Rapid assessment of national school health programmes in countries of South-East Asia

A summary
Rapid assessment of national school health programmes in countries of the WHO SE Asia: A summary
Rapid assessment of national school health programmes in countries of the WHO South-East Asia Region: A summary

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Background

In preparation for the “Regional Multisectoral Meeting to Strengthen School Health” in the context of the Sustainable Development Goals (SDGs) and the Global Strategy on Women’s, Children’s and Adolescent Health, the WHO Regional Office for South-East Asia (WHO SEARO) requested all Member States of the WHO South-East Asia Region to carry out an assessment of their school health programmes on the basis of a template and prepare an outline for a narrative report provided by SEARO. Subsequently, WHO SEARO worked with Member countries to carry out a rapid national level assessment of their adolescent health and school health programmes to understand the status of planning and implementation readiness across multiple sectors. For this a standard assessment template was prepared to record findings from desk reviews of published documents and key person interviews (KPI).

The Objectives of the rapid assessment were to: analyse the adolescent health situation in each country; map existing adolescent health and school health legislation, policies, programmes, capacity and resources (including budgets); assess adolescents’ access to health services and unmet needs; understand strengths of the programmes (across adolescent health and school health); implementation barriers/challenges and opportunities; and provide suggestions/recommendations for improving the situation.

The Methodology included desk reviews of data, policy and programme documents (including risk factors and their social determinants), reviews of administrative reports related to programme activities, and interviews with key stakeholders from the health, education and other related sectors. Countries worked closely with WHO offices, ministries of health and education and other relevant government agencies, civil society, UN agencies and academics, to collect the required information and prepare their country profiles and reports. This report provides a narrative summary of assessment findings of the school health programmes from all South-East Asia Region countries except DPR Korea.
Leadership and governance of school health programmes

This section describes the results of the regional assessment in terms of involvement of governments in leadership and administration of the school health (SH) programme in Member countries of the Region. Two ministries were key to the governance – the Ministry of Health and the Ministry of Education – although some countries involved other ministries as well. In some countries international agencies also support the school health programme. A common finding of this assessment is that SH programmes in many countries suffer from weak leadership and inadequate funding.

In several countries of the Region the school health (SH) programme is situated within the Ministry of Education (MoE) as well as the Ministry of Health (MoH). This is the case in Bangladesh. In Sri Lanka the national-level responsibility of the programme rests with the Family Health Bureau of the MoH. Programme planning occurs at the national level and often at the subnational level too. In several countries there are formal mechanisms to coordinate actions for school health programmes between different ministries, although their effectiveness is less than adequate.

In Bangladesh Adolescent Health Committees include school health in their ToRs, but they had yet to start operating at the time of the assessment.

In Bhutan formal mechanisms include the National SH Committee (NSHC) with representation from MoE, MoH, all public health programmes as well as the School Agriculture Programme (SAP). Funds received in 2017–2018 totalled 7.65 million Bhutanese Ngultrum and funds allocated for 2018–2019 amounted to 4.5 million Ngultrum.

India’s School Health Programme has been in operation for a long time under the Ministry of Education. However, MoH launched a definitive National School Health programme under the National Health Mission in 2010 to address the health needs of school-going children and adolescents in the 6–18-year age groups in all government and government-aided schools. Subsequently, an “intensified school health programme” was drafted jointly by MoH and MoE. The programme is steered by the National Technical Working Group representing various ministries. The Secretary of the Ministry of Health and Family Welfare (MoHFW) is responsible for holding regular meetings with the ministries of education (MoE), women and child development (MWCD), and youth affairs and sports (MoYAS).

At the state level, a State Steering Committee exists and a District Coordination Committee is in place at the district level. In 2018, the upgraded National School Health Programme was launched under the aegis of the Prime Minister’s Health Scheme (Ayushman Bharat), which focuses on health promotion. The scheme, which is presently being rolled out, is the joint responsibility of the Ministry of Health and Ministry of Education and will be implemented
under the supervision of expert committees, and a National Technical Working Group with representation from all key ministries and stakeholders.

In Indonesia the programme operates via a joint agreement between four Ministries – of Health, Education, Religion and Internal Affairs.

In Maldives the programme is located within the Ministry of Education headed by a Director-General and Deputy Director-General of the Ministry of Education. At the national level, there is a School Health Co-ordinating Committee which includes MoE, MoH, schools, the Faculty of Health Sciences, health service providers and NGOs. Programme planning is based on yearly budget allocation, assessment reports and monitoring reports from schools.

Activities include ensuring incorporation of health and well-being as core subjects in the national curriculum through kindergarten to Level 12, training teachers to deliver skills-based health education, organizing orientation and training of school heads, senior management and SH teams. Sector-wide collaborative actions must be taken up with the health sector to identify essential public health services to be delivered through schools and ensure their implementation.

In Myanmar the School Health Programme is implemented by the Ministry of Education. There was a budget allocation of Myanmar Kyat (MMK) 1700 million in 2019, which is not adequate. The Ministry of Health and Sports is a partner. Planning and budgeting take place at the national level. The Central SH Committee is chaired by the Union Minister for Health and Sports; and the Union Minister for Education, and has participation from parents, teachers and community members; but no adolescents are included.

In Nepal, the SH programme is located in the Ministry of Education and within the Ministry of Health and there is strong political commitment from both. The Health Ministry had initiated a focused programme on ASRH which was reflected by the Safe Motherhood and Reproductive Act 2018, NAHD 2018 and NHSS Implementation Plan (2016–2021). Commitment to the education sector is reflected in the School Sector Development Plan 2016–2023, and includes topics related to health and nutrition including comprehensive sexuality education for adolescents.

At the national level, there is an SH Co-ordinating Committee with participation from the MoE, MoHF, schools, the Faculty of Health Sciences, health service providers and NGOs. The MoH and MoE independently plan for their respective sectors at the national level. The SH programme sees participation from the health, education, religion and internal affairs ministries. At the subnational level arrangements have been made with four local government units corresponding to the ministries. The budget is Nepalese Rupee (NPR) 10 800 000 for financial year 2019-2020 for WASH.

In Sri Lanka the responsibility for the programme at the national level rests with the Family Health Bureau (FHB, MoH). A National Steering Committee on SH has participation from MoE, MoH and other relevant ministries, the Health Promotion Bureau, and the non-formal and Special Education department etc. There is also a national committee on SH promotion that has intersectoral representation but does not include adolescents, teachers or parents.
directly. The central management structure includes Chief Community Physician (CCP) as the National Programme Manager, SH Unit, FHB, and Director, school health and nutrition branch. The SH programme is managed by MoH/Additional MoH (AMoH), Senior Medical Officer and Public Health Inspector. Dedicated funding is available from both MoE and MoH (Lankan Rupee (LKR) 48 million), through the SH Unit at FHB. However, this is reportedly inadequate.

In Thailand, the National Health Promoting Schools Committee was established in 1999, following which the Department of Health announced the policy on SH Promotion. The Minister of Public Health chairs the Committee. The Ministry of Public Health, in collaboration with the Ministry of Education, oversees the implementation of the HPS programme. Funding comes from the Ministry of Health and from Thai Health Promotion Foundation. Schools also use their own funds for implementation of SHP.

In Timor-Leste funding is received from the Ministry of Education, Ministry of Health, and international NGOs. Approved funding by the Ministry of Education for the SH Programme is about US$ 15 000. However, only a fraction of this has been received since 2018, which is inadequate to cover the 10 piloted schools targeted for monitoring.
Implementation of school health programmes

Most countries in the Region have multiyear plans for school health programmes and annual planning cycles. Countries implement the SH programme in different ways. The main programme activities include training of service providers, supervision, communication, development of IEC materials, research, and monitoring and evaluation.

Programme planning

Bangladesh has multiyear action plans targeted to adolescent health with some focus on school health. Consultations are held at national and subnational levels prior to planning. However, these include adolescent health, not specifically school health. Adolescents, parents, teachers and the community are included only at the subnational level. There are only 23 school health clinics in 20 districts out of 64 districts in Bangladesh. Human and financial resources for school health services are very limited. However, there needs to be better coordination between MoHFW, MoE, MoY&S and Ministry of Local Governments. The programme focus is on communication, training, logistics supply, monitoring, and supervision.

Bhutan has an annual planning cycle. Planning and budgeting take place at the national and state levels. Funding is received from MoE, MoH and donor agencies. The Comprehensive SH Programme at the district level is implemented by the District Health Office (DHO) and by BHUs (Basic Health Units) and Health Assistants (HAs) at subdistrict levels.

The DHO has overall responsibility for planning, implementing, and reporting. Chief Medical Officers and HAs provide health education, school vaccination, health screening, outbreak control and investigation and preventive measures and services. The programme faces problems related to human resources and technical capacities.

Despite the difficulties, Bhutan has developed IEC materials, conducted surveys, research, monitoring and evaluation as well as capacity-building of teachers. However, the SH programme requires more inputs from government in terms of policy and strategic guidance, funding, better capacity-building of providers and logistics support to SH clinics.

India formulates plans at the national and state levels. SH programmes are coordinated by the Ministry of Education and Ministry of Health and Family Welfare (MoHFW). MoE administers the mid-day meal scheme, screening of students for anaemia and referring these cases to an appropriate health facility; control of worm infestation, nutrition counselling, In India a national programme known as the Adolescence Education Programme (AEP) was launched in 2005. It was a joint initiative by MHRD and the National AIDS Control Organization (NACO) in partnership with UNICEF, UNESCO and UNFPA to equip every adolescent (aged 10–19 years) with scientific information, knowledge and life-skills to protect themselves from HIV infection and manage their concerns pertaining to reproductive and sexual health. The Central Board of Secondary Education (CBSE) under the MHRD notified a comprehensive school health programme in 2006 for all schools affiliated to the Board across the country. This programme focuses on developing healthy attitudes and enhancing life-skills of students to overcome their health concerns.
awareness about adolescent-friendly health services; awareness about the importance of secondary education for girls and peer-educators, and screening for development delays and disabilities as part of the School Health Programme. MOHFW administers the “weekly iron and folic acid (WIFS)” distribution programme and the National Tobacco Control Programme (NTCP). Schoolchildren are screened by the mobile health teams under the Rashtriya Bal Swasthya Karyakram (RBSK) and those with major health issues are referred to the district early intervention centres (DEIC) and for care at tertiary level, free of cost.

The programme has been revised and upgraded several times over last two decades. India held consultations prior to drafting the guidelines for its recently upgraded School Health Programme. The SH Programme plans to utilize teachers as “Health and Wellness Ambassadors” to educate schoolchildren on prevention and health promotion.

In Indonesia the SH programme (UKS) has been implemented progressively in 34 provinces since 2012. The UKS has worked towards enhancing coordination among stakeholders, renewing regulations, and piloting the UKS model in Jakarta. The UKS initiative has been replicated at elementary, junior and senior high school levels. At the national and state levels, an acceleration guideline has been developed and a national working meeting convened for UKS. Other activities included conduct of SH competitions and award distribution in schools. Implementation challenges include a weak leadership and insufficient funding because the SH program lacks priority at the sub-national level.

In Maldives, the SH unit undertakes planning and monitoring of the SH programme for the country and coordinates with schools in Male’ and in the islands. Within schools planning is managed by the SH Focal Point. SHO reports progress of SH to MoE. School managements, health officers based in schools, school counsellors and nurses are responsible for programme implementation.

In Myanmar, programme planning follows a yearly cycle. The MoHS and MoE independently plan for their respective sectors at the national level. SH programme development was preceded by assessment, survey, programme evaluation and review. These activities were conducted jointly by MoE and MoHS. The SH Division, Department of Public Health, is primarily responsible for central-level implementation, while the Chief of Education Division of the Ministry of Social Development is responsible for coordination at the national level.

At the subnational level, health facilities and/or district health offices coordinate SH with support of NGO/INGOs. The management structure has been revamped at the subnational level. Focal persons from the District Education Office are responsible for the school programme. Actual implementation is done by SH focal persons from the district health and education departments. The state/regional health and education departments are responsible for state/regional-level implementation.

Nepal has an annual planning cycle with multiyear plans. Desk review of relevant policies, circulars, guidelines and other publications and national surveys were conducted as part of the planning process. At the national level, the MoHP and MoE independently strategize for their respective sectors. The MoHP is responsible for field-level coordination. The PHI is responsible for organizing and coordinating school-level activities with support from field-
level staff including SPHI, PHM, SPHM and PHNS. The SH programme is implemented through the District Education Office and Schools.

National and provincial authorities develop and implement training programmes to build the capacity of public health staff and education staff and are involved in procurement and distribution of anthropometric equipment and micronutrients for the SH programme, development of IEC materials for adolescents, teachers and parents, and convening meetings of the National Coordinating Committee on SH are other activities undertaken.

Sri Lanka has dedicated units in the Ministry of Health and Ministry of Education for planning, implementing, coordinating and monitoring the SH programme. Programmatic activities are planned in consultation with other ministries (in collaboration with MoE), professional colleges and developmental partners. Planning and budgeting for SH takes place at both the national and subnational levels. Director FHB, and the National Programme Manager/CCP are responsible for overall planning, implementation and island-wide management of the programme including conduct of M&E activities at the national level.

At the provincial level, the MO-MCH is the regional level focal point of coordination and the MoH is responsible for field-level coordination. Chief Medical Officers and SMOs are present in municipality areas and the PHI is responsible for organizing and coordinating school-level activities. Despite the organized management structure with qualified, skilled personnel at the national and subnational levels, there are gaps in implementation of the SHP.

In Thailand, SH planning and implementation are undertaken by the Health Promotion Officer in the district together with the Health Promotion Officer at the community health centre (CHC). The SH Officer-MoH and the SH Officer work together to prepare an annual plan. Standards and monitoring/reporting and training materials are prepared; trainings of health workers, teachers and students are conducted, and supportive supervision provided. Several activities are carried out at the municipality level: training on communication and behaviour change is provided on topics such as tobacco and alcohol use; SH committees are set up in schools; visits are conducted by health workers for check-ups and referrals. Health advocacy on reproductive health issues was also conducted.

Timor-Leste has an annual planning cycle. A working group consisting of MoH, MoE, Secretary of State for Youth and Sports Officer Programme, church authorities, international and national NGOs, teachers, the Youth Parliament and youth organizations participate in planning at the central level. Prior to implementing the SH programme, an international NGO conducted a survey from which guidelines were developed; and MoE officers supervised the identification of vulnerable schools (that had unhygienic environments, unsafe toilets, teachers who smoked while teaching and the like). At the district level the programme is led by the Director of Education and director of District Health Services in the municipality supported by the Ministry of Agriculture, Water and Environment. The District Public Health Officer for Health Promotion coordinates the SH programme activities at the municipality level. Management structure at the national level is led by the Officer of the School Health Program in the MoH, and the head of SH and Garden Department in the MoE.
Adolescent engagement in the School Health Programme

Adolescent engagement in school health programmes is generally weak although countries do realize the importance of active involvement of principals, teachers, local government, community influencers and students themselves.

India and Indonesia have peer education/peer counselling programmes, for which planned recruitment and training of peer leaders for health promotion is undertaken. However, their involvement in planning and implementation of activities in educational institutions needs to be strengthened.

Maldives has recommended inclusion of at least one youth member as an advocate in boards, councils and other bodies along with community, development partners, and parents. In Nepal, although adolescents are involved in designing ASRH-related IEC/SBCC materials and in the peer education programmes run by the Population Division of MoHP, participation of adolescents in development of policies/plan or curriculums or in programme design is non-existent. There is lack of involvement of adolescents in school management overall, and specifically within the school management committees.

In Thailand a recent study found that an overwhelming proportion of Youth Council members (91.7%) had insufficient knowledge about the management and functioning of the Child and Youth Councils as specified by the law. Participation of young people who are out of school at the management levels of the councils are limited. Younger children are also underrepresented because they are viewed as less capable than older children. The involvement of young female leaders, particularly at the national level, needs to be encouraged and closely monitored. Timor-Leste has also proposed to engage parents, teachers and students in the planning and implementation of the school health programme.

Services offered under School Health

While some countries (India, Maldives and Myanmar, for instance) had a package of services for adolescents, many countries did not report services targeted specifically at adolescents, neither were adolescents represented at the national committees and task forces. Even though countries had trained teachers and officers to implement the SHP. In Bangladesh, for instance, although ADH committees included school health in their ToRs, there was intersectoral representation at the national level – adolescents, parents, teachers, and community were included only at subnational levels. Myanmar and Sri Lanka did not have adolescent representation at the national level, although Sri Lanka had developed IEC materials for health promotion among adolescents and parents.

In Bangladesh, project/demonstration-based findings indicate that the BALIKA initiative has been successful in delaying child marriage. Rollout of the HPV vaccination through schools also provides an opportunity for health interventions in schools. Other activities at the school level include communication, trainings, logistics supply, monitoring and supervision.

In Bhutan programme activities at the national and state levels include surveys and research, monitoring and evaluation activities, development of Information, communication and
education (IEC) materials, school-based health screening by health workers for prevention, treatment of health conditions and referral, school-based vaccination programme (HPV and Tetanus) and capacity-building of SH coordinators/teachers.

In India, the SH programme has a big component of nutrition supplementation in the form of the mid-day meal scheme and weekly iron-folic acid supplementation (WIFS). Other services include nutrition counselling, periodic deworming, anthropometric assessment, screening for deficiency diseases, common childhood diseases, development delays and disabilities, provision of life-skills education and awareness about health services for adolescents under the national AH programme (RKSK). The national tobacco prevention initiative is integrated into the SH programme. It is envisaged that SH will be included under the Ayushman Bharat (UHC) programme.

Identification of 11 health themes has been part of the very comprehensive programme planning process. The new SH programme must align the SH activities with the academic calendar with the activities under the health themes would need to be integrated during a total span of six months in the entire academic period. Teachers will need to carefully schedule them. It would also be challenging for only two teachers per school to implement the activities in all classes of the schools. To maximize the time allocated to SH in schools, innovative activities that are interactive need to be prioritized for implementation during periods that are not earmarked for examinations.

In Indonesia SH activities are still at the nascent/planning stages. The National working group is developing UKS guidance and defining the package of services beginning with SH competition and awards.

Maldives has integrated health and well-being as a core subject into the national school education curriculum. Senior management and SH teams were organized and oriented and teachers were trained to deliver skills-based health education. SH collaborates with the health sector to identify essential public health services for effective programme implementation.

In Myanmar SH includes health education, school environmental sanitation, school-based disease control, nutrition promotion and food safety, medical examination (including primary oral care and dental examination), community outreach, counselling and social support, training, and research as well as sports and physical activities. The “Health Promoting School” programme was introduced in 2006 throughout the country covering nine domains: Health education, school environmental sanitation, school-based disease control, nutrition promotion and food safety, medical examination including primary oral care and dental examination, community outreach, counselling and social support, training, research, and sports/physical activity.

Nepal has introduced some basic activities with help from development partners such as teacher training in health education and some degree of monitoring and supervision by the parent-teacher associations (PTA) and school management committees (SMC).
Sri Lanka seeks to improve quality of SH activities through the development of guidelines, standards, protocols, surveillance, monitoring, and supervision (providing technical guidance and expertise on SH) to the Ministry of Health and Ministry of Education.

In Thailand the DoH has implemented several programmes related to the health of children and adolescents. These include the Oral Health Promotion Programme in schools (an intervention that integrates dental health promotion activities into the school curriculum) and the Dental Caries Prevention and Control Programme in four provinces in the deep south of the country.

Over 1000 rural schools are enrolled under the Oral Health Promotion Programme through networking of schools under the royal patronage of Her Royal Highness Princess Maha Chakri Sirindhorn. Other initiatives are the policy development project to reduce sugar consumption among Thai children and the Oral Health Education and Media Development Project for Thai children. The Youth-Friendly Health Service Project promotes reproductive health services through hospitals and their networks, at the community level, in schools and across other sectors.

In Timor-Leste the SH officer with the MoH and the SH and Garden officer collaborate to conduct training for health workers, teachers and students on programme implementation. Working groups have been set up to provide supportive supervision. Municipality-level activities include communication and behaviour change training for students, advocacy on the dangers of smoking and drinking alcohol and sexual/reproductive health, establishment of SH committees in schools, and visits by health workers for periodic check-ups of students and appropriate referrals.

**Staffing for the school health programme**

In Bangladesh the SH programme is implemented by SH section in the DGHS (MOHFW) at the national level, managers and medical officers in 20 districts (out of 64). However, the operations are not very efficient. At the field level, staff at school health clinics and frontline health workers promote AH/SH messages, provide counselling, and refer students to SH facilities. The judgmental attitude of some providers is a hindrance to the efficient functioning of the SH programme. Screening and referrals are not coordinated between education and health services, which hampers service delivery.

In Bhutan the SH Programme is implemented by health staff, teachers, counsellors and school nurses. CMOs and HAs work in schools and have close ties with MoH at the national and subnational levels. Trained SH Coordinators (SHC) are focal points for any health programme at the school level. They facilitate prioritizing of activities and sensitization of all teachers/staff of the school, assisted by a nodal teacher.

In India as part of the revised Ayushman Bharat programme, two teachers in each school are designated health and wellness ambassadors at the state level, and imparted training and incentivized for the additional responsibility. Education is provided to children on topics such as the need for exercise, hygiene, balanced diet, exposure to sunlight, physical activities, ways
to avoid diseases and the importance of mental health. Further plans include training sessions for master trainers to be provided by the MHRD through coordination with MoH; monitoring to be undertaken by the SCERT; the District Education Officer to coordinate overall programme implementation. Under the Rashtriya Bal Swasthya Karyakram (RBSK) a mobile health team with Medical Officer, ANM/Staff Nurse, pharmacist and nodal officer at state, district and block level are designated for SH programme monitoring.

In Maldives the SH Unit is located within the Ministry of Education. Staff at the SHU are trained to manage and implement the programme. At the subnational level there are SH officers in schools and 59 school counsellors who can deliver the programme goals.

In Myanmar, the Deputy Director of the SH Division of Department of Public Health is supported by basic health staff from the Township Health Department, rural health centre, and subcentres. The director of the SH division oversees programme management. A Programme Manager (of the rank of deputy director) is responsible for detailed planning, implementation and management at the national level. Basic health staff from the Township Health Department, rural health centre, and subcentres are responsible for township-level implementation. SH focal persons from township education departments and SH focal teachers from basic education schools of the MoE are responsible for school-level implementation, supported by a dedicated SH team (doctor, dentist and nurse).

In Nepal the Chief of Education Division of the Ministry of Social Development is responsible for coordinating SH activities. The programme is implemented by a full team including teachers responsible for teaching health and population syllabi and health staff from HFIs. Health facilities and/or district health office coordinate SH with support of NGO/INGOs. The entire management structure has changed (as a part of restructuring for decentralized governance) and is currently in transition. Focal persons of the District Education Office are responsible for implementation of the school health programme.

In Sri Lanka the Director, the FHB and the National Programme Manager/CCP are responsible for overall planning, implementation and management of the programme throughout the island. MO-MCH provides the regional-level focal point of coordination, and MoH provides field-level coordination. Chief medical officers and SMO administer the SH programme in municipality areas and the PHI is responsible for organizing and coordinating school-level activities.

In Thailand dedicated health staff, teachers, counsellors, school nurses and school directors provide direction and guidance to SH. Teachers responsible for teaching health and population-related subjects are specifically responsible for implementation. Health staff (HFIs) from both the ministries of health and education with their respective development partners also support the programme. The programme was begun in 89 schools and has now been expanded to other areas.

Health facilities, families, students and communities also support SHP. “SH promoter students” are responsible for conducting SH programme activities at schools. Peer educators from high schools support the programme. NGOs/partners who work in the municipality implement and monitor SH programme activities. Key implementers of the SH programme are
from the Ministry of Public Health who provide the general physicians, nurses and midwives. The Office of the Basic Education Commission (OBEC) under the Ministry of Education has established student protection systems in all schools. The Ministry of Education also develops quality sex education curriculums for schools.

In Timor-Leste the Ministry of Education has assigned the responsibility of implementation to teachers and Alunos promotor Saude Eskola.
Partnerships and Intersectoral coordination for school health programmes

Partnerships

Most Member countries have functional partnerships among different ministries, international agencies and development partners. However, sustained collaboration and coordination has remained a challenge in bringing about synergy of action.

In Bangladesh, MoE, MoWCA, MoY&S, MoLaw, development partners and INGOs have helped develop the SH programme. However, the SH programme needs to be managed through steering committees at the national level and coordination committees at all levels up to Union level, involving all partners under the leadership of the Government of Bangladesh.

The Royal Government of Bhutan partners with UNICEF, WHO, WASH, and the Public Health Engineering Division (PHED). The programme receives financial support from MoE, MoH and donor agencies. However, a multistakeholder strategic action plan is lacking to bring all SH players under a single umbrella.

In India a gamut of institutions, development partners, NGOs and international NGOs (INGOs) collaborate with the Ministry of Human Resource Development (MoHRD) and the Ministry of Health & Family Welfare (MoHFW). These development partners include UN agencies like WHO, UNFPA, UNESCO; INGOs and NGOS like ICRW, USAID, JHPIEGO, Centre for Catalyzing Change, Cornerstone, Pratham, Pravah, Breakthrough, The YP Foundation, TARSHI and Arpan as well as academic institutions like the Public Health Foundation of India, Delhi University, TISS, and NIHFW.

Indonesia has partnered with the ministries of education and health for implementation of the SH programme. Health staff from the PHC centres are responsible for AFHS in collaboration with the appointed teachers/school counsellors.

In Maldives the SH programme is managed by MoE. Funds for SH are included in the MoE budget. UN agencies (UNICEF, WHO and UNFPA) provide support by including SH in their annual workplans.

In Myanmar the school health programme is supported by a team dedicated to SHP in MOHS, MoE, and UN agencies like WHO, UNFPA, UNICEF and WFP.

In Nepal, SH is supported by both the ministries of health and education with their respective development partners such as WHO, ADB, WFP, UNICEF, Water Aid and SCI. Under the leadership of Information and Communication Centre of the National Health Education (NHEICC), H4L (USAID), GIZ and UNFPA have initiated the very successful mHealth initiative that delivers the interactive package named, m4ASRH.
In Sri Lanka the School Health Programme operates through its National SH unit, the FHB under the Ministry of Health as well as the Nutrition Branch of the Ministry of Education in collaboration with other ministries like MoYA, MoSS. Other partners are Sri Lanka College of Paediatricians, Sri Lanka College of Obstetricians & Gynaecologists, College of Community Physicians of Sri Lanka, experts from other public health programmes, and provincial, district and divisional level public health officers and academia as well as UN agencies like WHO, UNICEF, UNFPA.

In Thailand, The Ministry of Public Health in collaboration with the Ministry of Education oversees the implementation of the HPS programme. The Ministry of Public Health initiated the Health-Promoting Schools (HPS) Project, which is led by Department of Health in collaboration with the Ministry of Education, Ministry of the Interior and civil communities. The Ministry of Education, responsible for implementation of the SHP, is supported by civil society organizations and UN agencies.

**SH in Thailand: a success through partnerships**

SH is part of Thailand’s national agenda, implemented in partnership with health-related agencies. The national committee established a national plan and assigned cooperating agencies to implement activities funded by the government budget. Now, many schools in Thailand are participating in the SHP whose activities are included in the school curriculum. Integral to every SH programme are health promotion, health services, and health education (focusing on life-skill approaches).

To effectively implement this initiative, the Ministry of Education has positioned health issues of learners as a national priority; established a functional partnership and alliance with various departments in the Ministry of Public Health in order to support the SH programme; set up effective law enforcement to protect and support young people (including the Smoking Act, Alcohol Act and the Child Protection Act).

A Knowledge Management (KM) unit has also been established with support from the Thai Health Promotion Foundation to assist the public to access health information. The use of ICT has been expanded as a learning tool to spread awareness about health

In Timor-Leste the School Health Programme is supported by WHO and UNICEF, international NGOs such as SHARE from Japan, Water Aid, PLAN International, and an NGO, Mary Mackillop.

**Intersectoral collaboration**

Due to the presence and involvement of many partners, both national and international, functional coordination and collaboration remains a challenge. Government involvement and leadership is lacking in the necessary degree in some countries with weak stewardship, and inadequate oversight and guidance.
In Bangladesh AH and SH programmes are the primary responsibility of MoH. In fact, SH is not a separate programme under DGHS. A range of SRH-related educational programmes are being implemented by both government and nongovernment agencies in parts of Bangladesh, without consensus on course content, and which do not cover the six priority areas of sexuality education proposed by WHO/UNESCO.

Despite programmatic synergies, there are no steering or management committees at national or district levels. Involvement and coordination between the relevant sectors is low, e.g. between MoH, MoE, MoLGED, MoY&S, etc. There is a lack of intersectoral convergence, which leads to the existence of a broken link between the education and health departments on responsibilities for implementing various health-related activities. Lack of proper referral mechanisms between the schools and health clinics is a big challenge.

Very limited intersectoral linkages with the MoE exist in practice – there is a link, albeit broken, between the education and health departments on responsibilities for implementing various health-related activities. Although many partners are involved, coordination and collaboration with civil society organizations is weak. This has contributed to difficulties in ensuring the availability of a holistic response to meet the health needs of all adolescents.

The Health Sector Support Project (HSSP) of the World Bank in Bangladesh, which includes support for a school-based adolescent health and nutrition programme (SBAHP), is being developed in collaboration with the SH programme of MoH&FW. Collaboration and coordination are being strengthened in all relevant sectors. The steering committee at the national level, involving all ministries and stakeholders concerned, plays the stewardship role in the HSSP. One programme manager for both programmes will be appointed under DGHS.

In Bhutan inadequate coordination is observed between schools and health centres. There are competing priorities which result in less resources for the SH programme. MoE has linkages with the School Agriculture Programme, School Sports, and Life Skills Education programmes but there are no established linkages with NGOs and other departments.

A strong partnership between MoH and MoE in Bhutan has led to:

- reduction in STH and anaemia prevalence,
- high coverage of HPV vaccination,
- improvement in WASH facilities,
- reduction in outbreaks, and
- high percentage of schools with a trained SH coordinator.

Key persons suggested that intersectoral coordination could be strengthened by establishing a body/committee at highest level for collaboration/coordination not just between the MoH and MoE but also other ministries, corporations, NGOs, civil society. Better coordination is required among the different programmes that deal with adolescent issues within the MoH. Parents and adolescents must be included in school and school health committees.
India: SH programmes are under the Ministry of Health & Family Welfare (MoHFW), and also the Ministry of Human Resource Development (MHRD) since 2012, when the Mid-Day Meal Scheme was introduced by MHRD. Weekly iron and folic acid supplementation is given to children as part of the School Health programme and the Rashtriya Bal Swasthya Karyakram (RBSK) of the MoHFW and the National Tobacco Control Programme (NTCP). However, a common umbrella programme for facilitating implementation of these activities is missing at the school level. As a result, coordinating all these activities separately is a hindrance.

A regular coordination mechanism must be put in place between the national and the state governments for the implementation of the SH programme. The new national SH programme under the Ayushman Bharat scheme is expected to conduct its activities in balanced coordination with the ministries of health and education. It is expected that SCERT will be responsible for the monitoring of the activities wherein the district education officer will coordinate the implementation. The health department will support the education department in training and capacity-building of service providers.

Indonesia: The Ministry of Health and Ministry of Education are involved in SHP in Indonesia. At the field level, the SHP is implemented in collaboration with adolescent-friendly health services (AFHS) programme, appointed teachers or school counsellors.

Structurally, at the national level, coordination among ministries is challenging. There is no clear leadership and structure for this coordination. Ideas are provided by MoH, but implementation is by the ministry of human development and culture. Lack of capacity on the part of the local implementers and weak coordination between schools and the primary health centres in provinces are other difficulties. There is the need for a higher level of regulation to provide clear guidelines for intersectoral coordination.

Maldives: Intersectoral linkages are weak in Maldives and the role of MoH in SH is undefined. SH has very limited links with adolescent health and youth health programmes. Although the SH programme in the MoE is well established in terms of its integration into the curriculum and its access to school systems, provision of funds and human resources are needed for effective implementation. Robust intersectoral coordination needs to be developed through mobilization of support and advocacy.

There is a lack of a leadership role between the three ministries that collaboratively run the programme, i.e. the Ministry of Health, Ministry of Education and Ministry of Youth, each of which have their own programmes targeting youth. Unfortunately, these ministries do not collaborate with one another or coordinate their activities.

Integration of SH into the school curriculum has taken over 20 years to become operational. Currently a conducive policy environment has been created for SH implementation. At this juncture, critical linkages between the three ministries need to be created for effective implementation. For instance, linkages could be created between the health, youth and education programmes – wherein SH could be positioned as a public health programme and MoH could include components of SH in their plans.
A single ministry should take the lead and strengthen the intersectoral linkages in addressing the needs of adolescents. Technical expertise from MoH and other non-health sectors can be channeled to SH and AH for improvement of programme outcomes. A working committee (the SH Coordinating Committee) is necessary to steer the programme with representation from the Ministry of Education, Ministry of Health, Ministry of Youth, schools, Faculty of Health Sciences, health service providers and NGOs and youth advocates as well as community leaders.

Such a coordinating committee should have specific objectives, set goals and clear roles and responsibilities involving all stakeholders. Development agencies such as WHO, UNICEF and UNFPA can support institutionalizing the preservice and in-service teacher training and advocate for sufficient funds to run the AH and SH programmes effectively.

Nepal: The School Sector Development Plan 2016–2023 includes topics related to health and nutrition and comprehensive sexuality education for adolescents. However, due to poor coordination/collaboration between the sectors, the revised framework of the SH curriculum had removed health as a compulsory subject, thus drastically reducing an opportunity to educate school students of grades 9 to 12 on health issues. The SH programme is run in coordination with local health facilities, even though there is no formal plan or structure. There is a joint action plan on SH nutrition – which is operational in coordination with MoHP and MoEST. Similarly, the menstrual hygiene management (MHM) programme is being implemented with MoHP and MoEST. Both sectors are engaged informally and through technical group meetings.

Intersectoral collaboration and coordination is weak in Nepal. There are multiple initiatives from different ministries/organizations. MoHP and MoEST have a joint action plan on SH and nutrition. Similarly, the SH programme and adolescent friendly information centers (AFIC) are being implemented in coordination with health and education sectors. The Private and Boarding School’s Organization of Nepal (PABSON) has signed an MoU with NHEICC for recruiting nursing professionals to work in schools, but the progress of this initiative has been slow. The National ASRH Programme and SHP do not include issues such as child marriage and sexual abuse.

Coordination could improve by the formation of a formal structure for coordination; preparation of a framework with details of roles and responsibilities; creation of a dedicated platform for adolescents and the development of a Joint action plan engaging key sectors with adequate funding.

Sri Lanka: Sri Lanka needs to develop a separate comprehensive national policy for adolescents since policies for children and adults do not cover specific aspects of adolescence. A gap area is the weak linkage between the reproductive health information system of the health sector and the SH Promotion Programme Information Management System of the education sector. This limits the effective use of data for action. Another challenge is the ineffective use of subnational-level data to identify innovative approaches to deliver health interventions, such as for health education programmes.
Coordination and management of SH policy and strategies should be taken up by the Ministry of Education and implemented in collaboration with the Ministry of Public Health and other health-related agencies. The DCY took the leadership role for developing the National Child and Youth Development Plan 2012–2017. With proper support, the DCY’s role could be strengthened to make it an important partner and advocate for adolescent development.

Thailand: Thailand also has an active and powerful civil society movement, which could be tapped further as a resource partner.

Timor-Leste: Very limited government funds are allocated to adolescent health and SH programmes. Therefore, adolescent health and SH programmes are being supported entirely by international NGOs. On the demand side, students have requested more information and more services (one-day IEC sessions have proved to be insufficient). Evidence from schools indicate that multiple sessions on reproductive health are linked to decreasing rates of pregnancies among students.

Challenges include frequent staff changes, replacements, and lack of cooperation between school directors and teachers. It is difficult to involve staff from the two ministries in screening programmes, for example, when there are no SH programme indicators in the HIS reporting system.

Challenges faced by the programme in ensuring service quality are inadequate financial support; health providers have not yet received refresher training (following initial training in 2007). Teachers who have not been educated in biological sciences have difficulty teaching reproductive health to students even after receiving short-term training. Another gap is that the school feeding coordinator has not been involved in the activities of the SH programme at the time of the assessment. Overall, lack of cooperation between school directors and teachers hampers support for SH activities. Constant changes in staffing at all levels leads to confusion on the persons responsible for implementation.

SH programmes are perceived as being within the purview of the NGO sector; therefore, schools do not like to deal with SH issues. Some school directors do not use subsidy funds from the government to buy hygiene products for use in schools. Logistics issues such as transport to support health provider services for health promotion in schools pose problems. From the behavioural aspect, health personnel are sometimes insensitive to specific problems that youth face; and information does not reach adolescents living in remote areas. On the demand side many adolescents lack interest in seeking information about their health and well-being and don’t even use the existing services.

In terms of partnerships, several NGOs do not coordinate with line ministries in implementing SH activities; schools and ASRH need to prepare youth-friendly IEC and services that are appropriate for adolescents in their settings.

The key persons who were interviewed suggested strong coordination by the head of the health and school department (MoE) and SH programme officer of the MoH from the national level down to the municipality and local government level. Technical agreements between the most relevant ministries should be established so that officials can actively
engage in SH implementation. The health reporting system of the MoH should include SH programme indicators. Data entry forms should be standardized for government and private health-care providers for uniform reporting of SH programmes. Training for junior and senior high school teachers on adolescent health issues as well as capacity-building of health-care providers working at community health centres (CHC) and health posts should be conducted. This will enable them to provide IEC to adolescents from health centres and in schools. Mass media and electronics (TV talk shows and community radio) and apps on reproductive health should be used to provide information. Interpersonal and peer group communication as well as cooperation with young people’s organizations, cooperation with the Church and other relevant institutions for dissemination of accurate, culturally acceptable, gender-sensitive information on young people’s health and development are very important to create a groundswell of demand among youth. School inspectors must be advised to share information related to SH with school administration management and DPHO of health promotion.
Monitoring and evaluation (M&E) mechanisms of SH programmes

Most SEA Region countries have reported that the monitoring and evaluation (M&E) mechanism of school health programmes are in place. However, implementation and reporting were sporadic and uncoordinated.

In Bangladesh, the SH programme is being implemented since 1951 without any expansion/evaluation or revision. Joint visits happen irregularly; however, indicators are being developed. The state, district block, facility and Union level data are being used to revise the action plan.

Bhutan has a monitoring and evaluation plan. Indicators have been developed and are reported biannually through programme reports and Education Monitoring Information System (EMIS).

India has a monitoring and evaluation plan and has developed indicators (which are a part of the prescribed format in the guidelines). Data is collected through school/class monitor registers and compliance cards. Reports are received from state, district, block and facility levels. Monitoring is conducted monthly or quarterly, depending on programme implementation.

In Indonesia M&E is carried out by the UKS coaching team. The UKS programme is evaluated in terms of team functionality. Indicators have been developed and data is gathered down the cascade from the school level, district/kecamatan level, and regency and provincial levels. National evaluation of the SH programme in 10 provinces indicated that there were problems over human resources, availability of guidelines or printed material, and managerial issues that also resulted in lack of support from the private sector. The GSHS 2015 recorded that as many as 88.35% of secondary schools had no SH programme in place, 64% of secondary schools had no proper toilet, and around 30% of schools had no clean source of water. The national guidelines for SH programme acceleration (2015) have not been reviewed. In those areas where these programmes are separated, there are differing levels of collaboration. Generally, there is lack of capacity among local implementers and low coordination between schools and the primary health centres.

Maldives also has an M&E plan and indicators, although data for adolescent and youth health indicators are not yet included in the Health Management Information System, with the exception of adolescent birth rate. The data is used for planning and identifying gaps for improving the national level programme.

In Myanmar, data is collected from SH persons from RHCs and sub-centres and combined at the Township Health department. Frequency of data collection is monthly, quarterly and annually. SH activities at both school and health-care settings are monitored by SH focal persons at every level and data is reported back to the SH division quarterly. The data is used for planning and ad hoc requests for reports. SH activities are monitored separately in school
settings. However, monitoring, supervision and feedback mechanisms for SH and health promotion programmes require improvement.

In Nepal, EMIS does not provide information on whether ASRH is being taught in schools. Neither has there been systematic evaluation of SH programmes subsequent to the Global SH Survey. The programme does not have an M&E plan. Information on performance-based indicators are gathered through EMIS. Chain of reporting is from schools and resource persons to DEO/district units to the Provincial Directorate and therefrom to the central level (CEHRD).

Sri Lanka has an M&E Plan. Data is collected under three heads: Quarterly SH return (H 797), summary of school medical inspection (H 1247) and SH survey – detailed summary (H 1015B format); and from three levels: state, district, block and facility. The Monitoring and Evaluation Unit of the Family Health Bureau (FHB) compile the data and disseminate them internally to all relevant units. Summary of all findings are published in the Annual Report of the FHB. Sri Lanka has a comprehensive reproductive health information system. However, the timeliness, completeness and the accuracy of the data collected on SH needs to be improved. There is a need to strengthen the linkage between the reproductive health information system of the health sector and the SH Promotion Programme Information Management System of the education sector for effective usage of data for action. Another identified gap is the ineffective use of subnational-level data to identify innovative approaches to deliver health interventions (such as for health education programmes).

The SH programme needs revitalization through a detailed review and evaluation. It has to move forward with appropriate planning for expansion. Unlike ADH, SH has its own staff under MoH&FW which is an advantage for this programme. This favourable situation needs to be utilized as much as possible.

In Thailand, positive factors influencing NSHP implementation were reported such as coherence with current educational strategy, competition and encouragement by the system, sustained human capacity-building at the school level, participation of multiple stakeholders, sufficient understanding and acceptance of SH concepts, sharing information and collaboration among schools (in the same clusters), as well as fund-raising activities.

In Timor-Leste, M&E supports SH implementation at the national level. Two formats are used – one developed by the MoH and the other by MoE. From the MoE the Director of Schools and the school inspectors are responsible for M&E. From the MoH side, the reporting flow is from the community health centre to the District Health Services, which is then integrated into the report of the national health system.

Monitoring has not been carried out systematically because of a lack of indicators. The activities of the SH Committee depend entirely on NGO initiatives at present (for meetings, reports, and monitoring plans).
Results of Implementation of school health programmes: Key outcomes

In Bangladesh although SH has been implemented by the government starting with 20 districts, information on key results or outcomes have not been collected so far.

Bhutan reported reduction in STH prevalence, high coverage of HPV vaccination, improvement in WASH facilities, high percentage of schools with a trained SH coordinator and reduction in outbreaks, reduced absenteeism, and improved educational outcomes. Health promotion and disease prevention interventions are effective. Communicable diseases are effectively managed through collaboration with health centres, and the programme has benefited from a strong partnership with MoE. Concerns that remain are health risk behaviours such as drug abuse, tobacco use, mental health issues etc. However, lack of human resources at the national level (since health issues are the sole purview of the Health Ministry), lack of a collective approach and competing priorities are drawbacks to success.

India reported that the mid-day meal scheme has been particularly successful in providing one meal per day to schoolchildren in government schools, since it leads to better retention and less dropouts. Schools that become health promoting should be jointly recognised and acknowledged by health and education departments to motivate them to continue programme implementation over the long term.

In Indonesia, the number of students referred to the primary health-care services was a key result of the SHP. A national action plan for school-aged children and adolescents is in place and a national competition is conducted to emphasize the achievements of the programme. UKS has been comprehensive in addressing adolescent health in general and the main health problems. UKS are expected to strengthen health-seeking behaviours and help students avoid risky behaviours.

Maldives formulated an ASH Policy (SHP) or Policy on Health Promoting Schools in 2004. In March 2010 the Ministry of Education with assistance from UNICEF launched the National Quality School Initiative – “Child Friendly Baraabaru Schools” (CFBS) – in which health was identified as a key component. The SHP was revised and updated in 2011. In 2019, the Ministry of Education introduced health and physical education as subjects in the national curriculum. This step seeks to strengthen implementation of SH programmes in schools and extend their reach to adolescents.

In Myanmar the SH programme has implemented the “Health Promoting Schools” programme throughout the country, consonant with the WHO-SH initiative, since 1996. In 2006 the “Nine Domains” of the health-promoting school programme was introduced with the following components: health education, school environmental sanitation, school-based disease control, nutrition promotion and food safety, medical examination (including
primary oral care and dental examination), community outreach, counselling and social support, training and research, and sports and physical activity.

Nepal integrated ASRH issues into the health and population curriculum. A Nepal-specific CSE package was developed based on international technical guidance on sexuality education (ITGSE). This has resulted in a reduction of myths and misconceptions about menstruation. Overall teaching–learning experiences have improved, and teachers are less hesitant about discussing ASRH issues. Over 90 trainers from MoEST and over 250 teachers have been sensitized on CSE.

**Along with the capacity-building of teachers, adolescent-friendly information corners (AFICs) are being established in schools in Nepal, with the provision of ASRH and CSE materials. The aim is to generate the demand for adolescent-friendly SRH services being provided through health facilities. As the adolescents in selected schools are getting the benefit of the AFICs, there is a strong need of similar centres (AFICs) for out-of-school adolescents.**

Sri Lanka’s key results include 95% coverage of SH surveys, and significant progress in health and health-related indicators since 2016. Improvement has been reported in water, sanitation and hygiene provision in schools, reducing malnutrition among schoolchildren, and in the follow-up of developmental defects and immunization. Out of 10,162 schools, 3,066 schools were identified as “health-promoting schools”.

In Thailand SH is a part of the national agenda. A national committee has developed a plan and assigned cooperating agencies to implement activities funded by the government budget. Most schools in Thailand are participating in the SH programme and SH activities are included in the school curriculum.

In Timor-Leste an International NGO (SHARE) conducted an evaluation from 2016–2018. The study found that 80% of schools had conducted health education on a regular basis in schools. However, 42% of schools had not received dental health services from health workers; 27% of schools had not received eye check-up; 12% of schools have not received any general check-up; 48.5% of schools started implementing health screening after receiving training; 27.8% of schools established a school garden. There was only a little improvement in cleanliness in the environment of schools. Highlights of the programme implementation are multiple trainings of teachers and students have been trained in SH. About 90% of schools have started health education initiatives and four out of every five schools have conducted health education regularly for their students.
Implementation barriers and actions for improvement

Overall, lack of adequate funding, human resource constraints and sporadic capacity-building of teachers, reticent attitude of service providers and lack of knowledge among all levels of implementers present huge challenges to effective and sustained programme implementation. Lack of political will and vision at the national/programme planning levels also pose an impediment.

In Bangladesh, although SRH issues, both biological and psychosocial, are included in school textbooks for grades six to ten, teachers are not at ease with these subjects and avoid teaching these topics. Human and financial resources are limited. Although supervision is done at state, district, block and facility levels, periodicity is dependent on resource issues. SRH issues should be included in the teachers’ training curriculum and examinations as compulsory topics. Use of media and technology must be encouraged to provide comprehensive sexuality education in schools. School-based nutrition programmes also need improvement and focus in the light of the significant challenge of double malnutrition faced by many adolescents.

Bhutan: Bhutan faces huge resource constraints – both financial and human – at all levels. Accountability is weak, and lack of dedicated focal persons for adolescent health and SH in the districts and schools precludes focus on adolescent activities. At present, SH is ineffective in the face of health risk behaviours that are on the rise such as tobacco and alcohol use. Adolescents are also facing mental health issues which need to be addressed at the school level. However, WASH, health and nutrition programmes are well run, and SH is accorded importance by MoE, schools and parents. A trained SH Coordinator (SHC) is the focal point for all health programmes in 85% of schools in Bhutan. Coordination between schools and health centres is weak. NGOs are not involved. Although MoE has linkages with the school agriculture, school sports, and life skills education programmes, the country lacks a multistakeholder strategic action plan to bring all players in SH under one umbrella. Supervision of the SH programme is done through reporting at state, district, block and facility levels. Periodic supervision and monitoring of the programme is dependent on time and resources since the programme has only one staff at the national level. Reporting is irregular and the programme has not been evaluated. There is a need to create dedicated focal persons for SH in the districts and schools. In order to improve AH competencies, adolescent-related components in the pre-service curriculum should be made more robust. While teachers and students are fully involved in SH and are part of the programme, participation from parents, local government officials and opinion leaders in the communities needs to be strengthened.

India: Although SH falls under several programmes such as mid-day meal schemes and/or tobacco control, coordination is a problem since there is no common umbrella for all the interventions. Intersectoral convergence, between education and health, for example, is
There is a lack of proper referral mechanisms between the schools and health clinics and insufficient number of teachers to implement the programme. Low investment has led to poor management in organizing and conducting the “Adolescent Health Days” at the school levels, to patchy implementation of AH and weak advocacy at all levels. Ayushman Bharat is a promising initiative. The District Education Officer (DEO) is authorized for implementation but will require support from the Health Ministry. Capacity-building of service providers, maintaining quality, conducting e-learning for teacher training, introducing innovative ideas and time allocation at schools are all important. Incentivizing teachers and recognizing health promoting schools are key to programme sustainability.

Indonesia: Policies do not include child marriage issues, access to contraception for at-risk adolescents to prevent unplanned pregnancy, tobacco control, drug and alcohol prevention, and violence. Intersectoral collaboration between ministries and stakeholders is absent. There is no clear leadership and structure for coordination between four Ministries (i.e. the Ministry of Health, Ministry of Education, Ministry of Religion and the Ministry of Internal Affairs). The ideas are driven by the Ministry of Health, but the funding and technical coordination is managed by the Ministry of Human Development and Culture (Kemenko PMK). Decentralization has resulted in provinces having unequal resources and, therefore, the programme cannot be accelerated evenly. Most of the provinces and districts/cities have not allocated any specific budget for the SH programme.

Suggested actions include a review of the existing curriculum and engaging the SH programme staff; to simplify the programme and make it feasible for schools and improve participation of students and parents. A joint agreement has been made between four ministries to work collaboratively. A National Action Plan for SH and adolescent health for the years 2018–2020 has been developed involving five ministries, UN agencies (UNICEF and UNFPA), nongovernmental organizations (Rutgers, PKBI), youth-led organizations (ARI) and professional organizations (Indonesian Pediatric Society, Indonesian Obstetric and Gynecologist Society, and others). The Ministry of Health has involved all related stakeholders to improve adolescent health. It is important to channel resources from development partners and the private sector to the provinces that are not performing well and need support.

Maldives: Intersectoral linkages are weak, especially the role of MoH in SH. Moreover, there is weak commitment, coordination and collaboration for SH from the relevant sectors such as the Ministry of Health, which poses a major challenge to implementation of policies and plans. This includes weak financial obligation and assistance from policy-makers. Lack of adequate human resources and infrastructure poses a huge challenge faced by schools in implementing SH programmes successfully. Health-care providers in health facilities and schools working with adolescents frequently lack the necessary skills to interact appropriately and effectively. Necessary training and refreshers are provided from time to time but have not been sustained.

Suggested actions: The SHP was revised and updated in 2011 and the Ministry of Education introduced health and physical education as a subject in the national curriculum in 2019.
However, better orientation and advocacy with policy-makers is needed to secure their willingness to improve results.

Myanmar: The country lacks a national policy for SH services with intra-ministerial and intersectoral collaborative support mechanisms. Partnerships with allied programmes (such as mental health, oral health, environmental health, nutrition programmes and immunization) do not take place uniformly in all schools in the townships. Funding is inadequate, the differences between actual and potential capacities are often ignored, and there is no robust platform for programme execution. Lack of sufficient attention or failure to recognize differences between the actual and potential capacities of schools in different regions are impediments to successful programme implementation.

Existing infrastructure and facilities are not competent to provide quality adolescent and SH interventions, therefore implementation is small-scale and over a brief time period. Limited number of teachers with competencies, high turnover of peer educators, frequent dropouts, lack of physical/recreational activities, rapid staff turnover are other challenges. Other issues are stigma and discrimination for key affected populations at public health facilities, and social media-related misconceptions.

Less than 40% of schools in Myanmar implement health-promoting activities. This is due to the attitude of implementers at various levels and differing visions among related ministries. On account of insufficient human resources with no proper training teams, SH implementers cannot focus sufficiently on different segments of the programme. Therefore, information on various programmes cannot be provided across all levels, especially to the basic health staff.

Suggested actions include active political support from all levels of governance, political commitment, child-centric SH services that are aligned to the country’s legal framework and development of health-supportive policies. The SH programme should be under the Department of Basic Education of the Ministry of Education, be all-inclusive and in accordance with international standards. Improvement of capacity-building and infrastructural preparedness are necessary. School infrastructure in various states and regions is different and so programme implementation must be considered separately according to each region. SH professionals should be designated in all schools.

Multiple service delivery channels should be strengthened for implementation of prioritized interventions to benefit adolescents in a range of settings, particularly vulnerable adolescents, including: facility-based health services, school/college-based, workplace-related services, community-based health services, integrated provision of health information and services in sports clubs and recreation centres created for adolescents. Development of media-based approaches would further improve the programme and create demand for SH services. Engagement with adolescents, their families and communities to promote adolescents’ access to available health and other services is also important.
Examples of positive deviance from Myanmar SHP

Within the same state and region, programme activities were successful with significant outcomes and impact in some townships, while others did not fare equally well. The interest and commitment of the local health and education teams account for the difference in quality programming and sustainability. Lessons need to be drawn on ways to build leadership and commitment of local teams. This example demonstrates the need to strengthen documentation and promote implementation research that can help programmers better understand the “how” of interventions that are effectively taken to scale with quality, in order to contribute to the evidence base and the collective understanding of good practices.

Nepal: Nepal does not have a well-defined structure or roles and responsibilities in its provincial and local government in terms of ASRH and SH programmes, which poses an operational challenge. The SH programme is not linked to NGOs or youth clubs. A major drawback is the new curriculum framework wherein the subject of health education which includes ASRH/CSE issues is no longer part of the compulsory curriculum at secondary level. This also means that subject-specific teachers would not be available in all schools. This move deprives students from getting sound health, nutrition and hygiene related information from the school curriculum. Making teachers available for ASRH/CSE and their training is a challenge as there is no focal person for SH who would assume responsibility for ASRH/CSE/SH in schools. Teachers are uncomfortable discussing ARSH issues, there are conflicts of priority and time, lack of commitment, inadequate resources, and low demand, all of this adding to the challenges.

Suggested actions include that PTA and school management committees should be linked to NGOs, adolescents and youth clubs. The health sector should conduct dialogue with the education sector. The effectiveness of AFIC should be re-examined and mechanisms initiated to inform adolescents about ASRH as well as AFS issues. Advocacy meetings to engage provincial and local governments should be carried out and outreach extended to out-of-school adolescents through community learning centres (CLC), CBOs, and youth and sports clubs.

Sri Lanka: Although there is political commitment from the highest level of government and recognition of ADH as an essential programme, there is need for a separate national policy on adolescents and one that focuses specifically on school health. Even though a comprehensive reproductive health information system is in place, the timeliness, completeness and accuracy of data collected on SH aspects requires improvement. Moreover, efficient linkages between the reproductive health information system of the health sector and the SH promotion programme information management system of the education sector is critical for effective usage of data. Another identified gap is the ineffective use of subnational-level data to identify innovative approaches to deliver health interventions, such as for health education programmes. Implementation gaps include missed opportunities for updating policies to support SH programmes – for instance, including sexual and reproductive health issues in education. Furthermore, the target population is poorly represented in the programme implementation,
the programme lacks focus and balance between physical and mental health issues and school staff are more focused on improving academic achievements. There are human resource gaps including inequitable distribution of field staff and ineffective usage of services of existing staff (e.g. SMOs deployed at regional instead of municipal area). Other difficulties are ensuring a supportive environment for healthy behaviours and generating demand for SH services among adolescents and parents. There is also a lack of commitment and involvement of parents and the community in SH clubs.

Thailand: Overall, the programme lacks sustainability because supporting institutions are weak. The role of provincial officers is not delineated; the programme also does not cater to the diverse health problems of Thai children. The assessment found that supportive factors, such as parental and family engagement, are insufficient to protect the students from risks to their physical and mental health. Coordination between the relevant ministries and partners is needed to better address these gaps within the context of various ongoing programmes.

Suggested actions: The government should clarify the role of provincial officers and set up institutionalized capacity-building systems as measures to strengthen monitoring and evaluation activities. KM networks in schools could improve assessment of student risk behaviours associated with HIV/AIDS, reproductive health, mental health, dental health and obesity. An enabling environment that promotes healthy habits and supports parents in creating an environment free of smoking, alcohol and sexual harassment, needs to be created with support from the SH programme.

Specific suggestions from the key persons interviewed:

- Build on and strengthen existing platforms that address the most important issues affecting adolescents.
- Ensure that an integrated policy, strategy and action plan consisting of programmes to improve the health status of schoolgoing children are put in place and implemented. The progress should be coordinated and monitored by all the ministries and sectors concerned, at all levels. This should be a shared responsibility, with participation and commitment across sectors.
- Ensure the participation of all sectors concerned so that there is sufficient support for collaborative programmes. For example, the initiative should involve the DoH’s Health-Promoting Schools Project and Healthy Food in Schools Project, as well as the development of an effective health curriculum for students and instruction for health educators that is relevant to the local context.
- Promote research on students’ health, especially research aimed at generating evidence and knowledge related to the specific age group and area, to support evidence-based policy formulation.
- Information and surveillance systems should be strengthened to ensure the timely and effective monitoring of the health status of students.

Timor-Leste: Due to delayed implementation of almost all programme activities and plans on account of budget constraints the adolescent health and SH programmes are being supported entirely by international NGOs. Activities of the SH programme reflect the
priorities of the NGOs who are funding them, with MoE and MoH staff playing less significant roles. Operational and staffing challenges also hinder effective implementation. Implementation challenges faced include a lack of cooperation between school directors and teachers in supporting SH activities. There is the (incorrect) perception that SH programmes are the responsibility of NGOs, so there is no ownership of SH within the education sector. Some school directors do not use subsidy funds from the government to buy hygiene products for schools. There are also logistic challenges: health workers do not conduct regular visits to schools; transport cannot be provided to health providers who conduct health promotion in schools; there are difficulties in involving staff from institutions in activities such as screening programmes. Integration of indicators into the health system is a challenge as a result of which field activities are inadequately represented.

**Suggested actions:** Revise/strengthen MoUs with ministries and development partners. Committee terms of reference should state each Committee member’s responsibility within the SH programme. Maximum responsibility for SH should rest with the director of education and director of district health services in the municipality. Stakeholders/partners must provide an activity report to MoH, so that achievements can be noted and obstacles/needs resolved or facilitated. Coordination between the Ministry of Health, Ministry of Education, Ministry of Agriculture, Water and Environment and international and national partners needs strengthening so that an appropriate budget for SH programme activities can be allocated and included in annual plans at national and municipal levels. Regular working group meetings of adolescent health and SH programme partners, led by MoH and MoE at municipal and national levels, need to be institutionalized. Parents and community leaders need to be involved in the SH programme under the leadership of the School Director.
There is evidence from many countries that many adolescent problems can be successfully addressed through schools if SH could be considered as a public health programme of the MoH. Further, the MoH should include components of SH in their plans. In most countries, there is recognition by the government that provision of health services is constrained by a lack of access to these services, poor infrastructure and a shortage of health personnel, especially trained teachers, who are comfortable with discussing ASRH issues.

Some governments have already begun increasing the level of expenditure on health both absolutely and as a proportion of the total government budget with effect on SH – this practice should be adopted by all the countries. There is the realization among the health sector of what the SH programme can do in improving AH and there is the desire to collaborate with MoE and other ministries involved with child welfare and adolescence.

Several steering/coordinating committees at the national as well as subnational levels have been formed in various Member States. There is the possibility to utilize these committees to identify specific and emerging health needs and health issues of adolescents. However, much more needs to be done to encourage effective use of subnational-level data to identify innovative approaches to deliver health interventions through schools.

Intersectoral policies and activities need to be established in some countries and strengthened in others, so that each ministry can evolve a plan to allocate funds and human resources to strengthen AH activities in SH.

Adolescent participation – especially at the subnational levels – is missing in most countries. Student groups should be encouraged to actively participate in health promotion activities in the local community. Parents and caregivers should also be involved.

Overall, it may be said that school health faces multiple challenges in various Member countries of the SE Asia Region. In some countries, teachers consider SH to be an “out-of-scope” activity or an extra demand on their time with no extra pay. There are gaps in equitable distribution of field health staff to support SH, and lack of communication and proper coordination of SH activities with other ministries. Financial support is often inadequate, teachers may not have good health content to offer, coordination with NGOs and institutions may present problems. Sometimes neither the government nor the ministries accord priority to SH. These policy, programme, implementation, and monitoring challenges need to be addressed for SH to become an integral part of the national health agenda.