Operationalizing Health & Education Coordination:

RECOMMENDATIONS SURFACED THROUGH INTERVIEWS WITH AFRICA BUREAU MISSIONS

September 2021

CHILD HEALTH TASK FORCE

Contents

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Glossary

AFRICA REGION

This report uses the term "Africa Region" when referring to USAID-presence countries within sub-Saharan Africa and uses the term "sub-Saharan Africa" when referring to the subregion more generally.[2]

COUNTRY DEVELOPMENT COOPERATION STRATEGY (CDCS)

The strategy that defines USAID's chosen approach in a country and provides a focal point of the broader context for programs and activities. A CDCS presents expected results within a time-defined period, provides a common vision and an organizing framework, and summarizes the status of the ongoing portfolio and how that will be continued, updated, or revised to address new priorities, lessons learned, or changing circumstances. A CDCS usually has a five-year lifespan.

CHILD HEALTH TASK FORCE

A network of global and country-based organizations and individuals working to design and implement child health programs that take a life-course approach. Created in 2017, the Task Force aims to generate and share evidence on how to implement equitable, comprehensive, and integrated programs that will translate into better outcomes for children. As a learning community, the Task Force facilitates knowledge sharing, provides countries and child health stakeholders with access to a pool of technical experts, tested implementation tools, approaches, and engages members to translate knowledge into better practices.

DISEASE CONTROL PRIORITIES, THIRD EDITION (*DCP3*) CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT VOLUME

The *DCP3* Child and Adolescent Health and Development volume provides the evidence base for delivering health interventions through schools and proposes cost-effective essential packages of interventions targeted to school-attending children and adolescents that can be delivered in low-resource settings (1).

FRAMEWORK

Evidence-based operational guidance; in the context of this report, a school health and nutrition framework refers to guidance developed by a technical body to support governments and

[2] USAID is engaged in 38 countries within the Africa Region: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, eSwatini, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Republic of the Congo, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe. USAID has both health and education investments in 16 of these countries: Burkina Faso, Ethiopia, Democratic Republic of Congo, Ghana, Kenya, Liberia, Malawi, Mozambique, Niger, Nigeria, Tanzania, Togo, Rwanda, South Sudan, Uganda, Zambia.

implementers with the design and delivery of quality, holistic, and equitable school-based health services at critical developmental periods.

FOCUSING RESOURCES FOR EFFECTIVE SCHOOL HEALTH (FRESH)

A multisectoral framework and global partnership for promoting the educational success, health, and development of school-age children and adolescents through schools. FRESH was launched by UNESCO, UNICEF, WHO and the World Bank during the World Education Forum, Dakar in April 2000. The FRESH framework identifies four pillars that are essential infrastructure for delivering school health and nutrition programs and policies. They include:

i. Ministry/agency/school policies that are supportive of child health and development
ii. Skills-based health education, which includes and goes beyond a core curriculum guiding classroom instruction to include co-curricular and non-formal activities and routines
iii. Defined set of basic, scalable services to support educational success, health, and development; and
iv. Safe, sanitary, healthy physical environment and a positive psycho-social environment that includes student, parent, and community involvement.

HEALTH PROMOTING SCHOOL

A school that constantly strengthens its capacity as a healthy setting for living, learning, and working. This concept refers to a whole-school approach that extends beyond the delivery of a health curriculum or discrete health services to create a school environment that positively influences health behaviors.

HUMAN CAPITAL

Sum total of a population's health, skills, knowledge, experience, and habits.

HUMAN CAPITAL INDEX

An index launched by the World Bank in 2018 that ranks countries according to the projected labor productivity of a population based on the outcomes of their current investments. Rankings are estimated using data on child survival and childhood stunting, as well as the quality and quantity of education that a child born today can expect to achieve by the age of 18, and by aggregating these indicators against measures of productivity for a healthy individual who has achieved complete education.

LOCAL EDUCATION GROUP (LEG)

Collaborative forum of stakeholders within the education sector who develop, implement, monitor, and evaluate Education Sector Plans at the country-level. The LEG ensures that all parties are kept fully informed of progress and challenges in the education sector and participates in relevant policy dialogue and harmonization of donor support.

MULTISECTORAL ACTION/COORDINATION

Implies formal or informal efforts that involve more than one sector to advance a common policy and/or programmatic objective. These efforts can be organized around various avenues

including, but not limited to, resource mobilization, training, evidence generation, intervention implementation, etc. When used in relation to school-age children and adolescents, 'multisectoral action' can describe deliberate and coordinated work with actors across sectors (such as health, education, nutrition, gender, water, and agriculture, among others). Sometimes this term is used interchangeably with 'cross-sectoral', however in this analysis 'multisectoral' is used.

SCHOOL HEALTH AND NUTRITION

Services provided to students enrolled in primary or secondary education within school premises or in specially designated school health clinics that serve several schools.

Executive Summary

School-based health and nutrition service delivery plays a critical role in supporting the healthy development of learners. This stands to reason, as children need to be healthy enough to regularly attend school and to benefit from the education offered. Education investments are further leveraged when the physical and mental health needs of children are addressed as children and adolescents develop. These reasons justify the inclusion of school health and nutrition programs within the education purview. The health sector similarly benefits from this arrangement; delivering health services through schools is a cost-efficient platform to reach school-age children and adolescents, who otherwise have limited engagement with health clinics during this developmental period. For students, well-timed health interventions, coupled with quality education, afford individuals the foundation necessary to meet their developmental potential. As children grow and develop, these investments translate to a workforce that has sufficient soft skills and academic training to adapt and participate in an evolving, and increasingly technology driven workforce. Thus, school health and nutrition services are linked to the economic goal of strong human capital formation (1,2).

The challenges faced by the education and health sectors in 2020/2021 in light of COVID-19 are unprecedented on a global scale. The pandemic forced near-global school closures, affecting 1.6 billion children and youth globally at the height of the pandemic (3), and millions of these children may drop out of school permanently as a result (4). The global pandemic highlighted the irreplaceable and important safety net that school health and nutrition services provide on a near-daily basis, which in turn, has generated greater demand for these services from policy makers and from communities.

However, in some respects not unique, as practitioners in many countries have had to grapple with pivoting service delivery platforms during periods of climatic events, other health epidemics, and political instability. These realities have intensified the need to deliver health services to children wherever they reside and has forced governments and organizations concerned with the welfare of children to be nimble, timely, and crisis-resilient in adapting school-based services to widespread closures.

If prior research documents the importance of school health and nutrition for children, and if current events demonstrate their relevance, how do countries, practitioners, and development partners bridge the gap between knowing ‘what to do’ and ‘how to do it’ - particularly in a rapidly changing context? Put another way, what gets in the way of developing and delivering comprehensive school health and nutrition programs? What are the bottlenecks and constraints and how can they be overcome? Practitioners are often faced with these challenges, and rightly so, as a small percentage of literature offers operational advice, or otherwise, recommendations are too context specific to be replicated without substantial adaptation. Furthermore, tips on program implementation must be specific to the organization that would support it as organizational processes and culture are distinct enough to nullify any ‘one-size-fits-all’ solution.

The primary purpose of this report is to help bridge these two implementation questions by offering operational advice to Africa Bureau staff on approaches that can productively advance the healthy growth and development of school-age children. To this end, this report:

- **Provides the rationale for elevating multisector efforts**, supported by evidence summarized in prior USAID commissioned white papers and conceptualized in a logic model;
- **Presents tools that can be called upon for program design**; including existing guidelines, frameworks, and an initial stakeholder mapping for actors active in health service delivery in USAID-supported countries in the Africa region;
- **Summarizes the findings from interviews with Africa Bureau Mission staff**, to assess the existing gap between 'know-what' and 'how-to', and to explore constraints faced by Africa Bureau Mission staff to engage in multisector coordination, identify entry points for multisector engagement within the confines of siloed budgets, and share reporting responsibilities;
- **Distills findings of the interviews into a SWOT analysis focused on multisector coordination**, to examine strengths and weaknesses internal to Africa Bureau Missions and opportunities and threats in the broader country environment; and
- **Offers recommendations that build upon the SWOT analysis that can feasibly be acted upon by Africa Bureau and by the Bureau Missions**, to support multisectoral investments targeted to school-age children and adolescents, inform conceptualization of new project design and development in line with CDCS priorities and existing portfolios, and to direct USAID/Washington as it seeks to provide technical support to Africa Bureau Missions.

In composite, this report serves as the foundation for the Africa Bureau and its missions to consider different near- and medium-term pathways for advancing school health and nutrition programs in the context of advancing broader Bureau Mission CDCS objectives. Due to the heterogenous nature of Africa Bureau countries, not all findings from the SWOT analysis will hold in each context, nor will all recommendations be appropriate. Instead, both the SWOT analysis and recommendations are presented in the belief that the experiences of USAID staff in different Africa Bureau Missions will have cross-applicability for their colleagues elsewhere in the continent— even if lessons and approaches will inevitably need to be contextually adapted. Support after this report by USAID Africa Bureau will provide technical assistance to Bureau missions who wish to pursue stronger school health programs. Hence, these recommendations and strategic directions are made while cognizant of the operational constraints facing missions during this unparalleled global crisis.

Human Capital Formation and School Health: *What is the Link?*

Human capital is understood to be the degree to which individuals can meet their health, education, nutrition potential, as well as their ability to apply their soft skills and training to income generating activities. Aggregated at the country level, human capital reflects the sum total of a population's health, skills, knowledge, experience, and economic potential (5). The importance of human capital led the World Bank to launch the Human Capital Index in 2018, which assesses country indicators at critical periods throughout the lifecourse, including during school years (5).

Importantly, the Human Capital Index reveals the importance of prioritizing human capital in the Africa region; without significant changes to policy and investment, a child born today on the continent is estimated to reach only 40 percent of his/her potential relative to an individual who achieves full education and health benefits by adulthood (6). This also suggests that decisions made today determine how effectively countries in this region reach their economic growth potential.

> ***Human capital reflects the ability of populations to adapt, innovate, and perform competitively in markets.***

The health of the learner has significant implications for student readiness to learn and ability to benefit from the instruction provided. Simply put, healthy children learn better. On the individual level, poor learning outcomes translates to lost human capital and earning potential and, when aggregated to the national level, to reduced competitiveness and economic standing.

Two previously published USAID white papers detail the pathways through which well-timed and quality investments in health and education advance development targets across sectors in the short- and medium-term and also provides the global and regional evidence base to demonstrate that deliberate coordination across the two sectors can enhance gains through synergistic benefits (2,7). A key conclusion from both analyses is that greater investment by, and coordination with, the health sector for school-age children and adolescents can be a key factor in enhancing education returns. These returns accrue through better learning and attendance and creating an enabling environment for vulnerable children to transition to secondary school. Similarly, greater education investments targeted to strengthening foundational skills can influence health outcomes (see Box 1).

If the two prior white papers make the case for bolstering human capital through investments in school health and nutrition, the current report attempts to bridge the gap between knowing where to direct investment and how to implement the recommendations. The literature is thin on the implementation science, and even more threadbare when considering bolstering programming post crisis.

This report was commissioned to provide operational advice for the USAID Bureau for Africa to advance school health and nutrition. The purpose of the report is to specifically examine mechanisms to operationalize and strengthen multisector coordination within the Africa Bureau

Missions to improve the education, wellbeing, and development of school-age children and adolescents. This report takes the position that multisectoral coordination and well-targeted investments during the years in which children are in school are foundational to human capital formation.

The recommendations outlined in this report are inspired by thoughtful conversations with representatives of ten Africa Bureau Missions (Annex 1). The strategies proposed and accompanying tools were developed to meet the needs of USAID Africa Bureau Missions, recognizing that Africa Bureau Missions are situated within a broader landscape of in-country partners and work within the context of Agency and government policies. Criteria are also proposed for identifying Africa Bureau Missions that need support based on their capacity and commitment to make an impact in this area. While this report is regionally oriented, the recommendations and companion tools are intended to be applicable to USAID Africa Bureau Missions in other regions as well.

The focus on Africa within this report is a recognition that this region has the youngest and fastest growing population of all continents, accounting for 40 percent of children and adolescents ages 5-19 years worldwide (8). Demographic projections suggest that the total population will double by 2050 (9), which presents an urgent opportunity to strengthen the region's human capital through coordinated and well-timed health and education investments.

Box 1. USAID White Papers on Health and Education Investments to Improve Human Capital

The Health Finance and Governance Project (HFG) of the U.S. Agency for International Development (USAID) commissioned the *Maximizing Human Capital by Aligning Investments in Health and Education* discussion paper in 2018 (a). The analysis, which was largely rooted in the evidence base collated by the *DCP3* Child and Adolescent Health and Development Volume, detailed effective interventions that can be implemented by the health and education sectors from preconception through the first 1,000 days, early childhood, school-age, adolescence, and transition to the labor market to maximize human capital and productivity (b). This white paper explores how investments in human capital complements USAID's vision of self-reliance and concludes with five key messages:

i. The scale of the contribution of human capital to national economic growth and stability has been significantly under-recognized;
ii. Effective human capital development requires synergistic investment in health and education across a person's life;
iii. There are critical failures in the design of current approaches to investment in human capital;
iv. There is a strong evidence base on the most cost-effective ways to maximize human capital by investing strategically in both health and education; and
v. There are key actions that can be taken by both health and education programs during the first 8,000 days of life to maximize the development of human capital.

In 2019, USAID Bureau for Africa Office of Sustainable Development and the Bureau for Africa Institutional and Technical Support Services commissioned a second white paper to foster collaboration among education and health sectors and lay a strong foundation for human capital development in the Africa Region (c). The report, *Human Capital Investments: The Case for Education and Health in Sub-Saharan Africa*, has five key conclusions:

i. Human capital is a key determinant of national wealth and is lowest in Africa;
ii. Fostering human capital is critical to self-reliance;
iii. There are solutions to guide action;
iv. There is a robust evidence-base to inform action; and
v. There are key changes donors can make to current practice to maximize human capital and economic growth.

In addition, this white paper included targeted recommendations for the wider donor community, USAID Country and Regional Missions, and USAID Africa Bureau and Pillar Bureaus that support missions from Washington, DC to effectively champion and prioritize human capital investments through strategic planning, program and activity design, and implementation.

Source:

(a) Schultz L, Appleby L, Drake L. Maximizing Human Capital By Aligning Investments in Health and Education. Bethesda, MD; 2018.
(b) Bundy DAP, de Silva N, Horton S, Jamison DT, Patton GC, editors. Disease Control Priorities, Third Edition (Volume 8) Child and Adolescent Health and Development. Third. Washington, DC: World Bank; 2017.
(c) Schultz L, Bundy DAP, Drake L. Human Capital Investments: The Case for Education and Health in Sub-Saharan Africa. Washington, DC; 2019.

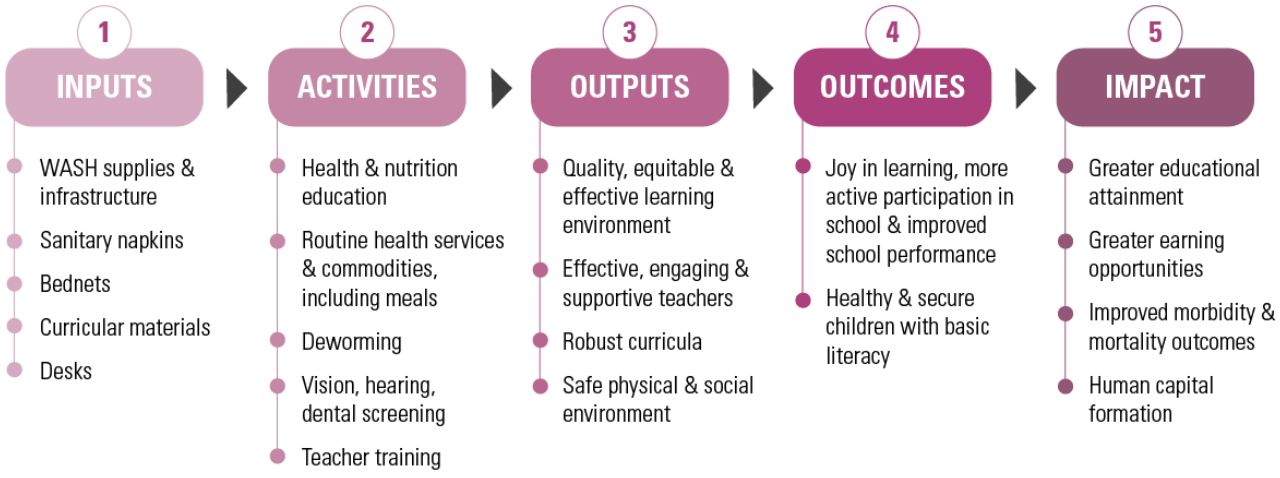
There is increasing momentum for interventions that support learners across their developmental trajectory. Over the last two decades countries made substantial progress towards the Millennium Development Goal of increasing school enrollment. As a result, the education sector has shifted its focus to improving how much students learn while in school.

Learning attainment tests, such as TIMMS, PISA, and others consistently show that schooling is not synonymous with learning. Poor learning outcomes and insufficient investments in the quality of education are among the key drivers of the global learning crisis (10). A student in Ghana, for example, can expect to have 11.6 years of schooling (a typical education system delivers between 10-12 years of schooling), yet achieve an average learning score of 229 (an advanced proficiency score on an international test is nearly three times as high, with a score of 625) (11). Regional averages suggest that students in sub-Saharan Africa are learning less than their peers in all regions, aside from South Asia (11).

Countries can improve the human capital of their population by implementing policies that make the education system more conducive for learning and by prioritizing evidence-based investments to make schools more effective for learners (10). Yet educational inputs on their own, while necessary for human capital formation, are not sufficient. Opportunities to learn must occur in a context where students' health and well-being are inclusively supported. This demands efforts go beyond the education sector as no single sector or intervention can independently achieve human capital objectives (12). Figure 1 presents a logic model that explores the relationship between school health and nutrition inputs and educational benefits.

The logic model shows how school health and nutrition inputs and activities in a broader educational context creates the conditions for an equitable and effective learning environment. These inputs and activities not only reduce the risks of dropping out of school, but limit 'presenteeism' where students lack the attentional capacities to benefit from classroom instruction. Several decades of research shows that a policy environment which promotes equitable access to routine health services can increase the average number of school years completed, improve learning outcomes, and foster better health outcomes for the most vulnerable and marginalized populations (13). It is important to highlight that despite achievements towards this objective, the COVID-19 pandemic has rolled back progress (14).

FIGURE 1. School Health and Nutrition Logic Model



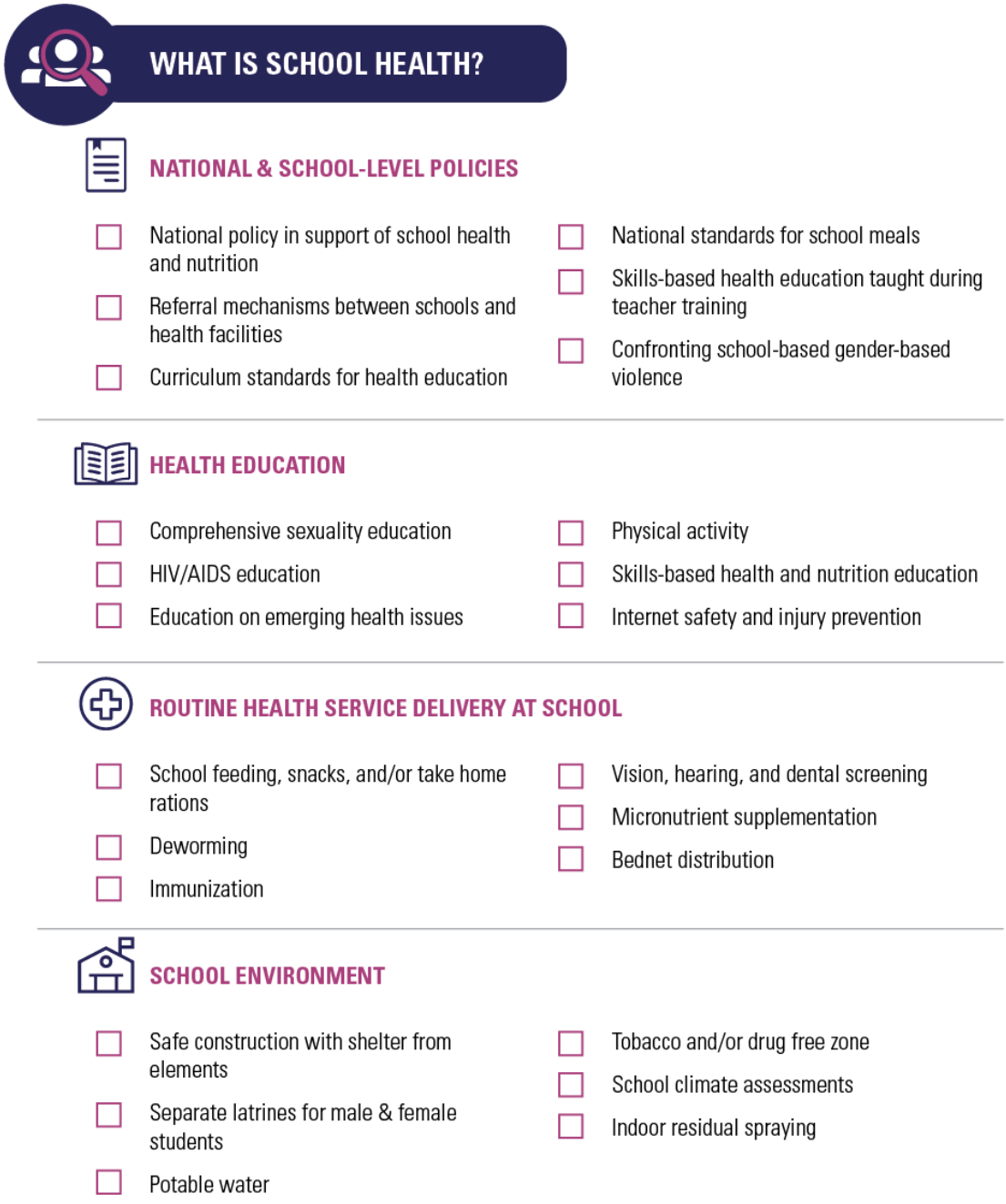
School health and nutrition has long been celebrated for its ability to deliver health and nutrition services at low cost simply by targeting children where they are and by reducing the burden on an already stretched health care system (15). For the education sector, the delivery of health services and health sector investments ensures that a child's poor health is not a bottleneck to learning, growth, and cognitive formation (16).

> ***For most countries, the challenge is to optimize existing multisector programs through coordination.***

School health and nutrition investments are among the most ubiquitous public investments worldwide (17), even if the delivery of a comprehensive package of school health and nutrition interventions are less common in low-resource settings. This demonstrates that opportunities exist in most countries to scale up the scope of services and tailor specific types of programs to local contexts. For most countries, the challenge is to optimize existing multisector programs through coordination, rather than to introduce a novel program in primary and secondary schools.

School health and nutrition programming may range from standalone interventions supported by a single sector (or actor) to integrated services that reach students at various points during their development. School health and nutrition services include, but are not limited to: vaccination, treatment of intestinal worms, daily meals and micronutrient supplementation, vision, hearing, and dental screening, life skills and nutrition education, among other interventions (Figure 2). Moreover, school health programs set the stage for children to thrive and become transformative agents in their communities (18).

FIGURE 2. Examples of the Breadth and Depth of School Health and Nutrition



The COVID-19 Pandemic and the Ramifications for Health Delivery when Schools are Closed

Global economic shocks, health emergencies, and instability constitute a profound threat to the well-being of children. In an effort to prevent and slow the transmission of COVID-19, more than 192 countries mandated some form of school closures. At the height of the pandemic, 1.6 billion children were estimated to be impacted by school closures worldwide (3). As a result, national, sub-national, and local school health and nutrition programs experienced severe restrictions on the traditional model of service delivery. Vulnerable children who were traditionally targeted to receive school-based health and nutrition services were likely to have an even greater need for care because of the crisis. The continuing crisis brings into greater focus the importance of multisector coordination for students' physical health, nutritional status, and mental wellbeing when schools are closed and creates a high bar for supporting children as schools reopen.

During the global COVID-19 pandemic, examples have emerged demonstrating how school closures and other related restrictions on movement have forced adaption and innovation, including greater collaboration across sectors to ensure the health and wellbeing of students. The adaptations shown in Box 2 demonstrate the ability of countries, partners, and donors to develop stopgap measures that meet children where they are and suggest that education actors can successfully coordinate with their health counterparts to mitigate disease transmission, develop actionable school health policies, and disseminate clear health messaging. Moreover, guidance developed by technical bodies and international finance institutions offer strategic actions for sustaining and/or re-establishing school health and nutrition programs in the wake of the pandemic (3,19–21).

The implications of the COVID-19 pandemic on schools and student health are profound even if not yet fully apprehended. For example, macro fiscal projections, due in part to the global pandemic, indicate diminished international aid in response to constricted economies (22). This landscape represents both a threat and an opportunity; such constrictions have already fostered dialogue on spending efficiencies across supported sectors. Box 3 explores additional approaches that have the potential to improve the education, development, and wellbeing of school-age children when fiscally constrained, with an emphasis on the potential for mobile technology and strategic public-private partnerships to respond to widespread health concerns.

BOX 2. Five Examples of how Countries, USAID Africa Bureau Missions, and Implementing Partners Coordinated Across Sectors to Deliver School Health and Nutrition Services during the COVID-19 Pandemic

BURKINA FASO: The health and education ministries worked together to develop national school reopening guidelines that appropriately accounted for disease mitigation measures once schools reopen (a).

ETHIOPIA: The Ministry of Education broadcast school lessons to engage students remotely during the pandemic and used this platform to disseminate age-appropriate messaging on physical activity, mental health, and hygiene (a).

GLOBAL: The UN World Food Programme (WFP) estimated that more than 320 million school-age children and adolescents who rely on school meals for their nutritional needs may have been at risk of acute malnutrition as a result of mid-day meal disruptions following prolonged school closures (c). As a result, WFP piloted a number of approaches to ensure vulnerable students remained fed during the pandemic, including digital food vouchers, contactless cash transfers, and delivery of take-home rations to families (d and e).

SENEGAL: The USAID Senegal Country Mission, together with technical experts from WASH, collaborated to establish the School Water Integrated Solutions for Health investment, devoting approximately $2 million to water needs in schools in the Matam Region. The activity is intended to improve students' learning conditions through better access to water at hand-washing stations, including adding or rehabilitating micro-boreholes with solar pumps and by bringing water to schools in arid areas with the help of donkey-drawn water carts. These investments are coupled with school hygiene education (b).

ZAMBIA: The Healthy Learners NGO partners with the Ministry of General Education in Zambia to deliver school health and nutrition services to primary schools across Lusaka. In response to the COVID-19 pandemic, Healthy Learners trained school health workers to disseminate timely and accurate health promotion messaging and collaborated with Zambia Ministry of Health and CDC to leverage schools as hubs for disease surveillance. In addition, Healthy Learners collaborated with both the health and education ministries to develop Zambia's COVID-19 guidelines for safe school reopening (b).

Sources:

(a) Save the Children. Save our Education: Protect every child's right to learn in the COVID-19 response and recovery. London, UK; 2020.
(b) Shors L, Schultz L. Meeting Children Where They Are: School Health & Nutrition in a Global Pandemic [Internet]. Child Health Task Force. 2020.
(c) World Food Programme, Food and Agriculture Organization of the United Nations, UNICEF. Mitigating the effects of the COVID-19 pandemic on food and nutrition of schoolchildren: Interim Guidance. 2020.
(d) GCNF. Webinar: School Meals in the Time of COVID-19: Impact and Responses in India. 2020. Available from: https://gcnf.org/covid/webinars/covid19-india-part1/
(e) School Meals and COVID-19 – GCNF. Available from: https://gcnf.org/covid/

BOX 3. Emerging Entry Points for School Health and Nutrition with Global Relevance

Mobile Technologies

Education-related technologies (often referred to as EdTec) have shown promise as a method to engage students remotely when schools are closed for prolonged periods, including recently, as a method to sustain teacher-student contact during the widespread COVID-19 lockdowns. The rapid increase in mobile-cellular subscriptions and coverage across sub-Saharan Africa (29) suggests that the development and application of school health and nutrition-related applications could be pivotal in improving the efficiency, appropriateness, and accountability of service delivery.

Mobile apps are now routinely used in many high-income countries in vision and hearing screenings (30). Mobile applications could also reasonably collect other indicators, such as height and weight, to track child development longitudinally. Similarly, applications could help schools in differentiating among infectious diseases that may present with overlapping symptoms to determine whether referrals to health clinics are warranted. Despite the potential for real-time monitoring and data sharing, neither global frameworks nor the research literature provides direction on the use of information technology for this purpose, including within the WHO/UNESCO's updated Health Promoting Schools guidance (described in more detail in the subsequent section).

Public-Private Partnerships

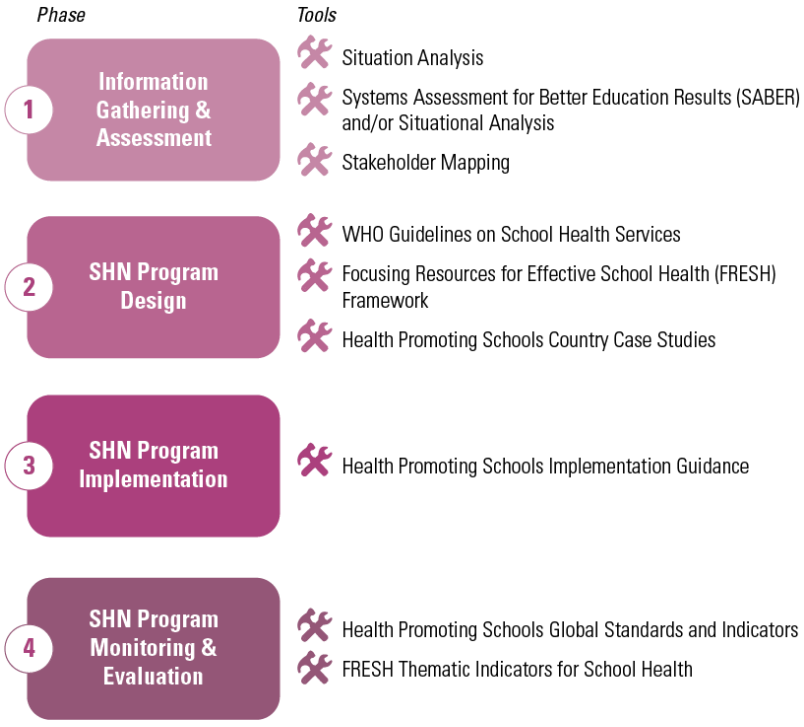
Public-private partnerships may be a fruitful area of collaboration, particularly when development initiatives and business opportunities have clear areas of intersection. For example, GIZ partnered with Unilever in the Philippines to instill good health and hygiene habits in schools as part of the Fit for Schools program; this included the provision of subsidized soap and other tools essential for management of hygiene facilities in schools (7). This partnership was initiated in 2016 and was extended in 2019 to support the improvement of the SDG sanitation indicators in schools. In light of the COVID-19 pandemic, the scope was further expanded with funds by FCDO to scale and integrate personal hygiene measures in schools (31).

Mining companies in DRC have also successfully supported the roll out of national malaria programs in their catchment areas to improve staff health and productive potential. The Tenke Fungurume Mining Company, for example, entered into a partnership with the Government of DRC to lead community-wide control efforts in the Lualaba Province, to distribute of insecticide-treated bed nets (ITNs), administer twice-yearly rounds of inside residual spraying (IRS) and conduct semi-annual school-based malaria prevalence surveys. Their collective efforts have yielded results: by 2015, this partnership was protecting approximately 200,000 people (32), the resident workforce population experienced a 60% reduction in malaria incidence, and school-age children in the surrounding communities experienced a 62% reduction of malaria prevalence

No Need to Reinvent the Wheel: *Using Existing Frameworks to Operationalize School Health and Nutrition*

All school-based health services, whether standalone or integrated, have guidance documents to ensure the quality of the intervention. Standalone school-based health—such as a vaccination campaign—are developed in accordance with intervention-specific guidelines, standards, and implementation approaches.

FIGURE 3. Existing Frameworks and their Relevance across the Programmatic Cycle



Over the past two decades, international technical bodies have developed frameworks to support governments and partners to design, implement, and monitor holistic and integrated school health and nutrition programs at the national and sub-national levels (Figure 3). These frameworks emphasize a system-based approach to address multiple health concerns, recognizing that a child's health and development can be constrained by any number of unaddressed issues. The use of these frameworks ensures that the program is cohesive, comprehensive, and equitable. Annex 2 further describes and summarizes school, health and nutrition frameworks and networks specific to low- and lower-middle income countries. Frameworks that were analyzed for this report largely focus on:

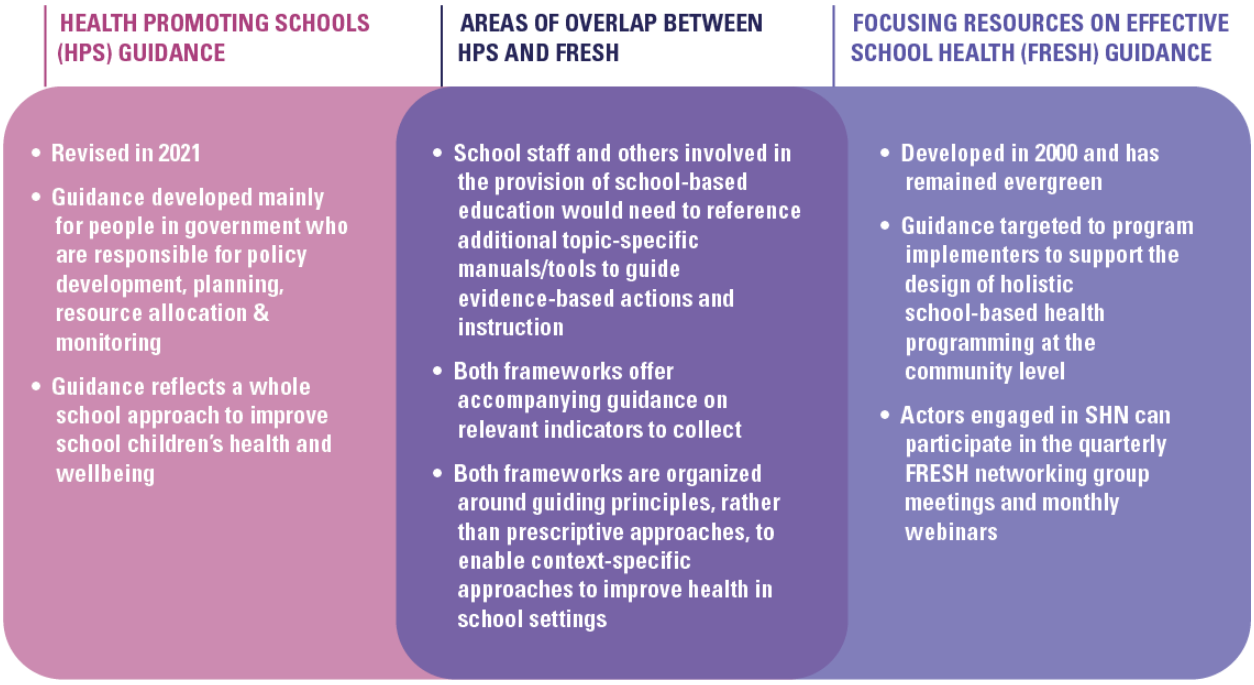
- Policy assessments to determine how current policies and service delivery compare to evidence-based best practices (i.e., SABER);
- Multisector collaboration to promote a holistic program delivered within a school setting that re-enforces the uptake of health behaviors (i.e., Health Promoting Schools); and
- Monitoring and evaluation to improve accountability, learning, and quality (i.e., FRESH)

Importantly many school health and nutrition frameworks encompass several of these domains.

The mostly commonly referenced frameworks include: WHO/UNESCO's Health Promoting Schools, UNESCO's FRESH Framework, and the World Bank's SABER. These frameworks have proven their value, as an analysis from 2015 shows that Health Promoting Schools are effective at improving some aspects of student health (Langford et al. 2015).

WHO and UNESCO updated their Health Promoting Schools framework in 2021, which now includes a focus on programmatic governance at the national and sub-national levels and is accompanied by implementation guidance (23). These guidance materials are intended to be complementary to the FRESH Framework, which has remained relevant since its publication. Figure 4 provides an overview as to how these two frameworks differ and where they share points of congruence.

FIGURE 4. Health Promoting Schools and FRESH: Complimentary Frameworks



SABER is unique among frameworks in that it does not provide prescriptive guidance, but rather, a method to benchmark existing policy, programmatic scope, and reach against best practices. SABER allows for a nuanced assessment, with the understanding that a country can be 'advanced' in one area but 'nascent' in another. Hence, SABER is a benchmarking tool to foster country derived solutions but does not advocate for a 'one-size fits all' solution. More detailed descriptions of SABER and the FRESH Framework are described in more detail in the prior USAID white paper (2).

Beyond the frameworks shown in Annex 2, there are several multi-component frameworks that focus on topics adjacent to school health and nutrition that have utility in contextualizing how to introduce and deliver programs in specific school environments. For example, the UNICEF Partnering with Religious Communities of Children Framework (2012) is a useful lens for the development of a

program in a religious school or broadly for religious schools in a country (i.e., madrasas), as technical guidance alone is likely not sufficient to advance school health and nutrition objectives within special populations such as these. Furthermore, the Indigenous School Health Framework was developed in tandem with representatives from indigenous populations, which increases the likelihood of community support and engagement—one of the four pillars of FRESH. Additionally, INSPIRE (WHO and others), School-Based Violence Prevention (WHO), and the Worldwide Initiative for Safe Schools (UNISDR) are aimed at the protection of children in school settings. Specific areas of overlap relate to school-based gender-based violence prevention, which is increasingly seen as falling within the umbrella of school health and nutrition. In summary then, substantial guidance already exists for USAID Africa Bureau Missions seeking to operationalize school health and nutrition programs in the form of comprehensive school health and nutrition frameworks, benchmarking tools, and complementary and adjacent frameworks. In addition, there are a range of formal and informal networks established to support knowledge sharing and exchange among practitioners, however, this report maintains a focus on global guidance instruments.

Africa Bureau Missions: *a SWOT Assessment for Multisector Coordination*

Significant resources exist for Africa Bureau Missions seeking to operationalize school health and nutrition programming, including prior USAID white papers detailing the evidence base for interventions, their benefits for improving health and education outcomes, and their relevance for Agency priorities (2,7).

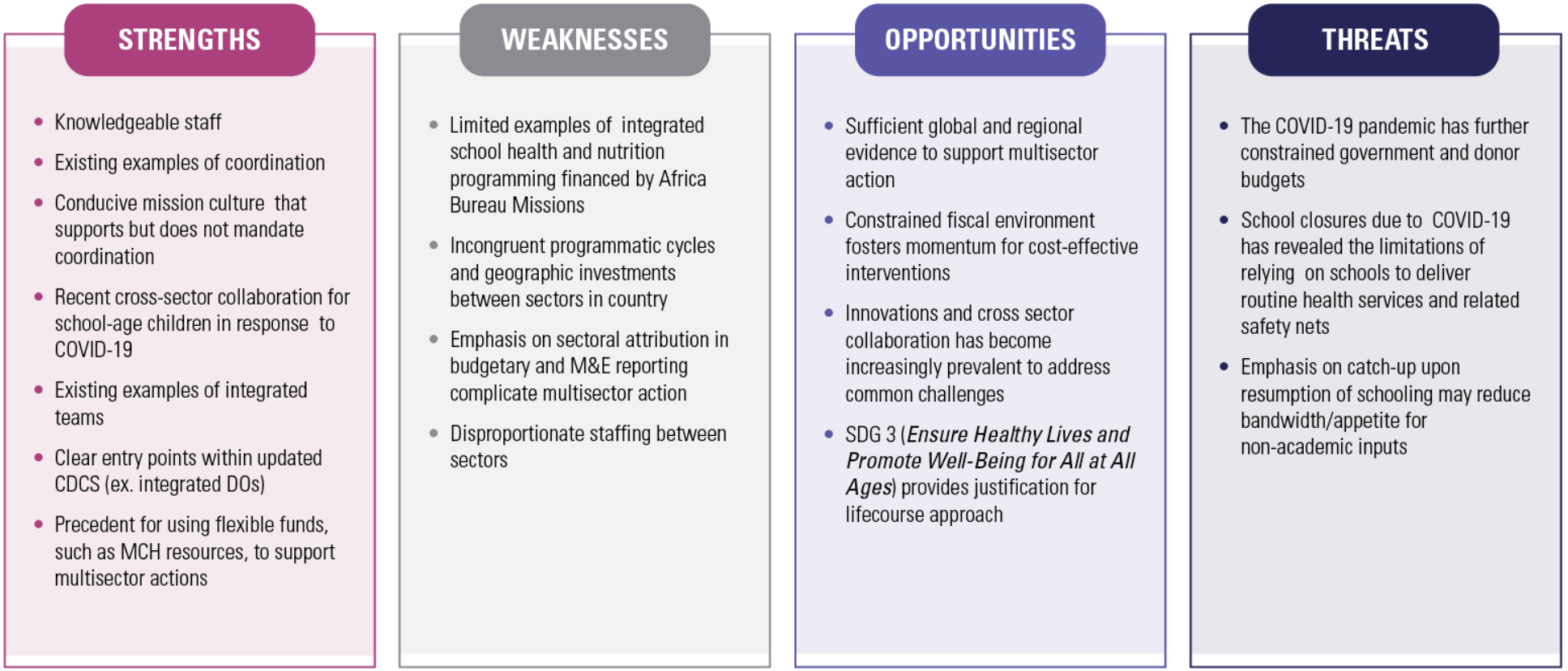
USAID/Africa Bureau Missions have a unique role in leveraging Agency financing and technical expertise to hone government development priorities. It is critical to understand the enabling and constraining factors that influence the ability for Africa Bureau Missions to affect change in favor of multisectoral actions generally, and for school health and nutrition investments specifically. At the invitation of Africa Bureau senior leadership, nearly 30 representatives from ten missions participated in focus group discussions to identify:

- **(i)** Recent examples of multisector coordination in Africa Bureau Missions;
- **(ii)** Entry points for broader internal mission coordination on how to achieve CDCS development objectives as well as external coordination with in-country partners;
- **(iii)** Adaptations in programming support in light of COVID-19;
- **(iv)** Staff perspectives on multisector coordination within the Mission; and
- **(v)** Needed outputs to facilitate internal and external health and education coordination.

The participating missions included: Ethiopia, Ghana, Kenya, Liberia, Malawi, Nigeria, Senegal, Tanzania, Uganda, and Zambia (see Annex 1). The themes that emerged from these focus groups are

organized into a SWOT assessment, to highlight internal strengths and weaknesses and external opportunities and threats, are summarized in Figure 5 and described in greater detail below.

FIGURE 5. SWOT Analysis from Focus Group Discussions with Africa Bureau Mission Staff



Strengths – Assets and Capabilities Internal to Country Missions

Knowledgeable Staff

- Africa Bureau Mission staff are aware of the global and regional evidence to support multisectoral action and the importance of coordinating effort between health and education teams. Staff demonstrated a desire to pursue coordination between health and education where appropriate as well as a distrust towards activities that were coordinated without careful planning.
- Africa Bureau Missions staff recognize that optimal human capital formation cannot be achieved through siloed efforts and recognized the number of multisectoral combinations to pursue is potentially vast (health and education, education and youth, education, and democracy/governance, etc.).

Existing Examples of Coordination

- COVID-19 has fostered greater coordination across sectors, particularly in missions that manage a portfolio of projects with overlapping target groups and complementary objectives. In these instances, coordination between health, education and youth teams was seen not just as a luxury but as a necessity to manage the workload of responding to the COVID-19 crisis.
- Examples of coordination between health and education programming already exist in Africa Bureau Missions, with examples unique to each mission (see Table 1). For instance, some missions have integrated health and youth offices that were the result of a multi-year rebranding and reorganization process. Other funds, particularly Maternal and Child Health (MCH) funding, was commonly reported as a bridge between activities to achieve more coordinated programming.

TABLE 1. Examples of Existing Multisector Activity in Africa Bureau Missions

Ethiopia & Kenya	• Education is co-located with youth, and this has resulted in health funds being channeled through the education and youth office. Common management of funds naturally has led to increased opportunities for cross sector work.
Liberia	• Health leveraged the Victims of Torture Fund to integrate mental health within schools • Health, via PMI, coordinated with education to pilot school-based bednet distribution
Senegal	• Water and education co-investment in handwashing stations in schools • Education partnered with the Global Fund to pilot school-based bednet distribution
Tanzania	• DREAMS works with education to reduce barriers to school entry for adolescents living with HIV (ex. provides uniforms, trains teachers on conducive learning environments, etc.) • Health investment to train teachers for hearing and vision difficulties with buy-in from MOH and MOE on training protocol and standardized materials

Uganda	• PEPFAR OVC funds managed by education office

Note: PMI = President's Malaria Initiative; DREAMS = Determined, Resilient, Empowered, AIDS-free, Mentored and Safe; PEPFER = U.S. President's Emergency Plan for AIDS Relief; OVC = Orphans and Vulnerable Children

Conducive Mission Culture

- A culture of coordination within Africa Bureau Missions is often enabled by management that empowers but does not mandate staff to coordinate.[3]
- Many Africa Bureau Missions have a current CDCS that justifies enhancing coordination between health and education programming in general and operationalizing school health and nutrition. Development Objectives (DOs) relating to the promotion of human capital formation were pervasive and provided natural points of entry for pursuing this work. Events such as portfolio reviews offer key moments to consider whether programs are meeting their objectives and whether there is scope to enhance coordination.

STRENGTHS
SUMMARY

- Knowledgeable staff
- Existing examples of coordination
- Conducive mission culture that supports but does not mandate coordination
- Recent cross-sector collaboration for school-age children in response to COVID-19
- Existing examples of integrated teams
- Clear entry points within updated CDCS (ex. integrated DOs)
- Precedent for using flexible funds, such as MCH resources, to support multisector actions

Weaknesses – Existing Constraints and Limitations Internal to Country Missions

Lack of common definitions for school health and nutrition

- There was not a common understanding across Africa Bureau Mission staff of what is meant by the terms *school health*, *coordination*, and *integration*. Coordination and integration were regarded as synonymous by some Africa Bureau Missions while in others integration was reserved for instances that were co-financed through health and education funds. School

[3] Examples of an empowering work culture include: management that establishes aspirations and facilitates staff cooperation as well as providing interested staff with the opportunity to learn from other country examples. Conversely, examples of a designating work culture include: management that defines activities, duplicates other country examples, and reinforces office hierarchy.

health was also sometimes viewed as programs that targeted youth versus health programs that take place at schools. Thus, if the objective is to operationalize school health and nutrition, some definitional clarity is required to make sure interested missions are pursuing the same goals. This point is addressed in the recommendation 1.1.3.

Human Resources

- Staffing is often disproportionate across health and education programs within the Africa Bureau Missions with ratios of one education officer to four health staff being common. Health officers themselves may be siloed into managing different health programs such as malaria prevention, HIV/AIDS and immunization. As a practical matter, this makes coordination difficult as the education staff may be overwhelmed in attempting to coordinate with health as well as youth colleagues. Conversely, the siloed technical specialties may make it less straightforward which health staff to engage. Without indicators or other approaches to measure coordination, good intentions to better coordinate with colleagues slip to the bottom of the task list.

Structural Limitations

- Barriers that impede effective coordination across health and education programs may be internal to the mission or arise in response to USAID/Washington mandates and priorities. These are limitations from the perspective of school health and nutrition but may be a strength in other regards. Examples include:

  i. *Limited overlap in geographic regions targeted by health and education sectors:* Health and education programs could be split between rural and urban programming or be separate by state and district. Where programs had no common geographical area, it is difficult for staff to identify clear entry points for coordination.

  ii. *Distinct target populations:* Many health programs focus on children under 5 whereas education programs may be restricted to school-age children. Where there is no overlap between age groups or other demographic factors, coordination is difficult if not impossible.

  iii. *Incongruent programmatic cycles*: Program cycles within the Africa Bureau Mission portfolio may be distinct enough from one another to render coordination difficult. Some programs may be winding down as other programs that are potentially complimentary are beginning.

  iv. *Strict rules around earmarks and attribution:* Coordination often requires some resources that can support flexible programming. While MCH funds have historically played this role due to their more flexible nature, these budgets are limited and support a range of evidence-based MCH interventions to prevent child and maternal deaths by helping women and children access essential, and often lifesaving, health services. MCH funding is focused in 25 priority countries (17 of which are in Africa) which account for about 70% of the global maternal and child deaths, with a strategic emphasis on reaching the most vulnerable populations and improving access to and the quality of care and services for mothers and children. Thus, there are limits to what extent MCH can function as a bridging mechanism between programs. Similarly, other funding requirements necessitate attributing project funds to specific outcomes and achievements, and with most

funds channeled through siloed programs, there is limited opportunity to develop and report against indicators that take a broader multi sectoral perspective.

v. *Nascent approaches to share learnings during critical periods:* There is a demand to learn from the coordination experiences of other Africa Bureau Missions, including in approaches used to respond to the novel, sudden, and competing demands that arose and are continuing during the COVID-19 pandemic. To illustrate this point, staff from one mission explained that school children were provided masks early in the epidemic, however, in the absence of coupling mask distribution with health education, children were seen swapping masks over the course of the school day. At this critical period, there were limited opportunities to share observations of what was successful and unsuccessful, thereby, other missions may have experienced similar 'micro-failures'.

WEAKNESSES
SUMMARY

- Limited examples of integrated school health and nutrition programming financed by Africa Bureau Missions
- Incongruent programmatic cycles and geographic investments between sectors in country
- Emphasis on sectoral attribution in budgetary and M&E reporting complicate multisector action
- Disproportionate staffing between sectors

Opportunities – Favorable Developments in the External Environment for School Health

Innovations enhance coordination among governments and donors

- Ministerial coordination has become more common in part due to the ubiquity of video conferencing options resulting from the COVID-19 crisis. Whereas prior to the pandemic arranging a face-to-face meeting between more than one Ministry was a substantial and rare undertaking, Ministry staff routinely now engage with one another through video conference calls, resulting in a situation where coordination across Ministries is not atypical or difficult to arrange.
- The necessity of coordinating decisions around school closures and surveillance of COVID-19 in schools has generated a natural emergence of strong inter-ministerial coordination between health and education. Similarly, coordination has also been enhanced amongst USG agencies, such as coordination between USAID and the US CDC on surveillance efforts.
- WHO/UNICEF child health redesign emphasizes multisectoral and lifecourse approach, lending further credibility to coordinated investments in school-age children and adolescents

Compelling Evidence and Rationale

- A 2020 meta-analysis (24) strongly disputes the logic encapsulated in the well-known Heckman curve, which stipulated that early interventions in a child's life are inherently more cost-effective than investments at later points along the lifecourse (25). Challenging this over-simplified logic makes space for considering how health resources must also support school-aged children.
- Other research now validates that human capital formation is not adequately predicted by years of schooling. Again, looking at years of schooling as a predictor for human capital formation in isolation is not helpful. Children must be healthy and ready to learn for other educational investments - including presence in school - to yield future dividends in terms of human capital formation (11).
- Primary healthcare is being redefined globally from the set of activities that take place in health clinics to a function that is delivered across platforms including health clinics, community hospitals and schools. This new functional definition creates opportunities for school health programs as primary healthcare is broadly reconsidered by organizations such as the WHO in how service delivery occurs (26).

Motivations for 'Business Unusual' Approaches

- School closures due to COVID-19 have increased demand for mechanisms to deliver routine health services and social safety nets beyond health facilities (especially meal delivery). Innovations developed for responding to the pandemic will have continued utility in responding to future shocks such as climate change related extreme weather events.
- Technology and mobile application developments enable non-technical school staff to make appropriate referrals to health facilities and track whether care was received (See Box 3).
- School health services may provide an additional incentive to select out-of-school youth to re-enroll.
- The need to surveil for COVID-19 outbreaks and new variants may offer additional opportunity, budget, and justification for Africa Bureau Missions to focus on school health.

OPPORTUNITIES
SUMMARY

- Sufficient global and regional evidence to support multisector action
- Constrained fiscal environment fosters momentum for cost-effective interventions
- Innovations and cross sector collaboration has become increasingly prevalent to address common challenges
- SDG 3 (*Ensure Healthy Lives and Promote Well-Being for All at All Ages*) provides justification for lifecourse approach

Threats – Challenges and Limitations in the External Environment

Constrained budgets

- Governments around the world will face constraints in responding to and recovering from the COVID-19 crisis as budgets are broadly constrained. According to a recent World Bank report, government per capita health spending is not anticipated to recover to 2020 levels until 2024 in low- income countries and not until 2025 in all other country income categories (27). In this environment, the crisis pushes governments and donors from strategic action and investments to 'fighting fires' where both financial resources and attention are spread too thin. Moreover, this shift from proactive strategic planning to reactive response will make it difficult to find support for any new programs or expansion of existing priorities.
- For schools that have reopened, the emphasis on 'catch-up' may reduce the interest and bandwidth for non-academic efforts. Meanwhile, the anticipated increase in drop-out rates among adolescent girls following prolonged school closures may mean that school-based interventions will not equitably reach females unless there is a complementary community effort to reach out-of-school children. For schools which do pursue school health and nutrition, adjustments will be necessary to the delivery of routine health interventions as countless children have been exposed to additional physical and emotional hardship. This combination represents a heavy burden for educational systems and teachers.

THREATS
SUMMARY

- The COVID-19 pandemic has further constrained government and donor budgets
- School closures due to COVID-19 has revealed the limitations of relying on schools to deliver routine health services and related safety nets
- Emphasis on catch-up upon resumption of schooling may reduce bandwidth/appetite for non-academic inputs

Strategic Actions for Africa Bureau Missions

This report proposes recommendations to respond to the themes that emerged from the SWOT analysis detailed in the prior section. Additional recommendations were retained from the prior USAID commissioned white papers on human capital, based on their complementarity to the themes that were surfaced in the focus groups and continued relevance. These include (i) reducing obstacles to school health and nutrition programming; (ii) removing structural bottlenecks; (iii) cultivating champions and supporting learning for staff; and (iv) affecting longer-term change through research and knowledge dissemination (Figure 6).

FIGURE 6. Routes to Operationalize Multisector Action for School Health

A common response from interviewees during this research is that in the COVID-19 era, staff are "stretched too thin", have "too many balls in the air" or spend too much time "fighting fires" rather than having the luxury to engage in long-term strategic planning. Work then has been reactive to the week-to-week perturbations of an unfolding pandemic and staff have had little bandwidth to contemplate program enhancement.

Recognizing that staff have competing demands for their time and attention, the strategic directions proposed may be viewed as a menu of choices for Africa Bureau Missions to consider and, like a menu, perhaps only a single item will be selected. Additionally, 'low-hanging fruit' opportunities exist where there are synergies among health, education, and youth team objectives where tasks can be shared. The recommendations offered in this report are not intended to be taken collectively at once; rather, the Africa Bureau and each Africa Bureau Mission are encouraged to use these as a guide to develop actionable, ambitious, and achievable steps to improve multisectoral coordination and investments to improve the education, health, and wellbeing of school-age children.

I. REDUCING THE OBSTACLES TO SCHOOL HEALTH AND NUTRITION PROGRAMMING

1.1 *Making it easier for Africa Bureau Missions to develop and finance multisector awards*

Nbr	Recommendation	Ease of Implementation
1.1.1	Develop a menu of school health and nutrition interventions that Africa Bureau Missions could reference to procure services in schools coupled with a table of procurement mechanisms	● ○ ○ ○ ○ ○
1.1.2	Develop standardized TORs/SOPs that can be tailored to each mission to better support engagement with existing school-based delivery mechanisms and with relevant working groups, such as the Local Education Group.	● ○ ○ ○ ○ ○
1.1.3	Facilitate the development of human capital-related sub-IRs by developing practical sample language for Development Objectives, intermediate results, and results frameworks with illustrative examples of activities*	● ○ ○ ○ ○ ○
1.1.4	Solicit a Broad Agency Agreement to convene a participatory concept generation (co-creation) for integrating multisector action within procurement processes*	● ● ● ○ ○ ○
1.1.5	Emphasize multisectoral action within advertised RFAs/RFPs by awarding extra credit to proposals that include multisectoral activities and that include funding for collaboration*	● ● ● ○ ○ ○

1.2 Formalizing coordination: *What gets assessed gets addressed*

Nbr	Recommendation	Ease of Implementation
1.2.1	Provide targeted TA to Africa Bureau Missions by request (e.g., finance joint education and health (virtual or in-person) TDYs to support the mid-term review of progress achieved against integrated CDCS objectives)	● ○ ○ ○ ○ ○
1.2.2	Define the roles, responsibilities and accountability mechanisms of staff supporting Africa Bureau Missions and staff in Washington who are or will be supporting multisectoral efforts; integrate the accountability mechanisms within staff performance evaluations	● ● ● ○ ○ ○

1.3 Knowing the Context: Assessing School-health Needs and Priorities

Nbr	Recommendation	Ease of Implementation
1.3.1	Conduct a situational analysis to inform country-level multisector strategic planning	● ○ ○ ○ ○ ○
1.3.2	Develop and maintain a multisector landscape analysis in order to inform priority setting discussions when drafting the CDCS Concept Note	● ● ● ○ ○ ○
1.3.3	Identify opportunities to strengthen engagement between health and education, including layering investments for siloed programs; co-locate activities that run adjacent to its mission and attribute project outcomes to their respective policies and strategies*	● ● ● ● ● ●

2. REMOVING STRUCTURAL BOTTLENECKS

2.1 Learn from pain points from current & historical USAID multisector investments in the Africa region

Nbr	Recommendation	Ease of Implementation
2.1.1	Advocate for the systematic collection and evaluation of sex- and age-disaggregated data for school-age children and adolescents within funded programming*	● ○ ○ ○ ○ ○
2.1.2	Together with Policy, Program and Learning and the Office of Development Planning, create guidance on reporting indicators for populations reached by co-located projects (or through co-financed efforts)	● ● ● ○ ○ ○
2.1.3	In the absence of dedicated funding for co-located activities, implement separate procurements under a single project with one results framework as well as one monitoring & evaluation plan*	● ● ● ○ ○ ○
2.1.4	Establish a mechanism for multisector coordination across a portfolio of investments,* including creating a coordination framework to guide Africa Bureau Missions	● ● ● ○ ○ ○

2.2 Align staff recruitment to meet current HR "pinch"

Nbr	Recommendation	Ease of Implementation
2.2.1	Conduct staff survey in each Africa Bureau Mission to assess whether there is sufficient staffing across the health and education sectors to support the additional time required for multisectoral coordination	● ○ ○ ○ ○ ○
2.2.2	Recruit a cohort of gender and youth advisors to bring technical expertise on cross-cutting issues that have relevance to school-age, adolescence, and youth populations	● ● ● ○ ○ ○
2.2.3	Recruit Program Officers to serve as an integration focal point/multisector committee chair to identify and position multisector engagement where opportunistic, and to ensure that actions to achieve cross-disciplinary Development Objectives are taken forward*	● ● ● ○ ○ ○

3. CULTIVATING CHAMPIONS AND SUPPORTING STAFF LEARNING

3.1 Engage vertical programs in Washington that reach populations of interest (e.g., malaria, neglected tropical diseases, nutrition, HIV/AIDS treatment and prevention, youth empowerment, etc.)

Nbr	Recommendation	Ease of Implementation
3.1.1	Lead sessions on human capital and school health at strategic trainings (ex. targeted to Program Officers; at new staff trainings) and at regional sector workshops to bolster technical capacity and interest among staff to support multisectoral coordination	● ○ ○ ○ ○ ○
3.1.2	Develop self-directed, online staff learning courses/microlessons on the benefit of co-investments and on how to procure essential school health and nutrition commodities/support	● ○ ○ ○ ○ ○
3.1.3	Leadership from the Regional Bureau for Africa participates in open meetings/venues on critical programs (e.g., PEPFAR, whose rules and regulations have substantial impact on the possibility of multisectoral work at the Country Mission level) to advocate for greater co-investments in activities that reach populations of mutual interest	● ● ● ○ ○ ○

3.2 Generate interest in school health and nutrition among ministries, youth populations, and donors		
Nbr	**Recommendation**	**Ease of Implementation**
3.2.1	Identify opportunities to improve advocacy, accountability, and a sense of agency among young people and other under-represented and vulnerable populations within funded activities*	●●●○○○
3.2.2	Reach political appointees in country (ambassadors, etc.) to elevate the drumbeat for school health and nutrition investments in diplomatic engagements with country governments	●●●○○○
3.2.3	Allocate resources through Cooperative Agreements to strengthen the capacity of local entities to co-plan and co-budget multisector activities, and, where relevant, align activities with existing supra-ministerial initiatives or with existing donor efforts to leverage resources toward human capital formation*	●●●●●●
3.2.4	Prioritize building broad institutional capacity across line ministries at the sub-national level to align with child health and multisector government strategies and strengthen local human resource and procurement capacity to lay the infrastructure for sub-national programming*	●●●●●●

4. AFFECTING LONGER-TERM CHANGE THROUGH RESEARCH AND KNOWLEDGE DISSEMINATION

4.1 Amplify USAID's voice in the global stage related to school health and nutrition		
Nbr	**Recommendation**	**Ease of Implementation**
4.1.1	Submit proposals for multisectoral, human capital-oriented panels at high impact conferences (ex. USAID Global Education Conference, Comparative and International Education Society, American Society of Tropical Medicine and Hygiene, Women Deliver, World Literacy Summit, Policies Against Hunger Conference, etc.)	●○○○○○
4.1.2	Ensure USAID participation within existing school health and nutrition regional and global networks (ie. FRESH Partnership; Child Health Task Force's Re-Imagining the Package of Care Sub-Group, Communities of Practice organized by the Research Consortium for School Health and Nutrition, etc.) to facilitate knowledge sharing and collective agenda building	●○○○○○
4.1.3	Host South-South learning exchanges in the USAID regional training centers to strengthen USAID-supported efforts to improve health service delivery through the school platform, particularly with representatives from states affected by fragility*	●●●○○○

4.2 Engage in implementation research to strengthen the design and targeting of school health and nutrition programs		
Nbr	**Recommendation**	**Ease of Implementation**
4.2.1	Engage a firm to conduct a robust review of existing school health and nutrition policies in USAID presence countries	● ○ ○ ○ ○ ○
4.2.2	Engage Africa Bureau Missions in pilot testing updated school health and nutrition guidance, such as the World Bank's Healthy SABER and WHO/UNESCO's Health Promoting Schools Guidance to generate buy-in, ensure the updated frameworks are operationally useful, and use the results to assess how country programs fare against best practice	● ● ● ○ ○ ○
4.2.3	Integrate prospective studies within multisectoral investments targeting school-age children to assess how investments influence known predictors of human capital formation	● ● ● ● ● ●

**Recommendations repurposed from the 2019 USAID Africa Bureau commissioned white paper; Schultz, Bundy, and Drake (2020)*

Criteria to Prioritize and Tailor Support to Africa Bureau Missions

One way to conceptualize how school health and nutrition is enhanced throughout the region is by considering actions that can be taken independently by Africa Bureau Missions and areas where the Africa Bureau can offer technical assistance. In the pyramid model (Figure 7), at the base of the pyramid, there are actions that all Africa Bureau Missions can take as well support that the Africa Bureau can provide to all missions. More selective possibilities are available to a narrower group of Africa Bureau Missions based on their unique situation. Table 2 below offers examples of tiered actions that Africa Bureau Missions and their USAID/Washington counterparts can take to support multisectoral coordination for school health and nutrition.

FIGURE 7. Illustrative Decision Pyramid for Prioritizing Technical Assistance

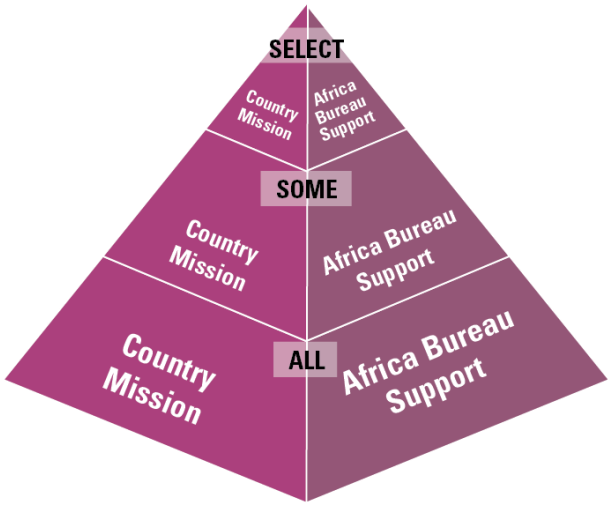


TABLE 2. Illustrative Examples of Actions Country Missions and the Africa Bureau Can Take Depending on how well Positioned they are to Progress School Health and Nutrition Efforts

TIER	COUNTRY MISSIONS	AFRICA BUREAU
SELECT	Program Officers are present to serve as an integration focal point, to identify and position multisector engagement where opportunistic, and to ensure that actions to progress integrated Development Objectives are taken forward Health and education investments are present in the same districts	In the absence of dedicated funding for co-located activities, implement separate procurements under a single project with one results framework and monitoring and evaluation plan[4]* Together with Policy, Program and Learning and the Office of Development Planning, develop guidance on reporting indicators for populations reached by co-located projects (or through co-financed efforts)
SOME	Current CDCS includes integrated development objectives There is an existing and current national school health and nutrition policy in place At least 2 years of overlap exists in the program lifecycle of the health and education programs	Recruit a cohort of program officers as well as gender and youth advisors to bring technical expertise on cross-cutting issues that have relevance to school-age, adolescent, and youth populations Develop a menu of school health and nutrition interventions that Africa Bureau Missions could reference to procure services in schools coupled with a table of procurement mechanisms Establish a mechanism for multisector coordination across a portfolio of investments,* including creating a coordination framework to guide Africa Bureau Missions
ALL	Health and education investments are present in the same country	Define the roles, responsibilities, and accountability mechanisms of staff in Africa Bureau Missions and in Washington who are or will be supporting multisectoral efforts; integrate the accountability mechanisms within staff performance evaluations

[4] Under this arrangement, discrete procurements can be disbursed for sector-specific or vertical programming-related activities, maintaining the specialized expertise and ministerial relationships honed by sector-specific implementing partners while collectively supporting interdisciplinary Development Objectives.

Stakeholder Mapping

Engaged stakeholders are critical to the successful implementation of school health and nutrition programming. Stakeholders include, but are not limited to, government leaders who develop and approve relevant policy and budgets, technical coordination committees that ensure programmatic coherence, implementing partners who deliver the mandated activities, donors who supplement national health and education budgets, and recipients that benefit from the interventions, among others. Government leaders are most engaged in creating the enabling environment for school health and nutrition activities to proceed in country, while implementing partners, schools, and students engage most frequently with the program (23).

It is critical for Africa Bureau Missions to have a robust landscape analysis of the relevant stakeholders in country when considering entry points to initiate or scale school health and nutrition programming in country. The WHO/UNESCO Health Promoting Schools Implementation Guidance offers guiding questions to support a stakeholder mapping exercise (28), the broad tenants of which include:

- Who has a direct or indirect influence on school health and nutrition implementation?
- Who is interested in school health and nutrition implementation locally, sub-nationally, nationally, or internationally?
- Who is not currently engaged in school health and nutrition but may become a new partner given the organization's focus and mandate?
- Which key stakeholders should be involved in school health and nutrition planning?
- Who has experience or can help work towards the goals and targets of school health and nutrition implementation?
- Which stakeholders could contribute (or hinder) to school health and nutrition implementation through action or inaction?

To facilitate a complete stakeholder analysis, Annex 3 provides an initial assessment of stakeholders engaged in the delivery of select school-based health services in the 16 countries in which USAID has investments in both the health and education sectors. The information captured in Annex 3 is not an exhaustive list of actors who support school-based health service delivery; for example, this resource does not capture programs led by governments themselves. Moreover, this resource maps stakeholders against a select number of health interventions, but does not capture all school health and nutrition services (including comprehensive sexuality education nor mental health) and should therefore be viewed as a starting point to a more robust mapping exercise.

Conclusion

There is robust global and regional evidence to justify a focus on investing in the school-age years and the challenge facing governments, donors, and implementing partners is translating the

evidence into action. Existing frameworks that are summarized and referred to in this report, guarantee that it is not necessary to reinvent the wheel. Each country context is unique, but the challenge and necessity of building strong school health programs is the same.

School health and nutrition programs will face an additional challenge of coordination with children out of school in response to the current global pandemic. In these challenging contexts, USAID will need to play a leadership role in advocating and advancing school health. This is particularly appropriate given recent research that shows how school health can be cost-effective, provide a vehicle and platform for the health sector to deliver services, contribute to a lifecourse-based approach, and support human capital formation. Many USAID CDCS documents already contain integrated Development Objectives that provide an operational justification for enhancing school-based programming. A SWOT assessment meanwhile found widespread interest in enhancing coordination among education, health, and youth mission staff, even as challenges to coordination remain.

Meanwhile, the ongoing need to surveil for COVID-19 outbreaks and new variants may offer additional opportunity, budget, and justification for Africa Bureau Missions to focus on school health. With governments prioritizing the reopening of schools, and with neither herd immunity nor an end to the COVID-19 pandemic in sight, fiscally constrained governments and Ministries of Education will be hard pressed to introduce any new programming or additions to school budgets. Yet with existing research already showing that enrollment and attendance is not enough to achieve education targets, it is essential to create or re-build strong school health programs. Much as the pandemic has resulted in forgone or delayed care among adults, school-age children have also missed out on routine health services that they may have received in school settings. This makes the case for school health even more of an imperative.

Annexes

Annex 1. Focus Group Participants

AFRICA BUREAU MISSION	STAFF MEMBER	TITLE
Ethiopia	Sonjai Renolds-Cooper	Chief, Office of Ed and Youth
	Yadesa Asfaw	Education Program Management Spec.
Ghana	Kevin Brown	Program Office Director
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	Arlene Phiri	HIV Prevention Officer
	Mutinta Nalubamba	Child Health Advisor

Annex 2. Existing Frameworks Related to School Health and Nutrition

Framework	Last Updated	Endorsed By	Definition/Vision	Dimensions of Model	Recommended Approach for Engaging Ministries?
Health Promoting Schools (HPS)	2020	WHO and UNESCO	A school that is consistently strengthening its capacity as a safe and healthy setting for teaching, learning, and working. The concept of HPS embodies a whole-school approach to promoting health and educational attainment.	1. Government policies and resources 2. School policies and resources 3. School governance and leadership 4. School and community partnerships 5. School curriculum 6. School social-emotional environment 7. School physical environment 8. School health services	1. Develop national plan to coordinate HPS 2. Identify roles and responsibilities for multiple sectors and levels of government 3. Develop collaboration group(s) across multiple sectors and levels of government
System Approaches to Better Education Results (SABER)	2011	World Bank	Support countries to systematically strengthen their education systems around six education domains, including school health and school feeding.	Instrument includes a rubric for assessing progress toward key policy goals and a questionnaire for collecting policy data, with data collected, verified, and endorsed in country.	Not specified
School Policy Framework Implementation of the WHO Global Strategy on Diet, Physical Activity and Health	2008	WHO	National and sub-national actions and policies to improve dietary patterns and increase physical activity in the school setting.	Guidance for countries to adopt their own school health and nutrition priorities and implement elements of the framework that can be taken forward	1. Recognize the outcomes that benefit both sectors 2. Feasible implementation for both sectors 3. Identify similar methods for M&E
WHO Nutrition-Friendly School Initiative	2007	EDC, FAO, SCN, UNESCO, UNICEF, WBG, WFP, WHO	Intended to serve as a mechanism for inter-connecting on-going school-based health and nutrition interventions to improve malnutrition in all its forms.	1. Written nutrition-friendly school policy 2. Awareness and capacity building of school community 3. Nutrition, health, and physical education 4. Supportive school environment 5. School nutrition and health services	Not specified

Child Friendly Schools	2006	UNICEF	Emphasis on holistic approach to child health and wellbeing	1. Rights based 2. Equity and equality and gender sensitive 3. Health promoting 4. Community partnerships 5. Safe protective and supportive 6. Effective quality education	Not specified
FRESH	2002	UNESCO, UNICEF, WHO, World Bank and Education International Inter-Agency Flagship Program in Education for All	Promote educational success, health, and development	1. Over-arching government, ministry/agency/school policies adopting multi-component approaches and multi-intervention programs 2. Classroom instruction and non-formal education promoting healthy & life skills 3. A defined set school-based or school-linked health, social, food and other student services 4. Defined minimum conditions for a safe, healthy physical environment and a positive psycho-social environment	1. Identify responsibilities and develop a coordinated plan of action 2. Strengthen capacity through in-service and pre-service training 3. Elicit priority areas through community input
The Essential Package	2002	UNICEF and WFP	Intended to compliment the FRESH Framework	1. Basic Education 2. Food for Education 3. Promotion of girl's education 4. Portable water and sanitary latrines 5. Health, nutrition, and hygiene education 6. Systematic deworming 7. Micronutrient supplementation 8. HIV/AIDS education 9. Psychosocial support 10. Malaria prevention 11. School gardens 12. Improved stoves	Not specified

Annex 3. Stakeholder Mapping

Burkina Faso

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | WEST), USAID (via ACT | WEST)	**MHH/ WASH**	CRS, IRC, CREPA, ACF, WaterAid, Antenna Foundation
HIV/AIDS		**SBGBV**	Plan International, INTERSOS, Educo
Immunization	GAVI	**School Feeding**	McGovern Dole (via CRS), WFP
Malaria		**Vision Screening**	Light for the World
Integrated Programming or TA	Helen Keller International, Save the Children, Partnership for Child Development		

CDCS

[PENDING]

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.38
BOYS	0.38
GIRLS	0.39

RISK TO EDUCATION

ALL CHILDREN	0.606	High
BOYS	0.603	High
GIRLS	0.609	High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

3.8 million

DRC

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | WEST), USAID (via ACT | WEST), SCI	**MHH/ WASH**	
HIV/AIDS	4children, Linkages, LIFT	**SBGBV**	DFID, FHI360, Girls First Fund, Promundo
Immunization	GAVI	**School Feeding**	WFP
Malaria	Defeat Malaria, Tenke Fungurume Mining Company	**Vision Screening**	
Integrated Programming or TA			

CDCS 2014-2021

DO1: Capacity at national-level institutions

DO2: Coordinated development approach

DO3: Durable peace

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.37
BOYS	0.37
GIRLS	0.37

RISK TO EDUCATION

ALL CHILDREN	0.782	Extreme
BOYS	0.788	Extreme
GIRLS	0.778	Extreme

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.1 to 0.2 million

Ethiopia

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | EAST), Evidence Action, SCI, USAID (via ACT | EAST)	**MHH/ WASH**	SNV, World Vision
HIV/AIDS	AIDSFree, FHI 360	**SBGBV**	DFID, COMO Foundation, GPE, Plan International
Immunization	GAVI	**School Feeding**	Mary's Meals, McGovern Dole, WFP
Malaria		**Vision Screening**	Sightsavers, World Vision
Integrated Programming or TA	Save the Children, Partnership for Child Development		

CDCS 2019-2024

DO1: Disaster Risk Management

DO2: Population Resilience to Shocks

DO3: Private Sector Growth

DO4: Service Delivery for Women & Girls

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.38
BOYS	0.38
GIRLS	0.38

RISK TO EDUCATION

ALL CHILDREN	0.596	High
BOYS	0.585	High
GIRLS	0.608	High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

2.5 million

Ghana

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | WEST), USAID (via ACT | WEST)	**MHH/ WASH**	CRS, Wash for Health (via Coca-Cola and Rotary International), Global Communities
HIV/AIDS		**SBGBV**	DFID, COMO Foundation, GPE
Immunization	GAVI	**School Feeding**	Mary's Meals, McGovern Dole, WFP
Malaria		**Vision Screening**	Sightsavers, Orbis International, Vision for a Nation
Integrated Programming or TA	Partnership for Child Development		

CDCS 2020-2025

DO1: Inclusive Economic Growth

DO2: Service delivery

DO3: Targeted support to northern regions

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.45
BOYS	0.44
GIRLS	0.46

RISK TO EDUCATION

ALL CHILDREN	0.492	Moderate
BOYS	0.493	Moderate
GIRLS	0.491	Moderate

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

1.7 million

Kenya

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | EAST), Evidence Action	**MHH/ WASH**	Amref Africa, SWASH+ Consortium (via CARE)
HIV/AIDS	DREAMS, 4children, AIDSFree, Linkages	**SBGBV**	DFID, GPE
Immunization	GAVI	**School Feeding**	Mary's Meals, McGovern Dole, Catholic Diocese of Lodwar
Malaria		**Vision Screening**	Brien Holden Vision Institute
Integrated Programming or TA	Save the Children, Partnership for Child Development		

CDCS

DO 1: Key systems (i.e. health, governance, and markets) improved

DO 2: Resilient vulnerable populations and environments

DO 3: Catalyzed economic growth opportunities

DO 4: Leverage regional opportunities and mitigate external risks

HUMAN CAPITAL INDEX (HCI):

ALL CHILDREN **0.55**

BOYS

GIRLS

RISK TO EDUCATION

ALL CHILDREN **0.434** Moderate

BOYS **0.451** Moderate

GIRLS **0.443** Moderate

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

1.75 million

Liberia

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | WEST), SCI	MHH/ WASH	SNV, World Vision, ZOA Liberia, Concern Worldwide
HIV/AIDS		SBGBV	GPE, Carter Center, Action Aid International, Mission Alliance
Immunization	GAVI	School Feeding	Mary's Meals, McGovern Dole, WFP, ZOA Liberia
Malaria		Vision Screening	Sightsavers, Eyelliance
Integrated Programming or TA	Save the Children, Mercy Corps		

CDCS 2019-2024

DO1: Market driven inclusive growth

DO2: Improved Governance and accountability

DO3: Healthy, productive, and educated populations

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.32
BOYS	0.31
GIRLS	0.32

RISK TO EDUCATION

ALL CHILDREN	0.548	High
BOYS	0.547	High
GIRLS	0.549	High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.28 million

Malawi

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | EAST), SCI, World Vision	**MHH/ WASH**	Water for People, WaterAid, World Vision, Welthungerhilfe
HIV/AIDS	4children, AIDSFree, Linkages, FHI 360	**SBGBV**	DFID, Oxfam International, COMO Foundation, World Education, Youth Net Counselling (YONECO)
Immunization	GAVI	**School Feeding**	GIZ, WFP
Malaria		**Vision Screening**	BICO, Sightsavers
Integrated Programming or TA	Save the Children		

CDCS 2020-2024

DO1: Public sector accountability

DO2: Youth health

DO3: Private sector wealth generation

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN **0.41**

BOYS

GIRLS

RISK TO EDUCATION

ALL CHILDREN **0.612** High

BOYS **0.558** High

GIRLS **0.561** High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

2.9 million

Mali

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	DFID (via ASCEND | WEST)	MHH/ WASH	Dubai Cares, WaterAid, World Vision, Plan International, UNICEF
HIV/AIDS	YouthPower	SBGBV	GPE
Immunization	GAVI	School Feeding	McGovern Dole (via CRS), WFP
Malaria		Vision Screening	Sightsavers, Eyelliance
Integrated Programming or TA	Save the Children		

CDCS

[Pending]

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.32
BOYS	0.32
GIRLS	0.32

RISK TO EDUCATION

ALL CHILDREN	0.706	Extreme
BOYS	0.694	High
GIRLS	0.718	Extreme

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.5 million

Mozambique

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO (via Crown), SCI, USAID	**MHH/ WASH**	Save the Children, World Vision
HIV/AIDS	DREAMS, 4children, AIDSFree, Linkages, FDC, PSI	**SBGBV**	FCDO, UNESCO, Oxfam International, CARE, Pathfinder, and UNFPA
Immunization	GAVI	**School Feeding**	McGovern Dole (via Planet Aid & World Vision),
Malaria	WVI, Malaria Consortium	**Vision Screening**	
Integrated Programming or TA	Save the Children		

CDCS 2020-2025

DO1: Healthier and better educated Mozambicans, especially the young and vulnerable

DO2: Diverse and inclusive economic development

DO3: Resilience of vulnerable populations to key shocks increased

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN **0.36**

BOYS

GIRLS

RISK TO EDUCATION

ALL CHILDREN **0.515** High

BOYS **0.513** High

GIRLS **0.517** High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.2 million

Niger

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO (via Sightsavers), SCI, FHI360	MHH/ WASH	World Vision
HIV/AIDS		SBGBV	Girls First Fund
Immunization	GAVI	School Feeding	Mary's Meals
Malaria		Vision Screening	
Integrated Programming or TA			

CDCS

[Pending]

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.32
BOYS	0.32
GIRLS	0.31

RISK TO EDUCATION

ALL CHILDREN	0.614	High
BOYS	0.602	High
GIRLS	0.626	High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.2 million

Nigeria

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO via Sight Savers, Evidence Action / Deworm the World, SCI, USAID (via RTI), PCD	**MHH/ WASH**	
HIV/AIDS	4children, AIDSFree	**SBGBV**	FCDO, UNESCO, Oxfam International, GPE
Immunization		**School Feeding**	McGovern Dole (via CRS), PCD, Food for Progress
Malaria		**Vision Screening**	
Integrated Programming or TA	Save the Children, PCD		

CDCS 2020-2025

DO1: Inclusive economic growth

DO2: Healthier, better educated population

DO3: Accountable, inclusive governance

SO1: Greater stability and faster recovery (select states)

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.36
BOYS	0.36
GIRLS	0.37

RISK TO EDUCATION

ALL CHILDREN	0.771	Extreme
BOYS	0.773	Extreme
GIRLS	0.769	Extreme

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

9.8 million

Senegal

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	USAID (via FHI 360)	MHH/ WASH	USAID
HIV/AIDS		SBGBV	UNICEF
Immunization	GAVI	School Feeding	McGovern Dole (via Counterpart), WFP
Malaria	Peace Corps	Vision Screening	Sightsavers (via GPE/WBG)
Integrated Programming or TA	PCD		

CDCS 2020-2025

DO1: Increased Inclusive and Sustainable Economic Growth

DO2: Improved human capital

DO3: Increased GOS Effectiveness and Accountability

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.42
BOYS	0.40
GIRLS	0.44

RISK TO EDUCATION

ALL CHILDREN	0.532	High
BOYS	0.539	High
GIRLS	0.524	High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.58 million

South Sudan

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO (via Crown Agents)	**MHH/ WASH**	USAID via IOM, SNV
HIV/AIDS	4children	**SBGBV**	GPE, AGENCI
Immunization	GAVI	**School Feeding**	Mary's Meals, World Food Programme (via Food for Hungry, Nile Hope, Plan International, World Vision, ADRA), Peace Corps, South Sudan Development Agency, Unity Culture and Development Center, Norwegian Refugee Council, African Community Rescue Organization
Malaria		**Vision Screening**	Sightsavers (via GPE/WBG)
Integrated Programming or TA			

Strategic Framework 2020-2024

DO1: Meeting Basic Needs

DO2: Household Resilience Increased

DO3: Improved Social Cohesion in Target Areas

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	0.31
BOYS	
GIRLS	

RISK TO EDUCATION

ALL CHILDREN	0.72	Extreme
BOYS	0.72	Extreme
GIRLS	0.741	Extreme

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

0.46 million

Tanzania

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO (via Crown Agents), USAID (via RTI), SCI	**MHH/ WASH**	Amref Africa, CARE, SNV, WaterAid, World Vision, UNICEF (via AusAid)
HIV/AIDS	DREAMS, AIDSFree, LIFT	**SBGBV**	UNESCO, FCDO, Rockflower, WUSC, Plan International
Immunization	GAVI	**School Feeding**	McGovern Dole (via Project Concern), PCD (TA), PCI International
Malaria	NMCP, NIMR Tanga	**Vision Screening**	Brien Holden Vision Institute
Integrated Programming or TA			

CDCS 2020-2025

DO1: Improve the foundational skills of children below age 15

DO2: Increase the empowerment, productivity, and engagement of Tanzanians from 15 to 35

DO3: Strengthen the capacity of state and non-state actors to benefit future generations

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN	**0.39**
BOYS	**0.38**
GIRLS	**0.40**

RISK TO EDUCATION

ALL CHILDREN	***Not in top 100 countries***
BOYS	
GIRLS	

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

--

Uganda

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO (via Crown Agents), SCI, USAID (via RTI)	**MHH/ WASH**	SNV, Water for People, WaterAid
HIV/AIDS	DREAMS, 4children, AIDSFree, Reach a Hand, Straight Talk Foundation, Peer-to-Peer Uganda	**SBGBV**	Raising Voices, FCDO, Girls First Fund, AGENCI, RTI
Immunization	GAVI, UNEPI	**School Feeding**	WFP, Mary's Meals,
Malaria		**Vision Screening**	Brien Holden Vision Institute, Light for the World
Integrated Programming or TA	Save the Children, World Vision		

CDCS 2016-2021

DO1: Increased community and household resilience

DO2: Key demographic drivers influenced

DO3: Increased accountability in key systems

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN **0.38**

BOYS

GIRLS

RISK TO EDUCATION

ALL CHILDREN **0.516** High

BOYS **0.542** High

GIRLS **0.538** High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

3.6 million

Zambia

EXAMPLE OF ACTORS ENGAGED IN SCHOOL-BASED SCHOOL HEALTH & NUTRITION SERVICE DELIVERY

INTERVENTION	ACTORS IN COUNTRY	INTERVENTION	ACTORS IN COUNTRY
Deworming	FCDO via Crown Agents, SCI	**MHH/ WASH**	USAID via FHI360, World Vision, UNICEF
HIV/AIDS	DREAMS, AIDSFree, LIFT	**SBGBV**	FCDO, Oxfam International, Como Foundation, World Education
Immunization	GAVI	**School Feeding**	Mary's Meals, Plan International, Self-Help Africa, ADRA
Malaria		**Vision Screening**	Vision Aid Overseas, Sightsavers, Orbis, Kitwe Eye Hospital
Integrated Programming or TA	Healthy Learners, Reformed Open Community Schools, World Vision Zambia		

CDCS 2019-2024

DO1: Accountable governance

DO2: Rural enterprise

DO3: Capacity to improve health outcomes in vulnerable populations

DO4: Quality of primary education

HUMAN CAPITAL INDEX (HCI)

ALL CHILDREN **0.4**

BOYS

GIRLS

RISK TO EDUCATION

ALL CHILDREN **0.565** High

BOYS **0.576** High

GIRLS **0.574** High

REPORTED NUMBER OF CHILDREN RECEIVING SCHOOL FEEDING

1.2 million

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