MOMENTUM COUNTRY AND GLOBAL LEADERSHIP

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

MOMENTUM Country and Global Leadership

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BECCAD	Basic Education, Child Care and Adolescent Development
CFPs	Country Focal Points
COVID-19	Coronavirus Disease
EFA	Education for All
EMIS	Education Management Information System
EVD	Ebola Virus Disease
DHIS2	District Health Information Software Version 2
FRESH	Focusing Resources on Effective School Health
FY	Fiscal Year
GDP	Gross Domestic Product
GOU	Government of Uganda
HCD	Human Capital Development
HIV	Human Immunodeficiency Virus
HPS	Health Promoting Schools
HPV	Human Papillomavirus Infection
IEC	Information, Education and Communication Materials
JSI	John Snow, Inc.
MAAIF	Ministry of Agriculture Animal Industries and Fisheries
MDAs	Ministries, Departments and Agencies
MoES	Ministry of Education and Sports
MoESTS	Ministry of Education, Science, Technology and Sports
MoH	Ministry of Health
MTRAC	Mobile Tracking
NGOs	Non-Government Organizations
NDP	National Development Plan
NSHP	National School Health Policy
NSHSC	National School Health Steering Committee
PE	Physical Education
PIASCY	Presidential Initiative on AIDS Strategy for Communication to Youth
RIA	Regulatory Impact Assessment
RTRR	Reporting, Tracking, Referral and Response
SABER	Systems Approach for Better Educational Results

SBS	School-Based Surveillance
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SHEP	School Health Education Project
SHN	School Health and Nutrition
SHP(s)	School Health Policy/Policies
SNs	Special Needs
SOPs	Standing Operating Procedures
SPAESHA	Strategic Planning Advisors for Education and School Health in Africa
SRGBV	School-Related Gender-Based Violence
SRH	Sexual Reproductive Health
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
UBOS	Uganda Bureau of Standards and Statistics
UGX	Ugandan Shilling
UNESCO	United Nations Education Scientific and Cultural Organization
UNICEF	United Nations Children Emergency Fund
US$	United States Dollar
UPE	Universal Primary Education
USAID	U.S. Agency for International Development
VACiS	Violence Against Children in Schools
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
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

Uganda gained independence in 1962 and although in 1963 a Commission was appointed to recommend educational goals for primary and secondary school, the economic decline of the 1970s, the 1979 war, and its aftermath had a negative impact on the education sector. Coupled with reduced financial resources for the Ministry of Education in the 1970s, the expansion of education at all levels was constrained. Since 1981, Uganda has worked to rehabilitate, restore, rebuild, and redevelop its education system. Education policy development occurs at many levels, from the official promulgation of national commissions to informed decisions at district or school level. These have resulted in commission recommendations and reports, sector development plans, policy reviews and formulations.

A significant landmark in the evolution of primary education in Uganda is the introduction of Universal Primary Education (UPE) in 1997. The UPE policy was implemented by President Museveni in accordance with the 1992 Government White Paper[1]. The policy mandated that the government give «free» education to up to four children from each family.[2] Later, this was altered when the President ordered that all children of school age should receive UPE.[3]

In 2021, the U.S. Agency for International Development (USAID) Africa Bureau and John Snow, Inc.(JSI)/Child Health Task Force jointly commissioned a report to identify pathways for advancing school health and nutrition programming in Africa. Uganda was selected for a follow-on activity, the Strategic Planning Advisors for Education and School Health in Africa (SPAESHA) project facilitated by MOMENTUM Country and Global Leadership, to identify areas for improving School Health Policy (SHP) implementation, focusing on the different elements of the school health system, processes, and platforms to create a realistic and context-specific policy strengthening plan.

This report uses government documents, literature reviews, and conversations as sources for understanding the School Health and Nutrition (SHN) policy environment in Uganda. In total 20 policy documents were reviewed across 7 sectors.

Key Findings:

The health challenges faced by Ugandan school-age children, aged 5 to 14 years old, are a matter of concern. According to the Global Burden of Disease data from 2019,[4] this group is particularly affected by various health problems. Malaria (42.75 percent), tuberculosis (TB) (29.8 percent), soil-transmitted helminths (25.95 percent), dietary iron deficiency (18.58 percent), upper respiratory infections (4.1 percent), oral problems (35.07 percent), fungal skin infections (16.68 percent), and anemia (43.27 percent) are the most common health problems faced by Ugandan school-age children (5–14 years old). Human Immunodeficiency (HIV)/Acquired Immunodeficiency Syndrome (AIDS) tops the rank of causes attributable to risk factors for death among 5-14-year olds followed by diarrheal diseases, indicating the need for targeted interventions and health promotion strategies to address risk factors and ensure the well-being of Ugandan school-age children. These conditions can have a significant impact on the well-being and development of children in this age group. Understanding and addressing these health challenges is crucial for improving the overall health and quality of life for this vulnerable population.

A number of school health initiatives have been rolled out in Uganda by government, development partners, and local actors to foster good health in schools. These have been implemented under the National Health Policy (minimum health care package, immunization, screening for malnutrition), the Children Act Amendment of 2016,[5] and the National Sexuality Education Framework,[6] the latter though with some contestation, especially among religious groups. These initiatives include adolescent reproductive health; guidance and counseling; school water and sanitation; sexuality education; and life skills; the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), as well as preventive and curative health programs such as deworming, Vitamin A supplementation, and immunization. Despite the number of school health initiatives, there is no approved SHP in place that would support coordination, monitoring, and accountability of these efforts. An attempt to develop a SHP in 2002 did not yield results. Subsequently, a draft SHP was developed in 2012 and renewed in 2021. This is expected to be approved in 2023. The draft policy was renewed in 2021 to address Cabinet recommendations for a Regulatory Impact Assessment (RIA)[7] which was missing in the 2012 draft.

The goal of the 2021 draft National School Health Policy (NSHP), is to enhance the quality of health in school communities in order to promote Education for All (EFA). The policy draft was developed within the broader national guiding framework which includes: the 1995 Constitution of Uganda[8], Uganda's Vision 2040[9] outlines a strategic framework for the country's development, the National Development Plan (NDP) III, the Education Act (2008), the Uganda National Action Plan for Nutrition (2013–2017), Health Sector Strategic Plan III (2010–2015), the Education Sector Strategic Plan (2020/21–2024/25), and the National Strategy to End Violence Against Children in Schools. The SHN policy draft covers eight components which are anchored on the four pillars of the Focusing Resources on Effective School Health (FRESH) framework.[10]

The NSHP will be implemented and coordinated by the Ministry of Education and Sports (MoES) in coordination with the Ministry of Health (MoH) using the program-based approach to planning and implementing government interventions. As a result, the District Health and Education offices will coordinate the delivery of these interventions at the school level in accordance with current policies and standards.

A multisectoral steering body was put in place to streamline the various school health interventions into a coherent framework so as to maximize synergies of the various stakeholder interventions in relation to school health. Some guidelines and standards, including development of the draft policy as mirrored above, have been put in place to guide stakeholders in handling the various school health issues. This framework enables various stakeholders to undertake interventions aimed at resolving the health challenges in schools and to report on them for purposes of effective accountability, although the monitoring and reporting framework for school health is inclined toward epidemics such as Ebola Virus Disease (EVD) and Coronavirus disease (COVID-19) and not the comprehensive school health package in its entirety or key/strategic indicators.

Uganda needs to popularize an investment case on school health and demonstrate its long-term, short-term, and immediate benefits to meet resource and funding gaps; this should also address the impact and scale of SHN interventions. The NSHP draft emphasizes the need for coordinated efforts to address various school health themes. Clear roles, responsibilities, and resource allocations for line ministries, departments, and agencies are essential. Implementation strategies should focus on effectiveness and avoid burdening already overworked and underpaid teachers in the country. The country needs to incorporate disaster risk reduction strategies in the 2021 policy draft, which is not mentioned, although in 2015 a guide to conflict and disaster risk management was launched by Ministry of Education Science, Technology and Sports. The Education Management Information System (EMIS) also needs strengthening to include school health data and multisectoral coordination, among others.

In conclusion, the report strongly recommends that a field assessment should be conducted, to take into account changes that may have occurred during COVID-19 and EVD with education institutions and learners. This would be conducted as part of the SPAESHA activity, with a key emphasis toward ensuring safety of learners and continuity of learning. Another high priority would be to focus efforts toward expediting the approval processes of the NSHP, and to also develop an implementation framework coupled with dissemination at various levels.

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 wellbeing 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 EVD and COVID-19, as well as inadequate Water, Sanitation and Hygiene (WASH) facilities in schools, highlight the prolonged underinvestment in school health within education systems.[11] A recent global World Health Organization (WHO)–United Nations Children Emergency Fund (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.[12] Globally, at the start of the pandemic, in the 60 countries (40 of which were on the African continent) 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. 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,[13] which affect the prevalence of mosquito-borne pathogens, particularly malaria and dengue.[14,15]

As school closures threaten to reverse historic education gains, 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, disrupting intergenerational cycles of health and social inequalities. 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 ministries of education and 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 in 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, thrive, and for countries to build stronger future economies,[16] the USAID Africa Bureau and JSI/Child Health Task Force jointly commissioned a 2021 report to identify pathways for advancing SHN programming in Africa. In this *2021 report*, ten African Missions were solicited to understand their contexts and optimal points of entry for augmenting existing resources. For many of the countries that were solicited, a number of strengths and opportunities were identified for better targeted investments alongside multisector school health coordination.[17]

Kenya, Malawi, Senegal, and Uganda were identified as countries well-suited for this activity and 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 diseases, school feeding, adolescent sexual reproductive health, under 5 nutrition and health, etc.).
- MOMENTUM and Country Global Leadership partner country offices' interest, capacity to engage and advocate, with strong government relationships.
- Receptiveness of ministries of education, health and the USAID Mission to the project.
- Previous school health programming or similar work.

The MOMENTUM Country and Global Leadership convened the SPAESHA activity to 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. SPAESHA will identify context-specific strategies to improve SHN by collaborating with stakeholders in Uganda. As Uganda is located in East Africa, outcomes of the project will inform adaptations within the sub-Saharan region of the continent; these strategies can then be applied in similar contexts throughout the East African region.

Both COVID-19 and the Sudan EVD, which recently affected Uganda's educational institutions and students, will teach valuable lessons about school health. Even if they were carried out on an as-needed basis, many projects in the area of school health have focused on adolescent reproductive health and not on the comprehensive school health package.

Although funding, coordination, adaptability, and consistent implementation have been obstacles, some implementing partners, including the Center for Health, Human Rights and Development, Reach A Hand, Save the Children, and the World Food Programme (WFP), have partnered with the Ministry in advocating for the approval and dissemination processes of the NSHP. Notwithstanding the fact that some of the programs are short-lived due to financing shortages, they would nonetheless produce thorough evidence for school health interventions.

This report takes a deeper dive into the SHN policy history in Uganda, the known and the emerging health needs of school-age children. It will be used to inform work plan activities and to establish contextualized deliverables related to policy strengthening. This desk 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: FRESH, Systems Approach for Better Educational Results (SABER),[18] and most recently, Health Promoting Schools (HPS).[19] 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 whole-of-government commitment to and investment in HPS are reflected in laws, regulations, policies, strategies, resource allocation, intersectoral collaboration, collaboration and engagement with schools and local communities, with a sustainable system of monitoring and evaluation.

Thematic areas and pillars are referenced throughout each report and are standard set by each framework. Their prominence in each SHN policy, or related polices, will vary. For the purposes of this report, "thematic areas" refer to the health issue covered in the policy and may include the following: Children with Special Needs (SNs); Deworming; Disaster Risk Reduction/ Emergencies; 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 Violence in the School Setting.

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. CFPs read all related policy documents and operational guidelines (see Table 2) to assess the extent to which each country's policies and practices met each standard. In cases where policies, strategies and guidelines were unclear or unavailable, CFPs met with government partners to understand policy documents and directives (see Annex II). This report uses both government documents and conversations as sources for understanding the SHN policy environment. In total, 23 policy documents were reviewed across 7 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 SHPs 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.

The CFP conducted additional searches on different resource materials that were not limited to policy documents, strategies, guidelines, or reports from ministries, departments and agencies (MDAs), on and offline. Some sites listed were from PubMed, Google Scholar, and the United Nations Education Scientific and Cultural Organization (UNESCO) digital library, among others, to better understand the status of SHN in Uganda.

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 assessments in Uganda. The field assessments will incorporate school observations and discussions with various stakeholders involved in the operationalization of school health or who benefit from SHN initiatives, including boys and girls. The aim is to have a clear understanding of 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 Conte xt

Education and School Health Background

Uganda gained independence in 1962, and although a commission was appointed to recommend educational goals for primary and secondary school, the economic decline of the 1970s, the 1979 war and its aftermath had a negative impact on the education sector. Coupled with reduced financial resources for the Ministry of Education in the 1970s, the expansion of education at all levels was constrained. Since 1981, Uganda has worked to rehabilitate, restore, rebuild and redevelop its education system. Education policy development occurs at many levels, from the official promulgation of national commissions to informed decisions at district or school level.[20]

Uganda's educational system has been guided by the Castle Commission report of 1963[21]. The commission's review confirmed its concern that a review of Uganda's education policy was urgently needed to meet the demand of the country for a fundamental transformation that will result in true independence and long-term development built on the foundation of self-reliance. It acknowledged that prior efforts that lacked the stability of the nation, effective political leadership, and direction from the government, had failed to adequately meet this demand. In the 1980s, attention was focused on the general reconstruction and rehabilitation of buildings, as well as the restoration of the provision of facilities and services, all of which had been damaged by war and civil unrest. Although the number of primary and secondary schools significantly increased in the early 1980s, the majority of the new schools were poorly designed and underequipped. The National Resistance Movement government came to power in 1986 and had a set of policies that focused on elements like: security, freedom, and human dignity. The policies were meant to reflect the goals of UNESCO's 40th international conference on education. The main themes that were consistently emphasized were: increased access to education, providing skilled labor for development, and building a complete and high-quality education system from primary school through university.[22] With regard to pre-primary education, the government confirmed adoption of developmental capabilities and healthy physical growth of the child through play/activities.[23]

A significant landmark in the evolution of primary education in Uganda was the introduction of Universal Primary Education. The UPE policy was implemented by President Museveni in accordance with the 1992 Government White Paper.[24] This policy mandated that the government give «free» education to up to four children from each family. Later, this was altered when the president ordered that all children who were of school age should receive UPE.[25] Tuition costs and Parent Teacher Association fees for primary education were eliminated under the UPE program. In comparison to the increase of 39 percent (0.9 million children) from 1986 to 1996, the gross enrollment in primary schools climbed from 3.1 million in 1996 to 7.6 million in 2003, a 145 percent increase (4.5 million children). The increase in enrollment was large and even though the policy did not make primary education mandatory or completely free, parents were still obliged to pay for supplies like pens, exercise books, clothes, and classroom buildings. Public spending on primary education had to rise significantly as a result of the UPE program; it went from 2.1 percent of the Gross Domestic Product (GDP) in 1995 to 4.8 percent of the GDP in 2000.[26]

From 13.7 percent in 1990 to 24.7 percent in 1998, the education sector's share of the national budget likewise increased. According to the country's Education Sector Investment Plan, at least 65 percent of the education budget was set aside for primary school, and the additional spending was covered in significant part by debt relief offered under the Heavily Indebted Poor Countries project. For UPE, MoES offered two different types of funds: capitation grants and grants for school facilities. Grants for capitation were distributed in accordance with the number of pupils enrolled in a school and their educational level. The MoES also issued recommendations for how capitation grants should be used in primary schools, with 50 percent going toward teaching materials, 30 percent going toward extracurricular activities, 15 percent going toward school administration, and 5 percent going toward school management.[27]

The Government of Uganda (GOU) commitments on education and health are contained in the 1995 Constitution of Uganda and further developed in a range of national legal and policy frameworks including the Education Act (2008), the Children Act Amendment (2016), legal precedent, Uganda's Vision 2040 outlines a strategic framework for the country's development, and the NDP III (2020/21–2024/25).

Parts XVIII and XX of the Constitution indicates educational and health objectives respectively and these highlight state actions in relation to promotion of health and education as core rights and as social services to the Ugandan populace. In addition, Article 30 states that "All persons have a right to education" whereas Article 39 provides for the right to a clean and healthy environment. Relatedly, Article 20 (1) of the same constitution states that, "fundamental rights and freedoms of the individual are inherent and not granted by the state." This implies that access to proper health care and information in an education setting is a right for all Ugandans via a structured framework as stipulated by policy.

Under the Education Act of 2008 the main objectives were to implement the Education Policy of the government inclusive functions and services, to decentralize education services, to implement the UPE Policy, to implement the Universal Post Primary Education, and Training Policy, to promote partnership with the various stakeholders in providing education services, to promote quality control of education and training, and to promote physical education (PE) and sports in schools. The word "health" appears twice in the Act and notes that the physical, health and moral welfare of the pupils are or will be adequately provided for and provides powers to the permanent secretary, chief administrative officer, or town clerk, as the case may be, to close schools in case of any health concerns. Notably, under the MoES the Performance Management Guidelines Annex 3 mentions education sector specific outputs for heads and principals of institutions; for instance, the PIASCY,[28] Health, and Wellness. These are measured termly especially for basic education and reported to the District Education officers who later report to the MoES.

Uganda faces major challenges in providing quality and accessible basic education to children and adolescents. Approximately 4 out of 10 young children between the ages of 3 and 5 now attend early childhood education, which represents a significant improvement from 2011, when only 2 out of 10 children were enrolled. Similar to this, 8 out of 10 children between the ages of 6 and 12 go to elementary school, and 1 in 4 go to high school. Many teenagers, particularly girls, do not attend secondary schools due to various factors, such as child marriage, teen pregnancy, mistreatment at schools, and tuition costs. Six out of ten persons who drop out of school do so due to financial reasons, and 8 percent of girls drop out due to pregnancy[29]. Similar issues with educational quality persist; according to a government poll from 2018, only 50 percent of Primary 3 students met the government's definition of proficiency in literacy and numeracy. In terms of urban-rural gap, the proportion of learners rated proficient in numeracy (68.4 percent) in schools in urban areas was higher than that of learners in schools in rural areas (51.2 percent).[30]

According to the 2014 SABER report, student absenteeism is a significant issue in Uganda. One in every three primary school students miss days, while in districts with island and fishing communities and agricultural estate or plantation-based incomes.[31] 1 out of every 2 children may be absent from school.[32] Low attendance rates have a negative impact on learning, prevent efficient use of educational resources, and hinder access to school-based health services. Contributing factors to irregular school attendance include lack of school lunches, low attendance rates by teachers, and shortage of school supplies and low importance given to education. Moreover, high rates of school dropouts also hinder learning, as indicated by poor completion rates and low learner attendance. The 2011 Uganda National Panel Survey,[33] revealed that 25 percent of respondents who were illiterate in 2005/06 and were 12 years or older had become literate by 2009/10. Men were more likely to have acquired literacy (38 percent) compared to women (19 percent). Further breakdown by region showed that central and western regions had higher literacy rates (32 percent and 33 percent, respectively) than eastern (18 percent) and northern (23 percent) regions.

Gross enrollment in schools significantly increased as a result of the introduction of UPE,[34] and Universal Secondary Education.[35] This makes it possible to address the various health needs of students in a well-organized and systematic way. In light of this, the NSHP (2012) was created to make sure that the needs, rights, and interests of all students at all levels were properly taken care of in order to improve educational outcomes.

SHN History in Education

A number of school health initiatives have been rolled out in Uganda by the government, development partners, and local actors to foster good health in schools. These have been carried out under the National Health Policy (minimum health care package, immunization, screening for malnutrition), the Children Amendment Act of 2016 and the National Sexuality Education Framework, the latter though with some contestation especially among religious groups. These initiatives cover adolescent reproductive health; guidance and counseling; school water and sanitation; sexuality education; and life skills; the PIASCY; and preventive and curative health programs such as deworming, Vitamin A supplementation, and immunization. Despite these, there is no approved SHP in place that would support coordination, monitoring, and accountability of these initiatives. Despite these initiatives, interventions have been carried out in a fragmented manner, without coordination. Hence it is difficult to account for the outcomes of these initiatives. This is partly the reason for the SHP; however, officials still see the need for a comprehensive country-wide assessment that might inform priorities.

School Health Kit:

The very first initiative on school health, although not comprehensive, was in 1986 on immunization and termed the Uganda School Health Kit on Immunization. Prior to the middle of the 1980s, health education activities were centralized in the MoH and mostly targeted at the adult population. However, it was decided that it was important to address the problem through a cooperative effort by the MoH and MoES after discovering that this process was relatively slow and that habit development can best be done during the early years of life. The School Health Education Project, or SHEP as it is more generally known, was born out of this.

School Health Education Project (SHEP):[36]

The SHEP was one of the major school health foundations at the time, aimed to improve people's health status by facilitating the acquisition of fundamental health knowledge, skills, and attitudes that allowed students, teachers, and the community to take charge of their own health. The SHEP process reviews from 1991 and 1993, along with the research results supported by the evaluation of the national AIDS drama competitions for primary, secondary, and primary teachers' colleges with regular monitoring, showed a commendable steady rise in beneficiaries' awareness to an average of 65 percent but fell short of satisfactory evidence in the beneficiaries' behavior change. Primary leaving examination results demonstrated that the SHEP had achieved objectives in respect to knowledge acquisition for this young group of primary completers. However, the ministry was concerned that the attitudes and practices were not being transformed at a commensurate rate. It was believed that by expanding the focus of life skills instruction, it would encourage students to put the knowledge they learned into practice by establishing healthy lifestyle habits among other beneficial behaviors (Ministry of Education & Sports, 1995).

The Basic Education, Child Care and Adolescent Development (BECCAD):

This new effort was born out of the pressing necessity to develop and acquire life skills in order to exhibit the required positive behavior. The BECCAD program sought to support children's and adolescents' full cognitive and psychosocial development within a nurturing family and community environment, and was supportive of universal access to education, prevention of HIV/AIDS/Sexually Transmitted Infections (STIs), and adequate care for children and adolescents from birth to adulthood. Life skills and Complementary Opportunity Primary Education, Child Care and Protection under the Ministry of Labour and Social Affairs, and Gender and Community Development, with Adolescent Development and HIV/AIDS falling under the Uganda AIDS Commission[37] and Non-Governmental Organizations (NGOs), were the two components of BECCAD that MoES was putting into practice.

2002 Attempt for a School Health Policy:

The first attempt at a SHP in Uganda was in 2002, with the goal of promoting the health and well-being of students in primary and secondary schools throughout the country. The document emphasized the importance of creating a safe and healthy school environment, addressing health-related barriers to learning, and promoting health education and practices among students and school staff. It covered various aspects of school health, including nutrition, WASH, reproductive health, mental health, HIV/AIDS prevention, and physical activity, and served as a guideline for schools and relevant stakeholders to implement comprehensive school health programs and initiatives that contribute to the overall development and academic success of students in Uganda. However this policy draft was not brought into effect because it was not comprehensive in its nature, and was succeeded by the drafts of 2012 and 2021.

Health Promotion:

Health promotion and education activities have been active for several decades; however, the origins are unknown. Typically they are rolled out to include health debates, talks, talking compounds, school clubs, Music, Dance and Drama and the use of Information, Education and Communication (IEC) materials. In addition, PE is compulsory in pre-primary, primary and secondary education institutions supervised by an assigned teacher. Information is disseminated also through school health clubs to other classes in the school.

School Nutrition:

Initiatives on nutrition and school feeding, food production, and income generation ventures have included promotion of school gardens/farms as well as provision of midday meals and involvement of communities in school feeding programs. These initiatives are complemented by the Uganda Multisectoral Food Security Project which is being implemented by a number of ministries: the Ministry of Agriculture Animal Industries and Fisheries (MAAIF), the MoES, the MoH, and the Ministry of Local Government in selected districts. Other interventions include micronutrient supplementation (Vitamin A, folic/iron for adolescent girls), and immunization. The WFP has supported school feeding programs, and USAID supported the school health reading program. In 2012, the USAID/Uganda School Health and Literacy Program began as a five-year initiative. It was then extended by an additional two years, and expired in 2019. The program was created to assist the MoES in its efforts to enhance early grade reading and foster HIV/AIDS prevention practices among Ugandan schoolchildren and adolescents by utilizing already-existing mechanisms. The Research Triangle Institute was in charge of carrying out the initiative.[38]

WASH in Schools:

The Education Act of 2008 clearly states the need for the establishment of WASH facilities in education institutions. Menstrual hygiene management interventions in schools have targeted head teachers, senior women and men teachers, and learners. Some of the organizations that have been involved include SNV, Water Aid, Water for People, Save the Children International, Red Rhino, and the National Water and Sewerage corporation. Much of the activities are concentrated around construction of gender segregated latrines, water harvest tanks, and boreholes, making of pads, hygiene education, sensitizations on handwashing, and drama kits in schools. Other initiatives include the operation and maintenance framework, solid waste management, and wastewater disposal in schools, and finally food hygiene and safety in school.

School Health Services:

These include first aid treatment, and an enrolled nurse and/or counselor to provide school health services including general medical check-ups, HIV/AIDS and sexual and reproductive health counseling, pregnancy check-ups, dental treatment, and immunization. UNICEF has supported the Expanded Program for Immunization (EPI) through both routine immunization programs and by collaborating with governments and other partners to organize biannual national immunization days. The national target for vaccine coverage is 90 percent. However, based on the Uganda Demographic Health Survey of 2016, the coverage for most antigens/ vaccines fell below the desired target, except for the BCG. This indicates that the uptake of vaccines was

low due to insufficient awareness, and some learners who were absent missed out on school-based health services. The inadequate coverage has led to outbreaks of vaccine-preventable diseases, such as measles, suggesting that certain children have not received complete immunization. Schools play a crucial role as partners in achieving successful immunization efforts. They host target populations, including children under the age of five, 10-year-old girls, and adolescent girls aged 15 and above. Schools provide an ideal setting for implementing, educating, and promoting immunization programs.

Growth and Development:

The MoES and other government and non-government sectors, such as the research community, faith-based groups, cultural organizations, parents, and students, initially worked collaboratively to promote sexuality education, via the SHEP, the Health Education Network, and numerous other initiatives, including Save the Youth from AIDS. In order to address HIV/AIDS among school-age children and youth in primary schools, the president of Uganda initiated the PIASCY campaign in 2003. Later, the program was expanded to include upper schools [post primary institutions]. In order to assist students in acquiring the self-knowledge, moral convictions, interpersonal abilities, and career/vocational knowledge necessary for them to choose healthy and productive life skills that are sustainable throughout their lifetime, the MoES developed a guidance and counseling curriculum in 2007.[39]

The National Sexuality Education Framework was produced by the MoES after extensive stakeholder input. This framework aims to establish an over-arching national direction for teaching sexuality to young people in a formal environment. It was created in accordance with current national pledges and policies, Vision 2040, the President's Fast-Track Initiative to Ending Aids in Uganda by 2030, the NDP, the National HIV strategy plan, and lastly the strategic plan for the education sector. The primary goals are to: i) empower young people to make informed decisions regarding their sexual and reproductive health, and (ii) empower them to use life skills to cultivate attitudes, values, and relationships that help them reach their full potential as humans as endowed by God. The framework has been used to create resource materials for those who implement sexuality education, a boundary document to improve content and support the promotion of sexuality education, and lastly curricula, textbooks, messages, and lesson planning for sexuality education, among other things.[40]

Emerging Issues:

Underscoring the importance of education, a UNFCCC news article (2016)[41] states that education is a key component of the global response to climate change, crucial for the rapid and effective implementation of the Paris Agreement and the Sustainable Development Goals. A key focus area of UNESCO's worldwide framework for education for sustainable development (2020) is climate action.[42] Two readers on the effects of climate change were given the go-ahead by the MoES in 2015,[43] for use in elementary schools and the national curriculum. The readers are designed for pupils in upper primary (P4–P7) and use narrative to explain climate change. Instead of needing to wait for the 5–7-year cycle of the National Curriculum Development, they were used as supplemental materials to enable more rapid integration. The readers serve as crucial proof of the MoES' commitment to include climate change awareness into the educational field.

The 2021 draft NSHP Problem Statement lists bubonic plague, hemorrhagic fevers, and most recently COVID-19 and EVD as some of the rising challenges that are affecting schools. In order to address these concerns, the MoES collaborated with the MoH on the development of guidelines and Standing Operating Procedures (SOPs) on both EVD and COVID-19, safe release of learners from education institutions, and other interventions to ensure safety of learners such as creating awareness, evacuations, among others. These are not mentioned in the policy draft. In Uganda, the first two years of the COVID-19 epidemic resulted in a severe decline in learning and educational quality. It is believed that over 15 million students missed school, with the longest school closure anywhere in the world over two years, and some teachers turned to other forms of employment.[44]

> With assistance from UNICEF's Peacebuilding Education and Advocacy Program, the GOU, through its Ministry of Education, Science, Technology, and Sports (MoESTS), created a regulatory framework known as the Conflict and Disaster Risk Management Guidelines (CDRM) for Educational Institutions. MoESTS developed A Guide to Conflict and Disaster Risk Management in Educational Institutions in Uganda (the CDRM guidelines), which was officially launched at the 22nd Education Sector Review in Kampala in August 2015. In order to guarantee children's right to an education regardless of the circumstances, MoESTS also worked to enhance individual, organizational, and institutional capacity in CDRM in education at the national, district, and school levels. The government is also implementing structural adjustments to increase security in schools, most notably by putting in conductors and lightning arrestors to safeguard learners.[45]

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.[46] There was acknowledgment of the role of education in achieving all the Sustainable Development Goals (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.

To elaborate further, Uganda committed to strengthening prevention and response to any forms of violence at the school level, online, and in emergency settings by scaling up evidence-based prevention approaches. These included socio-emotional learning, gender transformative and trauma-informed approaches in curricula and teacher training, to act as accelerators to violence prevention, learning, and lifelong physical and mental health. Notably, approaches also aimed to strength child-friendly referral systems to effectively respond to violence and provide sexual reproductive health education and psychosocial support programs to address challenges presented by the COVID-19 crisis. Looking ahead, the government committed to ensuring affirmative action in favor of marginalized groups such as adolescents, refugees, girls, and young women, and indigenous groups who may be excluded from education services. For example, the government plans to finalize the SHP, operationalize the National Teachers Policy, enhance teacher training, integrate life skills into the curriculum, and promote digital learning. They will support professional development for teachers, implement learning recovery programs, and increase investment in education through resource mobilization.

The GOU also pledged to support learning at all levels, including adult education. Uganda acknowledged that students who suffer or witness violence in and around schools have serious difficulties that affect their educational process and results. «We will expedite the SHP's completion to address health-related challenges in the education sector, pledges to create a strategy for resource mobilization and to use public-private partnerships to increase local funding for education from 11 percent of our GDP in 2022 to 20 percent of our GDP in 2030."[47]

Priority Health Issues Affecting School-Age Children

Even though it has been demonstrated that good school health can support higher educational achievements, it has long been disregarded and confined to fragmented efforts by the many education sector players. A thorough review of school health metrics reveals the following:

Prevalence of Diseases:

The most common illnesses among school-age children (5-14 years) are malaria (42.75 percent), TB (29.8 percent), soil-transmitted helminths (25.95 percent), dietary iron deficiency (18.58 percent), upper respiratory infections (4.1 percent), oral problems (35.07 percent), fungal skin infections (16.68 percent), and anemia (43.27 percent). HIV/AIDS tops the rank of causes attributable to risk factors for death among 5–14-year-olds, followed by diarrheal diseases.[48] A total of 28,674 primary school students and 5,154 secondary school students were HIV positive in 2016, according to EMIS, and 2,365 primary school teachers and 451 secondary school teachers were HIV positive.[49] With untreated HIV/AIDS, both students and instructors' health conditions deteriorate, which has a significant negative influence on their capacity to attend school. Additionally, these teachers and students experience significant levels of discrimination and stigma, which negatively impacts their concentration and decreases their engagement in educational activities at their respective levels. The HIV/AIDS epidemic has become a significant obstacle to fulfilling EFA objectives and the SDGs in education.[50] (Regulatory Impact Assessment for School Health in Uganda, 2021).

Teenage Pregnancy:

With 24 percent of teenagers between the ages of 15 and 19 having at least one child, Uganda is one of the nations with the highest rate of teenage pregnancy.[50] Teenage pregnancy in Uganda is a persistent issue. As of 2018, nearly 25% of women aged 15-19 had given birth or were pregnant. Over half of the girls have experienced childhood sexual abuse. Rural areas face higher rates (27%) compared to urban areas (19%). Factors such as poverty, high HIV/AIDS rates, violence, and limited access to health services exacerbate the problem.[51] The majority of adolescent mothers who fall pregnant have their second child fewer than two years after the birth of their first. In Uganda, there are over 300,000 illegal abortions every year, which accounts for 8 percent of all maternal fatalities, a large majority of which affect teenagers. Just 8 percent of adolescent girls who drop out of school may be readmitted, and teenage pregnancy accounts for 25 percent of these dropouts. Moreover, the Adolescent Health Risk Behaviour Survey (2016) found that almost one in ten teenagers has experienced an STI.

Nutrition:

According to the National Service Delivery survey,[52] 51 percent of learners in government-aided schools were not provided lunch at school. The findings also indicate that urban children (41 percent) are more likely to receive school meals than their rural counterparts (32 percent). The main nutritional issues affecting school-age children in Uganda include anemia, hunger, stunting, underweight, and overweight. 53 percent of preschool-aged children have anemia.[31]

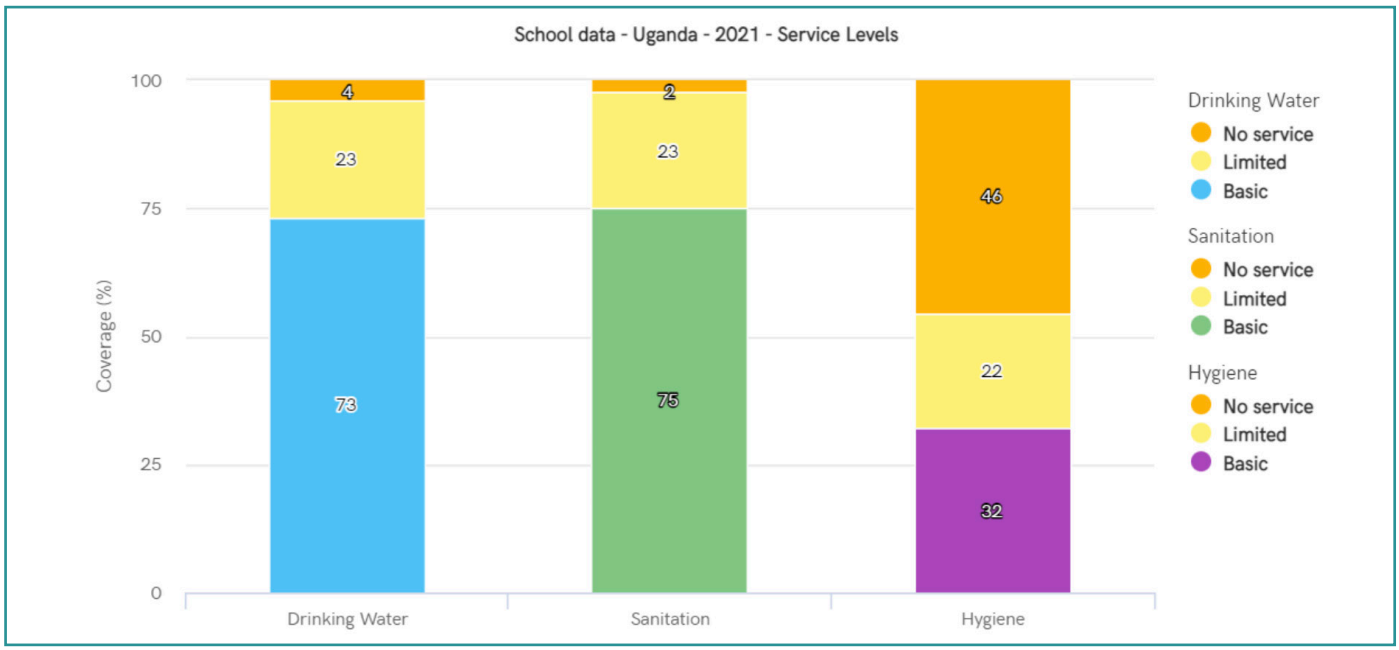
School WASH:

In 2021, 73 percent of government-supported primary schools had water from an improved source (piped, protected well etc.), while 77 percent primary schools had sex separated and usable toilets for learners. although only 29.5 percent were adequate. Only 32 percent of schools had handwashing stations with soap and water (JMP, 2021). Access to clean water and decent latrines remains a challenge in thousands of schools across Uganda, despite the WASH standards recommending 1.5 liters of clean water per day for learners and staff. The COVID-19 implication of closed schools after almost two years, brought forth the needs for schools to prioritize water, sanitation, and hygiene facilities. "The return to schooling in the nation is a cause for celebration, but it also serves as a reminder of the critical role of water and sanitation in schools", according to the national director of WaterAid in Uganda, which works hard to assist

supply clean water and toilets in schools. Only 52.1 percent of girls have access to disposable sanitary products, while 1.6 percent of schoolgirls use reusable pads. School absenteeism due to menstrual-related issues is prevalent among girls attending school, with a recorded rate of 26 percent in 2016 (Adolescent Health Risk Behaviour Survey, 2016).[54]

FIGURE 1: JMP SCHOOL WASH DATA - UGANDA

Note. Sourced from : https://washdata.org/data/school#!/dashboard/new



Physical and Intellectual Impairment:

A report by the Department of Special Needs and Education reveals that only 4 percent out of Uganda's 10 percent of disabled children attend school due to challenges such as insufficient assistive devices[55] The lack of physically acceptable school architecture, inadequate sanitary facilities, a lack of psychosocial support and counseling services, among other things, contributed to 73 percent of students with disabilities dropping out of school. According to EMIS, there were a total of 178,450 SNs students (94,158 males and 84,292 females) in primary education and a total of 17,277 SNs students (9,172 males and 8,453 females) in secondary education in 2016.

Fire Outbreaks:

Schools in Uganda face a serious threat from fire outbreaks. Investigations by the National Building Review Board (NBRB) revealed that 35 percent of fires occur in schools, often due to human actions (arson) or negligence (improper use of flammable materials). These fires have devastating consequences, particularly for younger students (aged 10 or less) and those with special needs. The NBRB has tasked the Building Committees and Building Control Officers to ensure that all school buildings are inspected to ascertain fire safety compliance ahead of the new academic year. Schools must be issued certificates of inspection as proof. These measures are crucial as investigations since 2020 have shown that every two in three fires are started intentionally or as a result of negligence. The most devastating fires often occur in dormitories at night when students are asleep.[56]

The 2023 annual crime report indicates 61 recorded fire outbreaks in schools, up from 55 in 2022, resulting in at least 64 deaths in 2023 alone. The 2024 NBRB report highlights significant non-compliance with fire safety standards in educational institutions, underscoring the urgent need for strict adherence to fire safety protocols.[57]

Alcohol and Substance Abuse:

Alcohol and substance abuse significantly affect school-age children in Uganda. A baseline survey revealed that 21 percent of students have tried drugs, with use increasing with age and class. Notably, 65 percent of students have consumed energy drinks such as Sting and Rock Boom, while 60 percent have tried local alcoholic drinks. Alcohol use is higher in boarding schools compared to day schools, and more prevalent in private schools. Peer pressure is a major facilitator of substance abuse, and sensitization programs have proven effective in reducing drug abuse tendencies among students.[58]

Mental Health and Psychosocial Challenges:

A Systematic Review and Meta-Analysis[59] examined the prevalence of mental disorders among Ugandan children and adults by analyzing 26 studies from 632 records using validated assessment tools. Findings indicate that 22.9 percent of children and 24.2 percent of adults in Uganda have mental disorders, with anxiety and depression being notably common. Children in Uganda battle with a number of issues: poverty, family dysfunction, land conflicts, and others. Approximately 45 percent of primary school learners and 25 percent of teachers experience socio-emotional difficulties. Efforts such as the Transformative Learning Collaborative project are addressing these needs by implementing socio-emotional interventions in schools, benefiting over 8,000 learners and improving teacher well-being.[60]

The prevalence of depressive symptoms among adolescent boys and girls in secondary schools in Uganda is 21 percent, while the prevalence of anxiety disorders is 26.6 percent with higher rates in females at 29.7 percent than in males 23.1 percent.[61] With 1.3 million refugees in Uganda, the need for mental health and psychological support is immense. During a multisectoral needs assessment, 40 percent of households reported limited access to psychosocial care for family members in distress. This lack of support puts children at risk of negative coping mechanisms, violence, self-neglect, and school dropout. It worsens mental health conditions like depression and psychosis. The multisectoral needs assessment also identified poor psychosocial functioning among children, associated with mistreatment, neglect, early marriage, and teenage pregnancy. Failure to address these challenges threatens peaceful coexistence and can increase conflicts and tensions between communities.

Violence Against Children in Schools:

According to the Violence Against Children in Schools (VACiS) survey of 2018, 1 in 3 girls (35 percent) and 1 in 6 boys (17 percent) reported experiencing sexual violence during their childhood. Of Ugandans aged 13-17 years, 1 in 4 girls (25 percent) and 1 in 10 boys (11 percent) reported sexual violence in the past year. Ugandan girls most often experienced sexual violence during the evening. In a series of factsheets on School-Related Gender-Based Violence (SRGBV), Together for Girls claimed that 2 percent of girls and less than 1 percent of males surveyed in Uganda in 2016 who were 13 to 24 years old had suffered sexual violence by teachers.[62] The VACiS survey (2018) reveals that 6 in 10 females (59 percent) and 7 in 10 males (68 percent) of persons aged 18–24 years reported experiencing physical violence during their childhoods. Relatedly, 4 in 10 girls (44 percent) and 6 in 10 boys (59 percent) aged 13–17 experienced physical violence in the last year. In addition, children reported that they often suffer violence by adults in the community, with 2 in 5 boys (41 percent) and 1 in 3 girls (31 percent) experiencing physical abuse by community members, most often from female and male teachers for girls and male teachers for boys.

The difficulty in creating safe spaces in schools is a result of teacher-inflicted violence. The first instance of physical abuse by an adult in the community included a male teacher for nearly half (45.7 percent) of girls and 60.4 percent of boys. Violence at the hands of teachers continues to be widespread despite the 2016 Amendment to the Children's Act expanding its ban on physical punishment to all schools and universities. By «raising accountability of duty-bearers,» the violence that takes place in schools is to be addressed.[63] This refers to the specific people who are violent toward learners in schools. Students who have been subjected to physically abusive teachers are reluctant to trust them. This might foster a climate of mistrust where students are afraid of all the adults working at the school, including the counselors and health staff. Teachers frequently serve as role models for their young students. One in four 13–17-year-old boys who admitted to abusing an intimate partner were more likely to have experienced sexual or physical abuse, according to the Violence Against Children survey.[64]

Road Safety, Safety From Accidents, Emergencies:

Children suffer a heavy burden of avoidable injuries, with road accidents, falls, and violence being the main causes, according to a Kampala study on child injuries. Of the 872 hospital visits due to injury recorded from August 2004 to August 2005, 6 percent of admitted patients died within two weeks, with 16 percent having severe injuries. These findings highlight the need for enhancements in commuting plans, road user education, and educational institutions, as well as injury prevention.[65] Pedestrians, including children of school-age, are the most vulnerable group of road users, with 40 percent of fatalities in 2016. This statistic highlights the urgent need for interventions to lower road-related injuries among children in Uganda.[66]

Stigmatization:

Many students experience severe stigma and prejudice from their peers, teachers, and other members of the school community because of their health, physical, mental, and psychological issues, including HIV, epilepsy, and physical impairment, among others. This mentally torments and demotivates the affected students, increasing their likelihood of dropping out of school.

Disaster Risk Reduction:

Since 1998, 1.8 million people in Uganda have been internally displaced due to floods, landslides, and drought, and there have been infrequent deaths from lightning strikes, mostly in schools.[67] A junior school in Masindi's southwest was struck by lightning in June 2011, killing 18 students and a teacher and wounding 36 others.[68] According to data from the Ministry of Disaster Preparedness and Refugees, lightning killed at least 160 students in the nation in 2014 and 205 students died between 2012 and 2013.[69] In the flood-prone western districts of Kasese, Bundibugyo, and Ntoroko, as well as the eastern districts of Amuria, Katakwi, and Serere, the late 2015 El Nino rains compelled hundreds of residents to take refuge in schools and medical institutions.[45]

Emerging diseases:

Following the confirmation of a COVID-19 case in the nation on March 18, 2020, His Excellency the President of the Republic of Uganda declared the closure of all educational institutions to prevent panic and the potential spread of further illnesses. More than 73,200 educational institutions were shut down as a result of this move, affecting more than 15,100,000 students and 548,000 teachers.[47] The problem statement of the 2021 draft NSHP, highlights the lack of capacity and readiness among educational institutions to effectively manage, mitigate, and control pandemics like COVID-19, EVD, bubonic plague, and hemorrhagic fevers, among others.

In 2022, 11 school children were diagnosed with EVD. Five schools in Kampala capital city Authority, Wakiso, and Mubende district were confirmed as having had some of the children who were infected with EVD. One of the children died from the disease and 170 contacts were identified from these cases. Among children, a total of 23 cases had been confirmed, of which 8 had died while 5 had fully recovered and 16 were under isolation.[70]

Food and Nutrition:

In a study done in Northern Uganda on the impact of Food for Education programs on school participation, results showed that in-school meal programs with an experimental take-home ration increased enrollment for those children not enrolled at baseline. Both programs had a large impact on school attendance and reduced grade repetition.[71]

As part of WFP efforts to support the governments of East and Central African countries in developing and implementing evidence-based interventions to improve the health status of school-age children in the region, in 2020 the WFP Regional Office (Nairobi), announced a review, commissioned to generate the best available evidence on the health and nutritional status of school-age children in the region.[72] A mixed-methods approach was used, which included a combination of methodologies including desktop and systematic reviews, secondary data analysis, and policy and stakeholder mapping efforts. School-age children in the region have a number of health and nutritional challenges that, if not addressed, will linger into adulthood. In connection with Uganda, it was noted that there was

a 40.66 percent prevalence of malaria, a 0.83 percent HIV prevalence, mortality trends from unsafe WASH, while for adolescents aged 15–19, unsafe sex was the main risk.[76] The regional review of school-based educational interventions suggested that they were effective in improving students' knowledge about HIV and sexual reproductive health (SRH). The common features of these interventions were the involvement of teachers and the integration of HIV/SRH education into the school curriculum. School-based educational events have the potential to incorporate all SRH issues and provide training opportunities for teachers and students.[73]

In a multilevel analysis conducted in Uganda based on health care utilization and hierarchical modeling, 78 percent of girls were unvaccinated against human papillomavirus infection (HPV), however, girls aged 11, 13 and 14 had higher chances of getting HPV vaccination as for girls aged 10 years who were in school compared to girls who were not in school. Therefore, schools would be ideal environments or locations to provide a pathway for better coverage and access to school health services.[74]

This study aimed to gather insights into the perspectives of primary school children in Uganda regarding the common diseases they experience and the medicines they use, in order to inform reforms and priority setting for school healthcare programs. Data was collected through a combination of rapid appraisal approaches, surveys, participant observation, and narratives from 80 children aged 8–15 years. The results revealed that children ranked malaria (91.3 percent) as the most severe and frequently experienced disease, followed by diarrhea (82.5 percent), skin fungal infections (66.3 percent), flu (40 percent), and typhoid (21.3 percent). Symptoms recognized by the children included high body temperature, vomiting, headache, weakness, appetite loss, and diarrhea. Treatment involved medication provided by the school nurse or self-medication using pharmaceuticals obtained from clinics, drug shops, pharmacies, and indigenous medicines from home and markets. These findings highlight infectious diseases as the primary healthcare needs and priorities for children in primary school and their learning outcomes, emphasizing the importance of addressing these issues within school health programs.[75]

National and Subnational School Health Strategies and Policies

The NDP III (2020/21–2024/25) and the Education Act (2008) are only a few of the national legal and policy frameworks that further enhance the GOU's commitments to health and education. Other frameworks include Uganda's Vision 2040 outlines a strategic framework for the country's development and the Children Act Amendment of 2016. A number of sectoral strategic plans also address the provision of education and health services and improved outcomes among children and youth, including: the National Health Policy (2012); the National Teacher Policy (2019); the Uganda National Action Plan for Nutrition; the Business Technical Vocational Education and Training Strategic Plan (2011–2020); the HIV/AIDS Strategic Plan (2017–2022); the Education Sector Strategic Plan of 2016/17–2021/22; the Health Sector Strategic and Investment Plan III, 2010/1–2014/15; the National Strategy for Girls' Education in Uganda (2014–2019); and the National Framework on Sexuality Education in Uganda (2018–2022), among others.

The goal of the draft 2021 NSHP is to enhance the quality of health in school communities in order to promote EFA. The SHN policy draft covers eight components which are anchored on the four pillars of FRESH.[76]

TABLE 1. LIST OF SCHOOL HEALTH-RELEVANT NATIONAL POLICIES IN UGANDA

NR	Area	Policy Name	Acronym	Start	End	Does this Fund SHN Initiatives?
1	**Education**	Education Act	EA	2008	NA	Yes
2		Education Sector Strategic Plan	ESSP	2017	2020	Yes
3		National Strategy for Girls' Education	NSGE	2013	NA	Yes
4		Government White Paper on Education	GWPE	1992	NA	Yes
5		Performance Management Guidelines	PME	2020	NA	Yes
6		Education Response Plan	ERP	2018	NA	Yes
7	**Health**	National Health Policy	NHP	2012	NA	Yes
8		National School Health Policy Draft	NSHP	2021	NA	NA
9		HIV Strategic Plan	HSP	2018	2022	Yes
10		Presidential Initiative on AIDS Strategy for Communication to Youth	PIASCY	2001	NA	Yes
11		National Sexuality Education Framework	NESF	2017	NA	Yes

NR	Area	Policy Name	Acronym	Start	End	Does this Fund SHN Initiatives?
12	**Governance**	National Development Plan III	NDP III	2020/21	2024/25	Yes
13		Vision 2040	Vision 2040	2013	NA	NA
14	**Child protection**	The Childrens Act (2016) (amended)	CA	2016	NA	Yes
15		National Strategy to End Child Marriage and Teenage Pregnancy	NSECMT	2022	2027	Yes
16		Elimination of Violence Against Children Strategy	EVCS	2015	2020	Yes
17		Comprehensive Refugee Response Framework	CRRF	2017	NA	Yes
18		Guide to Conflict and Disaster Risk Management in Educational Institutions in Uganda	CDRM	2015	NA	Yes
19	**Nutrition**	The Uganda Food and Nutrition Policy	UFP	2003	NA	Yes
20		Uganda Nutrition Action Plan II	UNAP II	2018	2025	Yes
21		Maternal Infant and Young Child Adolescent Nutrition	MIYCAN	2021	NA	Yes
22		Integrated Management of Acute Malnutrition Guidelines	IMAM	2020	NA	Yes
23		National Agriculture Policy	NAP	2013	NA	Yes

The policy framework informing formulation of the NSHP includes:

Vision 2040:

Vision 2040 sets the broad development agenda for Uganda which aspires to transform the Ugandan society to a modern and prosperous country by the year 2040. Realization of this Vision is sequenced into cyclical 5-year NDPs with the current NDP III being the running phase of the said Vision 2040.

NDP III:

NDP III 2020/21–2024/25 relates to human capital development and commits government to put in place the necessary policy, legal, institutional and regulatory framework to support the development of skilled human resources at all levels as well as to strengthen healthcare interventions to advance the welfare and livelihood of Ugandans. The GOU is committed to an inclusive and equitable quality education, promotion of lifelong learning opportunities, and to a skills revolution underpinned by science, technology, and innovation.

National Sexuality Education Framework:

The MoES developed a National Sexuality Education Framework in 2017 which provides age-appropriate content relating to human development, relationships, behavior, and sexual health. The implementation of this framework was launched in 2018 preceded by the guidelines, although some religious groups have reservations.

Elimination of VACiS Strategy:

The NSP VACiS, 2015–2020, has been developed with the vision of a safe learning environment that enables children in Uganda to stay in and complete school and be able to unlock their potential for development. The overall goal of the NSP VACiS is to ensure that measures are in place to prevent, protect and respond to violence against children in schools.

National Health Policy (2012):

The MoE developed and secured Cabinet approval for the National Health Policy in 2012, which lays down a comprehensive framework for addressing various health challenges faced in the country. A key intervention of the said policy is the Uganda National Minimum Healthcare Packages which define packages for control of communicable diseases including malaria, STIs/HIV/AIDS, and TB; integrated management of childhood illnesses; sexual and reproductive health and rights including family planning, adolescent reproductive health, and violence against women; strengthening mental health services; as well as other public health interventions including immunization, environmental health, health education and promotion, school health, improving nutrition, epidemics and disaster prevention, preparedness and response. The National Health Provisions on minimum health care packages are thus aligned with the proposed School Health interventions.

The legal framework for school health comprises the following:

Constitution of the Republic of Uganda (1995):

Parts XVIII and XX indicate educational and health objectives respectively and these highlight state actions in relation to promotion of health and education as core rights and as social services for the Ugandan populace. In addition, Article 30 states that "All persons have a right to education" whereas Article 39 provides for the right to a clean and healthy environment. Relatedly, Article 20 (1) of the same constitution states that, "fundamental rights and freedoms of the individual are inherent and not granted by the state." This implies that access to proper health care and information in an education setting is a right for all Ugandans via the structured framework stipulated by policy.

The Education Act (2008):

The Education Act makes provisions aimed at operationalizing Article 30 of the 1995 Constitution of the Republic of Uganda, which makes access to basic education a right for all Ugandans. Section 4 (1) of the Act states that "Provision of education and training to the child shall be a joint responsibility of the State, the parent or guardian and other stakeholders" whereas Section 4 (2) of the same Act states that, "Basic education shall be provided and enjoyed as a right by all persons." Section 5 of the same Act provides for responsibilities of parents and guardians in education of children to include: providing parental guidance and psychosocial welfare to their children; providing food, clothing, shelter, medical care and transport; participating in the promotion of discipline of their children; participating in community support to the school, among others. However, these functions are largely neglected resulting in a number of school health challenges under Section 2 of the RIA Report, 2021.

The Children Act Amendment (2016):

The Children Amendment Act makes a number of provisions in relation to advancing the welfare and livelihood of children in the country. Section 8A of the Act provides for prohibition of sexual exploitation for children. In addition, Section 106A makes provisions on corporal punishment and specifically, Section 106A (1) states that, "a person of authority in any institution of learning shall not subject a child to any form of corporal punishment" whereas section 106A and 106A (2) state that, "any person who subjects a child to corporal punishment commits an offense and is liable to imprisonment for a term not exceeding 3 years or to a fine not exceeding 100 currency points." However, despite the existence of such a deliberate and clear legal framework, corporal punishment continues to exist unabated in education institutions and there exists no evidence of perpetrators of this offense being prosecuted in courts of law in line with the above legal provision. Lastly, Uganda is signatory to a number of international commitments on promotion of education and good health. Key among these is the United Nations Convention on the Rights of the Child, the SDGs, the World Program of Action for Youth, the Scaling Up Nutrition Initiative, and the African Charter on the Rights and Welfare of the Child.

Evidence for SHN Strategies and Policy

The NSHP's guiding principles, criteria, and explanations are examined in-depth and analytically in the 2021 RIA report. The report details the issues with school health as well as proposed solutions and examines the potential costs and advantages of developing and implementing the NSHP.

According to the 2021 RIA report, consultations with a number of MDAs, development partners UNICEF, the United Nations Population Fund, and UNESCO, subnational governments, civil society, individuals, and faith-based organizations were conducted prior to the development of the policy. However, the draft NSHP policy has not yet been made public in light of the development's preceding consultation; possibly after it is approved, this will facilitate its public disclosure.

Issues considered controversial from the consultation process for the draft NSHP include the following:

1. Because of their health, physical, emotional, and psychological concerns, such as HIV, epilepsy, and physical handicap, among others, many learners endure significant stigma and prejudice from their peers, instructors, and other members of the school community. The pupils who are affected by this are psychologically tormented and demotivated, which increases the risk that they may quit school.

2. School feeding is still a contentious issue in the country. On the one hand, there are learners that are starving, are malnourished, and cannot afford one meal a day, whereas on the other hand, there are learners who are being overfed and are suffering from obesity and other NCDs. Thus, the need to balance these two extremes in the policy.

   Questions were raised with regard to the title of the policy. Stakeholders continuously inquired as to whether the title of "School Health Policy" ably captures all the stakeholders targeted by the policy. Some stakeholders suggested that the policy be named Comprehensive SHP, or Integrated SHP or Health in Education Policy. There was, therefore, need to take into consideration these various proposals and zero in on one title for the policy that is representative of the policy scope.

Other findings from the consultations were as follows:

- Due to absence of the NSHP, primary and secondary schools do not implement all the necessary components of school health programs that are tailored to address disease patterns and burdens.
- There is limited capacity at the school level, among teachers and management, to sensitize learners and provide counseling in the area of gender equality and sexual and gender-based violence (SGBV). In addition, there remains an information and knowledge gap on the incidence and prevalence of SGBV in schools in Uganda.
- The school health delivery system is not formally linked to the district and national health delivery system. Hence, they do not benefit from the national and district health delivery programs.
- School health facilities are underutilized, as they only provide first aid type services yet they have trained staff (enrolled nurses). This has escalated the need for referral arrangements even for cases that would otherwise be dealt with at the school level. In addition, the facilities are not supported by the national health programs, including essential drugs and capacity building programs, yet they serve a big population and have basic competent staff to provide Health Center II services.

- Coverage of IEC materials remain inadequate in terms of covering all the components school health, geographical distribution, and volume of materials provided. Where available, accessibility to learners is limited by not being displayed in areas frequented by learners, such as notice boards, dormitories, and dining rooms.

- There are no specific documented systems, processes, procedure and mechanisms to deliver effective school health programs at both national and district levels. This is attributed to the fact that there is no NSHP around which these systems, processes, procedures, and mechanisms would be developed and utilized.

- Many school clubs are undertaking school health-related activities. There is no mechanism to coordinate activities of the clubs for purposes of resource sharing and minimization of duplication of activities. It should be noted, however, that none of the clubs were performing the full functions expected of a typical health club. A typical health club would be a structure and mechanism for enabling learners' participation in implementation of the NSHP and linkage with school management on advancement of school health.

- There is over reliance on outsiders to provide SRH and HIV/AIDS information and services with limited emphasis on development of internal capacity of schools to ensure sustainability.

- Water and sanitation is the most appreciated and the most addressed component of the school health program. However, safe drinking water is not available in most schools and where efforts are made, it was not always available and most glaringly not available in dormitories at night. Personal hygiene is still a problem, especially, among male learners as comparative analysis from qualitative data shows less bathing frequency for boys as compared to girls. It was found that the school management puts attention more to the girl child and far less on the boy child in the area of personal hygiene.

- There is interaction between schools and the community regarding fostering health such as sharing water resources and learner's participation in community cleanliness work. However, there are no deliberate efforts to make learners enjoy this as part of social responsibility and joint planning and implementation of activities for mutual health benefit.

- There are a number of good practices that enhance existence and functionality of school health activities, facilities and environment including talking compounds, sharing resources with communities, local leadership supervising the nearby schools, smoke detectors, energy saving cookers, learner participation in income generation through school gardening, domestic water purification systems, use of closed incinerators, and emergency menstrual kits for girls.

- During the implementation of the NSHP, parents, religious, and cultural leaders should be involved at all levels because they play a critical role in building the child's foundation and providing their needs.
  The draft NSHP focuses more on in-school pupils leaving out the out-of-school children. There is a need to design a specific delivery model for out-of-school children to access health information and services.

Thematic Areas and Core Pillars in SHN Strategies and Policy

The draft national policy is aligned with single-issue guidelines such as the school feeding guidelines, sexuality framework, school WASH standards, Reporting, Tracking, Referral and Response (RTRR) guidelines on VACiS. All of the following thematic areas are covered in the policy; however, the order of priority needs to be established, either through the field assessment or follow-up surveys.

Wash (water, sanitation and hygiene).

Nutrition (including meals, supplementation, nutritional counseling).

Physical activity.

Sexual and reproductive health.

Menstrual health and hygiene and health screening (vision, hearing, dental, growth).

Vaccinations (national immunization program for Hepatitis B and HPV).

Preventive treatment (deworming etc.).

First Aid.

Life skills education.

Mental health and psychosocial support.

Violence prevention and response.

Eight different elements make up a complete school health program: health promotion and education, school health services, nutrition services, psychosocial support, health promotion for staff, preventive services, family and community involvement, and a healthy and safe school environment.

One of the advantages listed in the NSHP draft of 2021 is that the policy allows all parties involved in education management to take advantage of and integrate all feasible strategies, such as information sharing and raising awareness, multi-stakeholder coordination, as well as legal reforms, and this results in an efficient and long-lasting multiple strategy approach to tackling the identified school health challenges. Furthermore, it provides ministries and other relevant parties involved in guaranteeing school health with a government tool in the form of a policy that they may use to mobilize additional funding through donor support and enhanced government support for school health promotion.

The NSHP 2021 policy draft mentions aspects of provision for socio-emotional learning and physical environment to learners such as:

- Provision of counseling services at all levels of education to address social, emotional and psychological needs of learners.
- Implementation of initiatives aimed at establishing and promoting a safe, clean and conducive environment in and around education institutions, which is free of vectors and other disease carrying organisms, harmful physical objects, and hidden bushes among other things, which cause a risk to the lives and well-being of learners and other stakeholders in schools.

Health education is covered in the policy; however, skills-based health education is highlighted in the Adolescent Training Manual which mentions life skills, psychological, and mental health for adolescents. In the National Adolescent Trainers' Manual (p. 91), a component of skills is covered with the aim of promoting the following abilities: taking positive health choices, making informed decisions, practicing healthy behavior, recognizing and avoiding risky health situations.[77]

SHN Strategy and Policy Dissemination

The NSHP policy is still in draft form; only the various consultative meetings were carried out after the RIA in 2021 to inform the policy development.

What has been disseminated so far are operational documents to support implementation that mirror what is in the policy draft, for example, school feeding guidelines, guidelines to prevent VACiS, sexuality framework, prevention and mitigation of teenage pregnancy. The MoES also developed RTRR guidelines to prevent and mitigate VACiS.

The next steps expected for the dissemination are:

- Existing national facilitators within government with assistance from the development partners (e.g., Save the Children) will lead the dissemination.
- All levels will be catered for in the dissemination of the policy including policy makers, implementing and development agencies, the private sector, and academic institutions
- Dissemination through the district education departments who can cascade it down to the school heads, parents, and learners.

Multisectoral Coordination and Collaboration

The NSHP draft urges the necessity to create a National School Health Multisectoral Committee (NSHMC), which will be responsible for monitoring the provision of school health services in accordance with the SHP. The Permanent Secretary of the MoES will serve as the NSHMC's head, with the Permanent Secretary of the MoH serving as co-chair. The particular roles and responsibilities of various stakeholders are further highlighted in Annex 1 (Stakeholders' roles and Responsibilities).

There has been a national multisectoral committee for SHN since 2008. The committee has a formal Terms of Reference to coordinate SHN policy development and implementation, with roles and responsibilities outlined. The committee meets once a month and has contributed to the development of the national SHN policy, SHN training manual and service standards, indicators and SOPs during COVID-19 in schools, and the adolescent health training manual. Subnational, multisectoral committees are yet to be formed. Technical working group meetings are held by the MoES's Department of School Health and HIV, but all participants—including those from other line ministries like health and gender—are invited. Additionally, the School Health and Adolescents Health Division of the MoH meets and coordinates matters related to school health and sexual and reproductive health in the technical working groups with other line ministries such as the MoES, and other stakeholders.

As noted before, the NSHP will be implemented and coordinated by the MoES in coordination with the MoH using a program-based approach to planning and implementing government interventions.

Accountability is not sufficiently guaranteed by the Committee, which was intended to strengthen monitoring and tracking. Although the Committee's duties include integrating health issues into existing structures, current systems have already been deemed insufficient for counseling on sexual and reproductive health. The District Health and Education offices will coordinate the delivery of these interventions at the school level in accordance with current policies and standards. In response to the outbreak of COVID-19 in schools, the MoH and the MoES have undertaken collaborative efforts to control and prevent the spread of the pandemic within educational institutions. As part of this initiative, the implementation of a School-Based Surveillance (SBS) system utilizing District Health Information Software version 2 (DHIS2) and mTRAC program (mTRAC), a comprehensive reporting and monitoring tool, has been established. To ensure the effective execution of the SBS, training programs were conducted at the national and regional levels in November 2021 and January 2022, respectively. The primary objective of these training sessions was to equip the District Education Teams with the essential skills required to proficiently utilize the DHIS2–mTrac system. However, it has been identified that many members of these teams are currently lacking the necessary proficiency.

In light of this situation, the National School Task Force was established to coordinate and manage the response to COVID-19 outbreaks and other disease incidents in schools, including recent cases of mumps, EVD, and measles. Comprising representatives from various organizations such as the USAID Mission Uganda, Save the Children, the Infectious Disease Institute, Baylor Uganda, as well as officials from the MoH and MoES, the Task Force is chaired by the Incident School Task Force Command. Regular meetings, both in-person and online, are conducted, especially during outbreaks, and the outcomes of these meetings inform the decisions and actions of the national Task Force. Additionally, the team has been diligently working on developing resource materials to enhance the SBS systems, including job aids, IEC materials, as well as School Health Response Plans. However, it should be noted that there is a lack of consistent attendance from the education counterparts during the hosted meetings, which may hinder effective collaboration and communication between the two ministries.

Resource Allocations for School Health

The proposed budget for FY2023/24 for the Ministry of Education and Sports maintains a stable recurrent wage allocation of 124.598 billion Uganda Shillings, consistent with FY2022/23. However, there is a notable decrease in the non-wage budget from 245.095 billion to 140.371 billion Uganda Shillings and a reduction in the development budget from 101.704 billion to 42.506 billion Uganda Shillings, suggesting a potential shift in funding priorities or resource constraints. The budget includes specific allocations for school health initiatives, with 0.03 billion Uganda Shillings for general health interventions, 0.031 billion Uganda Shillings for HIV/AIDS and menstrual health management, and 0.016 billion Uganda Shillings for COVID-19 related interventions. These allocations represent about 0.0115% of the total budget, reflecting a commitment to enhancing health and well-being in schools.[80]

The education sector in Uganda had a budget allocation of 8.6 percent in 2022/23, but it is on a declining trend and below the 20 percent minimum requirement for African Union states. Primary education spending has decreased from 62.6 percent to 35.7 percent since 2017/18, while secondary education spending has more than tripled to 19.7 percent over the same period. The sector's budget is decentralized, with funds mainly channeled through local councils (projected at 59 percent in 2020/23), giving schools and councils autonomy on budget expenditure. However, most of the local government budget allocation is for wage and recurrent expenditure (at least 90 percent) rather than development resources, which affects development infrastructure such as building classrooms and latrines, leading to high pupil to classroom and toilet ratios and impacting the quality and access to education and school health services.[81]

The proportion of resources allocated through districts for the education sector in Uganda has declined from 67 percent in 2017/18 to a projected 59 percent in 2022/23, while funding through departments and agencies has increased from 22 percent to 33 percent over the same period. The MoES budget has remained stable, with a slight decline projected for 2022/23 to 8 percent of total sector spending. Domestic resources finance most of the on-budget support, with the government funding increasing from 91 percent in 2017/18 to 97 percent in 2021/22, and development partners' support decreasing from 9 percent to 3 percent over the same period.

However, the share of development partner support is expected to slightly recover to 5 percent in 2022/23, with notable projects including skills development projects by the European Union and World Bank, and the Uganda Secondary Education Expansion Project supported by the World Bank.

The education sector budget in Uganda is mainly financed by domestic resources, with a declining share of on-budget support from development partners from 9 percent in 2018–19 to 3 percent in 2020–21. The approved budget has grown by 48 percent over five years, from Ugandan Shilling (UGX) 2.78 trillion in 2018–19 to UGX 4.14 trillion in 2019–20, and it is expected to grow by 10 percent in 2022–2023. However, the ratio of the budget to GDP, ranging between 2.1 percent and 2.6 percent, has remained virtually unchanged over the assessment period. This is below the Incheon Declaration on Inclusive Education's proposed benchmark of 4–6 percent of GDP or 15–20 percent of overall spending for the education sector.[89]

In collaboration with international organizations and the corporate sector, the government will fund the execution of the NSHP. The financing of the policy actions and strategies will be in accordance with the relevant line ministries' medium-term strategic plans. The comprehensive costed Action Plan for implementing the NSHP includes a breakdown of the expenses associated with implementing this policy. Additionally, the draft further mentions that as essential stakeholders, the commercial sector, parents, community members, civil society, and development partners will all contribute significantly to funding the execution of this policy (NSHP Policy Draft, 2021).

In view of the above, the GOU has efforts to support school health although its specific allocation to school health interventions is not clear.

According to the Education and Sports Sector Semi-Annual Budget Monitoring Report Financial Year 2020/21[82], the budget for fiscal year (FY) 2020/21 was UGX 21.762 billion, of which UGX 8.924 billion (41 percent) was released, and UGX 6.113 billion (68.5 percent) expended by 31st December, 2020. The sub-program performance was good with over 70 percent half year planned output targets implemented. Under policies, laws, guidelines, plans and strategies, the department monitored 50 primary schools in the selected districts.

In addition, agricultural supplies for Karamoja WFP were procured and 12,343 candidates were provided with hot meals while 313 schools in Karamoja sub-region were monitored and offered support supervision.

According to the National Budget Framework FY 2021/22 Budget Brief No. 2021/2, the Human Capital Development (HCD) program received 20.4 percent of the national budget. The education sector accounts for approximately 51.8 percent of the HCD program allocation. From the budget brief, the allocation to the education sector was projected to marginally decline by 0.9 percent in FY 2021/22 to UGX 3.64 billion from UGX 3.68 billion in 2020/21, thus the development share of the sector budget will account for 15.2 percent of total education sector allocation. PE and Sports has an allocation of 1 percent, education inspection and monitoring has 0 percent, skills development 7 percent, and lastly policy, planning and social services has 2 percent. The aspects are close or mirror school health components but there is no specific allocation to school health as a stand-alone and this is at local government (The National Budget Framework FY 2020/21 Budget Brief No. 2020/2).[83]

The «Proportion of the Education and Sports Sector Budget Allotted to School Health» indicator is also masked by the evaluation indicators used in monitoring and tracking. It does not address the regional disparities identified in the earlier policies, which would have prevented an unfair distribution of spending between rural and urban areas. Additionally, this policy neglects to account for how the funds are used and whether they are achieving their stated goals.[84]

Aspects like child integrated days on immunization are supported through the Uganda national Expanded Program for Immunization. This is channeled through the MoH who provide the professional expertise (health workers, medical supplies) and manage the actual process in routine and outreach basis.

Presently, just one-third of Ugandan learners finish primary school, and secondary enrollment has been stuck at 30 percent for decades. The SDGs 90 percent target for universal health coverage is currently only 44 percent achieved. A child born in Uganda today will only be 38 percent as productive as they could be if they received a complete education and had access to good health, in large part because of these disparities. According to the research, this has an impact on the necessary sources and explicitly calls for boosting the education budget from United States Dollar (US$) 480 million to US$979 million by 2025, while basic health service spending must increase from US$703 million to US$914 million by 2030. “The government will have to invest heavily to absorb the growing number of students without any access or quality improvements in the sector,” said Cara Myers, World Bank consultant and co-author of the economic update.[85]

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

There are no operational guidelines for monitoring progress on school health and as Uganda takes strides toward approval of the NSHP, the development of a Monitoring, Evaluation, Accountability and Learning framework for school health is a critical area to ensure policy is backed by evidence. The monitoring and integration of HPS and student health and well-being into the EMIS is still in its infancy and mainly focuses on education indicators, although what is reported and available includes SRGBV indicators that are reported annually.

Other indicators, though not in the EMIS, but specific to school health are reported annually under the Uganda Bureau of Statistics. They conduct an annual education census and include the following thematic areas, and aspects of disability/SNs:

School WASH:

The number of latrines, toilets and facilities disaggregated according to learners, teachers and persons with SNs; sources of water for school, distance of water source, availability for handwashing station, waste management.

HIV/AIDS:

Adoption of HIV/AIDS and sexuality education policy; number of HIV/AIDS cases reported (registered and supported); and life skills received among the persons (teachers and learners) living with HIV/AIDS.

School Meals:

Number of schools that provide midday meals and the type of meals; sources of food for the schools; practical skills offered to learners.

PE and Sports:

Availability, number and capacity (size) of sports facility in the school; number of sports equipment; number of learners that participate in various sports activities at different levels, i.e, zonal, district, regional, national, East Africa and international.

An SBS system was piloted with support from UNICEF and scaled up in a number of districts to capture COVID-19 and EVD data with indicators specific to school health. While the pilot system only included primary schools in a few districts, the president's directive required rolling out school surveillance to both private and public schools at both primary and secondary levels in each of Uganda's 146 districts, for a total of more than 51,000 schools. This has not been successful in all districts, and besides does not include comprehensive school health indicators. However there have been ongoing discussions in the National School Health Taskforce to plan scale up of SBS using a standard set of indicators.

Conclusion and Recommendations

Uganda adheres to international commitments that require formulation of streamlined policies and interventions aimed at addressing school health challenges. What is not clear is why the national SHP has been on the shelf for so long. From the analysis, it is also clear that a SHP strengthens education sector interventions aimed at achieving improved education outcomes and quality of education at the various levels of the education system. A multisectoral steering body was put in place to streamline the various school health interventions in a coherent and elaborate framework so as to form and maximize synergies of the various stakeholder interventions in relation to school health. Some guidelines, strategies, and standards including the draft policy have been put in place to guide stakeholders to adhere to in handling the various school health issues and report on them for purposes of effective accountability.

There is little to no guidance on the percentage or amount of budget allocations for school health within government or development partner investments.

What is intriguing is that resource allocation seems to be declining as projected in the investment case for education. A monitoring and reporting framework is missing for a comprehensive school health package.

Some of the reviewed literature is dated, and since COVID-19, the context has significantly changed. This calls for a field assessment to compare desk review findings with observations, key informant interviews, and focus group discussions. The MoES findings on persons with disabilities is from 2008, though released by the National Union of Persons with Disability in Uganda in 2017. There is need for recent data so as to ensure thorough social inclusion. The country has also experienced suicide cases linked to mental health, though research on this is missing. Perhaps since COVID-19, stress is a contributing factor, with some learners struggling to catch up with learning after a two-year lock down. The data on prevalence of several communicable diseases and non-communicable is also not recent although other sources are available they do not seem to focus on the school setting.

Recommendations

1. The different MoES Basic Education departments, districts, and partners identified need to streamline, integrate, and routinize data collection efforts to inform planning and resource allocation at central and district levels. This should be aimed at strengthening EMIS with school health indicators and not just inclined on epidemics like COVID-19 and EVD. This system should focus on improving the health and well-being of learners, their educational outcomes, and the sectors that serve them, rather than just reporting.

2. Uganda needs to popularize an investment case on school health and demonstrate its long-term, short-term, and immediate benefits to meet resource and funding gaps. Ideally the investment case should also have specifics on the data required to monitor interventions and their effectiveness, and include recommendations on frequency and granularity of the data needed. Sampling surveys and routine information collection can complement each other. This could then be used for advocacy nationally and among key development agencies and private sector players. The dissemination would be made at all levels so as to build a robust coordination mechanism during planning and implementation of health and education interventions.

3. To serve as a reference for health professionals, policy makers, implementors, and other important stakeholders, school health interventions should be thoroughly evaluated. The majority of projects are carried out haphazardly rather than comprehensively in accordance with the FRESH framework or the approach for promoting health in schools.

4. There is also need to have deliberate efforts toward expediting the approval processes of the NSHP and also develop later on an implementation framework coupled with the dissemination at various levels.

5. To strengthen the food system/chain, the government or school health steering committee needs to enlist the support of all stakeholders, both public and private, including the MAAIF. In order to maintain a sustainable supply of food for students that has positive learning gains and outcomes as stated from the data above, right from planting to post harvest handling, issues concerning food logistics within the district and outside need to be apparent with parents.

6. The country needs to incorporate disaster risk reduction strategies in the 2021 policy draft, which is not mentioned, although in 2015 a guide to CDRM was launched by MoESTS.

7. In terms of governance and coordination, there is need to strengthen subnational engagements especially at lower-level government. As a country, the district nutrition coordination committees have made some progress especially from the Scale up Nutrition launch. Since these are multisectoral in nature, they would also synergize and house school health discussions. This should include child participation, which should be geared around functionality of school health clubs and other avenues for learners to express themselves on issues around school health. This will always inform the programmatic planning of key stakeholders on what must be done.

8. SHN themes are many and this means coordinated effort is needed as elaborated in the NSHP, 2021 (draft, p. 22, Section 6.2) to address them. The core roles and responsibilities of line ministries, department, and agencies should be clear with well-defined resource envelopes and implementation support toward school health. This will support clear implementation in addition to strategies that will harness and embrace effective implementation, rather than burdening teachers who are already unhappy with less pay and too much work in the country.

9. To help mitigate or ensure continuity in learning, government, partners, and development agencies together with the line ministries need to frontline a robust SBS system that feeds into the available reporting structures of community or disease surveillance. This will enable quick identification and control rather than past interventions that have led to extended closure of schools as a strategy, as well as delayed reporting and unclear referrals in some school settings.

10. To guarantee there are no geographic gaps in service delivery, the percentage of the budget allotted to the policy needs to be broken down into different districts and schools. The committee must also be accountable for ensuring that the funds they have been given reach the intended recipients and are not misused.

11. A field assessment needs to be conducted given the changes that could have occurred during COVID-19 and EVD which has affected education institutions and learners. Key to note is which strategies were utilized to ensure safety of learners and continuity of learning. And these should be incorporated into the NSHP. Also, it is important to know which interventions are being implemented and prioritized by the ministries and why.

Questions to be explored in the field assessment as a result of this desk review:

1. How EVD affected learning and what strategies were used to safeguard learners (inclusive of teachers) and ensure continuity of education.

2. Which school health initiatives are in schools, with or without a health human resource. If school health initiatives are not implemented, why not?

3. Child and parent participation platforms in decision-making and communication, including during epidemics on school health issues.

4. School feeding approaches and strategies that are cost-effective and sustainable.

5. Whether multiple themes are covered in the multisectoral committees.

6. The quality of interventions and learnings from them, beyond just an attempt at improving access to school health programs.

Prioritized recommendations for the policy strengthening action plan with line ministries under the SPAESHA activity:

1. Fast tracking approval processes of the policy, i.e, housing consultative meetings on identified gaps toward approval.

2. Harmonizing school health initiatives in the country, i.e, development of an implementation framework.

3. Expediting the strengthening of the EMIS to include school health indicators.

ANNEXES

Annex I. Stakeholder Roles and Responsibilities

KEY ACTORS	ROLES AND RESPONSIBILITIES	GUIDING FRAMEWORK
Ministry of Education and Sports	a. Chair the Multisectoral School Health Committee. b. Host the School Health/HIV Coordination Unit. c. Disseminate the National SHP. d. Develop implementation guidelines and standards of the SHP e. Coordinate policy implementation. f. Coordinate resource mobilization and utilization. g. Convene biannual meetings of the NSHMC. h. Periodically provide accountability on policy matters to all stakeholders. i. Ensure and re-enforce policy implementation in the education institutions.	1995 Constitution of the Republic of Uganda, Education Act (2008), Children Act Amendment (2016).
Ministry of Health	a. Undertake capacity building programs for the school health service providers. b. Conduct monitoring and evaluation of relevant school health interventions. c. Design and implement programs, projects and other initiatives in line with the SHP objectives and strategies. d. Mobilize and utilize resources for purposes of implementing the SHP.	1995 Constitution of the Republic of Uganda, the National Health Policy.
Ministry of Gender, Labour and Social Development	a. Ensure that child protection committees are in place and functional b. Disseminate parenting guidelines to all communities c. Support community mobilization for purposes of collaborating in implementation of the SHP d. Undertake initiatives to protect children from exploitation by way of sexual exploitation, child labor, child trafficking among others. e. Promote the tracking, reporting and referral processes for children undergoing abuse and any other form of exploitation to relevant authorities.	Constitution of the Republic of Uganda (1995), National Gender Policy, RTRR Guidelines, among others
Ministry of Agriculture, Animal Industry and Fisheries	a. Support food production, security, and nutrition programs in institutions of learning. b. Organize school food production camps. c. Support education institutions in setting up food storage facilities. d. Promote agricultural research, technological innovations, and transfer in education institutions. e. Prioritize support for food production to meet the nutritional needs of learners. f. Support districts vulnerable to food insecurity to develop strategies for food security in schools.	1995 Constitution of the Republic of Uganda, National Agriculture Policy (2015), National Agriculture Extension Policy.

KEY ACTORS	ROLES AND RESPONSIBILITIES	GUIDING FRAMEWORK
Ministry of Water and Environment	a. Support school WASH programs. b. Support learning institutions in promoting environment conservation education. c. Provide safe water to all school health service delivery centers and communities. d. Ensure availability of pit latrines or other waste disposal mechanism at all health centers and schools. e. Ensure school environment protection and conservation of land and water.	1995 Constitution of the Republic of Uganda
Ministry of Finance, Planning and Economic Development	a. Mobilization of resources for the implementation of the NSHP b. Monitor line ministries and agencies' spending on school health.	Constitution of the Republic of Uganda (1995) and the Public Finance Management Act (2015)
District Local Government - Education	a. Develop and implement District School Health Action Plans. b. Mobilize and allocate resources for implementation of District School Health Action Plans.	Constitution of the Republic of Uganda (1995) and the Local
Department	a. Disseminate the school health programs to all stakeholders in the District Council. b. Ensure plans at district and sub-county level prioritize school Health programs. c. Coordinate and monitor implementation of school Health programs in the district.	Government Act 2003
Ministry of Local Government	a. Mobilize and sensitize the community on government laws, policies and programs related to school health. b. Enacting byelaws related to children's welfare including bye-laws on children's health c. Ensure that resources are allocated to facilitate schools to implement school health programs. d. Supervise and monitor the implementation of government programs on school health. e. Undertake periodic school inspection on Basic Requirements and Minimum Standards.	Constitution of the Republic of Uganda (1995) The Education Act (2008) The Local Government Act (1997)
Ministry of Information, Communication and Technology	a. Encourage print, audio, and visual media to educate the community on school health. b. Promote a media code of conduct including censorship of transmission of certain types of information and materials. c. Establish information and communications technology infrastructure and network to facilitate effectiveness and efficiency of the referral system.	National ICT policy (2005)
Parliament of Uganda	a. Promote and support school health activities in constituencies. b. Increase allocation of resources for implementing the National SHP.	Constitution of the Republic of Uganda (1995)
Ministry of Justice and Constitutional Affairs	a. Ensure justice for children. b. Review existing laws addressing issues of children's health. c. Popularize existing legal frameworks to support the school health programs. d. Provide for appropriate legal frameworks to support school health.	Constitution of the Republic of Uganda (1995)

KEY ACTORS	ROLES AND RESPONSIBILITIES	GUIDING FRAMEWORK
Faith-Based Institutions/ Foundation Bodies	a. Ensure the implementation of SHP interventions in the respective schools and communities falling under their jurisdiction b. Collaborate with MoES and MoH as well as Local Governments in implementation of school health interventions. c. Participate in the review of various school health interventions and services. d. Popularize school health among followers and schools falling under the purview of respective FBOs.	
Civil Society Organizations	a. Popularize and disseminate correct information on NSHP to key stakeholders Contribute to research and sharing of best and emerging practices on school health b. Support capacity building of key stakeholders on school health c. Lobby and advocate for sustainable resources for the implementation of the NSHP d. Advocate for increased funding for human development interventions. e. Implement School Health activities at national, district and community levels f. Integrate School Health activities into NGOs and community-based organization programs	
Uganda Parliamentary Forum for Children	a. Advocate for the enactment of laws that consider child rights to good health. b. Raise awareness of the Members of Parliament on child rights c. Cause ministers to report on sector interventions on school health d. Cause ministries to allocate resources on school health.	1995 Constitution of the Republic of Uganda
Development Partners	a. Provide financial and other resources to facilitate implementation of the National SHP. b. Support harmonization of national and international development frameworks. c. Participate in monitoring, evaluation and review activities on implementation of the SHP.	
Media Houses / Practitioners and Artistes	a. Prioritize the delivery of school health information and messages through media channels. b. Advocate for provision and utilization of quality school health to communities.	
Cultural Institutions	a. Advocate for elimination of negative cultural practices that foster poor health b. Report children who are at risk of encountering harmful practices such as c. female genital mutilation and child marriage.	The Institution of Traditional or Cultural Leaders Act (2011)
Institutions of Research and Higher Learning	a. Conduct research on emerging issues on school health b. Disseminate findings widely to key stakeholders.	Universities and Other Tertiary Institutions Act (2001)
Private Sector Companies	a. Develop and implement corporate social responsibility plans that integrate School Health issues. b. Enhance Public-Private Partnerships for provision of quality school health services.	

Annex II. Key Informants Interviewed during Desk Review and Policy Audit in Uganda

No.	Name	Organization or Ministerial Represented	Reason for Interview
1	Dr. Mwenyango Irene	Ministry of Health	She is the principal medical officer in the School of Health, Adolescent division, and has vast experience in the school health field.
2	Semakula Henry	Ministry of Education and Sports	He is a Senior Education officer at the MoES supporting the dissemination of the school health policy and development and also a national trainer in various school health topics.
3	Kasule Muhammed	Ministry of Education and Sports	He is a technical advisor of school health at the MoES, supporting the dissemination and development of the school health policy and also a national trainer in various school health topics.

Endnotes

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