# Monitoring and Evaluation of School-Based Health and Nutrition Programmes: A Participative Review

## Assessing the need for a generic framework and identifying good practices and limitations in existing resources

Zero Draft for consideration

Review conducted on behalf of the FRESH partners
for the 'FRESH Partners Meeting'
held on 8th – 9th of September 2008

PCD The Partnership for Child Development

Save the Children USA

Zero Draft: 11 Aug 2008

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# ACKNOWLEDGEMENTS

This report was written by Mohini Venkatesh and Kristie Neeser from the Partnership for Child Development. We are very grateful to key resource people who provided valuable contributions to the development of tools, collation of data, and reviewed drafts of this report. The key resource people include: Natalie Roschnik (Save the Children USA); Claire Risley and Aulo Gelli (Partnership for Child Development).

The report would not have been possible without the contributions of key informants from the 24 organizations involved in the school-based health and nutrition programmes. The key informants include: Dan Abbott (Save the Children USA); Carmen Aldinger (Education Development Center); Désiré Aroga (Ministry of Education, Cameroon); Kishor Aryal (World Food Programme); Camara Balla (Ministry of Education/Ministry of Health, Guinea); Elisa Bosqué-Oliva (Schistosomiasis Control Initiative); Don Bundy (World Bank); Giovanna Campello (UNODC); Greg Carl (Thai Red Cross); Kreankrai Chaimuangdee (Lifeskills Development Foundation, Thailand); Therese Dooley (UNICEF); Lesley Drake (Deworm the World); Fiona Fleming (Schistosomiasis Control Initiative); Amaya Gillespie (UNICEF); Gaston de la Haye (Education International); Anna Maria Hoffmann (UNICEF); Grace Igweta (World Food Programme); Sharlene Johnson (Ministry of Education, Guyana); Moussa Kabore (Fondation de Dévelopement Communautaire, Burkina Faso); Tashmin Khamis (Child-to-Child Trust); Elizabeth Kristjansson (University of Ottawa); Rebecca Lamade (World Food Programme); Amicoleh Mbaye (Department of State for Education, The Gambia); Edwin Michael (Imperial College, London); Z. Momodu (Ministry of Education, Nigeria); Antonio Montresor (WHO); Sofialetecia Morales (WHO); Joviah Musinguzi (World Food Programme); Amado Parawan (Save the Children USA); Anthi Patrikios (Partnership for Child Development); Jenny Renju (MEMA kwa Vijana); Leanne Riley (WHO); Mbabazi Pamela Sabine (WHO); Mariëlle Snel (IRC International Water and Sanitation Centre); K.C. Tang (WHO); Alice Woolnough (Partnership for Child Development); Richard Yakubu (Catholic Relief Services); and Ekua Yankah (UNESCO). We are very grateful for their time spent in responding to our questions and for providing useful information and references within this report.

Our gratitude further extends to Michael Beasley, Celia Maier and Lucinda Johnson (Partnership for Child Development) who also provided invaluable comments to drafts of this report. Editorial assistance was provided by Anastasia Said (Partnership for Child Development).

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# LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AED | Academy for Educational Development |
| AIDS | Acquired Immune Deficiency Syndrome |
| ARQ | Annual Reports Questionnaire |
| CASP | Common Approach to Sponsorship-Funded Programming |
| CDC | Centers for Disease Control and Prevention |
| EDC | Education Development Center |
| EFA | Education for All |
| EMIS | Education Management Information System |
| ESART | EduSector AIDS Response Trust |
| ESSAPR | Education and Sports Sector Annual Performance Report |
| FAO | Food and Agricultural Organization of the United Nations |
| FFE | Food for Education |
| FHI | Family Health International |
| FRESH | Focusing Resources on Effective School Health |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| IATT | Inter-Agency Task Team on HIV and Education |
| INEE | Inter-agency Network for Education in Emergencies |
| IIEP | International Institute for Educational Planning |
| INGO | International Non-Governmental Organization |
| IPPF | International Planned Parenthood Federation |
| IRC | IRC International Water and Sanitation Centre |
| ISESCO | Islamic Education, Scientific and Cultural Organization |
| M&E | Monitoring & Evaluation |
| MDGs | Millennium Development Goals |
| MEASURE DHS | Monitoring and Evaluation to Assess and Use Results, Demographic and Health Surveys |
| MICS | Multiple Indicator Cluster Survey |
| NGO | Non-Governmental Organization |
| PAHO | Pan American Health Organization |
| PCD | Partnership for Child Development |
| RAAPP | Rapid Assessment and Action Planning Process |
| RBM | Roll Back Malaria |
| SC/USA | Save the Children USA |
| SCN | Standing Committee on Nutrition |
| SHN | School Health and Nutrition |
| SHAPE | School-Based Healthy Living and HIV/AIDS Prevention Education |
| SMART | Specific, Measurable, Attainable, Relevant and Time-Bound |
| STI | Sexually Transmitted Infection |
| UN | United Nations |
| UNAIDS | United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UNODC | United Nations Office on Drugs and Crime |
| USAID | United States Agency for International Development |
| WASH | Water, Sanitation and Hygiene |
| WFP | World Food Programme |
| WHO | World Health Organization |
| WHO WPRO | World Health Organization Regional Office for the Western Pacific |

# GLOSSARY

**Core indicators** Indicators that are recommended for reporting by all countries. (See definition of 'Indicators' below.)

**Evaluation** The assessment of the impact of a programme on desired outcomes.

**Indicators** Quantitative and qualitative measures/variables that are used to assess the status of progress towards goals, objectives, outputs, activities or standards. In order to access uniform data on core indicators, they must be accompanied by tools – from data collection to analysis, dissemination and use. These may be special surveys or routine collection efforts, with specific questionnaires, guidelines, reporting formats and databases.

**Logical framework** A logical framework (also called r*esults framework*) is the starting point for generating an M&E framework for development programmes. It presents programme activities and outputs to address priorities (e.g. worms and nutrition), as well as long-term objectives and goals (e.g. improvements in health and education), each with their associated indicators, so that they may be monitored and evaluated.

**Minimum standards** The minimum standards of programme activities and outputs are used to outline what should be provided and what should exist in schools as a minimum for the health, nutrition and well-being of children. They are used to set a benchmark for programmes and to assist in the measurement of comparable features across programmes in different situations through common indicators.

**Monitoring** The continuous assessment of programme processes (i.e. activities and outputs).

**Priority areas** Specific aspects addressed by various school-based health and nutrition programmes. The priority areas defined in this report are: education; HIV; malaria; water, sanitation and hygiene; worms; nutrition; sexual health; violence against children; substance abuse (i.e. tobacco, alcohol and drugs); physical activity; mental and psychosocial health; life skills; first aid; vision, hearing, dental and skin (see Annex A).

# EXECUTIVE SUMMARY

Over the past two decades, many governments and organizations have renewed efforts to develop more effective school-based health and nutrition programmes in low income countries. In large part, this has resulted from the growing body of evidence linking children's health and education; and the impact of school health and nutrition (SHN) programmes on improving these outcomes and contributing to Education for All (EFA) and the Millennium Development Goals (MDGs)[1].

A major breakthrough on the international consensus for SHN programming was achieved in April 2000 at the World Education Forum, where key international agencies agreed on a common framework for SHN programmes, called Focusing Resources on Effective School Health (FRESH). The FRESH framework promotes cost-effective programming by calling for the integrated implementation of a core group of four health-related approaches for schools in low income countries:

1. Health-related school policies;
2. school-based delivery of health services;
3. safe and sanitary school environment; and
4. skills-based health education.

The period since 2000 has witnessed a dramatic increase in countries adopting SHN policies and organizations implementing comprehensive SHN programmes.

Effective monitoring and evaluation (M&E) is considered essential if comprehensive SHN programmes are to be scaled up and sustained. Many resources have been developed by organizations to assist the M&E of SHN programmes in low income countries. The diversity of M&E resources that exists reflects the fact that SHN programmes are contextual and no one size fits all. Increasingly, however, stakeholders have wondered whether a generic M&E framework, adaptable to the local settings of different programmes, would synergise existing resources and avoid duplication that exists between different guidelines.

Thus, a review was undertaken to investigate the international consensus on the development and dissemination of a generic M&E framework for SHN programmes in low income countries. The Partnership for Child Development (PCD) and Save the Children USA (SC/USA) with the participation of the FRESH partners and a range of key informants representing: governments; United Nations (UN) agencies; international non-governmental organizations (INGOs)/non-governmental organizations (NGOs) and academic institutes, undertook this review to determine whether or not there is a need for a generic M&E framework; as well as identify good practices and limitations in existing resources.

The aim of this review is to form a starting point for discussions on how to develop and disseminate a future generic M&E framework. Such discussions are expected to be initiated at a meeting with the concerned 24 organizations to be held at the headquarters of the World Health Organization (WHO) in Geneva in September 2008.

The key findings of the review were:

- There is a strong demand for a generic M&E framework for SHN programmes, which is supported and recognized by different partners, especially national governments and stakeholders. Such a framework should be provided as a hard copy resource kit and through face-to-face training.
- Common health, education, and nutritional outcomes and programmatic processes based on the *'FRESH core activities'* should form the basis of a generic M&E framework.

- Common minimum standards for SHN programmatic processes are required so that standardized guidance is provided to organizations and so that comparability of programmes is increased. Guidance for particular contexts should be provided in specific modules of the framework.
- Core indicators for SHN programmes are required. Those indicators that are already internationally agreed upon and reported by ongoing tools are strong candidates for ensuring that the generic M&E framework for SHN programmes complements and fits within existing structures for data management.

Based on the information gathered from the review, a pictorial first draft of the generic M&E framework for SHN programmes is provided in Figure 8 (see page 23). The FRESH partners are requested to discuss the findings presented in this review in the meeting to be held at WHO Headquarters, Geneva in September 2008 to develop and disseminate such an M&E framework.

# 1. INTRODUCTION

Over the past two decades, many governments and organizations have renewed efforts to develop more effective school-based health and nutrition programmes in low income settings. In large part, this has resulted from the growing body of evidence linking children's health and education; and the impact of school health and nutrition (SHN) programmes on improving these outcomes and contributing to Education for All (EFA) and the Millennium Development Goals (MDGs). The 1990s were characterized by the promotion of good practices in SHN through various agency initiatives[1].

In recognition of the benefits of SHN programmes and based on good practices of organizations, a major breakthrough on the international consensus for SHN programming was achieved in April 2000 at the World Education Forum in Dakar, where a joint partnership effort by the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF), the World Health Organisation (WHO) and the World Bank led to the framework Focusing Resources on Effective School Health (FRESH). The FRESH framework calls for an initial set of four core activities to be comprehensively implemented in all schools in order for low income countries to meet the health needs of school-age children. As opposed to health interventions that are implemented separately, this approach is more effective and cost-effective when delivered as a package, and provides a basis to scale up efforts and increase the quality and equity of education. The four core activities endorsed by the framework are: school-based health policies; skills-based health education; school-based health services; and the promotion of a safe and sanitary school environment. These activities must be supported by partnerships at different levels – between teacher and health workers, the education and health sector, and schools and communities – and the full participation of all children (in particular girls and orphans and vulnerable children).

Since 2000, there has been a substantial increase in the number of comprehensive and holistic SHN programmes in low income countries. A survey of international development agencies in 2006 showed that the percentage of organizations that promoted school-based health services, skills-based health education and a safe school environment increased over the period from 46% to 76%[2]. In order to further scale up, systematise and sustain the good practices in SHN programming at project, country and global levels, there is a growing need for more effective monitoring and evaluation (M&E) of these programmes[3]. Monitoring is the continuous assessment of programme processes, while evaluation is the assessment of the impact of a programme on desired outcomes. Consistent and standardized M&E is essential for decision makers to address programme concerns where they exist and commit necessary funds to further improve health and education.

Many resources have already been developed by key agencies and countries to assist the M&E of specific SHN interventions. For example, the WHO has specific guidelines for the M&E of school-based deworming[4] programmes, which are being used by countries to monitor their national school-based deworming programmes. Other existing resources within the wider health and education sector (e.g. Family Health International's Behaviour Surveillance Surveys) also contain valuable information for SHN programmes. Many more resources are currently being developed for specific health concerns. For example, the United Nations (UN) Standing Committee on Nutrition is developing nutritional indicators for programmes in several sectors including education[5]; the United Nations Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team (IATT) on HIV and Education is developing methods and instruments to measure the impact of education on HIV&AIDS[6]; and UNICEF and WHO are identifying indicators to monitor violence against children in different settings, including schools. Additionally, different organizations have their

own M&E systems, which may or may not be linked with national systems for M&E. This could lead to a proliferation of systems and duplication of efforts.

As SHN programmes have become more comprehensive, it has been suggested that there is a need for a generic M&E framework for SHN, which is equally comprehensive as FRESH. Such a framework would synergise existing resources and avoid any duplication that exists. The framework would also simplify M&E for SHN practitioners and serve as a ready resource kit that may be used directly or adapted to expand the evidence-base of their programmes. It would also assist in reducing costs, and increase the effectiveness of ongoing efforts in the M&E of SHN programmes. For example, international agreement on a core indicator on malaria prevention through schools might allow the collation or comparison of data across a country or countries, with only marginal cost implications.

However, as SHN programmes are contextual and no one size fits all, consensus on a generic framework for M&E that is adaptable to the local settings of these programmes is needed. There has been a call for coordinated efforts in the M&E of SHN programmes at a number of recent meetings, such as the Islamic Education, Scientific and Cultural Organization (ISESCO), UNESCO and WHO "First Regional Conference on Health Promoting Schools in the Eastern Mediterranean Region" in 2007; and the FRESH Partners Forum in 2006. At the WHO Technical Meeting on "Building School Partnerships for Health, Educational Achievement and Development" in Vancouver, June 2007, stakeholders identified that concerted efforts in international collaboration on M&E of SHN programmes should be made. Following on from this meeting, the WHO offered to co-host a meeting on behalf of the FRESH partners[a] in order to gain consensus on the need for a generic M&E framework for SHN programmes and to agree on the next steps for its development. In preparation, the Partnership for Child Development (PCD), with support from Save the Children USA (SC/USA), and in full consultation with all key partners, conducted a participative review of the M&E of SHN programmes, for discussion at the meeting, scheduled in Geneva for September 2008.

[a] FRESH partners are: Child-to-Child Trust, EDC, Education International, FAO, IRC, PCD, RBM Partnership, UNAIDS, UNESCO, UNICEF, UNODC, WFP, WHO and the World Bank.

# 2. PURPOSE AND METHODOLOGY

## 2.1 Purpose

The purpose of the participative review was to assess the need for a generic M&E framework from a range of key informants; and to conduct a literature review of existing M&E resources, identifying good practices and limitations.

The aim of the participative review is to provide the background to guide an international consensus on the development, agreement and dissemination of a generic M&E framework for SHN programmes in low income countries.

## 2.2 Methodology

In order to inform consensus for the generic M&E framework, the review was conducted using participatory methods involving key informants on SHN, representing governments, UN agencies, INGOs/NGOs and academic institutions, working at both the national (including sub-national) and international levels. The key informants were selected from: the FRESH partner organizations; a list of organizations working in SHN[2]; and Networks of Ministry of Education SHN and HIV Focal Points in sub-Saharan Africa and the Caribbean[7]. These key informants work in one or more priority areas relevant to SHN programmes (see the complete list of priorities in Annex A) and provided their opinion on the need for a generic M&E framework of SHN programmes; key considerations for its development and dissemination. The key informants also provided resources related to potential elements of the M&E framework to identify good practices and limitations (i.e. inconsistencies and gaps) and thus, areas for consensus.

The potential elements reviewed for consideration in the M&E framework of SHN, and reasons for their selection, were as follows:

- **Logical Framework:** *A logical framework* (also called *results framework*) is the starting point for generating an M&E framework for development programmes[8]. It presents programme activities and outputs to address priorities (e.g. worms and nutrition), as well as long-term objectives and goals (e.g. improvements in health and education), each with their associated indicators, so that they may be monitored and evaluated.

- **Minimum Standards:** *Minimum standards* of programme activities and outputs are used to outline what should be provided and what should exist in schools as a minimum for the health, nutrition and well-being of children. They are used to set a benchmark for programmes and to assist in the measurement of comparable features across programmes in different situations through common indicators.

- **Core Indicators:** *Indicators* are quantitative and qualitative measures/variables that are used to assess the status of progress towards goals, objectives, outputs, activities or standards. Core indicators are those that are recommended for reporting by all countries. In order to access uniform data on core indicators, they must be accompanied by tools – from data collection to analysis, dissemination and use. These may be special surveys or routine collection efforts, with specific questionnaires, guidelines, reporting formats and databases.

In summary, the potential elements would relate to each other in the M&E framework as illustrated in Figure 1.

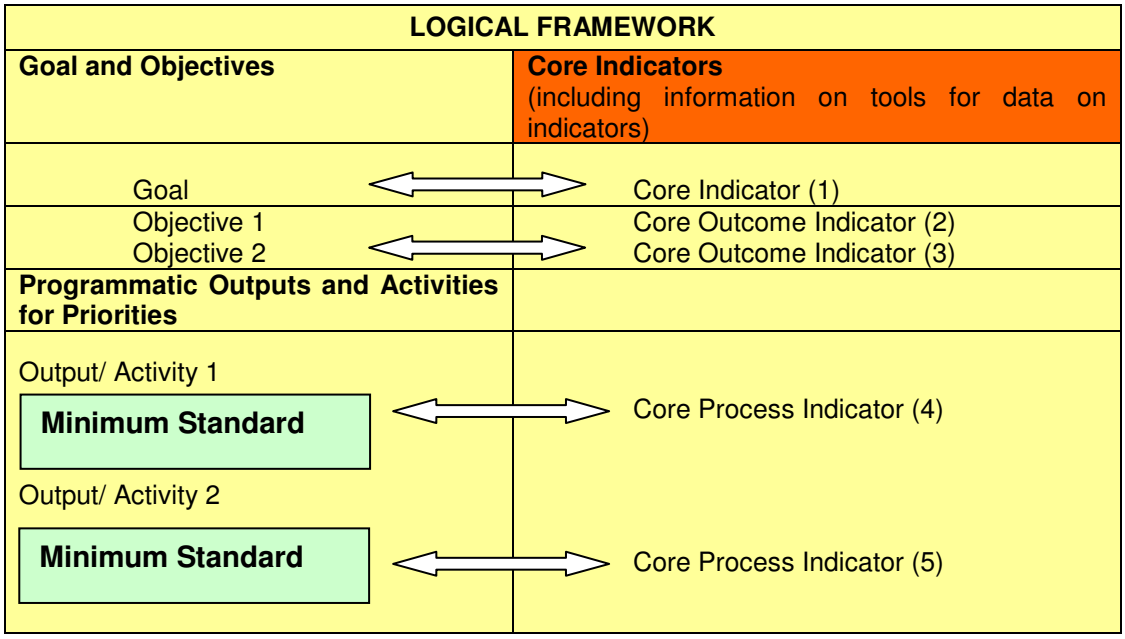



**Figure 1. Relation between logical frameworks, minimum standards and indicators**

#### *2.2.1 Key informant responses*

From 24 organizations, 38 informants responded to the review, either directly through telephone interviews or via emails (see Annex B for the list of key open-ended questions asked). Since some informants were from the same organization but worked in different offices at different levels, and because there were joint interviews with informants from one office, in some cases, the unit of analysis was the office they represented. A total of 35 offices were represented, with 17 working at national level and 18 at international level (see Annex C for the details of the key informants, their offices and organizations, and Annex D for the profile of offices represented).

#### *2.2.2 Literature review of M&E resources*

In total, 125 resources (100/125 were recommended by key informants), including documents and web-based resources, were short-listed for review around the potential elements for the M&E framework (see List of Resources). To aid the review, literature review templates were used in Microsoft Excel, which assisted in sorting and analysing the documents.

The literature review primarily focused on resources relevant to SHN programmes in low income countries, and those that may concern school-age children and youth aged between 5 to 24 years. While resources of high income countries were not reviewed, they may provide lessons and good practices during the development of the M&E framework. Materials on community-based schools were accessed, but specific guidelines for addressing the non-formal education sector and its M&E were not reviewed. Overall, the literature review is an initial assessment of resources where illustrations of some of the findings are provided. However, a more detailed analysis of all documents and all programme priorities may be required during the development of the M&E framework.

# 3. RESULTS

## 3.1 Need for a generic M&E framework for SHN programmes

Key informants from the 35 offices provided their opinion on the generic M&E framework for SHN programmes, with specific information in relation to minimum standards and indicators. Overall, there was a high demand for the framework, with 34 out of 35 offices mentioning the need for either common minimum standards or core indicators for SHN programmes.

### *3.1.1 Usage of minimum standards*

Twenty-seven out of 35 offices said they were aware of and/or used minimum standards for SHN programmes. However, in open-ended responses 9 out of the 27 offices said that these standards were general guidelines for SHN programmes. They had not been *"institutionalized"* and explicitly defined as minimum standards. The examples of standards provided varied, some relating to the overall package of interventions and others to specific interventions:

- Nine out of 27 offices quoted comprehensive frameworks for SHN programmes e.g. FRESH, Child-Friendly School, the World Food Programme (WFP) Essential Package and Health Promoting Schools, as minimum packages.
- Fifteen out of 27 offices mentioned standards for school-based health services of deworming, and/or nutrition and/or water and sanitation.
- Four out of 27 offices mentioned curricular and/or health education standards.

These documents and resources were short-listed for the review (see List of Resources).

### *3.1.2 Reasons for common minimum standards for SHN programmes and important considerations for their development*

Thirty-three out of the 35 offices reported the need for common minimum standards for SHN programmes that can be referred to and adapted at the local level. As open-ended responses, the main reasons provided by more than one office (see Figure 2) were that it would:

- **Guide SHN programmes:** On the type and level of activity and output to be attained, and make it easier to *"provide advice"* to programme implementers.

- **Lead to more standardized and unified programmes:** Those aspects that are common between programmes and priorities can be *"unified and standardized"*. This will *"facilitate a common understanding"*.

- **Make it easier to compare and monitor programmes:** Common minimum standards will make it *"easier to compare programmes"* implemented by different organizations. They will also make it easier to monitor programmes (e.g. for *"quality assurance"* by the education inspectorate).

- **Lead to better coordination between different programmes, and the priorities they address:**. Links between programmes/different priorities (e.g. worms and micronutrient supplementation) through common minimum standards *"will increase the synergistic effect"* of comprehensive programmes.

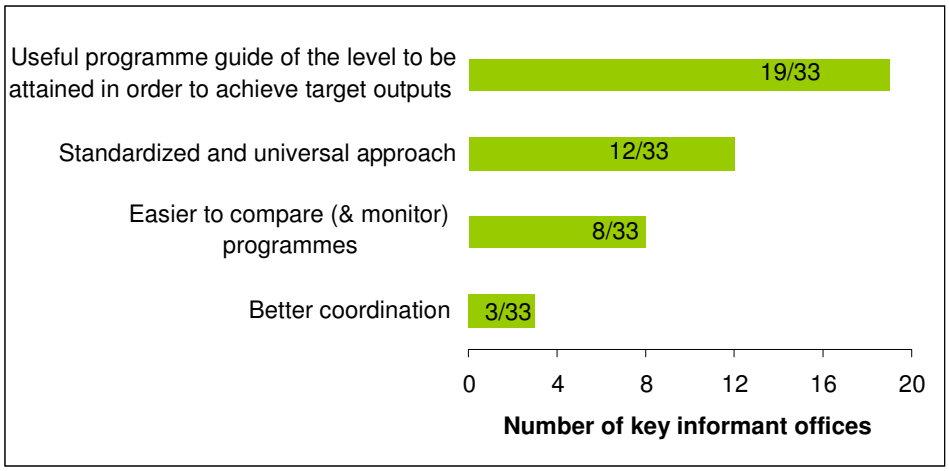



**Figure 2. The main reasons for having common minimum standards**

Similarly, in open-ended responses the main considerations for the development of minimum standards that were suggested by one or more offices (see Figure 3) were that they should be:

- **Adaptable to local context and based on local capacity:** The minimum standards should be flexible so that they can be adjusted according to the "*local context"* culture; capacity (which may be high or low); health; and nutritional needs. Government lead is essential to provide agencies a context specific framework.

- **Based on evidence and operational experience:** To *"assess the evidence"* in the priority area (e.g. sanitation standards) alongside the current situation to develop minimum standards.

- **Participatory methodology for development:** Discussion with stakeholders at both national (including teacher representatives) and international levels is crucial in order to develop a coordinated product, which is supported and funded. To use existing coordinating mechanisms that are already in place (e.g. *"school sanitation thematic group coordinated by the IRC"*).

- **Possible to monitor:** Minimum standards should not be too general that they cannot be monitored, and used for comparing programmes. It can be *"written as a curriculum document"* to be relevant; and be accompanied by a set of core indicators, to measure that the desired output has been attained. To link the minimum standards with programme impact on education, health and nutrition.

- **Use FRESH/comprehensive SHN framework:** There is *"consensus on the FRESH framework"* at the World Education Forum, and this can be revisited as an organizing framework for the minimum standards. To address main aspects of a comprehensive SHN programme.

- **Key domains are covered using a modular (menu of options) approach:** In order to address local issues and priorities, *"a modular approach"* is needed to give *"options for implementation"*. The menu can also depend on the different levels of capacity and resources available.

- **Simple messages in user-friendly format:** The standards need to be simple and well-organized and presented as a *"user-friendly"* resource, available in different languages.

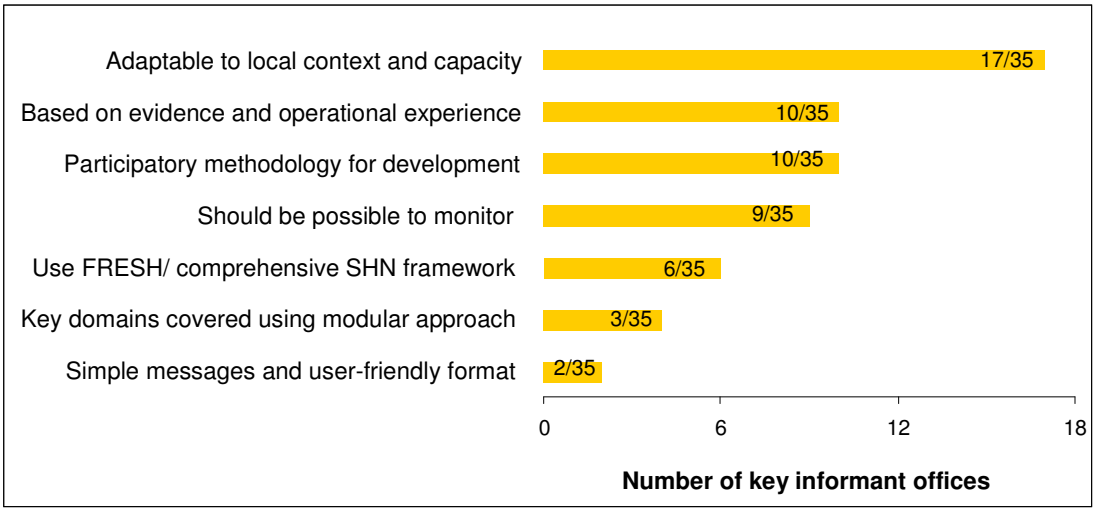



**Figure 3. Important considerations for the development of common minimum standards**

#### *3.1.3 Usage of core indicators*

Thirty-one out of 34 offices mentioned that they use a set of indicators for SHN. Fewer offices (24 out of 33) mentioned referring to or using indicator guides or publications specific to SHN. The publications mentioned by 11 offices were organizational documents, while 4 offices referred to international sources containing core indicators.

#### *3.1.4 Reasons for core indicators for SHN programmes and important considerations for their development*

Thirty-two out of the 35 offices reported the need for core indicators for SHN programmes. Such a set of core indicators would be internationally agreed, and presented with clear definitions, guidelines on calculation and interpretation, and tools for accessing data. As open-ended responses, the main reasons provided by more than one office (see Figure 4) were that core indicators would help to:

- **Compare and aggregate data:** The comparison and aggregation/compilation of data from organizations for national analysis would be easier with core indicators. This would help in understanding the overall national or international picture and influence policy. Core indicators would also allow *"comparison over time"*. The increased comparability of data due to core indicators would also reduce costs for M&E (by not needing to do special surveys) and increase efficiency.

- **Show commitment and concentrate efforts on SHN programmes:** The presence of core indicators that are used for M&E will help to *"build a strong case for school health issues"*. The evidence of *"the impact of SHN programmes is a given"*, however, this needs to be demonstrated in order to sustain interest and advocate at all levels (e.g. *"funding and commitment from donors"*) and keep programmes at scale. Core indicators will also help ensure this accountability.

- **Provide guidance to organizations in countries:** Core indicators will provide guidance on how to measure "*the standards countries are trying to achieve*". It will help *"demystify M&E",* and provide *"guidance to programmes on what measures they should use".* Although there are core indicators and different guidelines for some SHN priorities (e.g. HIV and worms), they *"need to be compiled in to one set"* and presented for SHN as a whole.

- **Measure the impact on benchmarks and targets:** Core indicators help to monitor the status and measure the change a programme has had towards a set benchmark or target. They are a *"common link to minimum standards"* and important for measuring impact and for determining a *"causal link between actions and school health outcomes"*.

- **Access better data:** Core indicators are *"important to provide stronger"* and more accurate data to show better association between actions and outcomes. Data captured will be more useful to demonstrate the impact, and can be used for policymaking. It will also add to the authenticity of data.

- **Reduce the number of indicators:** Currently there are far *"too many indicators*" which make it very *"burdensome"* for implementers (e.g. teachers) to report. A set of core indicators will make it easier to report and use data.

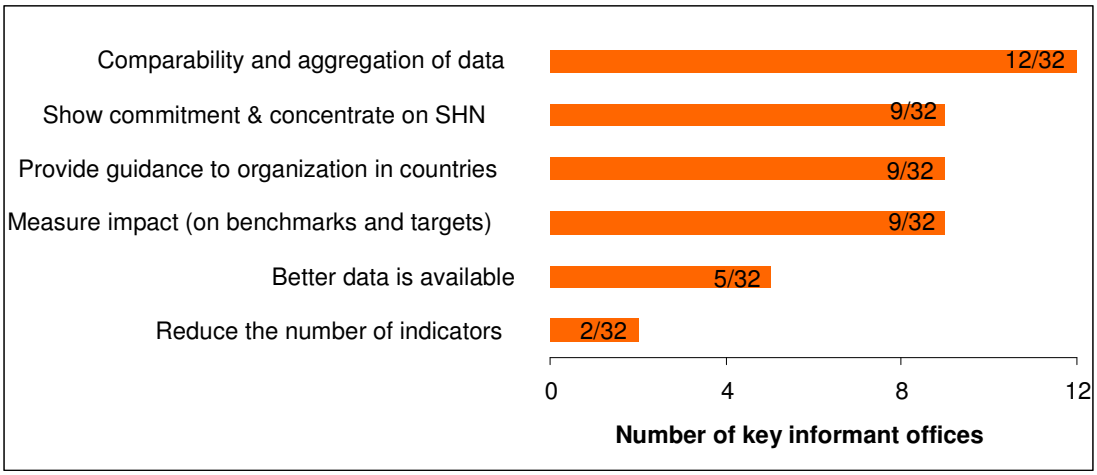



**Figure 4. The main reasons for core indicators**

Similarly in open-ended responses, the main considerations for the development of core indicators that were suggested by more than one office (see Figure 5) were that they should be:

- **Specific, Measurable, Attainable, Relevant and Time-Bound (SMART):** Twelve offices mentioned one or more of the following as important for core indicators: specific (and sensitive), measurable, attainable, relevant (and realistic) and time-bound (SMART). It must be feasible (attainable) to collect and analyse data for core indicators. They need to be *"measurable in a cost-effective manner"* using existing structures in place. They need to be *"simple, understandable and practical" as well as "valid and reliable"*. The *"data collection frequency for the core indicator should be practical"*, and, as far as possible, should be *"collected as part of regular work"* (but not creating additional work).

- **Supported and recognized by different partners:** The core indicators need to be developed in consultation with and supported by national government organizations, NGOs, and other national and sub-national stakeholders. All stakeholders (including those that will use tools for measuring indicators) need to be involved during the development, during follow-up guidance, and during training support. This will increase ownership and *"buy-in of indicators"*.

- **Consult existing indicators, tools (surveys) and structures:** As a large number of data and indicators already exist, these must be consulted and, where possible, *"tools (e.g. surveys) need to be coordinated"*. This is needed

*"to enable integration* (of indicators) *in existing mechanisms"*. The *"evidence of success of existing indicators"* and *"links to existing sources of data"* are strong criteria for selecting core indicators. Organizations *"have already bought into* (some impact indicators for) *EFAs and MDGs, so these should be used where possible"*. If *"there are good routine data collection systems such as Education Management Information Systems"* that include SHN indicators, these should be considered.

- **Linked to minimum standards/programme activities and outputs:** Core indicators *"need to be available for process evaluation"*. They *"should be linked to minimum standards"*. They should be covered *"within FRESH"* activities.

- **Applicable to different contexts:** Core indicators should be *"usable in different contexts",* with *"targets for indicators different for different countries"*. The indicators *"should be adapted and validated for each country"*. While core *"indicators should remain the same to be comparable, the context must be considered when interpreting them". "A guide to use these indicators in different settings is needed"*.

- **Linked to goals and objectives:** Core indicators should be linked with *"health and education impact"* in the programme *"log-frame"*.

- **Additional/optional indicators:** As each country's context is different, there should be some *"optional indicators"* that countries could *"pick and choose"* from. The core indicators list *"should not be too restrictive"*.

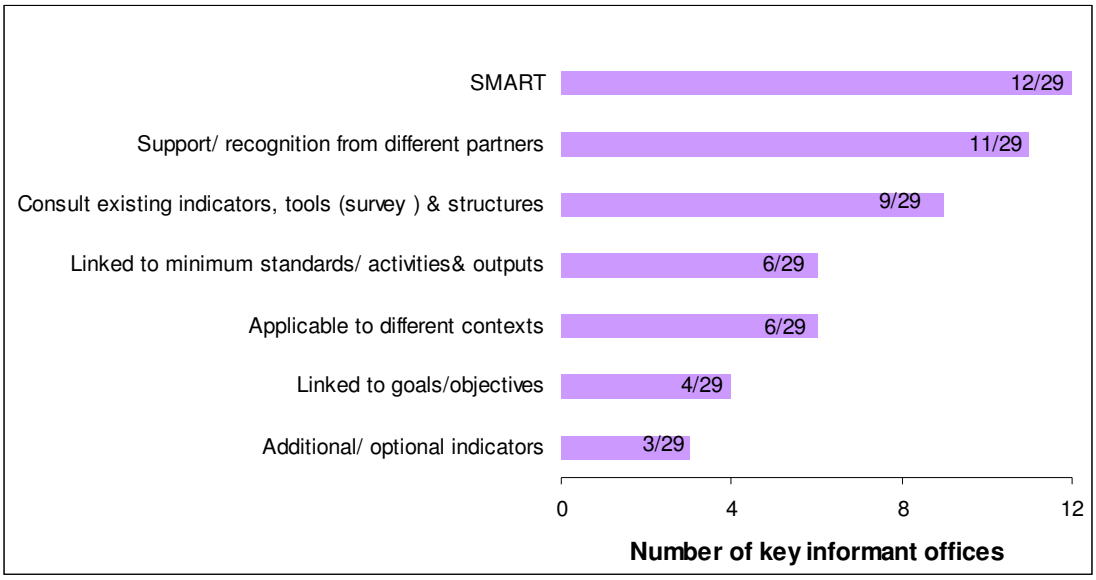



**Figure 5. Important considerations for the development of core indicators**

Twenty-nine offices further gave their opinion on the administrative level at which the core indicators would be useful. Twenty-eight offices mentioned that they would be useful at the national level, while 24 offices mentioned that they would be useful at the sub-national level, and 21 offices mentioned they would be useful at the international level. Offices working at both the international and national levels had similar responses on the level at which core indicators would be useful (see Figure 6).

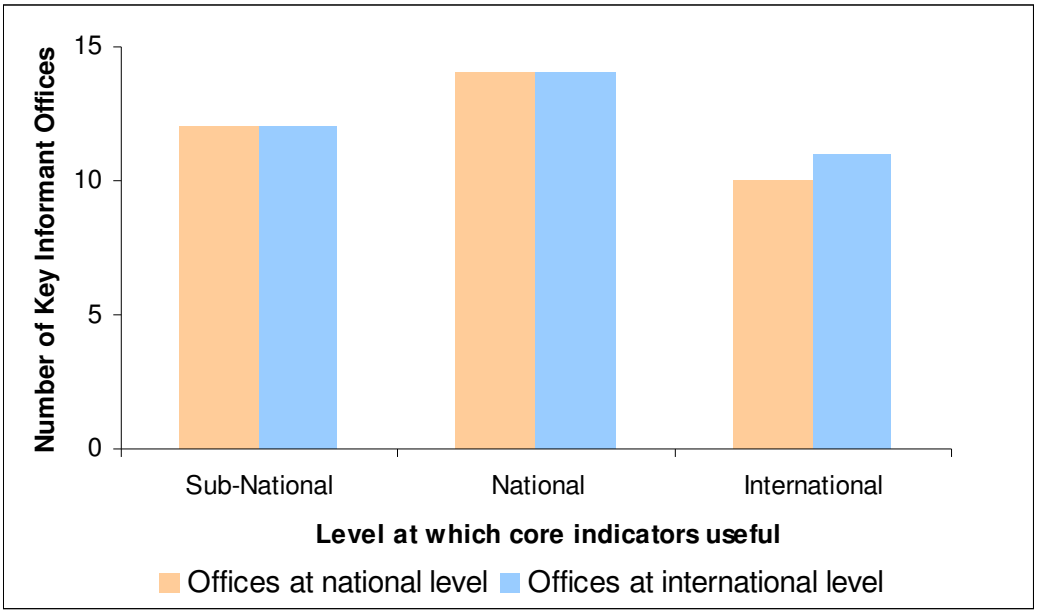



**Figure 6. Responses on the level at which core indicators would be useful**

In open-ended responses, offices reported that core indicators would be most useful:

- **At all levels:** *"Once the indicator is clearly defined, it can be used at all levels"* (e.g. the percentage of children dewormed). *"Some activities are done only at sub-national level"* (e.g. teacher training and blood sample collection), therefore after raw data are collected and analysed, data on the indicator should be aggregated at different administrative levels for both national, and *"international comparisons"*. Disaggregate values of core indicators should be available as far as possible (e.g. percentage of teachers trained by district) to note differences and *"to interpret and use data"*, especially *"in large and heterogeneous states"*.

- **If linked between different levels:** The level at which a core indicator would be most useful *"would depend on what is being measured"* (e.g. children or a school policy), and *"the level of decision making"* (e.g. at district or at national levels). *"Indicators for different levels should be interlinked and complementary"*, so that *"decision makers at each level can use that information"*. *"In-country indicators can be linked up to the international level"*.

#### *3.1.4 Dissemination of the generic M&E framework*

Twenty-eight informant offices also provided their opinion on the usefulness of different formats for the dissemination of the generic M&E framework. The overall comment was that the format would depend on target users. The formats most preferred by the offices were hard copy resource kits and face–to-face training programmes (median rank: 5/5). Specific comments on this were that *"face-to-face should use a peer education approach, where peers teach peers and the training is cascaded"*. A hard copy resource kit would *"need to be user-friendly, well laid out, and translated"*.

Web-based kits, email lists and CDs were not as preferred a format (median rank: 4/5) due to poor internet connections and lack of access to computers in low income and rural settings. However, it was mentioned that in order to adapt materials *"it is important to have a CD version"*.

Online training programmes and access to experts by phone were least preferred (median rank: 3/5) due to similar reasons of poor internet connections, lack of access to computers, as well as *"high costs associated with phone calls"*.

## 3.2 Literature review of M&E resources

Resources were reviewed in a stepwise method, by first identifying documents that included logical frameworks, core indicators and minimum standards by priority area. This was followed by a more detailed collation of individual logical frameworks, standards and indicators from different documents into a template, and an analysis and summary of the collated findings. The main good practices and limitations identified in the review of resources are presented below. Details of how this information may be used for the generic M&E framework are discussed along with recommendations by key informants in Section 4.

### *3.2.1 Logical framework*

A review of the logical frameworks for programmes implemented at country level found that at times the frameworks were not just limited to SHN programmes, and that priorities varied greatly between organizations. Out of the 7 offices that provided their logical frameworks for their programmes in low income countries, 2 were on general SHN, 2 were on nutrition, 2 were on education and 1 was on HIV prevention. Subsequently, their goals and objectives also varied. However, some common outcomes (i.e. goals and objectives) identified between different offices were either an improvement in: health and nutrition; education; or in health-related knowledge, attitude, behaviour and skills of school-age children relating to EFA or MDGs (see Table 1). The activities and outputs also varied greatly between organizations depending on their priority, the context, their mandate and the level at which they work. However, for SHN programmes implemented at national or sub-national levels, some common activities and outputs for these levels can be summarized as:

1. Development and promotion of school-health related policies.
2. Provision of skills-based health education.
3. Provision of school-based health services.
4. Promotion of a safe and sanitary school environment.
5. Promotion of supportive partnerships and participation.

These five areas complement the *'FRESH core activities'*, on which there is international consensus, therefore making the five areas good practice.

### *3.2.2 Minimum standards*

Fifty-one documents were identified to contain standards relevant to SHN programmes (see List of Resources). In most documents (46/51), standards were presented in the form of guidelines, principles, checklists or essential criteria; only a few contained explicit standards (see Box 1). Minimum standards were found to be explicitly listed in only 2 documents, namely the *School Feeding Handbook* and *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*. Given this limitation, standards (explicit or otherwise) as opposed to minimum standards alone were reviewed. Only 7/51 documents were M&E guideline documents, while the rest were documents containing SHN programme information on priority areas (e.g. worms and malaria).

On reviewing 28 documents in more detail, it was found that some standards were common for different priority areas, especially under the three programmatic processes of: provision of skills-based health education; development and promotion of school health-related policies; and promotion of supportive partnerships and participation, as illustrated in Boxes 2 to 4. A good practice identified was that standards were common between documents, many of which were inter-agency publications. This makes it easier to agree on common standards and minimum standards which cover all priorities for the M&E framework.

Standards that may be specific to priority areas under these three programmatic processes (e.g. HIV prevention education should include information on both, how the virus can and can not spread) are not illustrated below.

**Table 1. Summary of logical frameworks from organizations implementing SHN-related programmes***

| Common Logical Framework | World Food Programme | Catholic Relief Service, Ghana | Education Development Center | Ministry of Education, Kenya |
|---|---|---|---|---|
| **PRIORITY AREAS** | | | | |
| **General SHN intervention** | **Nutrition** | **Worms** | **HIV** | **Education** |
| **OUTCOMES (Goals and Objectives)**** | **Goals** | | | |
| 1. Improved Educational Outcomes (e.g. in access, equity, attainment, and cognitive and psychoeducational outcomes)<br>2. Improved Health and Nutrition Outcomes<br>3. Improved Health-related Knowledge, Attitude, Behaviour Skills Outcomes | Meet MDGs through food assisted interventions | Improved educational attainment | Prevention of new HIV infections among learners | Ensure equity of access to basic education |
| | **Objectives** | | | |
| | 1. Increased enrolment, attendance, capacity to concentrate and learn<br>2. Reduced gender disparity | 1. Health and nutritional status of primary school students improved<br>2. Health behaviours among primary school children improved | 1. Learners acquire skills in HIV and STI prevention | 1. Quality of learning environment in schools improved<br>2. Improved health for primary school pupils and teachers |
| **PROGRAMMATIC PROCESSES (Outputs and Activities)**** | **Expected Outputs and Activities** | | | |
| 1. Development and promotion of school health-related policies<br>2. Provision of skills-based health education<br>3. Provision of school-based health services<br>4. Promotion of a safe and sanitary school environment<br>5. Promotion of supportive partnerships and participation | 1. Timely provision of food to improve access to education in schools and non-formal education centres | 1. Increased capacity of teachers to deliver school health messages<br>2. Increased availability of micronutrients and deworming drugs in school<br>3. Sensitization campaigns on school health | 1. Adapted interactive learning experiences suited for local learner HIV education<br>2. Train teachers and learners | 1. National standards, guidelines and procedures for the provision of primary school infrastructure<br>2. Establish district coordination unit |

* The logical frameworks were adapted from the original documents.
** Outcomes and processes are general and can be adapted to a programme context. Accompanying indicators not displayed.

**Box 1. Documents explicitly containing standards for SHN programmes**

Department of Mental Health, Thai Ministry of Public Health. 2005. *Teacher Manual: Student Care and Support System*.

INEE. 2004. *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*.*

Senderowitz, J, *et al.* 2006. *Standards for Curriculum-Based Reproductive Health and HIV Education Programs.*

UNICEF. 2008. *Life Skills-Based Education: Concepts and Standards*.

WFP. 2000. *School Feeding Handbook*.*

* Documents explicitly stating minimum standards for SHN programmes.

**Box 2. Examples of standards and sources for skills-based health education**

| Standards | Sources (and priorities under which the standard was discussed)* |
|---|---|
| Health education should be combined with building children's life skills | **General**<br>WHO, WPRO. 1996. *Regional guidelines: Development of health-promoting schools- A framework for action*.<br><br>**HIV**<br>Aldana, S, *et al*. 1999. *Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools*.<br>Senderowitz, J, *et al.* 2006. *Standards for Curriculum-Based Reproductive Health and HIV Education Programs.*<br><br>**Malaria**<br>Clarke, N, *et al*. 2007. *Malaria Prevention and Control*.<br><br>**Water, sanitation and hygiene**<br>IRC. 2008. Monitoring and evaluation - WASH in Schools.<br>van Hooff, I, *et al.* 1998. *Towards Better Programming: A Manual on School Sanitation and Hygiene.*<br><br>**Nutrition**<br>Save the Children. 2007. *CASP: The Common Approach to Sponsorship-Funded Programming*.<br>UNESCO, *et al.* FRESH School Health Tool Kit.<br><br>**Prevention of violence against children**<br>Pigozzi, MJ, *et al*. 2005. *Inter-Agency Peace Education Programme: Skills for Constructive Living*.<br><br>**Substance abuse**<br>UNODC. 2004. *School-based education for drug abuse prevention.*<br><br>**Life skills**<br>INEE. 2004. *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*.<br>Peppler Barry, U. 2000. *The Dakar Framework for Action. Education for All: Meeting our Collective Commitments*.<br>UNICEF. 2008. *Life Skills-Based Education: Concepts and Standards*. |
| Skills-based health promotion and disease prevention should be integrated in the curriculum | |
| Education materials should be culturally and locally relevant | |
| Teachers expected to teach about health and nutritional concerns should receive training and accurate information | |

* Documents cover one or more standard listed.

**Box 3. Examples of standards and sources for school health-related policies**

| Standards | Sources (and priorities under which the standard was discussed)* |
|---|---|
| Government level policy should inform the SHN programme | **HIV**<br>Aldana, S, *et al*. 1999. *Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools*.<br>Monasch, R, *et al*. 2005. *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS.*<br>**Water, sanitation and hygiene**<br>van Hooff, I, *et al*. 1998. *Towards Better Programming: A Manual on School Sanitation and Hygiene.*<br>**Nutrition**<br>Government of Brazil, *et al*. 2007. *Nutrition Friendly Schools Initiative*.<br>WFP. 2000. *School Feeding Handbook.*<br>**Substance abuse**<br>UNODC. 2003. *School-based Drug Education: A guide for practitioners and the wider community*.<br>**Mental and psychosocial health**<br>INEE. 2004. *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*.<br>Skevington, S, *et al*. 2003. *Creating an Environment for Emotional and Social Well-Being*.<br>**Life skills**<br>Harris, R, *et al*. 2004. *Embracing Diversity: Toolkit for Creating Inclusive, Learning-Friendly Environments*. |
| Schools should implement policies to support health, nutrition and well-being of teachers and learners | |
| School policies should meet local needs and be developed in consultation with the community | |
| Policies to increase inclusiveness and protect vulnerable groups should be in place | |

* Documents cover one or more standard listed.

**Box 4. Examples of standards and sources for supportive partnerships and participation**

| Standards | Sources (and priorities under which the standard was discussed)* |
|---|---|
| Children, teachers and communities should be involved in the SHN activity | **General**<br>Jones, JT, *et al*. 1998. *Health-Promoting Schools: A healthy setting for living, learning, and working*.<br>Save the Children. 2007. *CASP: The Common Approach to Sponsorship-Funded Programming*.<br>**HIV**<br>Aldana, S, *et al*. 1999. *Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health-Promoting Schools*.<br>**Water, sanitation and hygiene**<br>van Hooff, I, *et al*. 1998. *Towards Better Programming: A Manual on School Sanitation and Hygiene.*<br>IRC. 2008. Monitoring and evaluation - WASH in Schools.<br>Roschnik, N. 2008. *Monitoring School Health and Nutrition programs: Guidelines for program managers*.<br>**Nutrition**<br>Government of Brazil, *et al*. 2007. *Nutrition Friendly Schools Initiative*.<br>WFP. 2000. *School Feeding Handbook.*<br>**Mental and psychosocial health**<br>INEE. 2004. *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*. |
| Children, teachers and community members should be trained to promote SHN programmes | |
| Both the Ministries of Education and Health should be involved in the SHN programme | |
| Political leaders at all levels should be involved in supporting SHN programmes | |

* Documents cover one or more standard listed.

Some standards were specific to a priority area, especially under the two programmatic processes of: provision of school-based health services; and promotion of a safe and sanitary school environment as illustrated in Boxes 5 and 6.

**Box 5. Examples of standards and sources for a safe and sanitary school environment**

| Standards | Sources* |
|---|---|
| **Priority area: Water, sanitation and hygiene** | |
| Schools should have adequate quantities of water | van Hooff, I, *et al*. 1998. *Towards Better Programming: A Manual on School Sanitation and Hygiene.* |
| Schools should have gender segregated latrines along with hand washing facilities | INEE. 2004. *Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*. |
| Schools should dispose refuse safely | IRC. 2007. *Towards Effective Programming for WASH in Schools: A manual on scaling up programmes for water, sanitation and hygiene in schools*. |
| There should be activities for maintenance of hygiene facilities | IRC. 2008. Monitoring and evaluation - WASH in Schools. |
| | Roschnik, N. 2008. *Monitoring School Health and Nutrition programs: Guidelines for program managers*. |
| | WFP. 2000. *School Feeding Handbook.* |
| | WFP, *et al. The Essential Package: Twelve interventions to improve the health and nutrition of school-age children*. |

* Documents cover one or more standard listed.

**Box 6. Examples of standards and sources for school-based health services**

| Standards | Sources |
|---|---|
| **Priority area: Worms** | |
| If the prevalence of soil-transmitted helminths is more than 50%, treat all school-age children | Montresor, A, *et al.* 2002. *Helminth control in school-age children: A guide for managers of control programmes*.<br>Montresor, A, *et al.* 1998. *Guidelines for the Evaluation of Soil-Transmitted Helminthiasis and Schistosomiasis at Community Level*. |
| **Priority area: Nutrition** | |
| Schools should maintain minimum food safety standards | Government of Brazil, *et al.* 2007. *Nutrition Friendly Schools Initiative*. |
| School feeding and micronutrient supplementation should depend on the prevailing nutrition situation and needs | Nepal. 2005. *National School Health and Nutrition Strategy*.<br>UNESCO, *et al. FRESH School Health Tool Kit.*<br>WFP. 2000. *School Feeding Handbook.* |
| **Priority area: Physical activity** | |
| Schools should provide physical health services | Ministry of Public Health and Sanitation and Ministry of Education. 2008. *Kenya National School Health Policy*.<br>UNICEF. *The Learning Plus Index*. |

Therefore, the M&E framework could present modules on minimum standards for programmatic processes which address specific priority areas (e.g. water and sanitation).

Standards that may be common for priorities under these two programmatic processes (e.g. ensuring the learning environment is safe and free of dangers is common for priorities of mental and psychosocial health and violence against children) are not illustrated.

A limitation found was that details on the standards were not uniform across documents. This included the length of explanatory notes on the standard and the requirements stipulated by the standard. For example, there were differences on the quantity of water that should be available in schools in Water, Sanitation and Hygiene (WASH) in Schools and the *School Feeding Handbook*.

Another finding was that standards may be met at one or more administrative levels. For example, the standard that teachers receive training for skills-based health education, may be met at national and sub-national levels, while the standard that schools have adequate water is met only at the school level. This may be an important consideration to be addressed by the M&E framework.

#### *3.2.3 Core indicators*

Fifty-eight documents and web-based resources were identified to contain indicators (i.e. measures) relevant to SHN programmes (see List of Resources). Most documents (54/58) explicitly called them indicators, while in a few they were presented as measures but not called indicators. Seven other documents – most of which were SHN documents – used the term 'indicators', however, these referred to an increase or decrease in a qualitative behaviour or other programme aspect. Since these did not coincide with the working definition for indicators used for the review (see purpose and methodology) they were not included in the list of documents containing indicators. This difference in the terminology of indicators was seen as a potential limitation for M&E, and it is therefore recommended that this is clarified in the M&E framework. Only 10 documents mentioned the term 'core indicators' (see Box 7); therefore, indicators as opposed to only core indicators were reviewed.

An initial review of the 58 resources containing indicators showed that the number of resources containing SHN-related indicators for some priority areas such as education, HIV, nutrition, deworming, water and sanitation, sexual health and life skills were far greater than for first aid, malaria, violence against children, physical activity and mental and psychosocial health (see Figure 7).

**Box 7. Number of sources containing 'core indicators'**

Gyorkos, T. W. 2003. Monitoring and evaluation of large scale helminth control programmes.

Meusel, D, *et al.* 2006. *Global Strategy on Diet, Physical Activity and Health: A framework to monitor and evaluate implementation*.

Monasch, R, *et al.* 2005. *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS*.

Montresor, A, *et al.* 2002. *Helminth control in school-age children: A guide for managers of control programmes*.

Pisani, E, *et al.* 2000. *National AIDS Programmes: A Guide to Monitoring and Evaluation*.

UNAIDS, *et al.* 2004. *National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV//AIDS prevention programmes for young people*.

USAID, *et al. HIV/AIDS Survey Indicators Database*.

Warner-Smith, M, *et al.* 2007. *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators*. Geneva: UNAIDS.

WFP. Standardised School Feeding Survey.

WHO. STEPwise approach to surveillance.

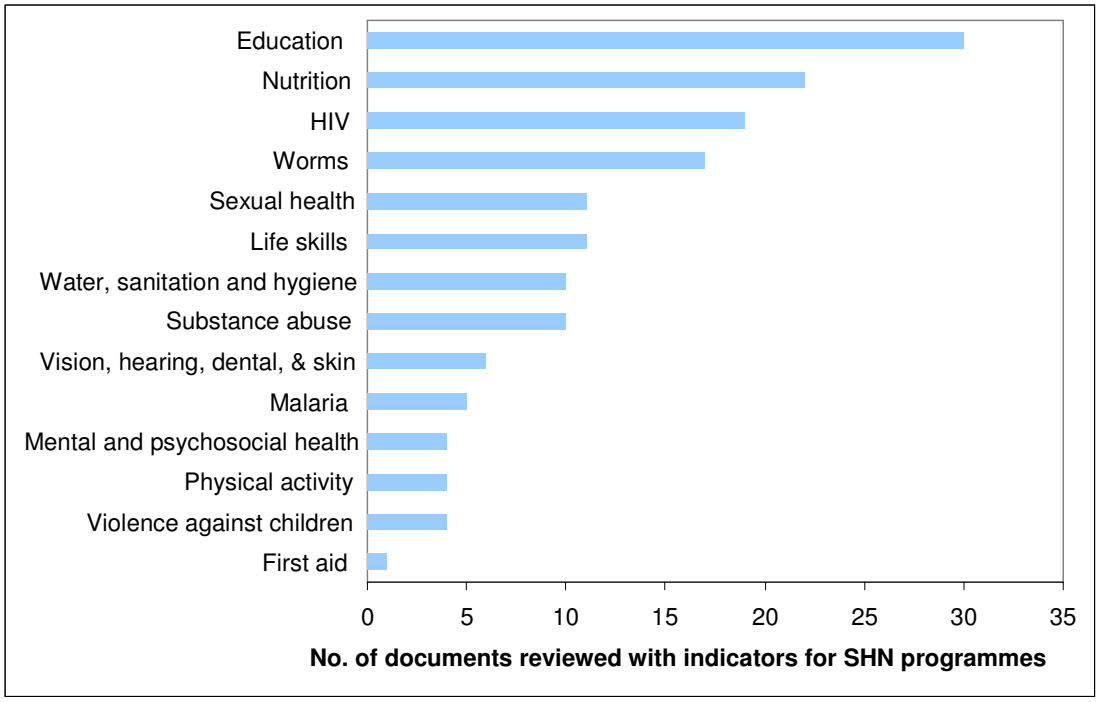



**Figure 7. Number of reviewed documents containing indicators on priority areas**

***Programmatic process indicators***

A closer analysis found that many of the SHN-related indicators for the different priority areas were similar for programme outputs and activities under each of the processes complementing FRESH (see Box 8 for illustrations of summary indicators). However this was not initially evident for two main reasons. First, the indicators were named differently and had varying emphasis in the different sources (e.g. percentage schools with at least one policy publicized and enforced and percentage of schools with published physical activity school policy). Second, in many cases, indicators were not accompanied with definitions on how they are calculated in order to assess if the indicators were similar or the same (see Table 2). Certain qualifiers in an indicator such as 'functioning' in number (%) of schools with functioning SHN committee also need to be explained (see Box 10).

**Box 8. Examples of indicators* for different priority areas that are similar under each process**

**Provision of skills-based health education**
Number (%) of schools providing skills-based health education to students
Existence of school health and well-being awareness programmes

**Provision of school-based health services**
Number (%) of schools providing a SHN service
Number (%) of school-age children receiving drugs (i.e. drug coverage)

**Development and promotion of school health-related policies**
Existence of national policies to promote health, nutrition and well-being of school-age children
Percentage of schools with a published school health-related policy

* These indicators are summaries of those indicators that were found to be similar.

Some indicators were common across all SHN programmatic processes and even to those unrelated to SHN, as illustrated in the summary indicators in Box 10. This good practice of indicators that are similar across the programmatic processes and common across priority areas for a particular process provides a strong foundation for agreement and inclusion in the M&E framework. Where international agreement and data on indicators already exists, those indicators are good practices. For example, the percentage of schools providing skills-based HIV education to students is disaggregated for HIV and internationally agreed by the UN General Assembly as a core indicator. Government National School Census Reports in some countries are beginning to include SHN-related programme information, and these also present good practices as the indicators have already been incorporated into the government's reporting systems.

**Table 2. Number of documents with at least one defined indicator**

| Document type | Number of documents containing indicators | Number of documents with at least one defined indicator (%) |
|---|---|---|
| M&E guideline documents | 21 | 16 (76%) |
| Documents with databases | 11 | 7 (64%) |
| SHN document | 13 | 3 (21%) |
| **Total*** | **45** | **26 (58%)** |

*The document total does not include those which contain logical frameworks and policies.

**Box 9. Examples of SHN-related process indicators in National School Census Reports**

**Nigeria**
No (%) of schools with anti-AIDS clubs
No (%) of schools with information on HIV provided
No (%) schools with health workers trained in HIV

Where indicators are defined and found to be similar but not the same, an agreement on a core indicator for the M&E framework is needed in order to reduce the number of indicators. For example, drug coverage may include the number of enrolled and un-enrolled school-age children dewormed in one programme (e.g. as reported on the WHO Global Databank on Schistosomiasis and Soil-Transmitted Helminths), while in another programme it may include the percentage of enrolled children dewormed (e.g. as reported in the *School Feeding Handbook*). Similarly, some indicators are similar because they are tracking a particular aspect, and a choice needs to be made on a core indicator. For example, the number of schools with a trained teacher, the number of teachers trained and the number of teacher training sessions, all look at the presence of trained teachers.

Links were identified between some indicators, which may be used for monitoring at different administrative levels. For example, data on the existence of school health and well-being awareness programmes (see Box 8), which are collected at the school level, may be used for an indicator to monitor the percentage of schools participating in a programme at both the district and national levels (see Box 10).

**Box 10. Indicators common across the five programmatic processes that complement FRESH activities**

Number (%) of schools participating in a programme
Number (%) of schools with a trained teacher
Number (%) of schools with functioning SHN committee
Number (%) of teachers trained
Number (%) of teacher training sessions

Some of the indicators were specific to a priority area, as illustrated in Box 11. Those indicators particular to a priority area may be presented in the M&E framework in a module specifically addressing that priority area.

**Box 11. Examples of process indicators specific to water, sanitation and hygiene**

Number (%) of schools with access to safe water
Number (%) of schools with functional latrines
Number (%) of schools with separate latrines for girls
Number (%) of schools with functional hand washing facilities

The indicators on water, sanitation and hygiene closely connect to some of the standards for water and sanitation under promotion of a safe and sanitary school environment (see Table 3). Such a connection between the minimum standard and the indicators for its monitoring is a good practice and is important to present in the M&E framework.

**Table 3. Examples of the connection between a standard and an indicator**

| Standard | Indicator |
|---|---|
| Schools should have adequate quantities of water | Number (%) of schools with access to safe water |
| Schools should have gender segregated latrines along with hand washing facilities | Number (%) of schools with separate latrines for girls<br>Number (%) of schools with hand-washing facilities |

***Outcome indicators***

Some indicators for measuring goals and objectives of SHN programmes were internationally agreed either by a declaration or an international goal such as the MDGs and EFA, or the UN General Assembly Special Session (UNGASS) on HIV&AIDS, and reported by all countries. These are core indicators. There are other indicators that are internationally agreed, although through processes other than declarations (e.g. inter-agency documents or surveys), and may not be reported by all countries. Both sets of indicators are good practices because there is consensus from national governments and international agencies on them.

Further, data on some indicators are collected through ongoing surveys or routine collections and are available on open-source databases or other open-sources of published data (see Table 4). These may or may not be available across all low income countries (e.g. percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the last 7 days is available for 36 low income countries). These indicators are also good practices because data as well as tools (e.g. surveys) and institutional structures for these indicators already exist.

Data on some indicators were reported by more than one survey (tool), such as attendance rate reported in the National School Census Surveys and Multiple Indicator Cluster Survey (MICS). Although this is a good practice, there are differences in the survey methodologies (e.g. MICS is a household survey, while the National School Census Surveys are school-based). Therefore, data from these two surveys cannot be compared.

The presence of aggregate (e.g. net enrolment rate) and composite indicators (e.g. percentage of youth with comprehensive knowledge of HIV) is a good practice and

important to adopt in the M&E framework. This will limit the number of indicators to the main comprehensive measures in the framework.

**Table 4. Examples of internationally agreed indicators and their data sources**

| Outcomes | Indicator | Database or data source | International agreement |
|---|---|---|---|
| **Improved Educational Outcomes** | Enrolment rate (gross and net) by gender | UNESCO Institute of Statistics Database | MDGs and EFA |
| | Attendance rate | National School Census Survey Reports, Multiple Indicator Cluster Survey database | World Summit for Children, MDGs, World Fit for Children Declaration |
| | Primary completion rate | UNESCO Institute of Statistics Database, Multiple Indicator Cluster Survey Database | World Summit for Children, MDGs, World Fit for Children Declaration |
| **Improved Health and Nutrition Outcomes** | HIV prevalence among youth aged between 15 to 24 years | AIDS Indicator Survey Database | UNGASS |
| | Proportion (%) of population with haemoglobin below 110 g/l | WHO Vitamin and Mineral Nutrition Information System Database | |
| **Improved Health-Related Knowledge, Attitude, and Behaviour, Skills Outcomes** | **HIV and Sexual health** Percentage of youth with comprehensive and correct knowledge about AIDS | AIDS Indicator Survey Database (DHS) | UNGASS |
| | Percentage of young people aged between 15 to 24 years who have had sex before the age of 15 | AIDS Indicator Survey Database (DHS) | UNGASS |
| | **Physical activity** Percentage of students who were physically active for a total of at least 60 minutes per day on all 7 days during the last 7 days | Global School Health Survey Country Fact Sheets | |
| | **Substance abuse** Percentage of children aged 12 to 16 years that smoked before the age of 10 | Global Youth Tobacco Survey | |
| | Percentage of youth aged between 15 to 24 years who ever consumed alcohol | Behaviour Surveillance Survey Report | |
| | **Violence against children** Percentage of students who were physically attacked one or more times during the past 12 months | Global School Health Survey Country Fact Sheets | |
| | **Hygiene** Percentage of students who never or rarely washed their hands after using the toilet or latrine during the past 30 days | Global School Health Survey Country Fact Sheets | |
| | **Mental and psychosocial health** Percentage of students who seriously considered attempting suicide during the past 12 months | Global School Health Survey Country Fact Sheets | |

# 4. DISCUSSION AND CONCLUSIONS

The review found that there is a strong demand for a generic M&E framework for SHN programmes from 34 out of the 35 key informant offices. A general finding of the literature review was that there are several resources that could be used to inform the M&E framework. Eighteen of the 35 key informant offices recommended that it is very important that the development of the framework is supported and recognized by different partners, especially national governments and stakeholders with national SHN policies and systems having an important role in the dissemination of the M&E framework as well as harmonization of resources used for M&E of SHN. Formats most preferred for disseminating the framework were a hard copy resource kit and face-to-face training.

The literature review of **logical frameworks** found that organizational priorities and activities varied greatly. Therefore, in order to develop a generic M&E framework, a common logical framework would be required, on which core indicators and minimum standards would be based. The common outcomes, and programmatic processes based on the *'FRESH core activities'* – identified by key informants and the resource review would provide a strong basis to gain consensus on a logical framework.

Thirty-three of the 35 key informant offices stated the need for common **minimum standards** on SHN programmes. Both key informants and the resource review identified that in general there were standards and guidelines for SHN programmes, however these have not been institutionalized as minimum standards and have not been used uniformly by all organizations. Disparities between standards (e.g. quantity of water available in schools) need to be addressed in the framework. Informants felt minimum standards need to be specific enough *"to allow monitoring"*, while flexible to provide opportunity for *"local adaptation"* and contextualization. Some standards for programmatic processes were common for the different priority areas (e.g. violence against children and substance abuse). These standards, especially if mentioned in inter-agency publications and if based on evidence and operational experience, would need to be included in the generic M&E framework. Standards that are specific to a priority area would need to be presented with indicators in specific modules, as mentioned by key informant offices. Some minimum standards could be met at a particular administrative level. Therefore guidance on the level that is targeted would need to be provided. This would also make monitoring easier.

Thirty-two of the 35 key informant offices stated the need for **core indicators** on SHN programmes. On reviewing resources provided by key informants, it was found that the use of the term *'indicators'* varied between M&E and SHN documents. It is therefore recommended that the terminology is clarified in the M&E framework. The review also found that some resources did not define the indicators, and this, as mentioned by key informants, needs to be addressed in the M&E framework, so that the measures are *'SMART'*.

Both the resource review and key informants identified that some process and outcome indicators are already internationally agreed as core indicators or are being collected by ongoing tools. These indicators are strong candidates for ensuring the M&E framework for SHN programmes complements and fits within existing structures (e.g. government systems) for data management, and builds on existing resources. Existing data on these indicators can be used secondarily for situation analyses prior to programme planning. This may be followed by primary data collection during the programme. Data on some indicators are only available in some countries; some of these may be presented in the framework as *"optional indicators"*, as suggested by key informants.

Data for some indicators which are collected and monitored at one administrative level were also found to be linked to indicators at a higher administrative level.

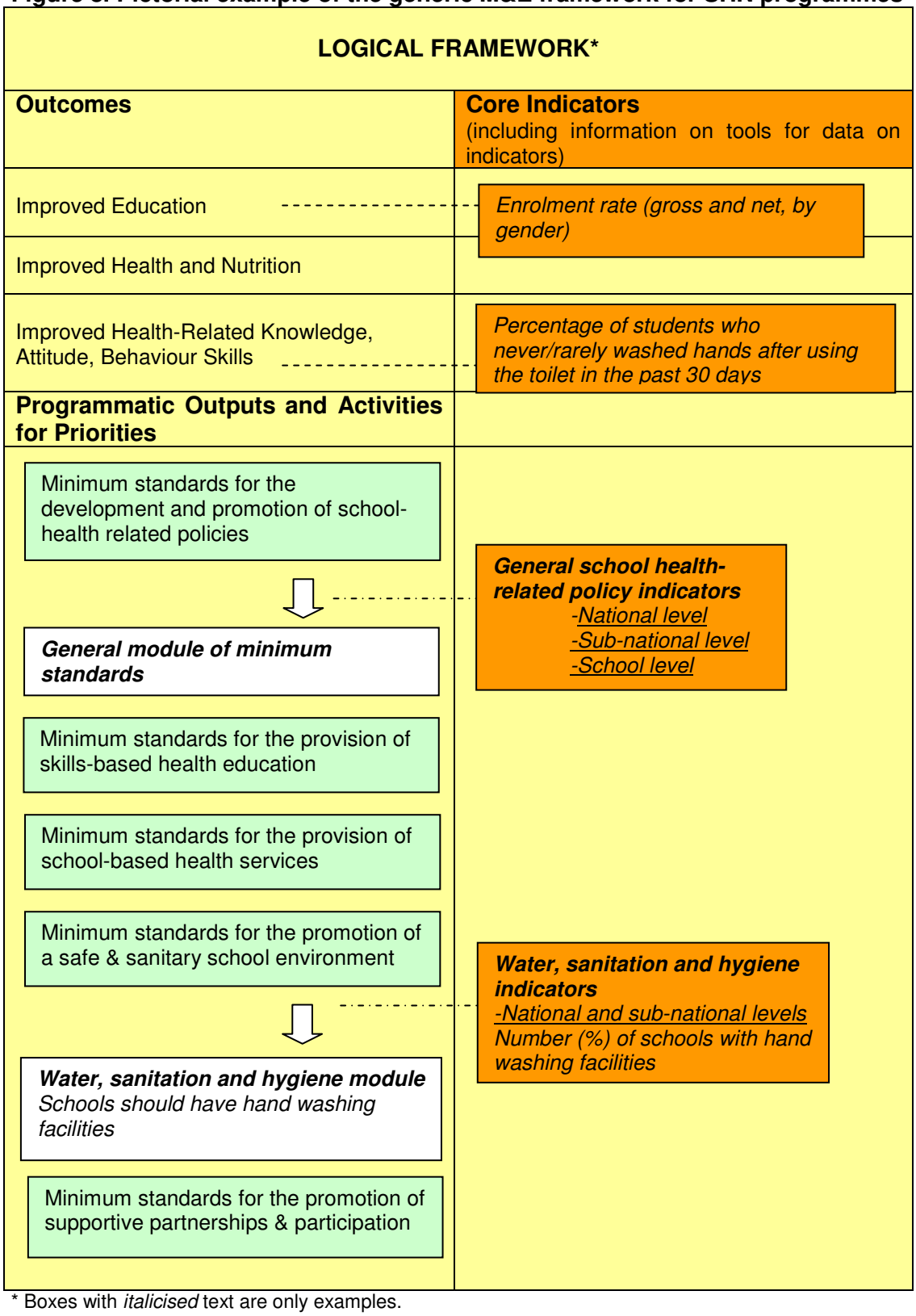
Informants recommended that the framework should try and ensure that indicators for different administrative levels *are "interlinked and complementary"*.

A good practice that was identified in some cases was the use of aggregate and composite indicators, which provide a comprehensive picture of the aspect measured. These should be used in the framework, in order to *"reduce the number of indicators"*. However, it is very important to explain the levels of disaggregation (e.g. by age and gender) so that the data collected are rich for decision making. Specific questions which are asked for information on the different aspects of composite indicators need to be maintained.

Last but not least, informants recommended that the good practice of links between standards and process indicators identified in the resource review needs to be evident in the M&E framework.

Based on the information gathered from the review, a pictorial first draft of the generic M&E framework for SHN programmes is provided in Figure 8. The FRESH partners are requested to discuss the findings presented in this review in the meeting to be held at WHO Headquarters, Geneva in September 2008 to develop and disseminate such an M&E framework.

**Figure 8. Pictorial example of the generic M&E framework for SHN programmes**




* Boxes with *italicised* text are only examples.

# 5. LIST OF RESOURCES

**Key:** **§** Resource contains log frame; **†** Resource contains standards;
***** Resource contains indicators.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# 7. LIST OF ANNEXES

### Annex A: List of priority areas for SHN programmes

| Priority areas |
|---|
| Education |
| HIV |
| Malaria |
| Water, sanitation and hygiene |
| Worms |
| Nutrition |
| Sexual health |
| Violence against children |
| Substance abuse (tobacco, alcohol and drugs) |
| Physical activity |
| Mental and psychosocial health |
| Life skills |
| First aid |
| Vision, hearing, dental and skin |

## Annex B: List of key open-ended questions to key informants

Q1. Are you/your organization involved in school-based interventions to improve children's health, nutrition and ability to learn?

Q2. Do you have a log-frame (logical framework) for your school-based health and nutrition activities? If **Yes,** kindly share a copy of the latest log-frame or goals, objectives, expected outputs of the programme.

Q3. Are you aware of any minimum standards for school-based programmes in general, OR for elements of these programmes? (e.g. deworming, HIV prevention, life skills education, etc).

Q4. Are you aware of any reference documents that might contain minimum standards for school health programmes? If **Yes**, please provide the names.

Q5. Do you think there is a need for common minimum standards for school health programmes that one can refer to, and adapt to their context? Why/why not? What might be some of the important considerations for the development of common minimum standards for school health programmes?

Q6. Do you have a set of indicators for your school health programmes (e.g. deworming, nutrition, HIV and malaria prevention) which you use to measure:

a) the impact on children; OR
b) whether the programme was implemented as planned.

If **Yes**, please provide a list of the indicators.

Q7. Are you aware of indicator guides/publications specific to school health programmes? If **Yes,** please provide the names of the references.

Q8. Do you think there is a need for a common set of core indicators for school health programmes? Why/why not? At what level would such core indicators be useful? What other important considerations are required for their development?

Q9. From where do you get data to monitor and evaluate your school health programmes (e.g. on nutrition, deworming, and HIV prevention)? Is there an existing system for school health data collection? Please explain.

Q10. Is there a standardized database within your organization for storing and accessing the data?

Q11. Is the data entered in to any other database system? e.g. EMIS or a HMIS?

Q12. Do you have any data collection and analysis tools/guidelines for your school health programmes?

Q13. Is there a standard reporting system in your organization that school health programmes follow?

Q14. What are the main challenges which you face during the monitoring and evaluation of your school-based health interventions? Or (if not linked to a specific programme) what are the main challenges or barriers to effective M&E of school-based health, nutrition and HIV prevention?

Q15. Do you have successes or good practices relating to monitoring and evaluation of your school-based health interventions, which you could share with us?

Q16. Do you have any other suggestions or comments on improving the monitoring and evaluation of interventions on school health programmes?

## Annex C: Details of key informants and their offices/organizations

**Catholic Relief Services**

*1. Monitoring and Evaluation*

Richard Yakubu, Monitoring and Evaluation Manager

**Child-to-Child Trust**

*2. Child-to-Child Trust*

Tashmin Khamis, Director

**Department of State for Education, The Gambia**

*3. HIV/AIDS Unit*

Amicoleh Mbaye, Sub-Saharan Africa Focal Point

**Deworm the World**

*4. Deworm the World*

Lesley Drake, Executive Director

**Education Development Center**

*5. Health and Human Development*

Carmen Aldinger, Project Director

**Education International**

*6. Education International*

Gaston de la Haye, Senior Consultant

**Fondation de Dévelopement Communautaire, Burkina Faso**

*7. School Health and Nutrition*

Moussa Kabore, Monitoring and Evaluation Manager

**Imperial College, London**

*8. Division of Epidemiology, Public Health and Primary Care*

Edwin Michael, Senior Lecturer

*9. Partnership for Child Development*

Alice Woolnough, Programme Manager

Anthi Patrikios, Operations Manager

*10. Schistosomiasis Control Initiative*

Elisa Bosqué-Oliva, West Africa Regional Programme Manager

Fiona Fleming, Country Programme Manager

**IRC International Water and Sanitation Centre**

*11. IRC International Water and Sanitation Centre*

Mariëlle Snel, Programme Officer

**Lifeskills Development Foundation, Thailand**

*12. Lifeskills Development Foundation, Thailand*

Kreankrai Chaimuangdee, Director

**MEMA kwa Vijana**

*13. Clinical Research Group*

Jenny Renju, Research Fellow

**Ministry of Education, Cameroon**

*14. SHN & HIV Unit*

Désiré Aroga, Focal Point for HIV/Education and Coordinator of Network of Focal Points for Central Africa

**Ministry of Education/Ministry of Health, Guinea**

*15. SHN & HIV Unit*

Camara Balla, Focal Point for HIV/Education and Coordinator of National SHN Program

**Ministry of Education, Guyana**

*16. SHN & HIV Unit*

Sharlene Johnson, HIV&AIDS Focal Point

**Ministry of Education, Nigeria**

*17. HIV&AIDS Unit*

Z Momodu, HIV&AIDS Focal Point

**Save the Children USA**

*18. Office of Health, Development Programs for Children*

Dan Abbott, SHN Specialist

*19. Philippines Country Office*

Amado Parawan, Child Health & Nutrition Specialist

**Thai Red Cross**

*20. AIDS Research Centre*

Greg Carl, Officer for Psychosocial Development

**UNESCO**

*21. Division for UN Priorities in Education Section/HIV*

Ekua Yankah, Programme Specialist in HIV and Focal Person for School Health

**UNICEF**

*22. Secretariat of SG's Study on Violence Against Children*

Amaya Gillespie, Director

*23. Education Section (PD)*

Anna Maria Hoffmann, Education Specialist, HIV/AIDS and Life Skills Education

*24. Water & Environmental Sanitation*

Therese Dooley, Senior Advisor for Hygiene & Sanitation

**University of Ottawa**

*25. School of Psychology*

Elizabeth Kristjansson, Associate Professor

**UNODC**

*26. Prevention, Treatment & Rehabilitation Unit*

Giovanna Campello, Programme Officer

**World Bank**

*27. School Health and Nutrition*

Don Bundy, Lead SHN Specialist

**World Food Programme**

*28. World Food Programme, Headquarters*

Rebecca Lamade, Monitoring and Evaluation Programme Officer

*29. World Food Programme, Kenya*

Grace Igweta, Monitoring and Evaluation Programme Officer

*30. World Food Programme, Nepal*

Kishor Aryal, Programme Officer

*31. World Food Programme, Uganda*

Joviah Musinguzi, Food for Education Programme Assistant

**World Health Organization**

*32. Department of Chronic Diseases and Health Promotion*

K.C. Tang, Senior Professional Officer

Leanne Riley, Team Leader for Global School Health Survey

*33. Department of Neglected Tropical Diseases*

Mbabazi Pamela Sabine, Medical Officer and Epidemiologist

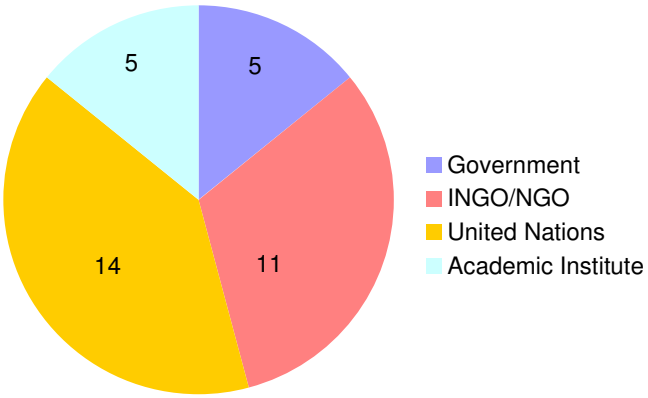
*34. Malaria, Vector Control and Other Parasitic Diseases*

Antonio Montresor, Public Health Specialist

*35. Pan American Health Organization*

Sofialetecia Morales, School Health and MDG Focal Point

## Annex D: Profile of offices represented




| Office Profile | Administrative Level Represented | |
|---|---|---|
| | **National** | **International** |
| Government | 5 | N/A |
| INGO/NGO | 6 | 5 |
| United Nations | 4 | 10 |
| Academic Institute | 2 | 3 |
| **Total** | **17** | **18** |