally, SC is one of the leading nongovernmental organizations (NGOs) in SHN and in many countries, the only international NGO implementing a comprehensive SHN program. SC is recognized for its innovative approaches to reaching school-age children in poor communities with treatments for common illnesses such as malaria and intestinal parasites.

SC works at various levels to address the health and nutrition problems of school-age children. At the community level, SC mobilizes and supports community and parent partnerships with schools for the delivery of school-based health and nutrition services and the promotion of healthy behaviors. SHN programming is delivered in areas where SC has a pre-existing base often through its “community school” program, a proven vehicle for providing community-based primary education (see below). This joint approach has created tremendous synergies, both in terms of resources expended, and in terms of education and health services working together to serve children.

Trends in SHN at Save the Children

Several successful trends, strategies, and areas of expertise in School Health & Nutrition at Save the Children are discussed below:

1. Links with Community Schools & Early Childhood Development

The best opportunity for SHN has been through community schools, where communities establish, manage, and are accountable for the education of their children (see *Basic Education* CASP module). The health and nutrition status of school children is the community’s concern and responsibility because it is linked to a child’s capacity to learn and remain in school. Some communities elect to adopt outreach strategies so the school becomes a site to provide health care beyond just school-going children. Communities participate in identifying priority areas as well as developing and implementing interventions.

A similar approach is used in ECD programs where communities participate in multi-sectoral approaches to address critical health and nutrition factors



This section provides critical background information on the foundations of SHN at Save the Children.

that affect children's healthy birth, development in their earliest days and years, and their ability to joyfully thrive and learn. Therefore, SHN interventions can be conducted in ECD centers. (See *ECD CASP Module*.)

2. SHN: Cost-effective interventions

SHN is highly cost-effective because:

- SHN uses generalized approaches such as mass deworming or micronutrient supplementation rather than selective treatment based on a diagnosis.
- SHN uses the existing health and education systems. Because there are generally more schools than health centers, school-based health interventions reach more homes and more children, including non-school going children and their families.

Annual deworming is estimated to cost US\$0.20–\$0.30 per child per year; vitamin A supplementation, US\$0.04; and a course of iron folate supplements only US\$0.10.

3. Advocacy for national programs

Using the successful model of delivering SHN through community and formal schools, SC has increased its impact through advocacy, government partnership, and the establishment of national SHN policies and programs.

4. HIV/AIDS and Reproductive Health



Children form attitudes and beliefs early in life and are more likely to practice healthy behaviors if they learn them before they have already adopted unhealthy ones. Schools offer the best venue for reaching large numbers of young children and youth with accurate HIV/AIDS and reproductive health information. As primary education enrollment rates rise, schools are also an effective venue for communicating messages into the entire community.

The SHN program provides the framework for designing, implementing, and evaluating effective HIV/AIDS prevention strategies. To address HIV/AIDS prevention, programs focus on specific behavioral goals, which are key in preventing the spread of HIV/AIDS. These behavior goals are similar to the goals of sexual/reproductive health programs (see *Adolescent Development CASP module*). Programs must go beyond the provision of information and develop comprehensive behavior-centered strategies, based on a sound understanding of the target population.

HIV/AIDS prevention programs target students and the community members who play a role in the formation of students' knowledge and attitudes about reproductive health and HIV/AIDS. Programs include the development of specific skills needed to avoid risky behaviors and establishment of a supportive school/community environment. HIV/AIDS prevention is linked to the reduction of adolescent pregnancy, abuse, and violence, and requires the same skills and training approaches.

SHN HIV/AIDS activities may overlap with activities conducted under *Early Childhood Development*, *Adolescent Development* and *Basic Education* modules. It is important that SHN teams work with other sectors to develop a comprehensive overarching HIV/AIDS strategy and common goals.

STEP ONE: SITUATIONAL ANALYSIS

The purpose of a situational analysis

Save the Children believes no one model works well everywhere, since values, expectations, needs, and realities vary considerably in different locations. Understanding the child rearing beliefs, practices, and concerns of a community is critical for truly effective programming. During a situational analysis, you will ask questions to help you gather this information. You will later base decisions about program design on the results of this process. The situational analysis can also be a chance for you to build a relationship of trust and mutual understanding and to promote community involvement in your project.

For more information about the purpose of a situational analysis, please see the *DM&E* CASP module.

How to do a situational analysis

Step 1: Review the questions on pages 9–11

On the following pages, you will find six lists of questions meant to help you gather information about six important topics related to SHN programming. For each list, select the questions that seem most relevant for your impact area

Step 2: Gather information

Gather the information you will need to answer the questions you identified in Step 1. Possible sources of information for the situational analysis may include:

- Secondary data: Documents from government agencies such as the Ministry of Education or the Ministry of Health.
- Primary research using participatory methods: Discussions with community members, families, children, and your staff, among others.
- Assessment of how existing services (SC and others) are working.
- A scan of the policy environment.

You will find more suggested resources for the situational analysis in the *DM&E* CASP module.

Step 3: Process the information (page 12)

Think about the information you gathered. What does it tell you about the needs and resources in your impact area?

Step 4: Write a brief report

After collecting information about the needs and resources in your impact area, you will write a brief report. The *DM&E* CASP module will help you organize the findings from your situational analysis and write the report.



Goal of this step:

Identify needs and resources in your impact area.

What you will need:

- This module
- The *DM&E* module
- *Information sources:* Government or other reports with data related to your impact area
- *Discussions and input:* Talk with key people in the impact area, local experts, parents/ caregivers, children, and CO staff.

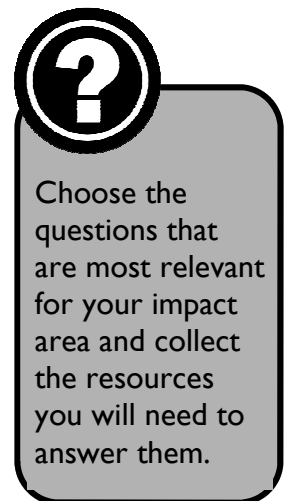
Key Questions to Guide a Situational Analysis

This section contains six lists of questions. The first five lists correspond to the results framework you will construct in the next step of the CASP process. The sixth list examines Save the Children's capacity to implement an SHN program in your impact area.

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

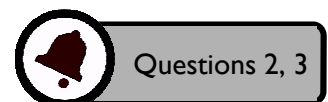
Questions about children's health and educational status

- [1] What are the most significant health and nutrition problems among the school-age group? Provide any data readily available. List sources when available. Try to identify health issues such as parasites and micro-nutrient deficiencies that are recommended in the SHN program. If there is no data on school-age children, include data on other age groups to provide an indication of the status amongst school-age children.
- [2] Does the education sector and, in particular, do schools within the impact area, suffer from low enrollments, high absenteeism, high repetition and dropout, and/or low school performance? How does this break down by age? Provide district level data where available or report results from a sample of schools. Consult the education team.
- [3] Is it likely that poor health and nutrition among school-age children contribute to low school enrollments and slow progress in school? What evidence is there for this in the impact area/in the country? If data is not available, conduct focus group discussions, and ask school and community members for the main causes of low enrollment, dropout and absenteeism.
- [4] What health services do school-age children seek? Where do they currently go for health care? How far is the nearest health centre from school/home?
- [5] What behaviors are likely to be contributing to children's poor health and nutritional status?
- [6] Are school-age children at risk of death and morbidity due to highly preventable diseases? Which ones?



Questions about the availability of SHN services

- [1] Are schools easily accessible to the population? Are teachers available to handle the student load?
- [2] Is girls' participation and progress in school a significant problem? Explain.



- [3] Is the participation and progress of Orphans and Vulnerable Children (OVC) in school a significant problem? Explain.
- [4] Do schools currently provide information about health? Is it regularly integrated into the curriculum?
- [5] Do schools provide any health services to students? To non-students?

Questions about Quality of the School Environment

- [1] Do children in schools have access to potable water supplies/water that is safe to drink?
 - [2] Do schools have functioning latrines?
 - [3] Do school latrines have hand washing facilities and soap?
 - [4] Do school latrines include separate facilities for girls? If not, does this affect the school attendance of girls?
- ⇒ *If data is not available, visit schools and collect the above information.*

Questions about Knowledge, Attitudes, and Interest

- [1] What do the community and children know about treatment for highly preventable diseases that are affecting school-age children?
- [2] What is known about current behaviors and beliefs related to health and nutrition?
- [3] Are children vulnerable to high risk behaviors related to health, including sexual health, especially HIV/AIDS? What behaviors specifically?
- [4] Are there health-related curricula that are used by government, SC, or other institutions? If so, have the teachers received training in the health curriculum? Is it utilized in the schools by the teachers? If so, do teachers use participatory teaching methods when teaching health topics?
- [5] Are there training activities for teacher and local health agents for health services for school-age children?



Question 3

Questions about Community Support and Policy

- [1] Are there existing health and nutrition programs for school-age children either within SC or through government or other institutions? List all programs including target age and expected outcomes.
- [2] Is there a national SHN strategy or program in place? And if so, what is the status of the program and what could be SC's role in supporting the national strategy or program?
- [3] Are there SHN-related policies in the health or education agendas, including those related to student abuse or corporal punishment, and are

there requirements related to providing health services or education to children? If so, are they implemented/enforced?

- [4] Is there regional support for this program area? Specify.
- [5] Do officials in the Ministries of Education and Health demonstrate an awareness and understanding of SHN Issues? At what levels? Explain. If they are aware, are they supportive?
- [6] Do teachers perceive any link between school performance, health behaviors, and health status?
- [7] Are the community/parents aware of all the health and nutrition issues identified by health officials/agents?
- [8] Do parents perceive any link between school performance and health behaviors and health status?
- [9] Is there demand from the community to address the health and nutrition problems among school-age children? If so, what needs are of greatest concern? How do you know?
- [10] Has there been community support for school-based health and/or nutrition activities? What kind of support is there?
- [11] Based on experience to date, what has been the reaction from the community to existing school-based health activities?

Questions about Save the Children's Capacity

- [1] What is the level of awareness and understanding of School Health & Nutrition in the Country Office and impact area? Explain.
- [2] Does your CO support programs in both the health and education sectors? What are these programs?
- [3] Does your CO have education programs that address issues related to the quality of basic education? What aspects of quality? Is SC recognized for this work; does it represent "better practice?" Does it include SHN strategies?
- [4] Does SC have the local-level capacity to develop and implement a SHN program? What/who specifically?

- [5] Are there local partners with relevant expertise and experience? Specify who and what especially related to the different interventions of SHN recommended activities. Is SC connected with these partners? Explain.

Processing the Situational Analysis

As you gather information to answer the questions above, you may want to record your most important findings in the Situational Analysis Summary Tool, found in the *DM&E* Module. You will then need to process the information you gathered, identifying problems that your SHN program should address, or resources you may be able to draw upon.

Below are some questions that may help you process your findings.

Processing your findings on Health & Educational Status:

- Do children in your impact area have health problems (e.g. parasites, micro-nutrient deficiencies) that could be improved by SHN? Could their education achievement be improved with these services?
- Are they currently receiving health care for their health concerns at school or nearby health clinics?
- What harmful behaviors could be improved by SHN programming?

Processing your Availability findings:

- Are schools easily accessible to the school-age population? Are girls more often left out of schools than boys? What other factors inhibit children's access to schools?
- What inhibits children's access to health services?

Processing your Quality findings:

- Do schools have adequate water and sanitation facilities? Are separate facilities needed for girls?

Processing your Knowledge, Attitudes, and Interest findings:

- Do children in your impact area suffer from diseases that could be prevented with improved knowledge, attitudes, or skills?
- Would children benefit from education on high-risk behaviors or HIV/AIDS prevention?

Processing your Community Support & Policy findings:

- Is the community in your impact area supportive of SHN interventions?
- Is the government supportive of SHN interventions? Are changes in policy required?

Processing your SC Capacity findings:

- Does SC have programs in the impact area that could be expanded to include SHN activities?



These questions will help you think about the information you gathered in your situational analysis and the needs and resources of your impact area.

- Do local SC staff have an adequate understanding of SHN issues?
- Can you identify potential partners for SHN projects?

STEP TWO: RESULTS FRAMEWORK

What is a results framework?

Now that you've gathered information about the needs and resources of your impact area, you are ready to begin using that information to design your program. The CASP results framework (RF) is a diagram that shows how your program will produce positive change for children. There are four major pieces in a results framework, from top to bottom:

- [1] **The goal:** At the top of the RF; the “big picture” positive change you want. The goal may be hard to measure.
- [2] **Strategic Objective:** The measurable behavior change that is needed to reach your goal.
- [3] **Intermediate Results (IRs)** Measurable, lower-level results that must occur in order to reach the Strategic Objective. Each IR may be supported by several **strategies**, or kinds of activities. Achieving all four of these lower-level results will allow you to achieve your Strategic Objective.
- [4] **Indicators:** Indicators are yardsticks for measuring progress toward the Intermediate Results and the Strategic Objective.

A results framework is a very important tool for designing your program and for monitoring it. In the program design process, the RF can help your team build consensus around shared objectives and strategies, and communicate those ideas to partners. As you implement your program, the RF will help you gauge your progress and adjust activities that are not producing the results you hoped for.



Goal of this step:

Map the findings of your situational analysis to a diagram of goals, objectives, and intermediate results.

What you will need:

- This module
- The DM&E module
- The findings of your situational analysis

Constructing your results framework

On the following page, you will see a results framework that has been developed by Save the Children SHN specialists. It represents the state-of-the-art for this core program area. While you will select strategies and indicators that address the unique contexts, issues, and needs of your impact area, you should use the goal, strategic objective, and IRs included on this model results framework.

On the pages following the results framework, you will find a more detailed description of each IR and the kinds of strategies that are recommended to achieve each result. You will notice that the four IRs correspond to the categories of questions in the situational analysis. This should help you begin to consider the findings of your situational analysis and choose strategies for each IR that best match the needs and resources of your impact area. In addition, a

comprehensive menu of key strategies is presented in step 3 of this module.

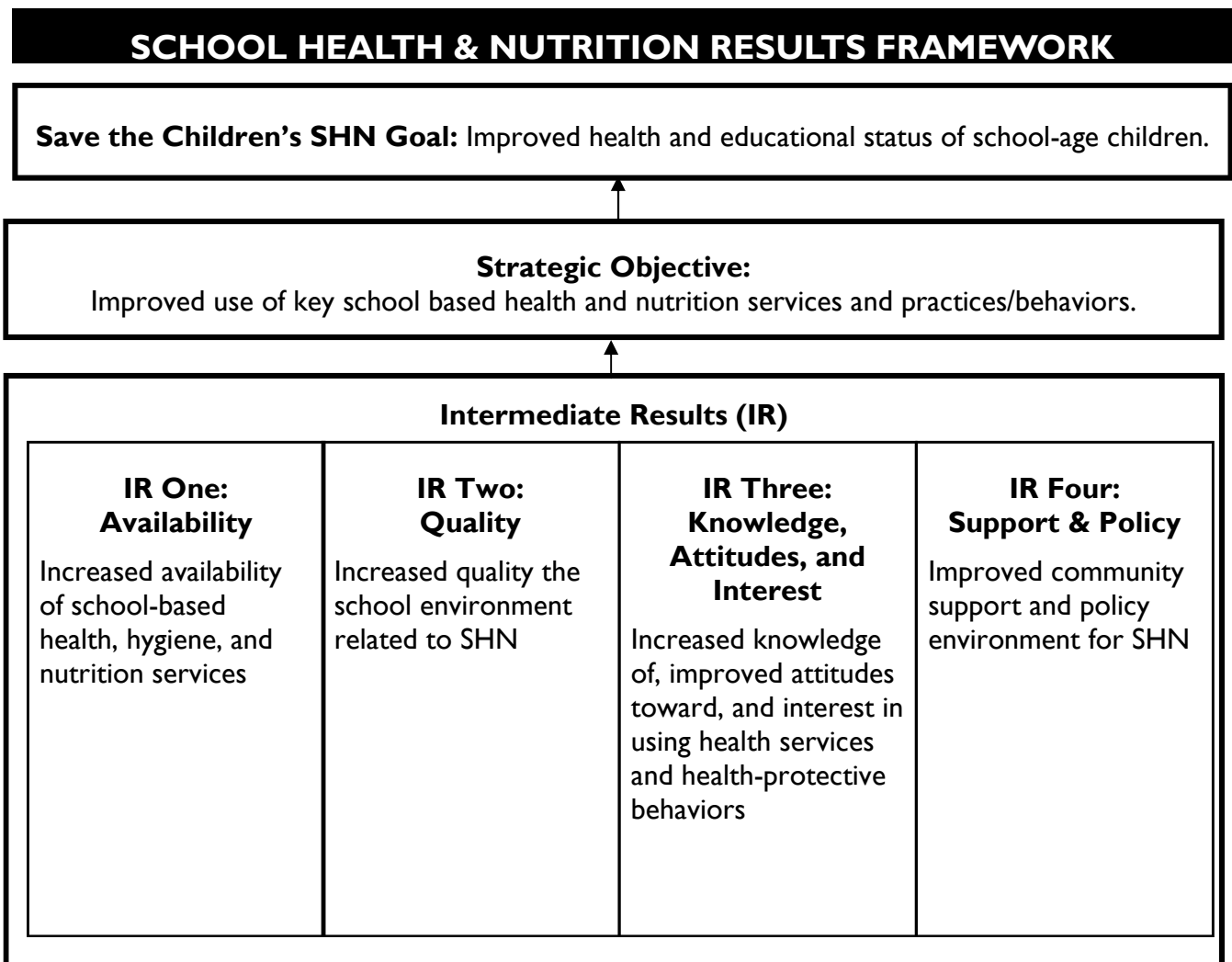
For each IR, you will need to use the findings from your situational analysis to consider:

- What are the highest priority needs in the impact area, based on gaps in each IR identified in the situational analysis?
- What kinds of solutions are cost-effective and likely to work?
- Does your Country Office have the capacity to implement these programs, with help from any partners you've identified?

Once you understand each IR and can see connections between the findings of your situational analysis and the results framework, you are ready to choose the strategies you will use in your program (see *Step 3:Key Strategies Matrix*) and the indicators you will use to measure your progress (see the *DM&E* module).

About the Strategic Objective: Improved use of SHN & Practices

International evidence indicates that the use of simple health and nutrition interventions provided in schools and the practice of preventive healthy behaviors will lead to the goal of healthier children who learn better.



IR One: Availability

The first intermediate result addresses problems of the availability of school-based health, hygiene, and nutrition services.

Strategies for IR1 may include:

- Iron, vitamin A, iodine, or multi-vitamin supplementation or fortification.
- Routine mass treatment of intestinal parasites.
- Treatment of common health problems, e.g., malaria, trachoma .
- Screening and classroom remediation for vision and hearing impairments.
- Psychosocial counseling for children.

Issues related to IR1 include:

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



About IR Two: Quality

The second intermediate result addresses the quality of the school environment, in particular regarding access to water and sanitation facilities.

Strategies for IR2 may include:

- Provision of hand washing facilities and adequate latrines (including latrines for girls).
- Provision of potable water in schools.
- Development of a system for maintaining SHN facilities, e.g., school hygiene committees (Also see IR 4).

About IR Three: Knowledge, Attitudes, and Interest

The third intermediate result addresses problems of child knowledge of, attitude toward, and interest in health services and health-protective behavior. Strategies to address this IR consist of behavior-centered health and nutrition education and communications.

Strategies for IR3 may include:

- Skills-based health education to enable children to stay healthy and avoid



These detailed descriptions of the SO and each IR will help you understand how the findings of your situational analysis fit into the results framework.

risky behaviors.

- Teacher training on skills-based health and nutrition education.
- Training of health workers and community participants on the different elements of SHN services.

Issues related to IR3 include:

- We know that changes in knowledge do not always translate into changes in practice—thus, building knowledge should be accompanied by efforts to build children’s skills so that they can take action for their own health.
- Children form attitudes and beliefs early in life and are more likely to practice healthy behaviors if they learn them before they have already adopted unhealthy ones.

Issues related to IR3 in communities affected by HIV/AIDS:

- Schools offer the best venue for reaching large numbers of young children and youth with accurate HIV/AIDS and reproductive health related information.
- Programs must go beyond providing information and develop comprehensive behavior-centered strategies, based on a sound understanding of the target population.



About IR Four: Community Support & Policy

The fourth intermediate result addresses problems of support systems and policy.

Strategies for IR4 may include:

- Educating caregivers and parents on improving children’s health and nutrition.
- Establishing security and safety in and around schools and establishing school health related policies with the community.
- Working with key stakeholders from the community up to the national level to ensure effective program implementation, increase sustainability, and create an environment favorable to meeting the health and nutrition needs of school-age children.
- Advocacy to scale-up to national-level SHN programming.

Issues related to IR4 include:

- Work with stakeholders in the formal schooling system (official, government schools) and in nonformal schools (community based and managed), if both exist in your impact area.
- Efforts to scale-up programs often take many months and years so results may be difficult to observe.

KEY STRATEGIES

Selecting strategies for your program

Based on the findings of your situational analysis and the description of each of the intermediate results in the Results Framework, you should be able to identify problems related to each IR—gaps between what is and what should be. The next step in designing your program will be choosing the strategies to best address those problems, using the resources you have identified in the community.

Ideally, you will select strategies that address all four IRs in a holistic way. When this is not possible, your team should work with technical staff in your country office, regional office, or in headquarters to choose among the IRs based on available resources and community needs.

How to select strategies



Goal of this step:

Choose the strategies that will best address the needs and work with the strengths you identified in your situational analysis

What you will need:

- This module
- The *DM&E* module
- The findings of your situational analysis
- The results framework

Although some possible strategies that could be used to address the problems related to each IR have already been presented in the Results Framework section, this next section of the module contains a comprehensive menu of the recommended strategies for each IR. The menu, called a “Key Strategies Matrix,” will help you compare strategies by giving you information about the costs, frequencies, and issues related to each strategy.


Again, not all strategies listed in the matrix will be appropriate for your impact area. Remember to base your strategy choices on the results of your situational analysis and to keep in mind the goal of SHN programming (“Improved health and education status of school-age children”), and each of the four IRs.

The next steps

Once you have chosen the strategies that will best address the needs and use the resources of your impact area, record your choices on the Summary Implementation Plan (SIP), found in the *DM&E* CASP Module.


To write your program description, select results indicators, and collect baseline data, you will need to continue in the *DM&E* CASP module.

Key Strategy	Frequency	Ease of implementing	Costs	Issues/Comments
Mass treatment of school-age children with praziquantel for schistosomiasis infection.	If prevalence rate \geq 30% of urinary schisto or \geq 50% intestinal schisto, treat 1 time per year. If prevalence rate $<$ 30% urinary schisto or $<$ 50% intestinal schisto, treat every 2 years. If prevalence rates of both urinary or intestinal schisto $<$ 10%, treat twice during primary schooling (entry and exit).	Simple.	Costs between 20–71¢ per child including delivery costs. Less than 2¢ per actual treatment. Training and supervision costs are minimal for this mass treatment approach when dose poles are used.	<ul style="list-style-type: none"> • Drug procurement and distribution system needs to be coordinated with available, on-going systems for the intervention to be sustainable. • Prevalence surveys require technical assistance from laboratory technicians and others. • Needs to be linked to effective behavior change communications for prevention (see hygiene and other practices) to improve sustainability. • Treatment-seeking behavior needs to be promoted especially when prevalence is too low for mass treatment. • Policy approvals needed from Health Offices to adopt new WHO recommendations for low prevalence schools and use height pole for dosage calculation.
Mass treatment of school-age children with Albendazole (400mg) or Mebendazole (500mg) for intestinal parasitic infection.	2-3 times per yr, if prevalence rate \geq 70%; 1 time per yr, if prevalence rate \geq 50% Mass treatment can be done when prevalence is lower if funding is available.	Simple.	Costs 3–20¢ per year including delivery costs. Less than 2¢ per actual treatment. Training and supervision costs minimal for this mass treatment approach.	<ul style="list-style-type: none"> • Drug procurement and distribution needs to be coordinated with ongoing systems if the program is to be sustained. • Intervention needs to be linked to effective behavior change communications program for prevention of intestinal parasitic infection (see hygiene practices) and to enhance the sustainability. • Treatment-seeking behavior needs to be promoted especially when prevalence is too low for mass treatment. • Policy approvals needed from Health Offices to adopt new World Health Organization (WHO) recommendations for mass treatment.
School-based mass distribution of vitamin A capsules for vitamin A deficiency.	Every 6 months.	Simple.	Costs 4¢/child including delivery. Less than 2¢ per actual treatment. Training and supervision costs minimal.	<ul style="list-style-type: none"> • Measuring vitamin A status is problematic; currently no reliable, quick, and easy field methods. • Need to ensure that girls who might be pregnant do not receive supplementation. • Should not take away from vitamin A supplies for higher priority groups. • Needs to be linked to effective communication strategies focused on dietary practices to prevent vitamin A deficiency.

 **IRI:** These key strategies address problems of access



IRI: These key strategies address problems of access

Key Strategy	Frequency	Ease of implementing	Costs	Issues/Comments
School-based mass treatment with iodized oil capsules targeted at high risk groups where iodized salt is not available.	Every 6–12 months depending on the severity of deficiency.	Simple.	30–40¢ per child including delivery. Iodine capsules are more expensive than other micro-nutrients treatments. Training and supervision costs minimal.	<ul style="list-style-type: none"> • Should be second priority to promotion of iodized salt. • Measuring iodine status in field conditions is problematic. Total goiter rate is not accurate and inappropriate to measure program impact. • Less attention given to the need for distribution of iodized oil with the advent of efforts to fortify salt with iodine. Need for continued promotion in areas of high risk not covered yet by salt fortification. • Should not diminish supplies of iodized oil for higher priority groups.
Schools as a mechanism for promoting and monitoring the fortification of salt and its consumption.	Periodic.	Simple.	Salt testing kits available from UNICEF. Promotional materials. Training of teachers and students.	<ul style="list-style-type: none"> • Potentially an under-utilized opportunity for promoting consumption of iodized salt. • Must include the promotional element and be linked to behavior change strategies if it is to contribute to alleviating the problem area. • Supply issues may require advocacy at different levels before promotion of consumption of iodized salt can be effective.
School-based mass treatment of iron on a weekly or twice weekly basis to alleviate anemia.	Once or twice a week for 10–15 weeks during high risk season. Number of weeks depends on funding and number of weeks in school term. One or two periods per school year.	Fairly simple.	Low cost. Training and supervision costs more substantial to ensure compliance.	<ul style="list-style-type: none"> • Time from teaching must be evaluated and minimized in light of the length of treatment. • Iron procurement and delivery system must be linked to available systems if programs are to be sustained. • Needs to be linked to effective behavior change strategies that prevent iron deficiency through diet strategies. • Should be linked to interventions that address other causes of iron deficiency—vitamin A supplementation, deworming, prevention of malaria, and avoidance of tea during iron-rich food intake.
School-based access to Reproductive/Sexual Health and HIV counseling and psycho-social support. 	Continuous.	Medium to difficult.	Heavy training of teachers, some counseling material.	<ul style="list-style-type: none"> • Trust of children, and parents for using counseling. • Gender of the teacher/counselor will impact utilization. • Time required may require additional personnel • Need referral system for abuse and other problems identified during sessions.

Key Strategy	Frequency	Ease of implementing	Costs	Issues/Comments
School-based screening for vision and hearing.	Once per year.	Simple to very difficult.	Low to negligible cost for tools and teacher training. High costs for provision of glasses and hearing aids, making this impossible in most contexts.	<ul style="list-style-type: none"> • Need to ensure that classroom management measures are taken in the absence of other actions (e.g. move children closer to blackboard). • Need to ensure that children who test positive for vision or hearing problems are not discriminated against by neglect of school teachers. • Need to ensure clear parent communication to follow-up with identified needs. • Need to link with referral services that include the provision of eye glasses and hearing aids.
School-based presumptive treatment of malaria.	Continuous.	Fairly simple.	Training of teachers and supply of malaria treatment.	<ul style="list-style-type: none"> • Drug procurement and distribution needs to be coordinated with ongoing systems; parent contribution/commitment necessary if the program is to be sustained. • Intervention needs to be linked to effective behavior change program for prevention of malaria infection, recognition of symptoms, and seeking of treatment. • Changing policies on malaria treatment requires continued surveillance of policies, especially in regards to effectiveness of treatment.




IRI: These key strategies address problems of access



IR2: These key strategies address problems of quality

Key Strategy	Frequency	Ease of implementing	Costs	Issues/Comments
In-school potable water provision.	Continuous.	Medium to difficult.	Low, depending on the technique for purification of existing water; high for new water sources (bore-holes, pumps). Moderate costs depending on the design.	<ul style="list-style-type: none"> • Requires mobilization and organization of the community to supply labor and on-going maintenance. • Technologies for purification vary greatly. • When a new water source is required, it means that the water is needed by everyone, not just school-age children. A method for sharing the water in the community is required.
In-school hand washing facilities.	Once, with ongoing maintenance.	Easy to medium, depending on type of facility.	Low to moderate, depending on type of facility.	<ul style="list-style-type: none"> • Technologies for hand washing facilities vary greatly. They can be very cheap and simple or more sophisticated and expensive. • Needs to be linked to effective behavior change communications to promote use of water and soap, not just water. • Difficult to practice behavior modeled in schools when households do not have necessary environment, therefore, work with communities to encourage household installation of hygiene facilities. • Needs to be linked to provision of soap or other abrasive/ cleansing materials for effectiveness of hand-washing.
Latrine Construction.	Once with on-going maintenance.	Medium; requires community organization and participation.	Moderate cost depending on the design.	<ul style="list-style-type: none"> • Requires mobilization and organization of the community to supply labor and on-going maintenance. • Needs to be linked to effective behavior change communications to promote use and care of these facilities. • Difficult to practice behavior modeled in schools when households do not have necessary environment, therefore, work with communities to encourage household installation of sanitation facilities. • May be a critical intervention to ensure enrollment and attendance of adolescent girls.

Key Strategy	Frequency	Ease of implementing	Costs	Issues/Comments
Behavior change communications to prevent malaria through promotion of the use of impregnated bed-nets.	Periodic.	Medium to difficult.	High initial costs to develop the appropriate behavior change strategy. Cost of the bed-net and the insecticide also high.	<ul style="list-style-type: none"> • SC has little to no experience in trying to use the schools to promote this preventive approach. • Family-focused intervention not specifically aimed at the school-age child.
Behavior change communications programs (Behavior centered health, nutrition, schistosomiasis, malaria, and hygiene education and training addressing: <ul style="list-style-type: none"> • Inappropriate dietary practices that contribute to malnutrition. • Unhealthy practices leading to intestinal and other parasitic diseases. • High-risk behaviors among youth such as unsafe and early initiation of sex, drug and alcohol use, etc. • Prevention of HIV/AIDS. • Prevention of traffic and home accidents. • Prevention of smoking. • Oral health practices. 	Continuous	Medium	High to medium initial cost for materials development or adaptation; requires training and support to teachers; requires awareness building of personnel and others for their support for this activity	<ul style="list-style-type: none"> • Effective programs and materials demand a process that identifies ideal behaviors, current behaviors and opportunities, feasible behaviors, major barriers, and major motivations for practicing behaviors. • A significant commitment both in financial and human resource terms must be made to implement the process. It requires time and a significant number of activities with the community and beneficiaries. If the process is short-changed, the communications program is unlikely to be effective. The cost is reduced drastically once the materials have been developed/adapted and the initial set of trainers and teachers have been trained. • Effective behavior change communications programs are critical to the sustainability of the benefits of medical and nutritional interventions. • Behavior is the bottom line for long-term changes in health and nutrition.

 **IR3:** These key strategies address knowledge, attitudes, & practice



IR4: These key strategies address problems of policy

Key Strategy	Frequency	Ease of implementing	Costs	Issues/Comments
Advocacy for changes to school policies.	Continuous.	Medium.	Medium.	<ul style="list-style-type: none"> • May entail higher-level contacts and issues where national policy changes are needed. • Best when coordinated with other activities under other intermediate results supported by the program.
Capacity building for schools (e.g. training of parent teacher associations or creation of groups for school health and nutrition).	Continuous.	Medium.	Low.	<ul style="list-style-type: none"> • Required at a range of levels—community, local, district, national for effective, sustained support to SHN.
Participant Defined Safe Schools policies.	Continuous.	Medium.	<p>Medium during initial community training/ workshop using Partnership Defined Quality (PDQ) method (see <i>Resources</i>).</p> <p>Low once policies/ Memorandum of Understanding (MOU) is established.</p>	<ul style="list-style-type: none"> • Requires communities that are fully engaged. • Children are a full participant not just a recipient of this activity. • May require referral to local authorities of teachers and others.
Parent-child communication guide	Continuous.	Medium.	Low: training need for lead parents/ PTA/ School management committee members.	<ul style="list-style-type: none"> • Requires cascading of training and responsibility. • Proper counseling and support of parents are essential to ensure the guides are used effectively. • Geared towards community and not really school-based so not all children will benefit; only children of parents who take interest will benefit. • A model guide is the “Cool Parent Guide” developed by the Malawi CO (see <i>Resources</i>).
Operational research.	Once at program initiation.	Medium.	Medium to high for establishing research environment and hiring researchers.	<ul style="list-style-type: none"> • Best combined when planned ahead as part of evaluation of program. • Data collected useful for advocacy. • Staff and community may not understand the need for comparison/control groups. • Allows CO to experiment with new activity or activity not recommended by previous experiences.

RESOURCES

General SHN Resources

- [1] Bundy, D.A.P., et al., Eds. (2006). *School-Based Health and Nutrition Programs. Disease Control Priorities in Developing Countries* (2nd Edition). New York: Oxford University Press. The chapter on SHN that appropriately summarizes need and issues is available at: <http://files.dcp2.org/pdf/DCP/DCP58.pdf>
- [2] Hall, Andrew et al. (2002). *A situation analysis of school health and nutrition in Ethiopia*. Save the Children USA. This situation analysis, carried out by SHN experts for SC's program in Ethiopia, can be used as a model situation analysis.
- [3] www.schoolsandhealth.org : Run by the World Bank and Partnership for Child Development. General information on SHN and FRESH (Focusing Resources on Effective School Health), updates on meetings and SHN programs by country. Links to other useful websites and a list of all publications on SHN related topics.
- [4] World Bank (2003). *School Health at a Glance*. World Bank produced information sheets on school health; available in English, French, Portuguese and Russian. The English version can be downloaded from: <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGSchoolHealth.pdf> The full series and other languages can be found at: <http://www.worldbank.org/hnp>

Resources on Access to SHN

- [1] Bundy, D.A.P. & Del Rosso, J.M. (1993). *Making nutrition improvements at low cost through parasite control*. Human Resources Development and Operations Policy World Bank Working Paper.
- [2] www.iccidd.org : Provides basic information on Iodine Deficiency and statistics by country; a contact e-mail for questions regarding iodine deficiency is also included
- [3] www.ovcsupport.net : A collection of information and tools on supporting OVC living in a world with HIV/AIDS
- [4] Save the Children Afghanistan (2004). *Eating Good Food: Nutrition education activities for use with children*.
- [5] Save the Children (October 2006). *Position Paper on School-Feeding*. This document outlines the pros and cons of school feeding programs and SC/US and SC/UK's position regarding this controversial topic.
- [6] www.trachoma.org : Basic information on trachoma and regular updates on related issues.
- [7] <http://www.who.int/wormcontrol/documents/new/en/>: Many useful documents on parasite control by World Health Organization can be

found on this website including: *How to Deworm School-age Children: Instructions for Teachers* and *Helminth control in school-age children: A guide for managers of control programs*.

- [8] WHO (January 2004). *Action Against Worms*. Partnership for Parasite Control (Issue 1). A step by step guide on how to set-up a deworming program. Download from:
<http://www.who.int/wormcontrol/newsletter/en/PPC4%20Newsletter.pdf>
- [9] World Bank (2003). *Deworming at a Glance*. World Bank produced information sheets on deworming; available in English, French and Portuguese. These documents can be downloaded from:
<http://siteresources.worldbank.org/INTPHAAG/Resources/AAGDewormingEngl10603.pdf>

Resources on Quality of School Environment: Water & Sanitation

- [1] Conant, Jeff. (2005). *Sanitation and Cleanliness for a Healthy Environment*. Hesperian Foundation, New York.
- [2] Conant, Jeff. (2005). *Water for Life: Community Water Security*. Hesperian Foundation, New York.
- [3] Curtis, V. (1998). *Hygienic, healthy and happy: A manual for setting up hygiene promotion programmes*. UNICEF, New York.
- [4] www.irc.nl : Up to date news. Thematic Overview Papers combine recent experiences, expert opinions and foreseeable trends with links to the most informative information.
- [6] Zomerplaag J and Mooijman A (2004). *Child-Friendly Hygiene and Sanitation in Schools*. Available on the 'Strengthening SHN Programs' CD-Rom (PCD, 2005)
- [7] www.unicef.org/wes/index_documents.html : A selection of technical, policy and advocacy documents produced by UNICEF on water, sanitation, hygiene and the environment. Including *Towards Better Programming: A manual on school sanitation and hygiene*.
- [8] World Bank, WSP and UNICEF (2005). *Toolkit on Hygiene Sanitation and Water in Schools*. A CD-Rom. Summary booklet at:
<http://www.wsp.org/publications/TOOLKIT.pdf> CD can be requested from Whelpdesk@worldbank.org. Soon to be available in French.
- [9] www.unesco.org/education/fresh : UNESCO tools on water and sanitation in schools including:
- *Water and Sanitation: A Checklist for the Environment and Supplies in Schools*. Strategies to ensure schools have adequate water, sanitation and hygiene facilities.
 - *Guidelines for the Provision of Safe Water and Sanitation Facilities in Schools*. Optimal and minimal acceptable standards for schools.
 - *Simple Technology for Filtering and Disinfecting Water at School*.
 - *Selecting an Appropriate Technology for Water Supply Projects*.

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



- [1] www.aidsmark.org/intervention/bcc.html : Collection of HIV/AIDS materials for building effective Behavior Change Communications (BCC) programs.
- [2] www.child-to-child.org : An educational process that links children's learning with action to promote health, wellbeing, and development.
- [3] www.ibe.unesco.org/HIVAids.html: The International Bureau of Education website includes: Databank of HIV/AIDS and education documents by country; Curriculum manual with tools for HIV/AIDS education and teacher training
- [4] www.safepassages.soton.ac.uk : A number of guides to good practice and research tools on sexual health for young people

Resources for Community Support and Policy

- [1] Howard-Grabman, L. and Snetro, G. (2004). *How To Mobilize Communities For Health and Social Change, A Field Guide*. Health Communication Partnership. Examples of community mobilization experiences worldwide, especially disadvantaged or marginalized groups in developing countries. Available at: http://www.hcpartnership.org/Publications/Field_Guides/Mobilize/pdf/
- [2] www.unesco.org/education/fresh : UNESCO tools to download on every element of SHN including the following on school policy: *School Health Policy Development: Basic First Steps (2004)*; *Basic Guidelines for the Development of School Policies, Governing Nutrition Interventions (2004)*
- [3] www.who.int/school_youth_health/resources/information_series/en/ : The World Health Organization has developed an information series on different aspects of SHN, including the following WHO and UNESCO tools: *Creating and environment for emotional and social wellbeing, (2003)*; *Steps to Becoming an Inclusive Learning-Friendly Environment (2004)*; *Evaluating the Psycho-social Environment of Your School (2004)*
- [4] Save the Children Malawi (2003). *Cool Parent Guide*. Guide for parent communication with children about HIV/AIDS and reproductive/sexual health.
- [5] Save the Children (2003) *Partnership Defined Quality Manual*. Guidebook to the PDQ approach. Available at: <http://savenet.savechildren.org/savenet/Development+Programs+for+Children/Health/Resources.htm>



GLOSSARY

Affected by HIV/AIDS

This module uses the phrase “children affected by HIV/AIDS” to mean: 1) Children living with parents who are infected by HIV/AIDS; 2) Children who are orphaned by HIV/AIDS; 3) Children who are infected by HIV/AIDS; 4) Children who live away from home because of HIV/AIDS. These children are often further isolated from others and may find themselves living on the street and devoid of family support.

Curriculum

The set of skills, attitudes, and performance objectives that students are expected to learn from an education program.

Dose Pole

A tool that determines that correct number of pills to give children according to their height.

Orphans & Vulnerable Children (OVC)

This term generally refers to orphans and other groups of children who are more exposed to risks, and more likely to experience negative outcomes, than their peers. From the perspective of your program, they are the children who are most likely to be missed by regular programs targeting children. Major categories of OVC include, but are not limited to: street children, children in the worst forms of child labor, children affected by armed conflict, children affected by HIV/AIDS, and children with disabilities.

Schistosomiasis

Schistosomiasis (also called Bilharzia) is a disease caused by parasitic worms that live in water snails. It is transmitted when people wash, swim or paddle in water that contains the snails. Although it has a low mortality rate, it causes serious damage to vital organs.