MOMENTUM COUNTRY AND GLOBAL LEADERSHIP

Strategic Planning Advisors for Education and School Health in Africa: Desk Review of School Health and Nutrition in Kenya

MOMENTUM Country and Global Leadership

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BOM	Board of Management
CFP	Country Focal Points
COVID-19	Coronavirus Disease 2019
ECDE	Early Childhood Development and Education
EFA	Education For All
FBOs	Faith-Based Organizations
FGM	Female Genital Mutilation
FRESH	Focusing Resources on Effective School Health
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPS	Health-Promoting Schools
JSI	John Snow, Inc.
KES	Kenya Shillings
M&E	Monitoring and Evaluation
MHH	Menstrual Health and Hygiene
MHM	Menstrual Hygiene Management
MNCH/FP/RH	Maternal, Newborn, and Child Health Services, Voluntary Family Planning, and Reproductive Health
MOE	Ministry of Education
MOH	Ministry of Health
MOICNG	Ministry of Interior and Coordination of National Government
MTEF	Medium Term Expenditure Framework
NCDs	Non-Communicable Diseases
NEMIS	National Education Management Information System
NESSP	National Education Sector Strategic Plan
NGOs	Non-Governmental Organizations
NSHIC	National School Health Inter-Agency Committee
NSHS	National School Health Secretariat
NSHTC	National School Health Technical Committee
PWDs	Persons with Disabilities
SABER	Systems Approach for Better Educational Results
SDGs	Sustainable Development Goals
SHN	School Health and Nutrition
SHP	School Health Policy
SPAESHA	Strategic Planning Advisors for Education and School Health in Africa
SRGBV	School-Related Gender-Based Violence
TVET	Technical and Vocational Education and Training
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VAC	Violence Against Children
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

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Executive Summary

Studies report that Kenya has implemented school health programming from the early 2000s. The Government of Kenya (GoK) and stakeholders have recognized that schools can be leveraged to impact children's health and reach children with knowledge and skills for lifelong healthy living. School health has been anchored in national policy—the Kenya School Health Policy (SHP) (established in 2009; second edition, 2018). The policy, jointly owned by the Ministries of Health and Education, is in line with Kenya's Constitution of 2010 that guarantees that every child has the right to education as well as the highest standard of health. Schools provide an immense opportunity to reach children and young people with health interventions. According to the Kenya National Bureau of Statistics, approximately 19.3 million Kenyans are aged between 3 and 18 years. The same report states that approximately 16.7 million Kenyans (86 percent) attend pre-primary, primary and secondary education.

Kenya has demonstrated commitment to improving the education and health among children. By committing 20 percent of the gross domestic product to education at the Transforming Education Summit 2022, GoK has created the opportunity for advocacy for more resources towards school health. Kenya's Medium-Term Expenditure Framework (MTEF) for the education sector for the period 2018–2022 shows that GoK has gradually increased allocations for school health to meet approximately 80 percent of the required funding during the reporting period.

Kenya's SHP of 2018 sets out eight thematic areas that reflect Kenya's health priorities.

The first thematic area covering **values and life skills** aims at ensuring learners acquire abilities and strategies for adaptive and positive behavior that enable them to deal effectively with the demands and challenges of everyday life. In addition, the SHP sets out recommendations to ensure monitoring of the acquisition of life skills and values in learning institutions.

The second thematic area, relating to **gender, growth and development**, is aimed at addressing gender-related issues which affect the education, health and well-being of learners. In addition, recommendations outlined under the thematic area ensure that learners are equipped with adequate and appropriate support, information, values, and skills to smoothly transit through various levels of growth and development. Of note, this thematic area recognizes that learners in Kenya are vulnerable to negative sexual and reproductive health outcomes including early and unplanned pregnancies, female genital mutilation, child marriages, sexual violence, and reproductive tract infections including sexually transmitted infections and HIV/AIDS. The SHP therefore recommends that learners be equipped with sustainable skills including age-appropriate sexual reproductive health information to support a smooth transition from childhood to adolescence. The SHP also recommends that girls should be protected from pregnancy. In addition, the policy states that when pregnancy occurs, girls should be supported to continue with their education.

Thematic area three, titled **child rights and responsibilities**, is intended to promote, safeguard, and protect the rights of learners as articulated in the United Nations Convention on the Rights of the Child (UNCRC, 1989). The thematic area is also premised on the idea that every learner or stakeholder should understand and uphold their responsibility towards learners, households, schools, society, and the state. Therefore, subject to their age, evolving capacity, and position, children and duty bearers should be guided on their responsibilities.

Thematic area four relates to **water, sanitation and hygiene** (WASH) and aims at reducing the incidence and prevalence of water, sanitation and hygiene-related diseases in learning institutions. In addition, the SHP positions Menstrual Hygiene Management (MHM) as a crucial element of the SHP, being important for dignity, gender equality, and the human rights of women and girls.

Thematic area five focuses on **nutrition**. The SHP aims at ensuring nutrition is sustainably promoted through offering adequate nutritional services, promotion of a healthy food environment, and nutrition education. The recommendations to involve parents and guardians in school nutrition is also aimed at reducing inconsistencies between suggestions and practices on nutrition at home and at school.

Thematic area six, **disease prevention and control**, aims at enhancing prevention and control of communicable and non-communicable diseases (NCDs) by early identification, timely intervention, health education, and mitigation of related stigma and discrimination.

Thematic area seven on **special needs, disability, and rehabilitation** is premised on data that estimates that 10 percent of the Kenyan population are Persons with Disabilities (PWDs), a majority of whom (67 percent) are of school-going age. This thematic area seeks to provide policy guidelines for stakeholders towards promoting the basic right to health and education for learners with special needs and disability. In addition, the thematic area is intended to enhance learning outcomes for all learners within an inclusive environment.

Thematic area eight, **school infrastructure and environmental health safeguards**, aims at ensuring that stakeholders enhance and promote gender sensitive and inclusive infrastructural and environmental safeguards and standard infrastructural designs in all learning institutions. The thematic area addresses compliance with building and construction guidelines; provision of safe playing grounds; adherence to environmental safety; provision of fire-fighting equipment and training; and transport safety.

Kenya's SHP is comprehensive and aligns with globally recognized frameworks for school health and nutrition policies, such as the FRESH framework.[i] The SHP assigns roles and responsibilities among stakeholders. The lessons learned in implementation of the SHP can be leveraged to respond to pandemics such as COVID-19. For example, the SHP recommended strategies to ensure capacity building among the members of the school community to strengthen detection and reporting of epidemic diseases such as Ebola and Zika virus. This was in line with the National Integrated Disease Surveillance and Response strategy. The SHP provides an elaborate structure for coordination and collaboration across sectors at different levels. Metrics for success are defined by a comprehensive list of indicators for tracking processes and outcome for school health.

Data on the extent to which the SHP 2018 has been implemented remains scarce. Our review did not find studies that have attempted to establish the coverage or effectiveness of school health interventions. In addition, routine monitoring data from the Kenya's National Education Management Information System (NEMIS) is not publicly available.

While the SHP 2018 provides an elaborate list of indicators for tracking school health, the document does not assign responsibility and frequency of data collection and reporting. In addition, how these data are utilized to improve program and policy decision-making remains unclear. These omissions may potentially create room for incongruous and inconsistent data collection, reporting, and use. The SHP 2018 did not provide evidential basis for the policy directions provided. The lack of reference data limits future review of the policy and strategies as new evidence emerges, due to lack of a basis for comparison.

This desk review report identifies short-term and long-term recommendations that will be validated in the field assessment. In the short-term, there is a need to invest in dissemination of school health policies and guidelines to ensure that stakeholders at all levels are involved. The process should also be systematically documented and advocate for increased public access to data from the Ministry of Education's NEMIS. This is to facilitate more effective and efficient monitoring and evaluation of the SHP and programs. Creation of a national school health dashboard will allow for integrating multi-agency data, including those from non-state actors and the private sector. To address funding gaps, we also recommend development of a case to demonstrate the long-term benefits of investing in school health.

Longer-term recommendations to improve school health include investing in action research and documentation of school health interventions to institute learning based on observed program effectiveness and efficiency. Development of a robust monitoring and evaluation framework that tracks implementation outputs and outcomes by integrating data from a wide range of sources, such as Health Management Information System (HMIS) and national surveys, is also recommended. County level leadership for school health should be facilitated to leverage resources and align stakeholder efforts at subnational level. Lastly, bottom-up and top-down communication among coordination structures for school health program should be enhanced to facilitate effective school health programming.

The field assessment will provide an opportunity to validate findings in this report. The assessment will also seek to address knowledge gaps that persist. First, stakeholder views on how to improve resource mobilization for school health interventions are required. Second, strategies to improve access to and utilization of school health data for decision-making among stakeholders will be explored. Stakeholder views on enhancing leadership, coordination, and collaboration, particularly at county, sub-county and school levels will also be sought. Fourth, cost-effective strategies that can be used to disseminate the SHP and related guidelines to all stakeholders will be explored.

[i] *The FRESH Partnership is a coalition number of UN agencies, donor organizations and global non-governmental/civil society organizations concerned with promoting basic education, health, safety, equity and various types of economic, social, sustainable and human development through, with and within schools, agencies and systems.* https://www.fresh-partners.org/a-summary.html

Introduction to Strategic Planning Advisors for Education and School Health in Africa

Moving Integrated, Quality Maternal, Newborn, Child Health and Family Planning and Reproductive Health Services to Scale (MOMENTUM), led by the MOMENTUM Country and Global Leadership, is a seven-year global project funded by the U.S. Agency for International Development (USAID). It provides targeted technical and capacity development assistance to programs for maternal, newborn, and child health services, voluntary family planning, and reproductive health (MNCH/FP/RH) to facilitate countries' journeys to self-reliance. It also aims to contribute to global technical leadership and learning, and USAID's policy dialogue for achievement of global MNCH/FP/RH goals through support to globally endorsed MNCH/FP/RH initiatives, strategies, frameworks, guidelines, and action plans. Through the Strategic Planning Advisors for Education and School Health in Africa (SPAESHA) activity, MOMENTUM Country and Global Leadership works with ministries of education and health, as well as global, regional, and local school health partners to strengthen School Health and Nutrition (SHN) systems for the health and well-being of school-age children.

Schools provide an extensive platform to reach children with health services that contribute to learning and being healthy throughout their lives. Contextually appropriate school health interventions will improve children's health status, increase attention and concentration, and result in improved academic performance. Schools provide a cost-effective and efficient platform to reach children at scale and are essential for creating equitable and inclusive education pathways for girls and boys to learn and reach their full potential.

Unfortunately, the continued effects of endemic diseases like malaria, and outbreaks such as Ebola and COVID-19, as well as inadequate WASH in schools, highlight the prolonged underinvestment in school health within education systems.[1] A recent global WHO–UNICEF Joint Monitoring Program survey found WASH coverage in sub-Saharan Africa to be generally low: 10 out of 19 countries surveyed had fewer than 50 percent schools with sanitation coverage and 47 percent of schools across 17 countries in the region had no water service.[2] Globally, at the start of the pandemic, in the 60 countries (40 of which were on the African continent[3]) at highest risk of health and humanitarian crisis due to COVID-19, one in two schools lacked basic water and sanitation services and three in four lacked basic handwashing services.[1] Climate change further reinforces the need to act, as growing evidence suggests that some of the greatest health impacts due to climate change will be on the emergence, re-emergence, and spread of infectious diseases,[4] which are already affecting the prevalence of mosquito-borne pathogens, particularly malaria and dengue.[4,5]

As school closures threaten to reverse historic education gains, disrupting intergenerational cycles of health and social inequalities, the United Nations and multilateral agencies are renewing commitments to school health across varying sectors due to the essential role they play in children's health, nutrition, protection, and learning potential. Renewed attention to health in schools offers an opportunity to leverage government commitments to school health and to strengthen the operationalization of school health policies. School health frameworks currently exist to inform policy and implementation, but they have been unevenly applied and monitored by ministries of education around the world and specifically in sub-Saharan Africa. Multisectoral collaboration and coordination between the Ministry of Education and the Ministry of Health will be critical to sustainable change. There has always been a need for comprehensive approaches to health policies and planning within

the education sector; COVID-19 has only exacerbated the existing gaps and demonstrated the need to make the education system more resilient to future infectious disease epidemics. While governments recognize the value of comprehensive, integrated SHN programming, the current challenge is how to make it more scalable and sustainable moving forward. The cross-sectoral nature of SHN lends itself to variations across countries with regard to how it operates, where it resides within ministries, and the relevant ministries involved in policy and programming. Ministries of Education, Health, Gender, Water and Environment, and Social Welfare often contribute their expertise and inputs into SHN via the health curricula, health services for school-age children, and the quality of the school environment. This can also make the impact, scale, and reach of SHN initiatives less visible or difficult to measure. Recognizing the global underinvestment and poorly targeted investment in school health, as well as its potential to foster health and education outcomes that better position children to survive and thrive and enable countries to build stronger future economies,[6] the USAID Africa Bureau and John Snow, Inc /Child Health Task Force jointly commissioned a 2021 report to identify pathways for advancing SHN programming in Africa.[1] In the 2021 report, 10 African Missions were solicited to understand their contexts and optimal points of entry for optimizing existing resources. For many of the countries that were solicited, a number of strengths and opportunities were identified for better targeted investments alongside multi-sector school health coordination[1]. Kenya, Malawi, Senegal and Uganda were identified as countries well-suited for this activity.

Kenya, Malawi, Senegal, and Uganda were selected using the following criteria:

- Existing national School Health Policies.
- Links to other USAID education or health initiatives (including linkages with the Child Health Task Force school health activities) taking place in that country that impact school-age children (basic education transitions, numeracy and literacy, neglected tropical disease, school feeding, adolescent sexual reproductive health, nutrition and health among children under 5, etc.).
- The USAID MOMENTUM Country and Global Leadership Project partner country offices' interest, capacity to engage and advocate, with strong government relationships.
- Receptiveness of MOE, MOH, and USAID Mission to the project.
- Previous school health programming or similar work.

The SPAESHA activity, convened by the USAID's MOMENTUM Country and Global Leadership Project, will identify the major barriers to SHP implementation in Kenya, Malawi, Senegal and Uganda, focusing on the different elements of the school health system, processes, and platforms to create a realistic and context-specific policy strengthening plan. This activity identifies the training of teachers and support to school management committees as major strategies to address many of the implementation challenges across varied thematic areas.

Kenya is strategically located in East Africa. By working with stakeholders in Kenya, SPAESHA will define context-specific strategies to enhance SHN that can be adapted in similar contexts within the East African region.

The GoK has increased investments in health and education, utilizing existing buy-in from various stakeholders and a policy environment prime for SHP strengthening. The Kenya SHP recognizes the importance of comprehensive and innovative health interventions in education.[7] The policy seeks a sustainable reduction of the impact of both communicable and NDCs to enhance values and life skills among learners, to improve WASH facilities as well as school infrastructure in schools, and to meet the diverse nutrition and special needs of

the learners, and of mainstream gender issues in education and health systems. In addition, recent menstrual health and hygiene (MHH)-related policies and reviews of new indicators may serve as a regional example for gender equitable school health policies.

SPAESHA is strategically timed for Kenya. The country's SHP 2018 is due for review in 2023. In addition, as with most countries around the world, the COVID-19 pandemic exposed vulnerabilities that could have profound implications for health, education and other social services. This work therefore provides a unique opportunity to provide evidence and technical support to strengthen SHN policies.

This desk review report takes a deeper dive into the SHN policy history in Kenya, the known and the emerging health needs of school-age children and will be used to inform work plan activities and establish contextualized deliverables related to policy strengthening. This desk review report is the first of several products, which aim to contribute to the global and regional evidence on school health.

Methodology

Three globally accepted frameworks are used to design SHN policies and programs: Focusing Resources on Effective School Health (FRESH),[8] Systems Approach for Better Educational Results (SABER),[9] and, most recently, Health-Promoting Schools (HPS).[10] The primary framework reference for the desk review was the HPS Standard 1 on government policies and resources because it is a more recent framework that incorporates and maintains key aspects from predecessor frameworks, FRESH and SABER. The aim of HPS is to ensure that whole-of-government commitment to and investment in HPS are reflected in laws, regulations, policies, strategies, resource allocation, inter-sectoral collaboration, and collaboration and engagement with school and local communities, with a sustainable system of monitoring and evaluation.

Thematic areas and pillars are referenced throughout this report as they are standards set by each framework. For the purposes of this report, "thematic areas" refer to the health issues covered in the SHP and may include the following: children with special needs; deworming; disaster risk reduction/ emergences; education for sustainable development; general life skills/social and emotional learning; HIV and AIDS; WASH; malaria; school feeding; nutrition; oral health, vision and hearing; physical activity; prevention and response to unintentional injury; sexual and reproductive health; substance abuse; and school-related gender-based violence (SRGBV).

Combined with the health thematic areas, four core pillars, or components, form the basis of an effective school program and include:

1. Health-related school policies and links with parents and the school community.
2. Safe, inclusive, supportive school environments: including access to safe water, adequate sanitation and a healthy social and psychosocial environment.
3. School-based health and nutrition services: including deworming, micronutrient supplementation, school feeding, dengue prevention and psychosocial counseling.
4. Skills-based health education: including curriculum development, life skills training, and learning materials.

Policy Audit

The first level of policy assessment utilized an online questionnaire structured by each component of the HPS Standard 1 on government policies and resources. Country Focal Points (CFPs) for the USAID MOMENTUM Country and Global Leadership Project read all related policy documents and operational guidelines (Table 1) to assess the extent to which each country's policies and practices met each component. In some cases, policies, strategies, and guidelines were unclear or unavailable. The CFPs then conducted a consultative workshop with key stakeholders to review emerging themes and discuss their implications for the SHP review. (Annex 1). This report uses both government documents and conversations as sources for understanding the SHN policy environment. In total, 21 policy documents were reviewed across 8 sectors.

Literature Review

To complement the policy audit, CFPs conducted a rapid literature search to understand the health status of school-age children, and potential emerging issues that may not have been documented or present at the initial development of the SHP and strategies. First, CFPs were provided with 48 global resources from their technical advisors. An additional 78 global resources were suggested by global SHN experts on our Global Advisory Committee to provide them with a good foundation of research, global initiatives, and policy reform to allow them to dig deeper in their respective desk reviews.

CFPs conducted additional searches from PubMed and Google Scholar for scholarly articles to better understand the status of SHN in Kenya. The words "school", "education," and "Kenya" were combined with the thematic areas of the Kenya SHP 2018 to construct key words for the bibliographic search. The thematic areas included: values and life skills; gender, growth and development; child rights and responsibilities; water, sanitation and hygiene; nutrition; disease prevention and control; special needs, disability and rehabilitation; and school infrastructure and environmental health safeguards. Up to date statistics relating to prevalence and incidence of disease conditions among school-attending children were sought. In addition, CFPs sought to identify experiences, challenges, and opportunities for implementation of school health interventions in Kenya.

The policy audit and literature review provide a critical foundation for understanding historical decisions and designs of SHPs, as well as potential development and evolution. Findings from this report will inform field assessment for Kenya. Formative assessments will incorporate school observations and discussions with various stakeholders involved in the operationalization of school health or who benefit from SHN initiatives. The aim is to have a clear understanding of the theory and intentions of SHPs alongside their perceived application and implementation. Analysis of these activities will allow for informed and prioritized opportunities for SHP strengthening. It will also provide concrete case studies to the global and regional SHN practitioner community and interested governments who wish to replicate or learn from this exercise.

Country Background and Context

Education and School Health Background

Kenya's Basic Education Act, 2013,[11] was developed to provide legal provisions that guide governance and management of basic educational institutions in Kenya. The Act recognizes the need to ensure safety, well-being, and health of all learners. Subsequently, the Ministry of Education's Sessional Paper No 1 of 2019,[12] was launched to provide policy guidance for the delivery of education as aspired in Kenya's Vision 2030,[13] and enshrined in the 2010 constitution.[14] The paper aims at strategic reforms that will realize quality, relevant, and inclusive education and training for sustainable development in Kenya.

The paper outlines important intentions that are related to SHN programs including:

- Strengthen the multi-disciplinary approach to support health services and assessment of learners with special needs and disabilities (Section 4.28, p. 77).
- Collaborate with other stakeholders to address issues of accommodation, infrastructure, staffing, HIV and AIDS, water, sanitation, health, and nutrition among hard to reach and vulnerable groups (Section 4.42, p. 85).
- Promote nutritional and health programs at pre-primary centers in collaboration with the line ministries of health, agriculture, and other stakeholders (Section 10.09, p. 181).
- Continue to fund school meals, health, and nutrition programs (Section 10.11, p. 183).

The Kenya National Education Sector Strategic Plan (NESSP) 2018–2022,[15] was developed to outline policy priorities, programs, and strategies for the Ministry of Education over the five-year period. The document encapsulates the commitments enshrined in Kenya's constitution and international and regional treaties related to education, such as the Education for All (EFA) goals and Sustainable Development Goals (SDGs), among others. It covers the following sub-sectors: Pre-Primary Education; Primary Education; Secondary, Adult and Continuing Education; Technical and Vocational Education and Training (TVET); University Education; Special Needs Education; and Teacher Education. There are also programs related to the National Qualifications Framework, Quality Assurance and Standards, as well as Science, Technology and Innovations. For effective alignment and delivery, a NESSP Co-ordination Unit, in the form of a multi-agency secretariat is situated under the Ministry of Education and charged with oversight for the implementation of this plan.

Studies suggest that Kenya recognized that schools offer an extraordinary opportunity to improve the health of students, their families and members of the community in a cost-effective manner as early as the 2000s.[16, 17] Early efforts focused on establishing whether children as health agents were able to influence change in different social environments.[16,18] As a commitment towards a national school health program, the GoK piloted a comprehensive school health program in two model districts in the coastal region of the country targeting 30 primary schools.[17] Subsequently, efforts to adopt a comprehensive rights-based approach to scale-up school health gained traction, culminating in the launch of the first National SHP in 2009.[17]

The policy sought to address education and health needs of all basic education learners including those with special needs and disabilities. It provided the objectives and strategies to address these needs. The policy further aimed at identifying and mainstreaming key health interventions for improved school health and education. To provide strategic guidance for the implementation of the SHP, the GoK also released the National School Health Strategy Implementation Plan 2010-2015.[19] However, in the period of the policy implementation, the Constitution of Kenya 2010 was promulgated, realigning the governance, education and health structure in Kenya. Some functions were devolved from the national government. The Basic Education Act 2013 was also enacted to provide a legal framework for the Ministry of Education. As a consequence, it was difficult to realize the objectives of the SHP 2009 since its implementation had not factored into the devolved governance structure.

The second version of the SHP was launched in 2018,[7] to take into account the changes in governance and other health and socioeconomic issues. NCDs, abuse cases among learners, gender-based violence, lack of adequate school infrastructure, and increasing nutritional needs among learners were also deemed to be responsible for reducing productivity, curtailing economic growth, and trapping the poorest people in chronic poverty in Kenya. Therefore, the revised SHP of 2018 was developed to provide appropriate policy directions.

Before the onset of the COVID-19 pandemic, Kenya had a well-structured school calendar that ran from January to December. The terms comprised three months of full learning and a month in-between for breaks.[20] COVID-19 and the attendant measures to contain it brought unprecedented disruption to the education system. Schools were closed to ensure safety of learners and school staff.[21] Social isolation among learners and their teachers was reported as a source of uncertainty and anxiety among learners. Many school-age children, lacking the protective school setting, experienced gender-based violence during the pandemic period.[21, 22] As the epidemic pressure eased and containment measures lifted, the education calendar was adjusted to make up for lost time, necessitating shorter vacation time and increasing anxiety for learners.[21, 22] In addition, studies suggest that COVID–19 related containment measures and worsening household economic status amplified school dropout rates, particularly among girls.[21] All these factors suggest the need for better response strategies for future epidemics/pandemics, particularly to ensure the safety and well-being of children.

Health and education in the context of Kenya's devolved governance structure

Kenya's Constitution, which was promulgated in 2010, created a devolved governance system involving one national and 47 county governments.[14] Devolution is a form of decentralization that involves large-scale transfer of political, administrative, as well as fiscal authority and responsibility. With regards to health and education, the national government is responsible for overall policy direction. The responsibility of delivery of health services is assigned to county governments.

Delivery of education services remains primarily a responsibility of the national government. However, the constitution assigned county governments the responsibility to deliver quality Early Childhood Development and Education (ECDE) services within the confines of the national ECDE Policy Framework. This structure calls for collaboration and coordination of the multiple levels of government and actors to ensure delivery of a comprehensive school health program.

Transforming Education: Commitments for Inclusive, Equitable, Safe, and Healthy Schools

With COVID-19 exposing the fault-lines of education systems globally, in September 2022 at the UN Transforming Education Summit, more than 130 countries committed to rebooting their education systems and accelerating action to end the learning crisis.[ii] There was acknowledgment in the role of education in achieving all the SDGs and a new emphasis on the need for innovations in education to prepare the learners of today for a rapidly changing world. Each country made commitments that aligned with their contextual needs and priorities.

At the Transforming Education Summit 2022, the GoK made several commitments that would impact school health and education.[23] Commitments to enhancing safety and health of learners, addressing gender issues in education with a focus to both boys and girls, and mainstreaming learners with disabilities and other vulnerabilities provide a strong basis for reinvigoration of the national school health program.[23] Further, the GoK committed to maintain the expenditure in education at a minimum of 20 percent of the total public expenditure providing opportunity to advocate for additional resources for SHN. Of significance to Kenya's SHP review, is the government plan to feed these commitments into the national education sector plan (2023–2027) and other education policies and guidelines.

Priority Health Issues Affecting School-Age Children

Life Skills and Values Among Learners

Kenya's SHP recognizes that learners in the modern-day world are faced with a myriad of challenges which require the right set of skills and values to surmount. Such challenges include negative effects of the use of online media (internet), substance use, corruption, gambling, early initiation of sex, negative ethnicity and others.[7] Life skills training empowers students to deal effectively with the demands of everyday life by improving self-regulation, making informed decisions, and building supportive social relationships. Studies in Kenya indicate that drugs and substance abuse among young people in learning institutions is a growing social and public health problem. A study conducted by Kenya's National Authority for The Campaign Against Alcohol and Drug Abuse and Kenya Institute for Public Policy Research and Analysis in 2019 found that 16.9 percent of primary school pupils were using at least one drug or substance of abuse.[24]

Since Kenya's independence, negative ethnicity has been a significant societal challenge that brings about marginalization, distrust, heightened ethnic tensions, and conflict, particularly during political elections.[25–27] School has been seen as an important avenue to address these societal norms. In addition, there is a growing body of evidence-based prevention science such as in mitigating substance use among adolescents.[28] The SHP also sought to address an epidemic of learner-initiated arson attacks that have been rampant in Kenyan schools,[29,30] posing a great risk to the safety of learners, teachers, and communities. Arson attacks typically involve deliberately setting fires within school premises, targeting various structures such as classrooms, dormitories, administration buildings, or other facilities. The extent of damage varies, ranging from minor incidents to more severe destruction. In addition to igniting fires, students have also engaged in acts of vandalism, damaging school

[ii] *More details at https://unevoc.unesco.org/home/UNEVOC+Quarterly+Issue+September+2022*

property like furniture, textbooks, and equipment. These incidents often lead to a significant disruption of academic activities, resulting in the temporary closure of schools and the displacement of students. In extreme cases, arson attacks have caused injuries or loss of life, with students, staff, or emergency responders harmed while attempting to control the fires or evacuate the premises.

The fear and trauma associated with arson attacks have had enduring psychological effects on students, teachers, and the community. For many learners, the perception of schools as safe learning environments has been compromised, negatively impacting the overall well-being of those involved.

Over time, numerous committees have been set up to investigate this unrest in schools. The committees acknowledged research with students, who cited frustration at authoritarian and inflexible school management, especially in boarding schools, as a major factor. These committees have made proposals and recommendations aimed at eliminating these actions.[31] Recommendations made by the committees include institutionalization of robust mechanisms of communication between learners and school administrative structures as well as entrenching values in the learning systems from a young age.[31]

The Kenya Institute of Curriculum Development directs that the life skills curriculum should cover a range of topics to help learners develop the necessary skills to cope with the challenges of everyday life. These topics are communication, decision-making, problem-solving, critical thinking, creativity, self-awareness, self-esteem, assertiveness, empathy, negotiation, resilience, stress management, time management, goal setting, leadership, teamwork, entrepreneurship, financial literacy, and environmental conservation.[31]

Special Needs

Kenya's SHP recommends that schools adopt, design and implement strategies that support inclusive education. Studies show that there persist barriers for schools to fully embrace inclusive education in Kenya.[32] In 2009, the Ministry of Health released the National Special Needs Education Policy Framework to address the challenges of learners with special needs and disabilities in accessing educational services.[33]

The document identifies learners with special needs as those with/who:

- Hearing impairments
- Visual impairments
- Physical impairments
- Cerebral palsy
- Epilepsy
- Mental handicaps
- Downs Syndrome
- Autism
- Emotional and behavioral disorders
- Learning disabilities (LD)
- Speech and language disorders
- Multiple handicaps
- Albinism
- Other health impairments
- Are gifted and talented
- Are deaf/blind
- Are orphaned
- Are abused
- Are living in the streets
- Are heading households
- Are of nomadic / pastoral communities
- Are internally displaced

The Special Needs Education Policy Framework therefore sought to ensure the realization of inclusive education and simultaneously mainstream special needs education at all levels of the education system.[33] Social norms that stigmatize people with disabilities, lack of sensitivity training, inadequate infrastructural modification to accommodate physical disability, insufficient numbers of special education teachers, and insufficient funding for modifying school resources and facilities remain as barriers for mainstreaming learners with special needs.[32]

Violence Against Children

In 2019, the GoK and UNICEF launched the Violence Against Children (VAC) Report.[34] The report highlighted that nearly half of females (45.9 percent) and more than half of males (56.1 percent) experienced childhood violence in Kenya. Among the 15.6 percent of females who experienced childhood sexual violence, nearly two thirds (62.6 percent) experienced multiple incidents before age 18. In addition, the study estimated that approximately 2.4 percent of males ages 13–17 had experienced sexual violence in the year prior to the study. Physical violence was the most common type of violence experienced in childhood in Kenya. Nearly two out of five females (38.8 percent) and half of males (51.9 percent) experienced childhood physical violence. Childhood physical violence by parents, caregivers, and adult relatives was common, affecting 28.9 percent of females and 37.9 percent of males. Childhood emotional violence by peers was also common, affecting 30.9 percent of females and 31 percent of males.

Corporal punishment and bullying have been outlawed in Kenya but have been a major barrier to the safety and well-being of learners in Kenyan schools.[35,36]

WASH

Schools play a key role in developing a culture of good WASH practices. In Kenya, the pupil-to-toilet ratio in public primary schools for both boys and girls is estimated at 34:1 and 29:1 respectively.[37] Ninety-two percent of all public primary schools have access to a source of water with borehole sources taking the largest share (51.8 percent) followed by rainwater (22.2 percent) and river water (17.8 percent).[37]

An important facet of WASH in schools is MHM.[37] Recent studies suggest that approximately 52 percent of adolescent girls and young women in Kenya lack access to puberty education, menstrual hygiene products, and facilities.[38] The GoK recommends that every female learner has access to clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period; soap and water for washing the body as required; and facilities to safely dispose of used menstrual management materials.[39] Lack of access to menstrual hygiene products in schools may hinder girls' ability to concentrate in class, attend school when menstruating, or at worst cause them to drop out of school completely.[40]

Stakeholders in Kenya also recognize that there are a myriad of cross-cutting challenges facing WASH in schools in Kenya. These include water supply disruptions, lack of child friendly WASH facilities for disabled and very young children, inadequate facilities for staff, lack of disposal facilities for used sanitary pads, and challenges of the sustainability of WASH intervention.[37]

HIV/AIDS

HIV/AIDS remains a leading cause of morbidity and mortality among school-aged children and adolescents in Kenya.[41] An estimated 4,333 children younger than 15 years died of AIDS, and an estimated 2,275 adolescents 10–19 years of age died in 2019.[41] Adherence to treatment, particularly in the school setting remains the greatest challenge facing adolescents and children who are living with HIV in Kenya.[42, 43]

Micronutrient Supplementation and Deworming

Surveys conducted in rural areas show that children from households affected by food insecurity are particularly vulnerable to micronutrient deficiencies.[44, 45] These do not allow them to reach their full physical and cognitive potential, and their educational and professional achievements in later life are impaired.[44] In Kenya, over five million school-age children are estimated to be at risk of common parasitic infections/infestations such as soil-transmitted helminth and schistosomiasis.[46] Such parasitic infections have been shown to retard growth and development in children and increase prevalence of malnutrition and anemia.[47]

Malaria

Despite recent progress, malaria remains a significant public health challenge in Kenya.[48] The Kenya Malaria Indicator Survey estimated a malaria prevalence of 6 percent among children aged between 6 months and 14 years.[48] It is estimated that malaria accounts for 50 percent of deaths among school-age children in sub-Saharan Africa.[49] In addition, the disease and associated complications have been shown to have a detrimental effect on the physical and cognitive development among children.[50] Poor cognitive development, impaired attention, and absenteeism further leads to suboptimal learning outcomes among school-aged children who suffer from malaria.[49] There exists a growing body of evidence to suggest that school-based interventions can improve learning outcomes in malaria endemic settings.[51, 52]

A review conducted in 2017 suggests that treatment of clinical attacks of malaria, chemoprophylaxis, and vector control are potentially effective strategies that can be utilized to address malaria in school-aged children.[53] The Kenya Malaria Strategy 2019–2023 provides a range of responsibilities for practitioners in the education sector.[54] These include mainstreaming of malaria prevention activities in the school curriculum; promotion of the use of long-lasting insecticidal nets in schools; facilitation of prompt diagnosis and treatment for all fever cases in schools; and participation in national malaria surveys in schools.[54] In the course of conducting malaria surveys in schools, diverse quantitative measures are employed to evaluate various facets of malaria control. These measures encompass the assessment of prevalence, morbidity, mortality, and intervention coverage. The extent to which these directives have been implemented remains unclear.

Impact of the School Health Interventions in Kenya

Few studies exist on the impact of the school health program in Kenya. Those that exist were found to be limited in geographic scope and their designs were cross-sectional in nature, thus limiting generalizability and overall quality. In a 2018 study done in Kajiado,[55] a largely semi-arid county in Kenya, the investigators found that implementation of the school health program that implemented the health education components of the policy increased health knowledge among learners and parents. Greatest improvements in behavior were reported in handwashing and safe preparation of food. Improvements in infrastructure were significant, including handwashing facilities, fencing, kitchen facilities, and first aid kits.

National and Subnational School Health Strategies and Policies

The GoK is committed to upholding the rights of all learners to basic, compulsory, and quality education as well as their highest attainable health standards. These rights, among others, are provided for in the SDGs, the Kenyan Constitution 2010, Vision 2030, the Basic Education Act 2013, and the Children Act 2001, as well as other legal frameworks in Kenya. In addition, the government recognizes that to achieve this, there is need for efficient and effective cooperation and collaboration of all stakeholders in the education and health sector. The MOH and MOE developed the SHP to create a platform towards the realization of a comprehensive school health program in schools.[7]

The overall goal of the Kenya SHP is "to provide a healthy, safe and friendly environment for all learners in Kenya" (p. 20). All strategies and policy statements are therefore geared towards school-age children. The SHP articulates how the learner's health and well-being will be safeguarded and promoted. The document is clear on strategies to address health needs of learners with disabilities and other special needs. However, strategies to support learners who have been marginalized by environmental conditions, for example, those in arid areas, are not articulated.

The SHP has an accompanying School Health Implementation Guidelines (2018) document to cover the implementation strategies, guidelines and responsible agencies for each thematic area.

- The SHP outlines overarching statements on gender, disability and special needs, and governance of health programs. It identifies that gender can play a positive or negative role in safeguarding the education, health, and general well-being of learners. The policy states that interventions that ensure that biological differences, gender roles, gender-based violence, and harmful cultural practices, such as child marriages and female genital mutilation (FGM), are adequately addressed among learners to ensure equitable health and learning. The SHP recognizes that approximately 10 percent of the Kenyan population comprise PWDs; a majority (64 percent) of whom are of school-going age. Therefore, the SHP provides policy guidelines for the MOE, MOH, and other stakeholders towards promoting the basic right to health and education for learners with special needs and disability.
- It also refers to the Safety Standards Manual for Schools in Kenya (2008). Since the launch of the SHP 2018, the Standards and Guidelines for WASH Infrastructure in Pre-primary and Primary Schools in Kenya (2019)[37] have been developed by the MOE, MOH and the Ministry of Water and Sanitation. However, these standards refer to the 2009 policy and accompanying implementation guidelines, perhaps because the 2018 SHN Policy was not officially launched at that time.
- The SHP captures the country's aspirations as mentioned in Kenya's Vision 2030,[13] and the Constitution of Kenya.[14] Article 43 (1) (a) of the Constitution of Kenya provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Further, the policy aims to operationalize Sessional Paper No.1 of 2019 as part of Kenya's legal framework that guides delivery of education in the country. The paper states that schools have the responsibility to "promote positive attitudes towards good health."[12]
- Kenya's Education System is centralized.[56] Policy formulation is reserved for the national level. No localization or subnational adaptation of the policy is mentioned; however, the chapter on policy implementation arrangements provides the school health governance structure. The role of county and sub-county school health committees is to oversee implementation of the policy, while the school level committee will implement the policy.[57]

TABLE 1: LIST OF SCHOOL HEALTH-RELEVANT NATIONAL POLICIES IN KENYA

No.	Area	Policy Name	Agency Responsible	Start	End
1	**Education**	Sessional Paper No.1 of 2019: Policy Framework for Reforming Education and Training for Sustainable Development	MOE	2019	
2		Basic Education Act No. 14 of 2013	MOE	2013	
3		National Education Sector Strategic Plan (NESSP)	MOE	2018	2022
4		Republic of Kenya National Statement of Commitment on Transforming Education	MOE	2022	
5		The National Special Needs Education Policy Framework	MOE	2009	
6		National Curriculum Policy	MOE	2018	
7		Education Sector Report for the Medium-Term Expenditure Framework (MTEF)	MOE	2018	2021
8	**Health**	Kenya Health Policy	MOH	2014	2030
9		Kenya National Strategy for the Prevention and control of Noncommunicable Disease	MOH	2015	2020
10		Health Sector Working Group Report Medium-Term Expenditure Framework (MTEF)	MOH	2018	2021
11	**Health and Education**	Kenya School Health Policy, 2018	MOE and MOH	2018	2023
12		National School Health Strategy Implementation Plan	MOE, Ministry of Public Health and Sanitation	2010	2015
13		Standards And Guidelines for WASH Infrastructure in Pre-Primary and Primary Schools in Kenya	MOE, MOH, Ministry of Water, Sanitation and Irrigation	2019	
14		Hygiene Promotion in Schools – Handbook for Teachers	MOE and MOH	2022	
15		Kenya School Health Implementation Guidelines	MOE and MOH	2018	
16		National School Meals and Nutrition Strategy	MOE, MOH, Ministry of Agriculture, Livestock and Fisheries	2017	2022
17	**Agriculture**	National Food and Nutrition Security Policy	Ministry of Agriculture	2011	
18	**Legal**	Constitution of Kenya	Entire GoK	2010	
19	**Development**	The Kenya Vision 2030	Entire GoK		
20	**Drug Control**	National Alcohol and Drug Abuse Policy	Ministry of Interior and Coordination of National Government	2018	
21	**Cross-cutting**	Menstrual Hygiene Management (MHM) Policy	MOH	2019	2030

Evidence for SHN Strategies and Policy

The SHP provides some evidence on the health priorities of school-age children, especially marginalized children. As mentioned above, chapters on gender, growth and development as well as special needs, disability and rehabilitation aim to mitigate marginalization by gender, age and disability. Stakeholder consultations and a desk review mainly informed the policy. The policy itself did not have any research directly cited; however, the policies and guidelines in the reference list had such evidence.[7]

While the thematic areas are the same as the 2009 SHP, the areas needing emphasis are NCDs, emerging and re-emerging diseases, abuse and gender-based violence, lack of adequate school infrastructure, and nutritional needs. The main areas of marginalization identified in the situational analysis were gender (girls), learners with disability and other special needs, and those in poor communities and households.

While the SHP did not reference any studies, stakeholders consulted in the development of this report shared a 2016 situational analysis commissioned by the GoK that informed the policy review.[58] The report documented some key gaps in the thematic areas identified in the 2009 SHP.[58] In addition, the situational analysis documented stakeholder consensus that the national SHP had progressed since the launch of the first SHP in 2009. Stakeholders also perceived that the content of the school health program was comprehensive.

The situational analysis report made the following recommendations as key to improving the health of school children and development of the next generation of human capital and workforce:

> ***Establishment of a School Health Secretariat*** under the auspices of Non-Governmental Organizations (NGOs) with support from UNICEF, the World Food Program (WFP) and the World Health Organization (WHO).

> ***Improve on coordination of school health programs in schools:*** The report noted that there was a huge number of agencies and interventions that were uncoordinated. In addition, some of the interventions were experimental in nature, requiring scrutiny and oversight.

> ***A three tier Minimum Progressive Package (MPP) – Bronze, Silver and Gold*** for each of the thematic areas to be developed by stakeholders. This was deemed important for rationalization, tracking aspects of duration, quality, and quantity in implementation.

> ***Broaden the scope of comprehensive school health programming:*** Areas that needed strengthening included the Value System, Behavior Change and Communication, and Coordination. These were deemed necessary due to persistent arson attacks and destruction in secondary schools.

> ***Address emerging public health issues*** including the Zika and Ebola viruses.

> ***Disposal of electronic waste (E-waste):*** The government's policy to increase access to computers among learners was deemed as an emerging threat to health and safety in schools if not properly addressed.[59]

Thematic Areas and Core Pillars in SHN Strategies and Policy

The overarching goal of the Kenya SHP 2018 was to provide a healthy, safe and friendly environment for all learners in Kenya. The SHP and the thematic areas were premised on the idea that school provides an organized structure that is conducive for the provision of health and nutrition services as well as a key avenue for disease prevention and control. Schools can either promote health or accelerate the spread of ill health.

The SHP outlined the following eight themes:

Thematic Area 1: Values and Life Skills.

Thematic Area 2: Gender, Growth and Development.

Thematic Area 3: Child Rights and Responsibilities.

Thematic Area 4: Water, Sanitation and Hygiene.

Thematic Area 5: Nutrition.

Thematic Area 6: Disease Prevention and Control.

Thematic Area 7: Special Needs, Disability and Rehabilitation.

Thematic Area 8: School Infrastructure and Environmental Health Safeguards

The thematic areas covered in the revised Kenya SHP of 2018 were maintained at eight, just as in the 2009 edition. The 2009 policy addressed eight thematic areas namely values and life skills, gender issues, child rights and responsibilities, nutrition, special needs, disabilities and rehabilitation, WASH, disease prevention and control, school infrastructure, and environmental safety. There were, however, areas of new emphasis in the 2018 SHP such as addressing growth and development as part of gender issues and including health safeguards as part of the school and environmental safeguards. Other sub-thematic areas that are more pronounced in the 2018 policy compared to the 2009 policy are vaccination, mental health and psychosocial support, and first aid.

Two factors were critical in shaping the priority strategies and interventions in the 2018 SHP—these were the Kenya Constitutions 2010 and emerging issues. Among the critical constitutional changes was the devolution of health service delivery, which is now implemented by county governments, while the national government maintains policy and quality assurance roles. The 2018 edition of the Kenya SHP also acknowledged and prioritized NCDs, and emerging and re-emerging diseases. The policy also addressed gaps in the dissemination and implementation of the 2009 policy by providing dedicated interventions in Information, Education and Communication. The 2018 SHP, however, did not address other emerging issues such as online/internet safety, child trafficking, and organized crime, in spite of a growing concern among stakeholders.

To operationalize aspirations laid out in the SHP, the following policies and standards were developed: Standards and Guidelines for WASH Infrastructure in Pre-Primary & Primary Schools in Kenya; National School Meals and Nutrition Strategy; and the Safety Standards Manual for Schools in Kenya (2017).

The Kenyan School Health Policy is comprehensive in that it covers the main pillars of the international FRESH Framework. These promote cost-effective programming through integrated implementation of four pillars regarding health-related approaches for schools:

PILLAR #1: Health-related school policies: The practice in Kenya is that schools implement national policies as prescribed at the national level. Schools do not develop school specific policies. There are, however, guidelines and related policies that are listed as necessary to inform the schools on implementation of the SHP.

PILLAR #2: Provision of safe water and sanitation as a first step toward a healthy learning environment: There are several provisions that target the promotion of access to safe water and sanitation in the SHP 2018. WASH is one of the thematic areas that has been provided with a substantive section in the policy document. Some of the priority actions provided for in the policy are adequate and well-maintained handwashing facilities, and adequate and acceptable management of solid and liquid waste in schools.

PILLAR #3: Skills-based health education: This FRESH pillar is covered in the thematic area on values and life skills. The policy places responsibility on the Ministry of Education and teachers to ensure all learners are taught and facilitated to acquire life skills in schools to enable them to deal with the challenges of day-to-day life. Two approaches have been used to realize this goal—one is through integrating the life skills in the curriculum content and secondly through providing training manuals for teachers and learners.

PILLAR #4: School-based health and nutrition service: The SHP identifies schools as an opportunity to influence behaviors that affect the health and nutrition of learners. Schools have also been identified as a space where most vulnerable children are likely to bridge deficits in nutrition. This includes opportunities to demonstrate and practice food production, proper handling, storage, preparation, and utilization of diverse nutrient-rich foods. School nutrition services are optimized to supply children who would otherwise suffer from malnutrition.

The SHP to some extent covers the provision of a safe physical and socio-emotional learning environment for students and staff and guidance on teaching skills-based health education. The SHP does not provide specific strategies for mitigating other forms of violence (apart from gender-based violence) and injuries including road traffic accidents that are identified as a leading cause of deaths among young people in the Kenya National Strategy for the prevention and control of NCDs. However, the Kenya School Safeguarding policy guidelines were developed to address this gap.[60] Considering that no other reports make mention of these guidelines, it is unclear the extent to which this document was disseminated and utilized by stakeholders.

The SHP completely covers the provision of school health services in the policy. On page 30, the SHP states that "The Ministry of Education and the Ministry of Health in collaboration with other stakeholders shall ensure nutrition is sustainably promoted through offering adequate nutritional services, promotion of healthy food environment and nutrition education." In addition, the document outlines the following strategies: 1. Optimizing school nutrition services. 2. Promotion of a healthy food environment. 3. Enhancing nutrition education in schools. 4. Parental and community involvement in school nutrition. The following services are also explicitly mentioned: preventive treatment (deworming); micronutrient supplementation; school meals; menstrual management; first aid; and vision.

SHN Strategy and Policy Dissemination

The Kenya SHP 2018 is jointly owned and led by both the Ministries of Health and Education. The SHP states that the National School Health Secretariat (NSHS), an organ composed of representatives drawn from both ministries is responsible for dissemination of the policy. As such, the School Health Secretariat is mandated to ensure that enough copies are printed, and disseminated in all counties, sub-counties, public and private primary schools, and public and private secondary schools in Kenya.[7]

In the situational analysis conducted to review the implementation of the SHP 2009, one key finding was that 33 percent of the schools had copies of the SHP 2009 and 26 percent had the guidelines. Therefore, it is most likely that not all schools had been disseminated with the policy; a result of lack of appropriate dissemination mechanisms in the SHP 2009.[7]

Informal interviews with officials from the MOH and MOE indicated that dissemination of the SHP 2018 was conducted in only 27 of 47 counties of Kenya due to lack of adequate resources. Dissemination was conducted through a cascade approach, where national facilitators disseminated to county facilitators, who in turn facilitated to school and community level. Dissemination was limited by available resources. However, this process was not documented.

Multisectoral Coordination and Collaboration

The SHP describes the national school health program as an inter-sectoral initiative in which ministries, stakeholders, and agencies collaborate in planning, implementation, monitoring, and evaluation of activities. The document stipulates multiple levels of coordination and leadership for the SHP (p. 50) comprising the Ministries of Health and Education as well as other state and non-state actors. The document assigns joint leadership for the school health program to the Ministries of Health and Education. The document also places County Departments of Health at the helm of implementation of the school health program. Importantly, counties are also charged with the responsibility of ensuring those that deliver school health services are adequately trained and comply with stipulated standards and guidelines.

This multisectoral coordination and collaboration includes the following entities:

The National School Health Inter-Agency Committee (NSHIC): The committee is the highest organ of the school health program bringing together representatives from relevant line ministries. The committee is co-chaired by the Cabinet Secretary, MOE, and the Cabinet Secretary, MOH. The committee is responsible for policy advisory, coordination, resource mobilization, and advocacy and is required to meet at least twice annually.

National School Health Technical Committee (NSHTC): This committee is the second highest organ of the school health program after the NSHIC which brings together technical representatives of the relevant two lead ministries, line ministries, technical representatives (Council of Governors, Education and Health Committee), development partners, NGOs and Faith-Based Organizations (FBOs). The committee is co-chaired by the Principal Secretary of the MOE and the Principal Secretary of the MOH, respectively. The NSHTC is responsible for overall policy implementation, strategic program oversight with decision-making authority, strategic leadership, ensuring progress towards overall goals with consideration of material changes, monitoring health trends, legislative changes, providing semiannual reports, and offering technical advice on the implementation of the program to the SHIC.

National School Health Technical Working Groups / Steering Committee: This committee is the third highest organ of the school health program. This committee brings together program managers with technical skills and hands-on involvement in various thematic areas from the lead two ministries, line ministries, development partners, NGOs and FBOs. They meet on a monthly basis, co-chaired by the Director of Preventive and Promotive Health (MOH) and the Director of Basic Education (MOE) or delegated to another senior ranking officer.

National School Health Secretariat (NSHS). The secretariat is composed of representatives drawn from relevant units within the MOH and MOE. The NSHS is responsible for undertaking administrative duties and coordinating the overall implementation of program activities; ensuring efficient coordination in the implementation of the SHP towards strengthening existing school health interventions; and coordinating and providing the lead in strengthening collaboration, partnerships, and networking for a successful implementation of a comprehensive school health program.

County School Health Committee: This is an inter-sectoral committee composed of the key ministries of education, health, national interior government, planning, devolution, water and sanitation, agriculture, labour and social protection, information, public works, as well as development partners and other stakeholders. The committee is responsible for assisting sub-county school health coordinating committees to interpret policies and implement the SHP.

Sub-County School Health Committee: This is an inter-sectoral committee composed of the key ministries of education, health, national interior government, planning, devolution, water and sanitation, agriculture, labour and social protection, information, public works, as well as development partners and other stakeholders. The committee is responsible for assisting sub-county school health coordinating committees to interpret policies and implement the SHP.

Ward School Health Committee: This committee is composed of the community and facility Community Health Extension Worker, Ward Public Health Officer, Health Facility in-Charge, Curriculum Support Officer, Ward Administrator, Chief and co-opts the Member of County Assembly. The committee discusses issues affecting the health of learners in school, including resource mobilization and appropriate allocation. The co-coordinators are the Ward Public Health Officer and the Curriculum Support Officer.

School Health Committee: At the school level, a committee comprising of the School Principal/Head Teacher, Board of Management (BOM) Chairman, Curriculum Support Officer, Ward Public Health Officer, Health Facility in-Charge, School Health Teachers (secretary), and student / pupils' Council President is charged with oversight or implementation of the SHP. The committee meets once per term.

Resource Allocations for School Health

The SHP states that the Ministries of Health and Education have the joint responsibility for resource mobilization and allocation. However, the SHP provides no further guidance on how to implement this directive.

The GoK education sector reports demonstrate annual allocations for school health, nutrition, and meal activities at national level. This is expected because education is not a devolved function with resource allocation at local government level. In the sector reports, financial resources requested against those allocated are quantified for each year. According to the education sector reports for the three years up to 2021, there is a single-line item per year labeled "school health, nutrition and meals". However, there are no specific sub-allocations for goods and services and support to government agencies that address school health. While it is known that there are contributions by local implementing partners, these are not systematically reported and availed. MOE sector reports show that for the last three financial years, a total of Kenya Shillings (KES) 10.2 billion was required against an allocation of KES 8.1 billion for school health, nutrition, and meals in the financial year, indicating a deficit of approximately 21 percent.

TABLE 2: SCHOOL HEALTH, NUTRITION, AND MEALS RESOURCE REQUIREMENTS AND ALLOCATION

Financial Year	Requirement (KES)	Allocation (KES)
2018/19	2.981 billion	2.681 billion
2019/20	3.446 billion	2.705 billion
2021/22	3.801 billion	2.727 billion
Total	10.228 billion	8.113 billion

The education sector narrative report also states that the resources allocated to the SHNM line item were utilized for the following activities:

1. ***School Feeding Program:*** Provision of meals in schools for learners where funds are disbursed directly to schools for food purchase from local farmers.
2. ***Sanitary Towels Initiative:*** Supporting primary school girls in the classes 6–8 who may be at risk of exclusion from learning due to menstrual hygiene challenges.
3. ***National School-Based Deworming:*** Local primary school teachers were trained on safe deworming and subsequently administered drugs to children of pre-primary and primary school-going age.

There is investment in pre-service training on health promotion sometimes; however, no details on this were collected.

No evidence was identified for supportive investments from the MOH, other ministries at national, subnational, and local level for SHN. This may be because the MOH, being devolved to the county and sub-county level, have respective agencies that provide budgets for school health activities that they lead.

Monitoring and Evaluation of School Health and Nutrition: For Improvements and Decision-Making

The monitoring and evaluation (M&E) of the Kenya SHP 2018 is a function of multi-level committees. The highest organ responsible for M&E of the policy is the NSHIC. This consists of the relevant line ministries and other stakeholders meeting bi-annually. It is co-chaired by the Cabinet Secretaries in the MOE and the MOH. At the lower level, M&E is undertaken by the NSHTC, which is the second highest organ after the NSHIC. Other organs responsible for monitoring and evaluating the implementation of SHP are the technical working groups, the NSHS and county, sub-county and school health committees. While these structures responsible for M&E are cascaded from the highest governance levels to the school community, there is little published evidence on their effectiveness or efficiency. In particular, there were no publications describing successes or failures in involving children in school health through the student/ pupil councils. At the time of undertaking this desk review, there were no government-led evaluations or action research that demonstrated effectiveness of the interventions.

Chapter 5 of the Kenya SHP 2018 outlines the framework for monitoring and evaluating implementation of the SHP and programs. The SHP (p. 60) provides a list of indicators and tools to track school health. Notably, the SHP 2018 did not identify the government agency responsible for each indicator. The tools used would be the routine monitoring systems: HMIS and NEMIS. While the two information management systems are critical in monitoring and evaluating the success in implementation of the SHP and programs, there was no evidence from published reports that indicated that the two systems shared data. In addition, there is no open access to NEMIS to stakeholders, contrary to the policy direction of open data.[61] This limits the ability of non-governmental stakeholders to play an effective role in monitoring and evaluating the implementation of the SHP. The extent to which data are extracted from the platforms and utilized for policy and program improvements are unclear. Proposals have been made to develop a national dashboard that allows integration of data across agencies, such as the Kenya HIV Situation Room.[62] Such a platform would ensure more effective and precise programming and reach more children with relevant school health interventions.

The monitoring of student health and well-being is integrated into the NEMIS to some extent. School health interventions such as deworming are included in the NEMIS. The Kenya National Examination Council also tracks student performance on life skills, including those related to health. Information is annually updated in school census reports for decision-makers; however, there have been delays with publishing these reports. The last school census report is from 2019. Also, what is not clear is how the M&E data is leading to policy review and adaptation. Other systems that exist for monitoring student health and well-being include the periodic national demographic health survey that tracks deworming, and micronutrient supplementation indicators at population level, providing a basis for school health interventions in these areas.

Conclusion and Recommendations

Kenya has prioritized school health since the early 2000s, demonstrating political support and good will. In addition, Kenya has had two versions of the SHP: an initial version launched in 2009, and a second revised version launched in 2018 to address changes in the governance, social and epidemiologic landscape. Over time, a broad range of interventions have been implemented under the auspices of the SHP. However, scarce data exist to demonstrate what is working and what is not. A 2016 rapid situation analysis commissioned by the Ministries of Health and Education demonstrated gaps in implementation of the policy as well as the need for addressing emerging threats. To our best knowledge, no comprehensive evaluation of the school health program has been done. In addition, scarce data exist on interventions implemented and lessons learned prior to 2009.

While our review found a wide array of policies and guidelines to support school health programs, the extent to which these documents were disseminated remains unclear. In Kenya, counties are mandated with delivery of services, including those related to school health. It is therefore required that elaborate mechanisms for dissemination of policies should be instituted to ensure that learners, teachers and communities are aware of the new policy directions.

Kenya's school health interventions are delivered through an integrated approach. Unlike many other national programs that adopt a silo approach, school health is mainstreamed. For example, skills training on health for learners is integrated in the national school curriculum, and non-technical health services such as deworming are safely delivered by schoolteachers. This is potentially an efficient approach, although conclusive studies are required.

Our review found evidence of GoK funding of the school health program as evident in education sector reports. However, in comparing the requirements versus the allocation, the reports demonstrated a funding deficit of 21 percent noted for the financial years: 2018/19; 2019/20; and 2021/22. In addition, the report only lists funding for three components: school meals, sanitary towels, and deworming. It is unclear whether and how other components of the school health program are funded. It is also unclear whether a comprehensive costing of the school health program has ever been done. Education sector reports are only reflective of exchequer financing. We found no data on funding from other sources such as the private sector and development partners.

Kenya has put in place NEMIS that is also used to monitor school health indicators. NEMIS is able to track school health activities, such as deworming, Vit. A supplementation, and HPV vaccine. However, our review found that NEMIS is not widely available to stakeholders as a decision-making tool. Kenya's MOH also runs a robust data collection and reporting system — the HMIS.

The governance and coordination of the school health program, from national to community levels, is well defined in the SHP. However, our review did not find evidence of collaboration and communication between the various levels of governance. There was limited data on the effectiveness of community and household interventions proposed in the SHP.

Recommendations:

Short-Term Recommendations:

- There is a need to invest in dissemination of school health policies and guidelines to ensure that stakeholders at all levels are aware and involved in implementation of school health activities. Such dissemination would transcend beyond passing of information to promotional campaigns that would ensure adoption of recommended interventions.
- Include Behavioral Surveillance Surveys (BSS) in schools that can provide valuable insights into learner, teacher, and community behaviors related to health, enabling schools to develop evidence-based policies and interventions that promote a healthier and safer learning environment.
- Advocate for increased public access to data from the MOH (HIMS) and MOE (NEMIS). This is to facilitate more effective and efficient monitoring and evaluation of the SHP and programs. There are opportunities in the current government's policy direction towards increased public access to government and the proposal to establish a dashboard housed by the School Health Division in the MOH and MOE. The dashboard will allow for integrating multi-agency data, including those from non-state actors and private sector.

- Develop an investment case to demonstrate long-term benefits of investing in school health.
- Develop a dynamic and adaptable SHP that not only addresses current challenges, but also remains flexible to accommodate the integration of emerging tools and technologies in health and education. As innovative tools, such as the malaria vaccine, HPV vaccine, digital platforms, and others become available, the updated SHN policy should proactively incorporate mechanisms to seamlessly integrate these advancements. Such a policy would establish continuous assessment frameworks to align the policy with evolving health and education interventions and incorporate a placeholder for addressing unknown costs associated with emerging vaccinations and training to maintain a robust and proactive policy framework.

Long-Term Recommendations:

- There is a need to invest in documentation of school health interventions so as to institute learning based on observed program effectiveness and efficiency. This may include building capacity for intervention/ action research in the school governance structures at the national and county levels.
- Develop a robust monitoring and evaluation framework that tracks implementation outputs and outcomes by integrating data from a wide range of sources, e.g., HMIS, national surveys.
- Invest county-level planning for school health to leverage resources and align stakeholder efforts at subnational level.
- Institute bottom-up and top-down communication and ownership among allocators for school health program.

Questions to be explored in the field assessment

1. Knowledge Gaps in intervention coverage and effectiveness of interventions

- To what extent has the Kenya SHP 2018 been implemented?
- What is working in addressing emerging health challenges such as those related to online safety?
- Was school closure an effective response in managing the COVID-19 pandemic?
- What is the capacity for utilization of evidence-based prevention science such as in substance use prevention?
- What works in harmonizing the role of central versus devolved governments?

2. **Funding for school health**

- How can resource mobilization and allocation for school health be improved?

  Probe: costed national implementation plan for school health; an investment case demonstrating long-term benefits of investing in school health.

3. **Monitoring and evaluation for school health**

- Currently, how is school health data used for program and policy decision-making?

  Probe: How frequently is this done? Who is responsible?

- How can we improve the use of school health data for decision-making and program improvement?

  Probe: development of dashboards.

4. **Stakeholder coordination and collaboration**

- How can we improve stakeholder coordination and collaboration, particularly at county, sub-county and school levels?
- How can we improve communication between the various levels of coordination of school health?
- How can we ensure that learners, parents and communities take up and sustain school health interventions?

5. **Policy dissemination**

- What cost-effective strategies can be used to disseminate SHP and related guidelines to ensure stakeholders at all levels are informed and engaged?

Prioritized Recommendations for the Policy Strengthening Action Plan with line ministries

1. Development of a funding gap analysis and investment case for school health for Kenya.

2. Development of a national framework/plan for Use of Data for learning, decision-making and Continuous Program Improvement.

3. Address gaps in **life skills targeted at emerging health and well-being** challenges such as mental health, online safety, insecurity (including radicalization to violent extremism.

4. The SHP should **embed mechanisms for process and impact evaluation** to inform development and implementation of future school health policies in Kenya and other similar contexts.

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ANNEX 1: PARTICIPANTS IN THE SPAESHA PROTOCOL AND DESK REVIEW WORKSHOP

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1.	**Dr Christine Wambugu**	Ministry of Health
2.	**Dr Richard Muthoka**	Ministry of Health
2.	**Florence Musalia**	Ministry of Education
4.	**Michael Kioko**	Ministry of Education
5.	**Beatrice Ooko**	Ministry of Education
6.	**Alex Mutua**	Ministry of Health
7.	**Mercy Mwongeli**	UNESCO
8.	**Dr Makeba Shiroya**	WHO
9.	**Jane Kamau**	UNESCO
10.	**Lucy Kimondo**	National Council for Population and Development
11.	**John Kirunga**	Ministry of Health
12.	**Beatrice Ochieng**	Ministry of Health
13.	**Margaret Mwaila**	National Council for Population and Development
14.	**Dr Michael Kiragu**	USAID Momentum Country and Global Leadership
15.	**Dr Abraham Afeworki**	USAID Momentum Country and Global Leadership
16.	**Samuel Munyuwiny**	USAID Momentum Country and Global Leadership
17.	**Teresa Akun**	USAID Momentum Country and Global Leadership

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