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MINISTRY OF HEALTH-ETHIOPIA

National School Health Program Framework

Addis Ababa, Ethiopia
August, 2025

Contents

Acronyms

ABE	Adult Basic Education
ANFEU	Adult and Non-Formal Education Units
AYH	Adolescent and Youth Health
CSA	Central Statistics Agency
DHIS2	District Health Information Software-2
EiE	Emergency in Education
EMIS	Education Management and Information System
EPHI	Ethiopian Public Health Institute
ESDP	Education Sector Development Plan
GBV	Gender Based Violence
GTMP	Global Trachoma Mapping Project
HC	Health Center
HEP	Health Extension Program
HEW	Health Extension Workers
Hgb	Hemoglobin
HIV	Human Immunodeficiency Virus
HMIS	Health Management and Information System
HPV	Human Papillomavirus
HTP	Harmful Traditional Practices
IEC	Information, Education and communication
IPIs	Intestinal parasitic infections
ISHP	Integrated SHP
ITNs	Insecticide-treated bed nets
MDA	Mass Drug Administration
MHH	Menstrual Health and Hygiene Management
MNS	Mental, Neurological and Substance use
MoE	Ministry Of Education
MoH	Ministry of Health
MTCT	Mother-to-child transmission
MUAC	Mid Upper Arm Circumference
NCD	Non-Communicable Diseases
NGOs	Non-Governmental Organization
PPP	Public private partnerships
PTA	Parent Teacher Association,

SBC/C	Social and Behavior Change Communication
SHP	School Health Program
STI	Sexually transmitted infections
SWASH	School Water Sanitation and Hygiene
TA	Teaching Assistant
Td	Diphtheria toxoids
TSEDU	Total Sanitation to End open Defecation and Urination
TT	Tetanus Toxoid
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
WASH	Water, Sanitation and Hygiene

Acknowledgment

TheMinistryofHealth-Ethiopia gratefully acknowledges all those who contributed to the development of the National School Health Program framework. This endeavor has been a collective effort, made possible by the dedication, expertise, and collaboration of numerous individuals and organizations.

We are deeply thankful to the team of experts and professionals whose knowledge, insights, and tireless efforts have enriched the development process. Their valuable contributions have ensured that the framework aligns with best practices and addresses the unique health needs of school-aged children across Ethiopia.

We also acknowledge the invaluable input and collaboration of our partners in government agencies, non-governmental organizations, academic institutions, and communities. Their collaborative spirit and dedication to improving school health have been indispensable. Particularly our gratitude goes to:

- USAID Healthy Behaviors Activity/FHI 360
- United Nations Children's Fund-UNICEF
- Zeleman communication, advertising and production agency
- Addis Ababa University, School of Public Health
- Ethiopia Public Health Institute-EPHI
- World Health Organization-WHO
- Ethiopian Health Education and Promotion Professionals Association- EHEPA
- United States Agency for International Development-USAID
- Amref Health Africa

This framework stands as a testament to the power of collective action and collaboration in advancing the health and well-being of our nation's future generations.

Forward

The health and wellbeing of Ethiopia's children and young people are central to our country's future. Schools are not only spaces of learning but also environments where lifelong wellbeing can be nurtured. It is with this understanding that the Ministry of Health, in close collaboration with the Ministry of Education, presents the revised National School Health Program Framework.

This framework affirms our conviction that students who are healthy are more likely to learn and thrive. It introduces a comprehensive approach that brings together health promotion, disease prevention and essential health services into the fabric of the education system. Rooted in evidence and responsive to the Ethiopian context, the framework is designed to guide stakeholders at every level in building learning environments where children and adolescents can reach their full potential.

The revised framework addresses previous gaps and emphasizes stronger coordination, equity and early intervention. It reflects our ambition to transform schools into supportive spaces that safeguard the physical, mental and emotional wellbeing of every learner. By providing a practical and structured roadmap, it aims to enable timely health services, strengthen referral linkages and promote inclusive and safe school environments.

I extend my sincere gratitude to the dedicated professionals, institutions and partners who contributed to the development of this important document. Your commitment to the wellbeing of our school communities is deeply valued.

As we move forward, let us commit together to transforming every school into a place where health and learning go hand in hand, and where every child in Ethiopia has the opportunity to grow in strength, confidence and hope.

Dereje Duguma Gemeda (MD, MIH)
State Minister

Forward

The future strength of Ethiopia rests upon the health and potential of our children and young people. Ministry of Education (MoE) recognizes that schools are not simply centers of learning, but critical environment where lifelong well-being is nurtured and educational outcomes are fundamentally determined. It is this deep conviction that healthy students are more likely to learn and thrive that underpins the revised National School Health Program (SHP) framework

This framework represents a robust and comprehensive approach designed to integrate health promotion, essential health services, and disease prevention into the very fabric of our national education system. The MoE acknowledged that good health and well-being play a critical role in achieving better educational outcomes for school communities. This revised framework is essential, as it addresses previous gaps related to coordination mechanisms and accountability.

Crucially, the success of this monumental national program relies on unwavering joint ownership and shared responsibility between our two ministries. While the Ministry of Education is responsible for school children and school related activities, the Ministry of Health is equally indispensable, and we stand fully responsible for the proper implementation of the SHP.

The implementation strategy demands that we act as a true co-partner: we are jointly responsible for coordinating meetings, providing strategic guidance, advocating for SHP activities, mobilizing necessary resources, and ensuring the program's quality and sustainability. Further, the Ministry of Education takes the crucial role in coordination and leadership concerning implementation activities within the educational sector. This framework ensures that health promotion is seamlessly integrated in to the school curriculum, strengthening health literacy, across all grade levels. I extend my sincere gratitude to all experts and dedicated partners who contributed to this important document. Let us commit to this joint strategic blueprint. By fostering this collaborative partnership and ensuring every policy, lessons and environment supports student health, we will realize our goal: creating a healthy, high-performing, and productive generation.

Ayelech Eshete W/Semayat
State Minister

Definition of terms

School: An institution designed to provide learning spaces and learning environments for the teaching of students under the direction of teachers from pre-primary to tertiary level of education

Pre-primary School: Consists of KG-1, KG-2 and KG-3

Primary level education: 1-6 grades

Middle school:7-8grades

Secondary school:9-12grades

Higher Education:TVET,Colleges and Universities

School health program: A program designed with a defined package of promotive and preventive eservice activities implemented to promote students' health, well-being and learning performance.

School Community: All school staff, including teachers, school governance (e.g. school board members), management staff, other school staff (e.g. administrative staff, cleaners, health professionals) and volunteers who work in the school, students, parents, caregivers, legal guardians and the wider family unit.

School Health Services: both school based and school linked health promotion and disease prevention services

Child: Any person less than 18 years of age

Adolescent: Any person between 10 to 19 years of age

Youth: Any person between 15 to 24 years of age

Young person: Any person between 10 to 24 years of age

Pre-primary children: children 5-6 years of age enrolled in KG or any other alternative pre- primary school setting

School-age children: Children attending schools at all levels in the country who are age 5 and greater

School Feeding Program: A School Feeding Program (SFP) in Ethiopia is a targeted social safety-net and education support intervention designed to provide regular, safe, nutritious food to school-aged children during the school day to improve their nutritional status, school enrolment, attendance, academic performance, and overall wellbeing.

School Health Technical Working Group: An inter-sectorial school health coordination committee comprised of members mainly from the Ministries of Health, Education, Women and Children, Youth and Sport, Water Resources and other relevant stakeholders.

Health Extension Program (HEP): A defined package of basic and essential preventive and selected high impact curative health services targeting households and communities

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health promotion: The process of enabling people to increase control over their health and its determinants and thereby improving their health.

School based health facilities: Primary care centers based in school at tertiary levels provide a combination of health promotion and preventive services.

SHP-implemented school: A school that has an operational School Health Program implementation standards, demonstrated by a functional school health coordination committee, a trained SHP focal person, active school health clubs and mini-media, a safe and healthy school and school surrounding environment, and the provision of basic school health promotive and preventive services including Health education, counseling, first aid and Menstrual Health and Hygiene (MHH) services.

Whole-school approach: An approach that encompasses all aspects of school life in order to improve students' educational performance, health, and well-being, as well as to create a supportive school environment, by identifying and addressing the school community's needs and engaging them in organized, collaborative efforts.

School Health Steering Committee: An inter-sectorial school health steering committee comprised of members mainly from the Ministries of Health, Education, Women and Children, Youth and Sport, Water Resources and other relevant stakeholders

Gender: -refers to socially and culturally constructed differences between men and women; as distinct from sex which refers to their biological differences. The social constructs vary across cultures and time, and change over time.

Sex: refers to the biological and physiological differences between males and females as determined by nature. It is biological, universal and non-changeable

Gender Club: is a student group platform that engages girls and boys in co-curricular activities that provide information and skills.

Gender-based violence (SRGBV): -is any form of violence or abuse that is based on gender roles and relationships

Gender equity: ensuring fairness in access to educational opportunities for girls and boys

Gender equality: eliminate all forms of discrimination so that all girls and boys and /or women and men have equal opportunities and benefits

SWASH: Provision of safe and adequate water supply, standardization and proportional improvement of latrine, proper cleaning and waste management in schools.

Executive Summary

Ministry of Health and Ministry of Education recognized that good health and wellbeing plays a critical role for better educational outcomes and improved health of the school communities. With this regard, this framework outlines a comprehensive approach to address various health issues affecting school-aged children and adolescents. The National School Health Program (SHP) Framework serves as a strategic blueprint to enhance the health and well-being of School Communities and learning performance of students through addressing diverse health challenges affecting school-aged children across in Ethiopia. It envisions creating healthy, health-literate students who can serve as agents of change in their communities and productive generation.

The framework was revised to address gaps in the previous framework: resource intensive, limitation on creation coordination platform and accountability mechanism. Aligning it with the revised national health and education policies, strategies and structural reforms, overcoming collaboration and partnership challenges during the implementation period of the previous framework and in place efficient and cost-effective ways and accountability mechanisms in realization of the SHP. This framework covers promotive and preventive health services for all school levels, including pre-primary, primary, secondary, and tertiary institutions, regardless of whether they are publicly or privately owned.

This SHP consists of six major pillars that guide the overall SHP which include: Advocate for adoption and implementation of healthy school policies, regulations and rules, promote school physical environment, improve school social-emotional environment, improve school- community engagement, strengthen school health promotive and preventive services and advocate to integrate health issues into school curriculum. It aims to implement a defined six School Health Program service packages.

A situational analysis reveals challenges like limited promotive and preventive health services, inadequate infrastructure, and weak multi-sectoral collaboration. To combat these issues, the framework advocates for collaboration across sectors, capacity building, and active involvement from school communities. It highlights the necessity for advocacy of sufficient resource, collaborative effort and training for teachers and health providers to ensure effective program delivery.

The framework proposes the formation of a Steering Committee and Technical Working Group (TWG) to oversee implementation, monitor progress, and ensure accountability. MoH will lead the overall implementation of the program, whereas MoE will co-lead the SHP. MoH and MoE are jointly responsible to organize and support by coordinating meetings and providing programmatic

guidance and administrative issues guided by a binding agreement by the two ministries. A separate implementation guide and service packages will be developed to accelerate the implementation of SHP.

In general, the National School Health Program Framework is a crucial initiative aimed at nurturing a healthy and productive generation. By addressing the diverse health needs of students and fostering collaboration among stakeholders, the framework intends promoting to create a conducive environment for learning, health and overall well-being. Successful implementation will demand commitment, collaboration, resources, and ongoing efforts from all sectors involved in the education and health of Ethiopia's youth.

SECTION-ONE: INTRODUCTION

1.1. Background

School health has evolved globally over several decades, with countries implementing programs to support schools and their communities in promoting better health. The School Health Program (SHP) is a whole-school approach that utilizes schools to foster physical, social, emotional, and psychological conditions for health and positive education outcomes. Governments and school communities acknowledge that health, well-being, and educational outcomes are interconnected, and schools are critical resources for influencing the health and well-being of students, families, and communities .

Schools are an important setting for promoting the health, well-being, and development of children and adolescents, as most are enrolled in school from pre-primary to higher education . Schools can provide a safe and secure environment for students to acquire knowledge, attitudes, behavior, skills, and experiences that are essential for becoming healthy, educated, and engaged citizens. Additionally, schools are viewed as safe places for seeking advice and support for health concerns, and they serve as outreach locations for delivering health services such as vaccinations, screening services, mass drug administrations, and access to healthy meals for students . More importantly, students have the capacity to make a positive impact on their community by disseminating health-related messages acquired from school.

Education has a profound impact on improving health outcomes. Levels of education are associated with healthier behaviors, greater access to healthcare, and longer life expectancy. Education improves health literacy, enabling individuals to make informed decisions about their health and navigate healthcare systems more effectively.

No educational system can function effectively unless it promotes the health and well-being of its students, faculty, and community. Importantly, every educational system should have policies, mechanisms, and resources in place to promote health and well-being in all aspects of school life, including the teaching curriculum, co-curricular activities and school governance based on participatory processes that include members of the broader community. Comprehensive school health program needs to be set up in a way which promotes health and well-being in all aspects of school life. Moreover, the future of a school should not be dependent on the enthusiasm and commitment of a few staff members or an individual school administrator; instead, it is crucial engaging the general public through Parent Teacher Association (PTA), Teaching Assistant (TA), education committee, Adult Basic Education (ABE), Adult and Non-Formal Education Units (ANFEU), and using other community structures/organizations .

Clearly, schools play an important role in empowering generations to make healthy life decisions, promoting long-term healthy behavior, and providing opportunities for economic independence and hope. Furthermore, schools provide an appropriate infrastructure for delivering awareness creation efforts to large numbers of school children, as well as youth, who are the age group most at risk, and to be embedded in communities, with the potential to reach more children and young people. A comprehensive school health program is designed in such a way that such positive changes are ensured and sustained.

Ethiopia has been implementing school health programs for several years. Various policies and strategies have also been designed and implemented to reach the school-age population through primary health care, which is the cornerstone of a sustainable health system for universal health coverage and the health-related Sustainable Development Goals (SDGs). As part of this Ministry of Education (MoE) in collaboration with the Ministry of Health (MoH) has developed and implemented a national school health and nutrition strategy since 2012 to enhance the quality of health in school communities by creating a healthy and child friendly environment for teaching and learning. Building on this the national SHP Framework that was developed and implemented since 2017, it is important to move beyond nutrition and close the gap on reaching children with health services by providing school health service packages. By this, SHP became one of the components of the primary health care system, particularly the health extension program. Further modeling schools in health were created to be a key component of the woreda transformation, which is the overarching goal of the second HSTP.

Further to that, the MoE incorporated health components into its Education Sector Development Plan (ESDP) as cross-cutting issues within priority programs. It aims to ensure that special needs and inclusive education, HIV/AIDS issues, drug abuse, water sanitation and hygiene activities, school health and nutrition interventions, environmental protection, and climate change activities are all given the attention they deserve in the overall sector plan. In the capacity building programme, it was foreseen under ESDP V to establish a unit for the full implementation of cross-cutting issues. However, the unit was not established as planned. Instead, close follow up and monitoring of progress was carried out by the respective directorates indicated in ESDP V. The ESDP VI has also indicated that these and other activities will be planned, implemented, and monitored by the indicated directorates .

Despite the fact that the School Health and Nutrition Strategy and the SHP framework for promoting health in schools were developed and implemented over ten years ago, the goal of a fully embedded, sustainable system has not yet to be realized. The experience of SHP implementation in the past consecutive years shows that, the health issue gets priority in the education sector. Despite this there were no established coordination mechanisms, leadership commitment, resource allocation and

weak monitoring and evaluation system. For this, designed strategies and interventions are required to institutionalize health promotion in all aspects of education systems, such as governance of the educational process and its content, resource allocation, educators' professional development, information systems, and performance management . Accordingly, to overcome the challenges and limitations, the MoH in collaboration with the MoE revised the framework by rebranding its name from school health and nutrition program to School Health Program (SHP) with the objective of aligning with global health promoting school initiatives, delineating coordination mechanisms and leadership roles that can be integrated into the school health programming. This framework gears to strengthen existing partnership and identifies key doable service packages to be implemented at schools that contribute to better health and academic performance of the students.

1.2. Situational Analysis

The situational analysis was conducted with per the ten SHP packages that have been delivered at all levels; from pre- primary to tertiary levels including TVETs.

1.2.1. Maternal, Child and Adolescent Health

1.2.1.1. Reproductive Health

Access to reproductive health (RH) information and services provides support and protects students from multifaceted RH problems during that critical time of transition. The most common factors associated with morbidity and mortality of adolescents and youth in Ethiopia includes early sexual debut, risky sexual practices, child marriage, early childbearing, unintended pregnancy, and unsafe abortion. Studies reveal that many students have inadequate RH knowledge .

Adolescent and youth morbidity in connection to early engagement in sexual activity has been detrimental. According to the PMA survey result from 2019, the median age at first sex is at 16.4years and the median age for first marriage is 17.8 years for rural girls which are lower compared to adolescent girls in urban areas . Modern contraceptive use among adolescents and youth has increased over the last two decades. Teenage pregnancy and motherhood are increasing from 12% in 2011 to 13% in 2016 and the unmet need for contraception remains high at 23.4 % for urban youth of the same age group .

There is a strong correlation between the impacts of RH problems on the equity of education specifically for secondary school level. Cognizant with this roadmap study claimed that traditional marriage practices (e.g. early marriage in many African communities) which mostly targets secondary school age children; and sexual maturation: poor management of sexual maturation may be preventing a

substantial number of young women from benefiting from secondary and technical and vocational education with the consequence of removing them from the pipeline. As a result, learners need evidence informed, age appropriate, culturally relevant, and legally accepted RH programs.

1.2.1.2. Gender Equality in Schools

Boys and girls must feel welcome in a safe and secure learning environment. Governments, schools, teachers and students all have a part to play in ensuring that schools are free of violence and discrimination and provide a gender-sensitive, good-quality education. To achieve this, governments can develop nondiscriminatory curricula, facilitate teacher education and make sure sanitation facilities are adequate. Schools are responsible for addressing school-related violence and providing comprehensive health education. Teachers should follow professional norms regarding appropriate disciplinary practices and provide unbiased instruction. And students must behave in a non-violent, inclusive way. The implementation of Ethiopia's Code of Conduct on Prevention of SRGBV in Schools has been patchy. Some school staff reportedly lacked commitment to or a sense of ownership of the code .

School-based compliant investigation, decision recommendation (committees, gender clubs, departments, units etc) and none school-based sectors (health, justice, social protection, etc) need to work hand-in-hand to prevent and create referral pathways on GBV/SEA against girls and boys including child marriage very serious concerns in the schools and around the schools.

1.2.1.3. Expanded Program on Immunization (EPI)

Main vaccinations that can be implemented at school settings are HPV, TT, Td, Measles, Polio, COVID 19, Cholera, yellow fever and meningitis. This will reduce the rate of accumulation of susceptible children and the risk of an outbreak of the particular disease.

HPV Vaccines were administered in schools and health facilities for two cohorts. More than 866,000 14-year-old girls took the first dose of the vaccine while 970,000 took the second dose, having received the first dose in January 2021. Two doses of HPV vaccine are required for full protection against the human papillomavirus which causes cervical cancer .

Currently the country practiced on improving school immunization capacity and vaccination interventions. The approach was found to empower education sectors at different levels to exercise accountability and share ownership of immunization outcomes.

There is a significant opportunity for the integration of immunization screening and service linkages with vaccines into schools in order to advance immunization coverage in the country. Having an established school platform for immunization will provide a modality for immunization catch up in early school years and will increase the potential uptake of current vaccines as well as those that will be introduced in the near future.

1.2.2. Disease Prevention

1.2.2.1. Common Infections, Infestations and Disorders

Despite an overall increase in coverage and quality of child health services delivered through existing strategies, health care utilization remains low due to barriers to access and limited demand. In order to achieve the full potential of demand-generation activities for accessing and utilizing health care services, targeting major school-age diseases while at schools can play a critical role. The common school-age childhood diseases and disorders are outlined below.

Intestinal infections and infestations

Infections, infestations and disorders are the commonest health problems of students at school. Soil transmitted helminths infections are among the most prevalent intestinal infestations in developing countries. Generally, these parasites are most common in areas with tropical climates.

The prevalence of intestinal parasitic infections (IPIs) among school children in Ethiopia is 52%. The intestinal nematode Ascaris lumbricoides infects approximately 25% of the world's population annually. The overall prevalence of A. lumbricoides was noted as 41.4% and was the leading cause of intestinal parasitoids followed by Schistosoma mansoni (27.6%), Trichuris trichiura (18.1%) and Strongyloides stercoralis (4.1%). Children in the age group between 5 and 10 years found more susceptible to the infection. The present evidence showed that A. lumbricoides was a major health problem among school children and requires annual deworming to control morbidity associated with intestinal parasites .

TB & leprosy and other respiratory tract infection

According to the National Health atlas Report in 2021, among the top twenty leading Cause of Death in Ethiopia, Susceptible TB is ranked fifth and Ethiopia missesan estimated 31% of TB cases each year. If undiagnosed and not treated these persons can die of TB, be chronically ill and continue to transmit TB in the community . Tuberculosis (TB) is contagious, and the transmission risk is high in congregate settings like school, especially in boarding school and universities. The crowded situation with limited ventilation both in classrooms and dormitories increases the risk of exposure to TB and

other aerosol infections. It greatly increases if TB becomes active and remains untreated, a person with active but untreated TB can infect 10–15 people per year .

In Ethiopia, close to 70% of annually notified cases are between 15-54 years of age, among which children accounted for 10% of the cases. Childhood TB is a major contributor to childhood morbidity and mortality particularly in high TB-burden settings and young children are more likely than adults to develop life-threatening forms of TB disease (e.g., disseminated TB, TB meningitis). The study conducted on Tuberculosis knowledge and attitude among non-health Science University students in three Ethiopian universities show that only about one third of students had a 'good' level of TB knowledge and that most students had at least some 'unacceptable' attitudes towards TB, lack important TB knowledge and have misconceptions about TB .

Therefore, such kinds of congregated settings should be target to implement TB infection control measures and emphasis needs to be given on increasing the knowledge of students and staffs about TB and Leprosy disease symptoms, transmission, and prevention have positive intentions to seek treatment for themselves and knowledge transfer to households and the wider community through school-based education programs also may assist in reducing the burden of TB and leprosy diseases.

Malaria

Malaria is one of the major public health problems in Ethiopia. About 75% of the total land mass of the country is considered malarious and around 52% of the population living in these areas is at risk of malaria. Despite the decrease in malaria mortality and morbidity, it remains a significant public health problem in the country. Ethiopia adopted a malaria elimination goal by 2030 and beyond by promoting the participation of the community and community-based institutions such as schools.

Although malaria affects every member of the community the proportion of individuals who are infected with malaria parasites is highest among school-age children , malaria has profound health and social effects on school-aged children affecting the critical period of learning and development such as cause's anemia among school-age children, impairs cognition, learning, and educational achievement, a leading cause of illness and absenteeism among students and teachers and impairs attendance and learning.

School-based malaria education intervention (engaging school children as health messengers) had a substantial impact not only on school children, but also on community in improving knowledge on transmission, prevention and bed net impregnation practices. The improved
knowledge and practices could be associated with the decrease in the malaria prevalence observed in the school children .

Currently, good quality malaria prevention, control, and elimination services are most needed currently; we need to find new approaches or use missed opportunities. In this regard, schools play a great role in malaria control and elimination endeavors particularly to improve the uptake intervention through community awareness creation and empowerment.

Eye Health

Around the world, an estimated 19 million children are visually impaired and are officially classified as either blind or with low vision. Of these, 12 million children are visually impaired due to refractive errors, which is easily diagnosed and corrected with a pair of glasses. In addition to refractive errors, primary school age children may be affected by allergic eye disease, conjunctiva infections, including trachoma, and eye injuries. Avoidable eye diseases accounted for about 97% of ocular morbidities. Children with sight problems must be provided with spectacles, low vision devices or medical intervention . Refractive services in schools, especially in primary schools for children aged 7-15 years, could contribute a great deal to relieve this burden. By 2015, the total number of schools performing screening had reached 1,750; however, only 250,000 students were screened and only 25,000 students received eyeglasses .

Hearing Defect

In a community-based survey in rural eastern Ethiopia in 2014, hearing loss was the most frequent disability among children aged 0 to 14 years. Among these students almost half of them had chronic ear discharge and the majority of children had treatable hearing problems. One of the main impacts of hearing loss is a child's ability to communicate with others. Spoken language development is often delayed in deaf children.

Oral Health

The major oral health problems include dental caries, periodontal disease, malocclusion and dental fluorosis. The most common chronic dental diseases in children worldwide are dental caries (tooth decay) and gum disease (gingivitis). Diseases of teeth and mouth affect children's ability to eat and chew, the food they choose, their appearance and the way they communicate. Pain from teeth and the mouth can compromise children's attention and their ability to learn at school, thereby hampering, not only their play and development, but also denying them the full benefit of schooling. Children with disabilities may suffer from long-term physical, mental, intellectual or sensory impairments that may hinder their full, effective and equal participation in society.

Schools play a critical role in promoting oral health by delivering structured health education that increases students' awareness of proper oral hygiene practices, such as regular tooth brushing, healthy eating, and the risks of sugary food consumption. Through the provision of essential health services such as routine dental screenings, schools help in the early detection and prevention of oral diseases. Engaging families and communities through coordinated efforts also ensures that oral health messages are reinforced at home, making the school health program an effective platform for improving and sustaining children's oral health.

Skin infestation

Studies report that the prevalence of ectoparasites (skin infestations) is still a public health problem affecting school children. Among the common skin infestations are head lice, scabies, myiasis, and tungiasis. These forms of ectoparasites are a major health concern in schools as well as in the wider community.

In school-aged children, head lice infestation can cause sleep disturbances and concentration difficulties, potentially leading to poor performance in school, social distress, discomfort, parental anxiety, embarrassment, and unnecessary absence from school. In developing countries, persistent infestation has also been associated with high morbidity, including secondary skin infections including impetigo. Tungiasis can also be incapacitating, especially due to severe physical disability emanating from its pathological effects of severe itching, pain and sensation of a foreign body on the skin. A survey undertaken in school children in southwest Ethiopia found that infestations were the most prevalent skin pathology followed by fungal infections, thus making it a disease of significant health concern24. Given that schools are usually the first-time children are exposed to varying highly contagious diseases, periodic screening among students is obligatory in a SHP to establish a healthy school environment.

1.2.2.2. HIV and Sexually Transmitted Infections

National HIV prevalence among young people (15-24) is low (0.34%), compared to adult prevalence (0.93%), necessitating attention and intervention. In addition, 41,788 children aged 0- 14 years are living with HIV in 2021, with 3,195 new HIV infections.

According to the EDHS 2016 report, the level of comprehensive knowledge is low among young people aged 15-24 years which was 24.3 among girls and 39.1 among boys. To the contrary, among survey respondents aged 18-24 years of age, a higher percentage (40%) of girls had sexual intercourse before age 18 than among boys (11.7%) which indicates that adolescent girls and young women are

more at risk for HIV than the boys. Only a little over half of young women (54%) and men (59.3%) in Ethiopia know that the risk of MTCT can be reduced by mothers taking special drugs during pregnancy.

The study conducted by MoE 2021 on Evaluation of Behavioral Change on HIV/AIDS and RH Issues at Secondary Schools in Selected Regions of Ethiopia show that about three fourth (74.9%) of students did not have adequate HIV knowledge. And more than 80% of students know at least one symptom of sexually transmitted infections (STI).

The results also show that 14.3% of students have started practicing sex. Furthermore, more than a quarter of students who have started practicing sexual intercourse did not use any contraceptives, and 2.6% of them used the riskier method of natural contraception. The sexual intercourse conducted by the students is the riskiest sexual behavior which is characterized by intercourse without condom (85.4%), sex with unknown partner (46.3%), and sex with partner who had multiple sexual partners (62.2%).

Moreover, high staff turn-over of life skill and peer education; weak workplace interventions at all levels of the education system; low accessibility of most of the school HIV/AIDS preventive activities (less than 50% of students have access to preventative activities); absence/weak mini-media, resource center and anti- HIV/AIDS clubs in some schools and little ownership at regional and school level (no focal person or coordinator assigned) are among the challenges.

1.2.2.3. Non-Communicable Diseases:

Available evidence shows Ethiopia is in epidemiologic transition. In the context of the epidemiological transition in Ethiopia, a triple burden of disease is already emerging with the mix of persistent infectious diseases, increasing non communicable diseases and injuries.

NCD Country Profiles 2018 Report by the World Health Organization indicated there were a total of 700,000 deaths in Ethiopia in 2016. Among these deaths 39 % was attributed to NCDs, 12% to Injuries and 49% to Communicable, maternal, perinatal and nutritional (CMNN) condition.

Overall cardiovascular diseases accounted for 16%, cancers for 7% and respiratory disease for 2% of all causes of death. Furthermore, diabetes accounted for 2%, injuries for 12% and other NCDs for 12% of causes of deaths in the same year . However, evidence shows that NCDs and their risk factors have an enormous impact on the health of children, adolescents and youths. UNESCO, 2017 reported that it is possible to prevent 70% of NCD by using simple behavioral intervention .

1.2.2.4. Mental, Neurological and Substance Use Disorder

Many factors have an impact on the well-being and mental health of adolescents. Violence, poverty, alcohol and substance use, stigma, exclusion, and those living in humanitarian and fragile settings can be mentioned for increased risk of developing mental health problems.

A meta-analysis on the prevalence of substance use of khat, alcohol, and cigarettes among secondary and university Ethiopian students found that more than half of students had used at least one of the substances.

Early exposure to these substances has been shown to be associated with increased risk of HIV infection and risky sexual behavior, increased violent behavior (particularly gender-based violence), poor academic performance, alcohol abuse, high risk taking, and suicide.

Currently the MoE finalized education law and revised and implemented school related code of conduct that focus on creating a safe school environment, punish the perpetrators on the school staff, students and teachers, and create multi-sectoral coordination.

The consequences of not addressing adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.

1.2.3. Water, Sanitation and Hygiene (WASH)

Provision of safe and adequate water supply, improved sanitation facilities and safe hygiene practices are essential services and interventions in schools. Schools should focus on improving WASH in schools to ensure that their students stay healthy. The World Health Organization (WHO) has identified school-based WASH as a key strategy to fight the global spread of infectious diseases. Schools should take a unified focus on improving WASH in schools because they have an opportunity like no other organization has, using the fact that their students are at the learning age about these essential principles they need to learn.

In Ethiopia the percentage of primary schools with an adequate water supply has been declining, from 40% in 2009 E.C. (2016/17) to 38% in 2010 E.C. (2017/18), and then to just 27% in 2011 E.C. (2018/19). About 79% of primary schools have toilets and of this, 34% are traditional (which do not meet standards) and 45% are improved toilets. Nearly 36% of schools have toilets accessible to children with special needs, and 49% are accessible to young children whereas in secondary schools 96% have toilets, the majority of which are improved toilets while only 23% have traditional toilets.

However, there are significant regional variations. According to a School WASH Mapping report prepared by the SIP directorate in 2017 . Limitations to sufficient WASH facilities in Ethiopian schools include limited capacity in planning, monitoring, evaluating and reporting WASH in schools; a lack of a public budget line for WASH and dependency on external financing; poor operation and maintenance capacity; low levels of awareness on proper use of facilities; inadequacy of existing facilities including lack of separate facilities for girls, and lack of WASH in emergency affected areas .

School cleaning and waste management

Schools, universities, and other places of education create lots of waste every day. The main adverse environmental impacts include expired laboratory chemicals, classroom dusts, garbage, containers, leftover food and packaging, waste from the school cafeteria, grass and noise impacts during ramp, used paper classroom, toilet renovation. School requires a sound Environmental and waste management system that establishes a safe, clean and healthy environment for teaching and learning process. School Waste management like segregation, collection and disposal which aim to reduce, reuses and recycle the wastes produced. Waste disposal system uses landfills and composting wastes.

Menstruating hygiene and health management

There is an increasing recognition of the potential positive impact of providing separate, private and safe latrines for girls towards improving their school attendance and retention. Therefore, the Ministry of Health defined a minimum package of information and services that are critical for addressing MHH in a comprehensive and dignified manner. The package comprises of four components (comprehensive awareness raising– creating demand, WASH facilities – supply, supply of sanitary pads and management and disposal of sanitary materials) as a minimum requirement for MHH interventions in different settings including in schools.

1.2.4. School Nutrition

School feeding programs play a key role in helping children realize their potential, both for themselves and for their communities. The Ministry of Education, in collaboration with WFP, officially launched school feeding program for the first time in 1994 with an initial pilot project covering 40 primary schools in Amhara, Tigray, Oromia and Afar regions to provide a nourishing meal to 25,000 school children in high-food insecure areas with low educational performance. The objective was to assist primary school children to attend school without feeling hungry. Take- home rations conditional to school attendance for pastoralist girls were also introduced in 2002. Given the promising result, the program further expanded to Somali and SNNPR during 2000- 2004, while also increasing coverage in other regions and supports some 649,000 students in more than 1200 primary schools in 2004/2006

Institutionalizing the school feeding program is at start. Addis Ababa City Administration has institutionalized the program by establishing an independent agency and made the program universal across all public schools. Similarly, the Ministry of Education (MoE) has created a separate unit of management for the program at the federal level-School Feeding Directorate.

1.3.4. School Health Emergency Management

Ethiopia is vulnerable to both natural and human made emergencies. In 2015, Ethiopia experienced the worst drought in 50 years. The education sector is one of the emergencies affected sectors. A review of emergency responses implemented from 2010 to 2014 shows that the number of school age children affected by emergencies averages 250,000 annually. About 2.1 million school age children were affected in 2015. This has grown to 2.8 million in 2017.

The recent global phenomena and pandemic COVID 19 which is affecting the education sector in many ways. All schools were closed during Covid-19. If the pandemic stays long, the education system may be facing a challenge to conduct the teaching process in the usual way.

Over the past years, Ethiopia experienced several periods of drought which have severely affected certain regions with regard to food security. Emergencies such as caused through natural catastrophes affect all parts of human life, including education. People may need to be on the move. Children may not be in a position to go to school. Funding may be distracted from education for emergency interventions and food.

ESDP VI has foreseen a cross-cutting program on education in emergencies as a means to be able to quickly respond to the circumstances arising out of emergency. To address these crises, the government, development partners and NGOs have coordinated efforts, led by the Education in Emergencies Cluster, providing temporary learning spaces, scholastic materials, school feeding, WASH facilities, accelerated school program, and psychosocial support. The concept of school health is international in its development, with many countries around the world working on program which reduce common health problems, increase the efficiency of the education system and advance public health, education and social and economic development in each nation.

Injuries are the other important public health problems affecting children and adolescents. Injury prevalence is highly associated with age and stage of development. According to the Global Health Estimates (GHE 2014), injuries caused 5.14 million deaths globally and of those, 372,512 were in children under 5 years and 367,540 among children aged 5-14 years. Child injuries are a serious public health problem, and unintentional injuries are among the top causes of child mortality in Ethiopia.

1.2.5. Social and Behavior Change and Life Skills to promote healthy lifestyles.

The National Health Promotion Strategy (2021-2025) indicates that further health improvements in Ethiopia are possible with improved awareness and adoption of healthy behavior of the school community, which can be facilitated through social and behavior change (SBC) approaches.

School-based SBC interventions like peer-education, life skill education, Mini-Media, School Community Conversation (SCC), community radio and HIV resource center, that address students' awareness, attitudes and behavior regarding improving health literacy, are limited in Ethiopia.
Likewise, despite several HIV/AIDS and RH behavior change efforts by the MoE, the majority of students did not have adequate knowledge on HIV/AIDS and RH. The RH education to students increases a six percent by behavior change efforts by the MoE, but both RH and HIV knowledge were not associated with a decrease of high risk sexual behavior, this suggested that the school- based HIV/AIDS and RH behavior change interventions are not resulting in increased knowledge and improved preventive sexual behavior of students .

This suggests that revision of the existing school SBC is mandatory in alignment with the new SHP version so as to equip learners with appropriate KAP since schools are an appropriate setting for the introduction of health education and play an important role in an individual's socialization process. In addition, schools are also an economically efficient way of reaching out to young people by making use of existing infrastructure. It is also a place where children and adolescents can easily be reached on a larger scale.

Schools are an appropriate place for the introduction of life skills education as they play an important role in the socialization process of an individual. In addition, schools are an economically efficient way of reaching out to young people by making use of existing infrastructure. It is also a place where children and adolescents can easily be reached on a larger scale. Experienced and influential teachers can serve as role models as they practice and exercise life skills and capitalize on their high level of credibility with parents and other community members. Life skills development in school also contributes to creating an enabling environment for learning and self-development and lays a strong foundation for the future life of the students through building self-confidence, resisting peer pressure and fostering respect for themselves and others.

In the Ethiopian context, adolescents face risk of substance use (e.g., alcohol, tobacco, and khat), early sexual initiation, and teenage and unintended pregnancy, potentially resulting in unsafe abortion. This is mainly due to lack of information, education, services and skills that help them make informed decisions.

These problems are often addressed by life skills development to equip students to mitigate peer pressure and improve decision-making and control other social and emotional factors that may influence them.

1.3. SLOT Analysis

The overall strengths, limitations, opportunities and threats (SLOT) analysis in implementing the SHP were assessed during a round table discussion among experts from MoH, MoE, partners and stakeholders. The following outlines the agreement reached during the review.

Strength	Limitation/Weakness
• Linkage and referral system created between schools and health facilities • School feeding program implementation in schools • Strengthening different clubs and committees at schools • Incorporation of health component in the new school curriculum reform • Identifying health issues as one thematic area for research at the tertiary level • Sectoral policy and strategies on health (Health in all policies) • Inclusion of health-related sensitive indicators in EMIS and HMIS • The expansion of infrastructures such as community radios digital learning education in the education sector • Implementation of life skills, peer pressure and other health related issues in schools • The presence of clinic /health centers at tertiary level • Increasing primary health service coverage • Incorporation of health component in school curriculum.	•Limitedadolescentsandyouth engagement in the program • Nonexistent or limited health services in schools/universities • Infrastructure and space limitations in schools (Classrooms, toilets, clean water, playground) • Weak multi sectoral collaboration • Weak monitoring and evaluation • Lack of accountability • High turnover of teachers and other staff • Under resourced and substandard of clinics in school institutions(tertiary) • Poor communication skills on the side of service provider • Low motivation of service providers due to lack of on-the-job training and unsatisfactory salary.

Opportunities	Threats
•Launching ofnewinitiatives like TSEDU-Ethiopia Initiative • Favorable global momentum on adolescent and youth health through SDGs • Focus on quality of education by the government • Increasing number of schools, pre-schools, TVETs and universities • Increased student enrollment rate • Different sectoral policies focus on youth • The Improvement of Infrastructure and Technology Advancement	• Frequentand recurrent emergency • Environmental/climate change (famine, conflict & drought) • Instability and conflict) • Misuse of technology • Availability of shisha, khat, alcohol drinks nearby school institutions

Table 1: School Health program SWOT analysis

1.4. Rationale

Investing in improving the health status of young people, particularly those in school, holds significant importance in fostering a healthier and more productive citizen. Implementing school health programs effectively can empower students to become influential advocates for health within their families, communities, and peer groups.

Nationally, over 27 million students are at school. Therefore, implementing the SHP would help to access almost one-third of the Ethiopian population. What is irony is that children in the age range 5 to 9 years are not addressed in any health strategies including the child survival strategy. Hence, the rationale of implementing the SHP will be addressing such equity gaps as it is more comprehensive health strategy. What is more, it is the “golden window” of opportunity in terms of improving the overall lifetime health of populations. About 70% of adulthood diseases are the result of health behaviors and actions during young age . Overall, SHP is the most efficient and cost-effective way to improve students’ health and academic performance.

An assessment of the implementation of the 2017 School Health and Nutrition Framework was conducted in the pilot regions, Amhara and Tigray. The challenges identified through this assessment served as key justifications for revising the framework.

The major reasons to revise the existing school health program framework are:

- The previous school health framework had resource intensive and unrealistic goals which were difficult to achieve (totally required cost were above 11 billion ETB for administrative, human resources, infrastructure and logistics cost).
- The need for alignment with the revised national health and education policies, strategies and structural reforms.
- There was a limitation on creating coordination platform and accountability mechanisms in the previous framework,
- The emerging new health initiatives and programs that can be implemented at school were not included in the framework document.
- To track the progress, the monitoring and evaluation system was also not well designed and not aligned with global standards & indicators.

SECTION-TWO: STRATEGIC FRAMEWORK

2.1. Goal: To create healthy, high performing and productive generation

2.2. Objectives

General objective:

- To improve health andwell-being ofstudents,families,communitiesandlearning performance of students through implementing school health program in Ethiopia.

Specific Objectives

- To harmonize coordinated efforts towards effective SHP implementation
- To improve the health literacy of school community
- To enable students to be health change agents for their families and community at large.
- To help early detection of diseases through routine screening
- To promote a convenient, healthy and friendly school environment

2.3. Scope of the framework

The SHP framework is intended to encompass health services including health promotion and preventive services for students across all levels and types of schools irrespective of their ownership (i.e. private, community, NGOs and government owned.

The SHP framework provides the list of service packages that will be delivered at school based and linking them with existing public health care delivery institutions. It will be aligned with already functioning programs.

2.4. Guiding principles

Socio-cultural context oriented :There are many rules, regulations, religious and cultural valuesand normsprevalenttoregulate society in a good manner. As a result, the socio-cultural environment adhered to implementation of SHP becomes the basic notion for the program's sustainability within the community.

Equity and inclusion The package guides SHPs to recognize and address the health needs of studentsofdifferentage levels, different disability types, geographical location and economic level in an equitable manner. For those students with special needs, the existing system and infrastructure will be utilized to address their health needs.

Life course approach : Efforts are targeted to break or disrupt negative intergenerational cyclesthat arecreatedbyorcontribute to health inequities. Students in turn will create the condition for healthy future generations as parents, grandparents and caregivers.

Student friendly services : An approach to care and service that consciously adopts the perspectives of individuals,families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their health needs and preferences in human and holistic ways.

Collaboration : Effective implementation of the SHP requires strong collaboration between theeducation andhealth sectors, as well as with communities, development partners, and other stakeholders to ensure shared ownership, coordination, and resource mobilization.

Innovations:More investment will be made for testing and scaling up of new ideas, technologies, productsandtheories/models to increase access, utilization and coverage of services.

A whole school approach : Whole school approaches to health and well-being also require supportiverelationships, safe, gender-equitable physical and social environments and greater opportunities for learning in the school as a social community.

Ensure Stakeholder Engagement : Meaningful, strong, sustained engagement, participationandresponsibilitybystakeholdersare important for effective implementation of SHP.

2.5. Strategic Approaches

Thefollowingapproacheswillbeemployed for successful implementation of SHP:

Creating Ownership

The strategic approach to SHP implementation is underpinned by the core principle of joint ownership by education and health sector, which allows the sector to integrate SHP into its core activity plan and ongoing activities. It also allows the ministry of health to take the coordination and leadership role of SHP implementation at all levels. To foster ownership, SHP implementation should integrate at all levels of existing health and education systems.

Furthermore, school health is an integral part of school plans and ongoing activities, and all teachers and school administrative bodies are accountable for health promotion, education, and students' health and well-being.

Capacity Building

Capacity building of SHP coordination bodies at all levels and service providers including health care providers, teachers and counselors at school is the approach to ensure ownership and sustainability of SHP implementation.

Advocacy

Advocacy for higher officials and stakeholders to have common understanding on SHP approaches and system integration including getting their commitments, attention and resources.

Inter-Sectoral Collaboration and Partnership

Inter-sectoral collaboration and partnership are crucial for addressing challenges. The coordinated efforts of different sectors, such as government, private industry, non-profit organizations, and civil society, to address the issue of school health. MoE and MoH play a central role in communication and information sharing, joint planning, implementation and monitoring and evaluation of school health activities. The collaboration must be flexible and responsive to respond and follow up to health needs of school communities. Global evidence pinpointed that the effective implementation of SHP seeks the crucial role of MoE in coordination and leadership. Since school health is not the responsibility of one single sector, the establishment of an institutional framework, along with collaboration and networking, advocacy and resource mobilization, and monitoring and evaluation will govern the overall work at all levels of program implementation.

School Community Engagement

School communities should be engaged in different school-based curricular and co-curricular activities including in creating a healthy and supportive school environment to foster the provision of SHP. It comprises all activities associated with the establishment, functioning and sustainability of partnerships between schools and local communities. It requires structured, transparent establishment of a partnership. This might include a written agreement or shared plan and activities for ensuring that partnerships function well, such as a shared commitment by all parties, opportunities for review and reflection and, at times, improving the functioning of the partnership.

School Health Services and Referral Linkage

This service consists of promotive and preventive interventions to students within the school setup or in collaboration with the catchment health facilities along the tires. The school health services need to be adequately resourced, appropriately and equitably delivered and responsive to the specific health needs of the school community they serve.

SECTION-THREE: SCHOOL HEALTH PROGRAM PILLARS

Several factors influence the physical, social and mental health of students, and their learning process. These factors include health conditions of the students themselves, physical and social environment in their school, quality of life of their parents, their own knowledge about health promoting practices, and availability of health services within the school and their surroundings. The SHP Pillars include:

1. Advocate for adoption and implementation of healthy school policies, regulations and rules
2. Promote safe and supportive school physical environment
3. Improve school social-emotional environment
4. Improve school - community engagement
5. Strengthen school health services
6. Advocate for integration of health issues into school curriculum

3.1. Healthy School Policies, Regulations and Rules

Establish clear policies and governancestructures toguide the implementation of the SHP at the national, regional, and local levels. Healthy school policies need to ensure alignment with national health and education priorities, and provide oversight to ensure consistency and effectiveness, which are clearly defined and broadly promulgated directions that influence school actions and resource allocation in areas that promote health. If these existing policies do not already address health issues, they could be expanded to do so. This pillar is supplemented by the Ministry of Health's undergoing health in all policy initiatives.

This involves laws, regulations, rules, protocols, and procedures that are designed to guide or influence behavior. Policies can be either legislative or organizational. Policies often mandate environmental changes and increase the likelihood that they will become institutionalized or sustainable. Healthy school policies include: a policy on healthy food, smoke-free and prohibits alcohol and substance use, first aid, a policy on the control of helminths and other parasites, WASH accessibility, health screening and a safety plan for implementation in the event of natural or other disasters.

Strategic Actions:

- Advocate for adoption and implementation of school health policies, rules, regulations to promote health and well-being in schools, covering nutrition, physical activity, mental health, hygiene, and sanitation.
- Promote school health policies are evidence-based, culturally sensitive, and inclusive.
- Promote review mechanism to periodically update and adapt school health policies to changing needs and circumstances.

3.2. School Health Curriculum Integration

The school curriculum contributes to health literacy by advancing the knowledge, skills, attitudes and behavior of students and the school community. Integrate health education into the school curriculum across all grade levels and subjects. The aim of this pillar is to ensure that the school's curriculum educates and promotes all elements of physical, social– emotional and psychological health, well-being and development. An effective school health curriculum should be designed to motivate children and youth to maintain and improve their health, prevent disease, reduce health- related risk behaviors and develop and demonstrate health-related knowledge, attitudes, skills and practices.

Develop age-appropriate and culturally sensitive learning materials and instructional strategies to promote health literacy and foster healthy behaviors among students. Health education should cover topics such as nutrition, physical activity, mental health, hygiene, reproductive health and injury prevention.

Strategic Actions:

- •Advocate for reviewing existing health curricula, adapting them to align with national health policies, and integrating key components into the school curriculum.
- •Promote to ensure the curriculum being evidence-based, culturally sensitive, and addresses the health needs and priorities of students.
- •Coordinate the collaboration with relevant stakeholders to incorporate health education into various subject areas, including science, physical education, and social studies.
- •Advocate integration of health education into pre-service teacher training programs to ensure that future educators are adequately prepared.
- •Engage in the development of age-appropriate learning materials and resources to support the integration of health education into the school curriculum.
- •Provide technical support for the incorporation of practical activities, such as group discussions, role-plays, and projects, to make health education interactive and engaging.

3.3. School Physical Environment

The school physical environment includes safe clean drinking water (with regular water quality monitoring), gender and culturally appropriate sanitation/toilet facilities, adequately spacious class rooms, comfortable seating arrangements, play grounds, canteen that provides healthy food, a child friendly environment and access for disabled and physically challenged students. A healthy, safe, secure, accessible environment within and around the school establishes the prerequisites for optimal health and learning (e.g. lighting, fencing, water and sanitation, menstrual hygiene room with its basic

facilities (girls), food provided to students) for all students and members of the school community. Physical environment of a school should receive dedicated investments to ensure it is safe, secure, healthy and inclusive for all students and the school community. It should accommodate the needs of school communities with disabilities. Its aim is to ensure that the school physical environment facilitates health promotion by being accessible, needs-based and aligned with national policy and regulations.

Strategic Actions:

- •Assess the current physical infrastructure of schools nationwide.
- •Advocate to ensure school infrastructure is safe, conducive to learning, and accessible to all students, including those with disabilities.
- •Promote for ensure that all schools have access to safe drinking water, adequate sanitation facilities, and proper hygiene practices (include separate MHH safe space).
- •Promote regular maintenance and cleaning schedules for WASH facilities.
- •Develop and implement safety and security protocols to ensure the physical safety and well-being of students and staff.
- •Establish emergency response procedures and provide training to school staff and students.
- •Promote a clean and healthy school environment by implementing waste management and pest control measures.
- •Develop and maintain safe and accessible playgrounds and recreational spaces for students to engage in physical activity and play.
- •Incorporate green spaces and gardens into school grounds to promote environmental awareness and connection with nature.
- •Ensure that all classrooms and other learning spaces have adequate natural and artificial lighting and ventilation.
- •Ensure that school facilities are accessible to all students, including those with disabilities.

3.4. School Social-Emotional Environment

The social-emotional environment is a combination of the quality of the relationships among staff, among students, and between staff and students. It encompasses the norms, values, behavior and attitudes of individuals in the school communities and the quality of their interpersonal interactions. The aim is to ensure dedicated investment in the social–emotional environment of a school to promote the well-being, confidence and mutual respect of all members of the school and local communities. SHP requires that an inclusive, supportive, safe environment be prioritized in school policy, and that its philosophy is embodied by students, staff and community members in all their interactions. Below are suggested frameworks:

Promote Positive Relationships: Encourage positive interactions among students, teachers, staff, and parents. Foster a sense of belonging and community by organizing events, clubs, and activities that bring people together. Assign mentors or advisors to students to provide guidance, support, and encouragement.

Strategic Actions:

- •Advocate integration of evidence-based Social and Emotional Learning (SEL) programs into the curriculum to enhance students' social, emotional, and academic skills.
- •Collaborate to offer ongoing professional development opportunities for educators to enhance their skills in promoting a positive social-emotional environment.
- •Provide training on topics such as conflict resolution, emotional regulation, and culturally responsive teaching.
- •Implement mentoring programs to provide additional support for students in need.
- •Engage parents and the community in promoting a positive social-emotional environment within the school.
- •Integrate mindfulness, stress reduction, and emotional regulation practices into the school day.
- •Create safe spaces within the school where students can seek support and practice self- care.
- •Encourage student participation in decision-making processes related to school policies and practices.

3.5. School Community Engagement

School community engagement is vital for creating a supportive and collaborative environment that promotes student well-being and success. Successful engagement of the school communities empowers communities to participate in multiple facets of education and health support. Active engagement and consultation within the school community (e.g. between school staff and parents and caregivers) and between the school and the local community (e.g. between school staff, students, local businesses, local community structures, NGOs and government) are critical to implementing SHP. SHP requires that the entire school community be engaged and that all stakeholders are committed to

a collaborative partnership with a shared vision for success. Engagement and collaboration strengthen both the school and the community in relation to health and well-being and for longer-term impacts.

This pillar aims to ensure that the school community collaborates with local stakeholders in SHP and recognizes its mutual benefits. This includes engaging parents and caregivers and the broader community as partners in their children's learning and encouraging the school's role as an important entity in the local community.

Strategic Actions:

•Form committees comprising parents, teachers, students, and community representatives to oversee and actively participate in the planning, implementation, and monitoring of school health activities.

•Organize community meetings, workshops, and awareness campaigns to inform parents and community members about the importance of school health programs and encourage their active involvement.

•Establish health clubs within schools to promote health education and encourage students to take an active role in promoting healthy behaviors among their peers and in their communities.

•Launch health promotion campaigns focused on key health issues, such as handwashing, oral hygiene, nutrition, and physical activity, to raise awareness and encourage healthy behaviors among students and the broader community.

•Collaborate with local health centers and community health workers to provide health services, such as immunizations, health screenings, and deworming, at schools and in the community.

3.6. School Health Services

Schoolhealthservices that promote physical, mental, and emotional well-being of students within the educational setting are the basis for effective SHP. These services are combining promotive, preventive, first aid, and referral services for students, teachers, and surrounding communities. Schools offer a strategic setting to provide accessible, school-based or school-linked health services, embedded within the community of which the students and their families are part. Ensuring high-quality, evidence-based school health services—including school feeding—is vital for children's and adolescents' health, well-being, and academic success.

The school health services include various services, such as health promotion, health education, screening, preventive interventions, clinical assessment and first aid services in school based and referral linkage. The school health services aim to ensure the delivery of SHP packages through school based and school linked interventions.

The SHP aims to ensure that school-based or school-linked health services are adequately resourced, appropriately and equitably delivered and responsive to the specific health needs of the school community they serve. Basically, the school-linked health services need to be aligned with the existing HEP service delivery packages. It is imperative to establish protocols for providing accessible and quality health services within schools, including preventive screenings, immunizations, first aid, and referrals to healthcare providers. Collaborate with local health authorities to ensure the availability of necessary resources and expertise. The School health promotion and disease prevention service packages are broadly grouped as follows:

1. Maternal and Child Health promotion service
    - Awareness creation on routine and catch-up vaccinations and immunizations
    - Reproductive Health Services promotion
    - Gender Equality in Schools: providing a safe and inclusive learning environment
2. Health Promotion and Disease Prevention
    - Common infections, infestations and disorders prevention and control service
    - HIV/STI prevention and control services
    - Prevention and control of non-communicable diseases (NCDs) and injuries
    - Mental, neurological and substance use (MNS) disorders prevention and support
3. Promotion of Water, sanitation and hygiene (WASH) provision
    - Water, sanitation and hygiene WASH
    - School cleaning and waste management
    - Menstrual Health and hygiene Management safe space
4. School nutrition promotion services
5. Strengthen school Emergency and injury prevention and management
    - School health preparedness, response & recovery during education in emergency
    - Emergency and Injury Prevention and Management
6. Socialandbehavioralchangecommunicationandlifeskillsdevelopment

SECTION-FOUR: CONCEPTUAL AND LOGICAL FRAMEWORK

Figure;1, Belowhighlights the conceptsused todevelop the Ethiopian NationalSchool Health Program and guides selection of interventions appropriate for the priority health problems among children and adolescents in schools.

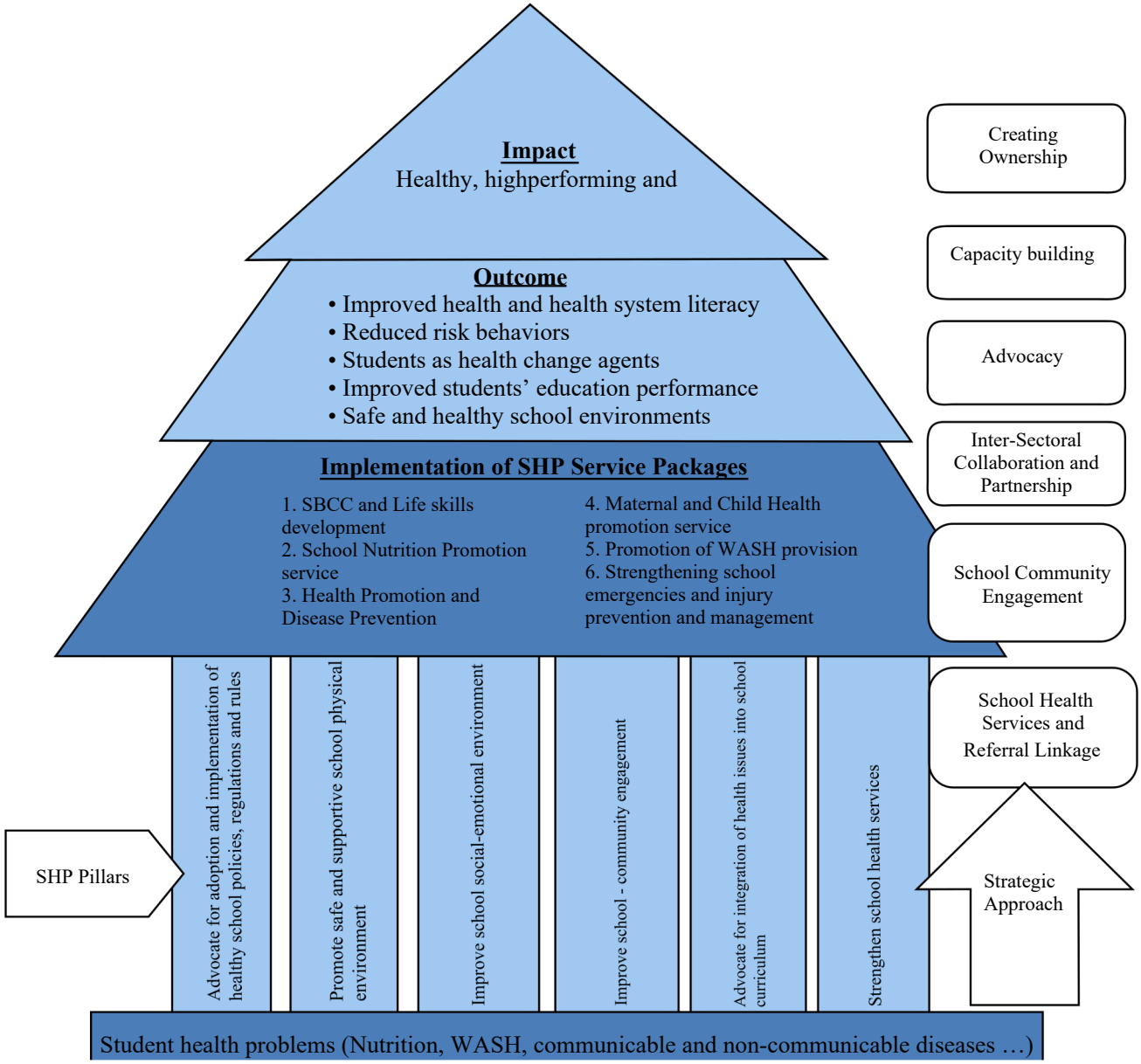

Figure 1: School Health Program conceptual and logical framework

SECTION-FIVE: IMPLEMENTATION MODALITY

5.1. Coordination and Partnership

The SHP will be implemented with joint partnership and collaboration between the ministry of health and ministry of education through a bilateral agreement tied with memorandum of understanding. This includes Coordination and Partnership in advocacies of SHP including capacity building, resource mobilization and technical support with and by the support of implementing agencies. At each stage of program implementation, the formulation of the program management organization and the powers and responsibilities delegated to each sector will be identified in such a way that a clear accountability mechanism exists.

Both the MoH and MoE will be fully responsible for the proper implementation of the SHP. However, the MoH will take the leading role while the MoE as co-leader of the program. The MoH will produce the required guiding documents, SOPs and job aids in collaboration with the MoE.

Since the School Health Program (SHP) extends health promotion and disease prevention services to schools, its coordination and partnership will align with the existing structures at all levels to support the education system in its implementation.

The SHP and its service provision indicators need to be integrated into the planning and reporting system of the education and health sector (DHIS2 and EMIS) for routine evaluation and monitoring. The aforementioned implementation modality, particularly coordination and partnership, is summarized in the figure below. A steering committee/TWG will be formed at the federal and regional levels, comprised of higher officials from both sectors (State ministries and deputy RHB). TWGs will be formed at each level with technical experts

Implementation Modality: Structural arrangement for SHP Implementation

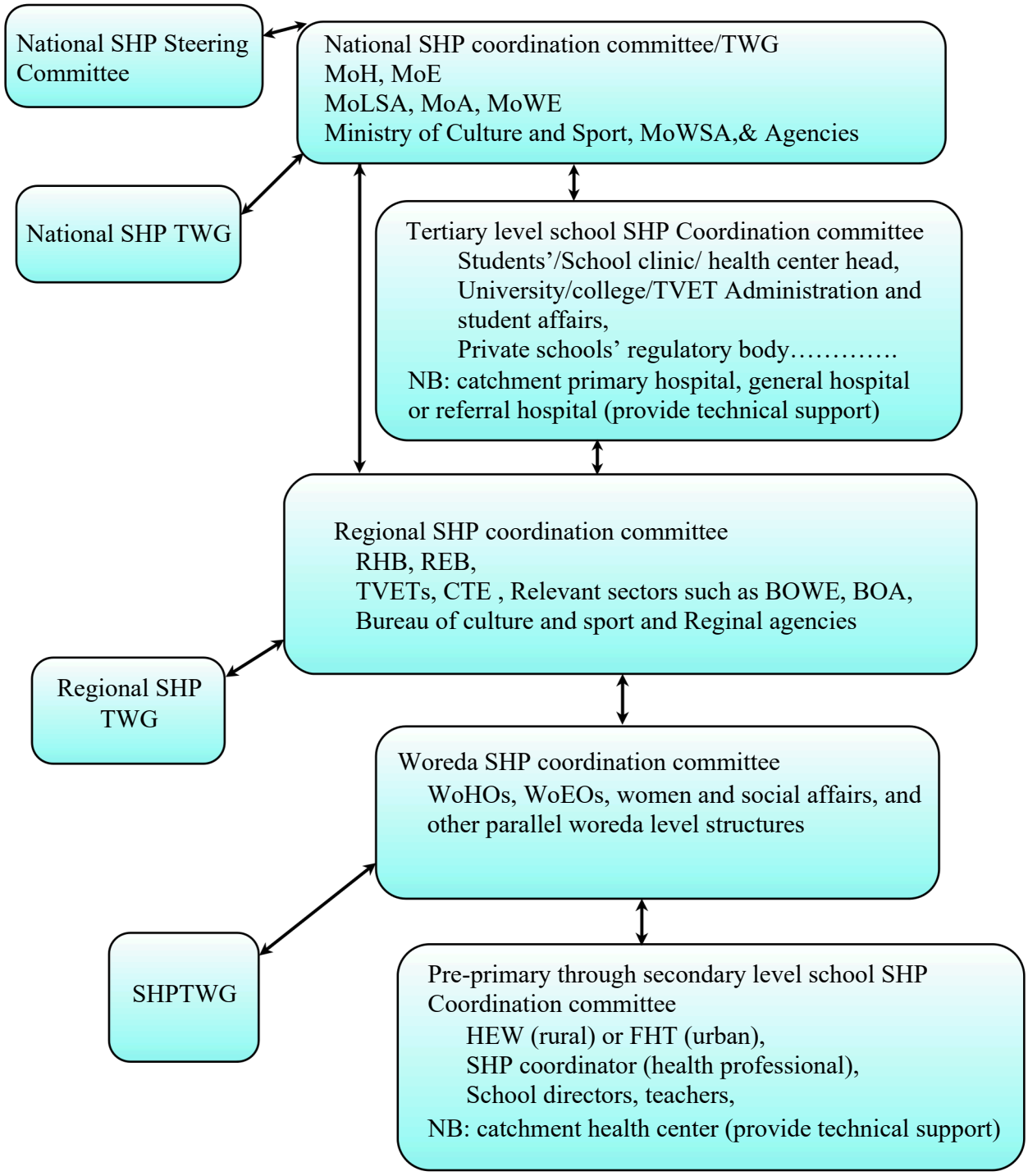

Figure 2: Structural arrangement for SHP Implementation

Guidelines for the SHP will establish and improve coordination mechanisms to promote healthier school /regulations/rules, promoting a supportive physical and social-emotional school environment, ensure school community engagement in the school health program, and provide school health services for the school community's health and well-being.

Taking lessons learned from the SHP framework implementation since 2017, organizing coordination bodies from federal to lower level is mandatory for effective and sustainable SHP implementation. The stakeholders will be represented in the SHP implementation committee (steering committee and technical working group) at national, regional, woreda, and Kebele/school level. The coordination will be clearly demarcated with specific roles and responsibilities to ensure efficiency and effectiveness in the SHP implementation system. Organizing coordination bodies at the federal, regional, and local levels is essential for effective and sustainable SHP implementation. At each level (national, regional, woreda, and school levels) stakeholders will be represented in the SHP implementation committee (steering and coordination committee). To ensure sustainability and effectiveness in the SHP implementation system, coordination will be clearly defined with specific roles and responsibilities.

5.2. Human Resources and Infrastructure

School health services provided by school clinics at tertiary level (universities, colleges and TVETs) will be reoriented to provide promotion and prevention services. For tertiary levels with no health facilities (TVETs), the federal and regional education sectors are responsible for establishing/ arranging school health services. The Ministry of Health is responsible for capacity building and technical assistance.

At the pre-primary through secondary school levels, SHP coordinators (typically school directors) and designated focal person will be appointed to oversee the implementation of school health services, working in coordination with health professionals from nearby health posts or health centers. At woreda level, SHP coordinators will be assigned from the woreda health and education offices for coordinating and monitoring SHP implementation.

5.3. Program Financing

Many aspects of the SHP packages are already being implemented through MoH or MoE and are budgeted for in existing federal MoH or federal MoE budgets. For the successful coordination and partnership in implementation of the SHP program, MoH will advocate and mobilize resources for capacity advocacy, building, orientation, strengthening health clubs and health learning material development.

5.4. SHP promotive and preventive Service Provision

The educational institutions jointly with the health system are mandated to provide health promotion and disease prevention services through school based and linked services. To support this mandate, strong collaboration and linkage with the existing catchment health system for additional services is required. The linkage will be as follows: pre-primary, primary, middle school and secondary school collaborate and linked to health centers or health posts. Similarly, colleges, universities and TVET are collaborate and linked to a health center, general hospital or teaching hospitals.

5.5. Roles and responsibilities in SHP

Organization	Role and Responsibilities
Joint responsibility of MoH and MoE	• Promote and advocate SHP activities, using different media outlets (both electronic and print media) • Promote to create an enabling environment for scale up and sustainability of SHP • Advocate to ensure quality of the SHP service provision • Ensures the integration of package activities, strategies and results are monitored, evaluated and reported within the DHIS2 and EMIS systems • Initiate joint data management system for tracking SHP implementation • Coordinate and give training (capacity development) to health workers, school community, stakeholders and other staff on SHP • Assist the Regions to identify their program gaps and management deficits and provide them with the technical assistance or the capacity development they require • Prepare and distribute SHP Implementation guideline, standards, training materials, Sop, job aids, manuals and facilitate actual implementation of guidelines including the roll out of trainings • Mobilize resources for SHP implementation • Strengthening public private partnerships (PPP) to support the SHP • Joint operational and strategic planning • Joint monitoring and evaluation • Establish coordinating body • Support Cascading of the SHP program at all levels • Knowledge/Evidence Generation • Document and scale up SHP best practices
Ministry of Health	• Coordinate the SHP implementation • Advocate for allocation of budget and provision of logistic support to all level • Coordinate and provide in-service and other short-term training for implementation of SHP

Organization	Role and Responsibilities
Ministry of Education	• Coordinate the SHP implementation • Advocate for allocation of budget and provision of logistic support to all level • Facilitate implementation of SHP • Ensure the SHP is incorporated in the curriculum and co-curricular activities • Ensure the alignment of SHP with other strategic document and manuals • Assign SHP focal at all school level • Customize co-curricular materials with SHP • Coordinate all stakeholders and actors at all levels on SHP • Digitalizing SHP accordingly with the education • Jointly conduct different sport competitions for students and entertainment programs
Ministry of labor and skill	• Facilitate implementation of SHP • Ensure the alignment of SHP with other strategic document and manuals • Assign SHP focal at all school level • Engage in SHP coordination and collaboration platforms at all levels
Ministry of Water and Energy	• Consider accessibility of new water scheme to school during construction • Consider accessibility of new Electricity line to school during construction • Technical support to school as needed
Ministry of Culture and Sport	• Prepare different sport competitions for students and entertainment programs • Strengthening and support sport training material • Give shorth and long-term training to school community (different sport games and life skill)
Ministry of Women and Social Affairs	• Provide technical support to school as needed • Support and conduct gender inclusive interventions using different approaches
Ministry of Agriculture	• Promote different nutrition sensitive agriculture activities in schools • Provide technical support for school community • Develop school gardening training materials • Provide technical and material support in the preparation and practice of school gardening

Organization	Role and Responsibilities
Development partners/ Private sector/ CSOs	• Engage to support MoH/ MoE and its structural offices at all levels to implement the SHP to the optimal level • Adopt the package to develop promotional materials including tools, learning aids, etc. • Provide support to MoH/ MoE in familiarization, dissemination and implementation of the SHP • Collaborate with MoH/ MoE in evaluating the effectiveness of the SHP • Promote SHP information to community organizations. • Provide technical support and consultation for the implementers. • Play advisory role for the service providers
Joint Responsibility of BoH and BoE	• Promote and advocate SHP activities, using different media outlets (both electronic and print media) • Advocate for Creating an enabling environment for scale up and sustainability of SHP • Promote quality of the SHP service provision • Ensures that package activities, strategies and results are monitored, evaluated and reported within the DHIS2 and EMIS systems • Coordinate and give training (capacity development) to health workers, school community, stakeholders and other staff on SHP • Assists Zones and Woredas to identify their program gaps and management deficits and provides them with the technical assistance or the capacity development they require • Contextualize the developed guideline, including translation to local languages; and disseminate SHP guideline, standards, training materials, SoP, job aids, manuals and facilitate actual implementation of guidelines including the roll out of trainings • Mobilize resources for SHP implementation • Strengthening the public private partnerships (PPP) to support the SHP • Joint operational and strategic planning • Joint monitoring and evaluation • Establish coordinating body • Cascade implementation, scale up and sustainability the SHP program at Zonal, Woreda and school level • Document and scale up SHP best practices

Organization	Role and Responsibilities
Regional Health Bureaus	• Coordinate implementation of the SHP • Designing and implementing in-service and other short-term training program for implementation of SHP • Support and distribute logistics all level
Regional Education Bureaus	• Coordinate implementation of SHP • Mobilize resources for SHP implementation • Facilitate actual implementation of implementation • Coordinate all stakeholders and actors at regional level • Cascade and contextualized co-curricular materials • Prepare different sport competitions for students and entertainment programs
Regional labor and skill bureaus	• Facilitate implementation of SHP interventions • Promote adequate water, sanitation and menstrual hygiene facilities in TVETs
Regional Water and Electric Bureaus	• Consider accessibility of new water scheme to school during construction • Consider accessibility of new electricity line to school during construction • Technical support to school as needed
Regional Youth and Sport Bureaus	• Promote and conduct periodic sport competitions for students • Give short- and long-term sport activity trainings to School community (different sport games and life skill)
Regional Women and Social Affairs Bureaus	• Provide technical support to school as needed • Give gender sensitive short-term training to school community
Regional Agriculture Bureaus	• Provide technical support for agriculture activities • Provide and cascade school gardening training to Zones and Woredas

Organization	Role and Responsibilities
Joint Responsibility of ZoH and ZoE	• Promote and advocate SHP activities, using different media outlets (both electronic and print media) • Support for quality of the SHP service provision • Assist Woredas to identify their program gaps and management deficits and provides them with the technical assistance or the capacity development they require • Mobilize resources for SHP implementation • Strengthening public private partnership (PPP) to support the SHP • Joint monitoring and evaluation • Establish coordinating body • Cascade the SHP program at Woreda and school level
Zonal Health Department	• Coordinate SHP • Facilitating implementation of SHP
Zonal /Education Department	• Coordinate SHP • Facilitate actual implementation of SHP intervention
Zonal Water and Energy Development Department	• Consider accessibility of new water scheme to school during construction • Consider accessibility of new electricity line to school during construction • Technical support to school as needed
Zonal culture and Sport Department	• Promote and conduct periodic sport competitions for students • Prepare different entertainment programs
Zonal Women and social Affairs Department	• Provide technical support to school as needed • Give gender sensitive short-term training to school community
Zonal Agriculture Department	• Provide technical support for agriculture activities • Provide and cascade school gardening training to Woredas

Organization	Role and Responsibilities
Joint responsibility of WoEO & WoHO	• Promote and advocate SHP activities, using different local platforms • Support SHP service provision • Coordinate and give training (capacity development) to health workers, school community, stakeholders and other staff on SHP • Assist PHCUs to identify their program gaps and management deficits and provides them with the technical assistance or the capacity development they require • Mobilize local resources for SHP implementation • Strengthening public private partnership (PPP) to support the SHP • Joint monitoring and evaluation • Establish coordinating body • Cascade the SHP program at PHCU and school level
Woreda Health Office	• Coordinate SHP at woreda level • Facilitating implementation of SHP • Coordinate all stakeholders and actors at woreda level
Woreda Education Office	• Coordinate implementation of the SHP • Facilitate actual implementation of SHP Interventions
Woreda Agriculture office	• Provide technical support for agriculture activities • Give short term school gardening training to school community as needed
School (from pre-primary to university level)	• Own kebele education and training board for effective implementation • Coordinate all stakeholders and actors at kebele/institutional level • Administrative control of SHP staff • Jointly monitor and evaluate the SHP activities with collaboration of nearest health facility • Record and report SHP activities to the respective office • Create sense of shared responsibility about the intervention package for the whole school and surrounding community • Mobilizing and liaising with the school community including educators, the school governing body and other role-players. • Ensuring that all components of the SHP packages are provided to all students • Build partnerships with external providers including NGOs and other community organizations. • Implementing SHP co-curricular activities at the school level

Organization	Role and Responsibilities
Health center/ Hospital	• Support all technical part of SHP in the health center catchment • strengthen referral linkage mechanisms. • Jointly conduct outreach campaigns • Conduct periodic screening • Monitor and evaluate the SHP activities • Create sense of shared responsibility about the intervention package for the whole school community • Establish linkage with different stakeholders facilitate sensitization and orientation activities on implementation of SHP • Assist the school to identify their SHP gaps and management deficits and provides them with the technical assistance or the capacity development they require
Health Post	• Work with SHP staff and school community • Monitor and evaluate the SHP activities • Plan the activities with collaboration of schools • Advocate for and promote activities at school and community levels; and include SHP as a priority agenda for their own Kebele • Strengthen referral linkage mechanisms.
Community	• Engage in SHP activities • Support implementation process of the package • Engage in Resource mobilization and contribution.
Kebele Admin	• Support in the implementation of SHP activities • Advocate for and promote SHP activities
Students	• Engage with all activates of SHP

Table 2: Roles and responsibilities of stakeholders in SHP implementation

SECTION-SIX: MONITORING, EVALUATION AND LEARNING

A monitoring and evaluation plan will be in place to assess the implementation of the SHP and each individual package. A monitoring and evaluation framework is outlined below in Table 1 and a more detailed list of specific indicators is designated in Annex II. The indicators are designed to assess and measure the accessibility of the overall SHP and the individual service packages as well as the program's outputs, outcomes and overall impact. As needed, service delivery registers, tally sheets and reporting formats will be provided to track data at the schools and the reports will be integrated with the DHIS2 and Education Management Information System (EMIS). In addition, regular and integrated supportive supervision will be conducted by sectors and partners to identify the gaps in implementation and provide support accordingly. Regular review meetings involving all concerned stakeholders will be held to evaluate the implementation of the program as well as to share best practices. In line with this, high performing (model) schools and Woredas will be evaluated, graded and awarded based on a set of defined metrics. Moreover, for evidence-based program implementation, research will be completed to identify the implementation status, challenges, outcomes and impact of the program and the findings will be used to improve program implementation.

Table1: Monitoring and Evaluation Framework.

Inp u t	Process	Output	Outcome	Impact
* National policies/ strategies/fr am-works * School curriculum and co-curricular manuals/guides * SHP Steering committee / TWG * SHP focal/Health workforce * School health package, guidelines, job aids * Register, reporting and referral formats * Code of conducts (HSP MOU)	* Establishing TWG * Delegating/ Assigning SHP Coordinator/focal * Training of health workforce/ school health focal, TWG members, SHP coordinators * Conducting advocacy meetings and sensitization workshops * Signing MOU * Supportive supervisions & review meetings * Integration with the	* Functional SHP Steering committee/TWG * Schools with the minimum package of school-based and school linked health services * Health education sessions conducted per package health services provided * Students screened for nutritional/ psychosocial or	* Reduced NCDs risk factors (use of alcohol, tobacco, physical inactivity, unhealthy diet) * Reduced educational wastage (drop out, repetition and absenteeism) * Reduced adolescent pregnancy, HIV/STIs,	* Reduction of age specific morbidity and mortality * Improved student performance * Health literate generation * Quality of education * Improved gender equity and inclusion

* School community engagement .	education and health sector data system (DHIS2, EMIS) * Developing message/ communication guides, job aids, training manuals * Preparedness of school for public health emergencies	mental/ common childhood disease /congenital problems, common infectious diseases * Trained SHP focal, health workforce * Active school health clubs * Increased number of students engaged in co- curricular activities	* Reduced incidence of common infectious diseases among students (TB, URTI, Pneumonia) * Reduced violence in schools * Improved nutritional status of students * Improved health seeking behaviors and service utilization of students * Improved student knowledge on healthy behaviors * Model schools in health * Improved health and health system literacy * Public health emergency resilient system in schools * School community ownership	

Annex I: M & E Indicators for SHP

Indicator	Indicator definition	Indicator calculation Numerator	Sourceof information Denominator	Data collection frequency	Remark	Responsibility	Indicator disaggregation
Percentage of schools with minimum school health packages	Proportion of all schools with minimum package of school health packages. Minimum package means providing 6 school health packages	Schools with minimum school health package	All schools	EMIS/HMIS	Annually	Joint (MoH & MoE)	Disaggregated by level (primary, secondary, tertiary)
Percentage of students who received deworming drug	Proportion of students who received the deworming drug	Number of students who received deworming drug	Total number of eligible students for deworming	EMIS/HMIS	Biannually	Joint (MoH & MoE)	
Percentage of school students who obtained visual screening	Proportion of school students who obtained visual screening at the beginning of the school year	Number of students who received annual visual screening	Total number of students	EMIS/HMIS	Annually	Joint (MoH & MoE)	Disaggregated by result
Percentage of school students who obtained visual screening	Proportion of school students who obtained hearing screening at the beginning of the school year	Number of students who received annual hearing screening	Total number of students enrolled per grade	EMIS/HMIS	Annually	Joint (MoH & MoE)	Disaggregated by result
Percentage of schools implementing screening vaccination status of students at enrollment	Proportion of schools implementing screening vaccination status of students at enrollment	Number of schools implementing screening vaccination status of students at enrollment	Total number of schools	Report	Annually	Joint (MoH & MoE)	
Percentage of fully immunized preschool students	Proportion of fully immunized preschool students	Number of fully immunized preschool students	Total number of preschool students	Report	Annually	Joint (MoH & MoE)	Disaggregated by grade
Percentage of students screened for malnutrition	Proportion students screened for malnutrition	Number of students screened for malnutrition	Total students screened for malnutrition	EMIS/HMIS	Quarterly	Joint (MoH & MoE)	Disaggregated by age

Indicator	Indicator definition	Indicator calculation		Source of information	Data collection frequency	Remark	Responsibility	Indicator disaggregation
		Numerator	Denominator					
Percentage of malnourished students linked for management	Proportion of malnourished students managed	Number of malnourished students managed	Total number of students screened	HMIS			MoH	Disaggregated by age
Percentage of schools providing nutritional counseling services	Proportion of schools providing nutritional counseling services	Number of schools providing nutritional counseling services	Total Number of schools	EMIS/HMIS	Quarterly	Joint (MoH & MoE)		
Percentage of schools with school gardening service	Proportion of schools with school gardening service	Number of schools with school gardening service	Total number of schools	EMIS	Quarterly		MoE	
Percentage of schools with food cooking demonstration session	Proportion of schools with school cooking demonstration session	Number of schools with school cooking demonstration session	Total number of schools	EMIS/HMIS	Quarterly	Joint (MoH & MoE)		
Percentage of students supplemented with Vitamin A	Proportion of students supplemented with Vitamin A	Number of students supplemented with Vitamin A	Total number of students eligible for Vit A	HMIS/EMIS	Bi annually		Joint (MoH & MoE)	
Percentage of students screened for MNS	Proportion of students screened for MNS risk factors	Number of students screened for MNS risk factors	Total number of students	HMIS/EMIS	Annually	Joint (MoH & MoE)		
Percentage of schools with safe school environment	Proportion of schools with safe school environment	Number of schools with safe school environment	Total number of schools	Admin	Annually		MoH	Inspection
Percentage of schools with functional school health clubs	Proportion of schools with functional school health clubs (definition to be defined)	Number of schools with functional school health club	Total number of in the schools	Assessment			Joint (MoH & MoE)	
Percentage of schools participated on community outreach activity	Proportion of schools participated on community outreach activity	Number of schools participated on community outreach activity	Total number of schools	HMIS/EMIS	Annually		Joint (MoH & MoE)	Disaggregated by level (primary, secondary, tertiary)

Indicator	Indicator definition	Indicator calculation	Source of information	Data collection frequency	Remark	Responsibility	Indicator disaggregation
		Numerator	Denominator				
Percentage of students who received training on life skills	Proportion of students who received training in life skill sessions	Number of Students who received training in life skill	Total number of students	HMIS/EMIS	Quarterly	Joint (MoH & MoE)	Disaggregated by level (primary, secondary, tertiary)
Percentage of teachers who received training of trainer on life skills	Proportion of teachers who received training of trainer in life skill sessions	Number of teachers who received training of trainer in life skill	Total number of teachers	HMIS/EMIS	Quarterly	Joint (MoH & MoE)	Disaggregated by level (primary, secondary, tertiary)
Percentage of schools with functional hand washing facilities	Proportion of schools with functional hand washing facilities	Number of schools with functional hand washing facilities	Total number of schools	Admin report	Quarterly	MoE	
Percentage of school with functional latrine facility as per the national standard	Proportion of school with functional latrine facility as per the national standard (functional to be defined)	Number of school with access to functional latrine facility as per the national standard	Total number of schools	HMIS/EMIS	Annually	MoE	
Percentage of schools with safe drinking water as per the national standard	Proportion of schools with safe drinking water as per the national standard	Number of schools with safe drinking water as per the national standard	Total number of schools	Admin report	Annually	MoE	
Number of schools with MHH facility	Number of schools with MHH facility	Number of schools with MHH facility	Number of schools with MHH facility	Admin report	Annually	MoE	
Percentage/ Number of schools with proper solid waste disposal facility	Percentage of schools with proper solid waste disposal facility	Number of schools with proper solid waste disposal facility	Total number of schools	Admin report	Annually	MoE	
Number/ Percentage of schools with proper liquid waste disposal facility			Total number of schools	Survey	Annually	MoE	

Annex II: Memorandum of Understanding (MOU)

Between

Ministry of Health (MOH)

Represented by: Dr. Dereja Duguma

Hereinafter referred to as “MOH”

And

Ministry of Education (MOE)

Represented by: Mrs. Ayelech Eshete

Hereinafter referred to as “MOE”

Preamble

The Ministry of Health (MOH) and the Ministry of Education (MOE), hereinafter collectively referred to as the “Parties,” recognizing the importance of promoting and safeguarding the health and well-being of school-age children and adolescents, acknowledging the vital role of intersectoral collaboration in achieving school health programs, and desiring to establish a formal structure to oversee and guide the implementation of school health program, have reached the following understanding:

1. Establishment of the National School Health Program Steering Committee

1.1. The Parties agree to establish a National School Health Steering Committee (NSHSC), hereinafter referred to as “the Committee,” to provide guidance, direction, and oversight for the implementation of school health programs across the country.

1.2. The Committee shall be composed of representatives from the MOH and the MOE, as well as relevant stakeholders, including but not limited to, representatives from other ministries, educational institutions, health institutions, and civil society organizations.

1.3. The Committee shall be coordinated by representatives from the MOH and the MOE, with each party having equal responsibility and authority.

2. Objectives of the National School Health Steering Committee

2.1. The primary objectives of the National School Health Steering Committee shall be:

a. To provide strategic direction and oversight for the implementation of school health programs.

b. To advocate for the integration of health and education policies, programs, and services at the national, regional, and local levels.

c. To advocate for the importance of school health and well-being among policymakers, stakeholders, and the general public.

d. To mobilize resources and support for the implementation of school health programs.

e. To monitor and evaluate the progress and impact of school health programs and interventions.

f. To ensure the sustainability and scalability of school health programs.

3. Functions of the National School Health Steering Committee

3.1. The functions of the National School Health Steering Committee shall include, but not be limited to:

a. Provide leadership and guidance in updating national policies, guidelines, and standards for school health programs.

b. Facilitating the dissemination of information, tools, and resources related to school health.

c. Promoting intersectoral collaboration and partnership between the MOH and the MOE and other relevant stakeholders.

d. Identifying and addressing gaps and challenges in the implementation of school health programs.

e. Monitoring and evaluating the implementation and impact of school health programs.

f. Advocating for the allocation of adequate resources for the implementation of school health programs.

4. Meetings of the National School Health Steering Committee

4.1. The Committee shall meet regularly, at least once every year, to review progress, discuss challenges, and make decisions regarding the implementation of school health programs.

4.2. Additional meetings may be convened at the request of either Party or as deemed necessary by the co-chairs of the Committee.

4.3. The Committee may establish sub-committees or working groups, as necessary, to address specific issues or tasks related to the implementation of school health programs.

5.Responsibilities of the Parties

5.1. The Ministry of Health (MOH) shall:

a. Provide technical support and expertise to the National School Health Steering Committee.

b. Mobilize resources for the implementation of school health programs.

c. Coordinate with relevant stakeholders to ensure the successful implementation of school health programs.

d. Monitor and evaluate the implementation and impact of school health programs.

e. Report regularly on the progress and achievements of school health programs.

5.2. The Ministry of Education (MOE) shall:

a. Provide technical support and expertise to the National School Health Steering Committee.

b. Integrate health education and promotion into the national school curriculum.

c. Coordinate with relevant stakeholders to ensure the successful implementation of school health programs.

d. Monitor and evaluate the implementation and impact of school health programs.

e. Report regularly on the progress and achievements of school health programs.

6. Review and Amendment

6.1. This MOU may be reviewed and amended by mutual consent of the Parties.

7. General Provisions

7.1. This MOU constitutes the entire understanding between the Parties with respect to its subject matter and supersedes all prior agreements and understandings.

Signatures

IN WITNESS WHEREOF, the Parties here to have caused this Memorandum of Understanding to be executed by their duly authorized representatives as of the date first above written.

For the Ministry of Health (MOH):

Signature: _____

Name: _____

Position: _____ Dereje Duguma Gemeda (MD,MIH) State Minister

Date: _____

For the Ministry of Education (MOE):

Signature: _____

Name: _____

Position: _____ Ayelech Eshete W/Semayat State Minister

Date: _____

Annex III: Terms of Reference for TWG for the NSHP of Ethiopia

1. Background:

The National School Health Program of Ethiopia aims to improve the overall health and well- being of school-aged children across the country. Recognizing the importance of a multi-sectoral approach, a Technical Working Group (TWG) will be established to provide technical guidance, support, and oversight to ensure the successful implementation of the program.

2. Objectives:

The objectives of the Technical Working Group (TWG) for the National School Health Program are as follows:

- To provide technical guidance and support in the development, implementation, monitoring, and evaluation of the National School Health Program.
- To ensure the alignment of the National School Health Program with national policies, strategies, and guidelines.
- To coordinate and facilitate collaboration among stakeholders involved in the National School Health Program.
- To review and provide recommendations on the progress, challenges, and impact of the National School Health Program.
- To ensure the sustainability and scalability of the National School Health Program.

3. Composition :

The Technical Working Group (TWG) will comprise representatives from relevant government ministries, non-governmental organizations, civil society, academia, and other stakeholders as deemed necessary. The composition will include, but not be limited to:

* Ministry of Health
* Ministry of Education
* Development partners (UNICEF, WHO, etc.)
* Academia/Research Institutions
* Professional Associations
* Civil Society Organizations

4. Responsibilities :

The responsibilities of the Technical Working Group (TWG) for the National School Health Program include, but are not limited to:

a.Development of Policies, Strategies, and Guidelines:

- •Review and provide technical input into the development of policies, strategies, and guidelines related to the National School Health Program.
- •Ensure alignment with national health and education policies, strategies, and guidelines.

b.Program Development and Implementation:

- •Provide technical guidance and support in the development, implementation, monitoring, and evaluation of the National School Health Program.
- •Ensure that the program is evidence-based and follows best practices.
- •Review and provide recommendations on the annual work plans and budgets.

c.Coordination and Collaboration:

- •Facilitate coordination and collaboration among stakeholders involved in the National School Health Program.
- •Foster partnerships and networking to leverage resources, expertise, and support.

d.Monitoring and Evaluation:

- •Review progress reports and provide recommendations for improvements.
- •Monitor the implementation of the National School Health Program and ensure that it is on track to achieve its objectives.
- •Evaluate the impact of the National School Health Program and recommend adjustments as necessary.

e.Advocacy and Resource Mobilization:

- •Advocate for the prioritization of school health within the national agenda.
- •Support resource mobilization efforts for the National School Health Program.

f.Capacity Building:

- Identify capacity gaps and develop strategies for building the capacity of stakeholders involved in the National School Health Program.

5. MeetingFrequency :

The Technical Working Group (TWG) will convene regular meetings, at least once every quarter, to review progress, address challenges, and provide guidance on the implementation of the National School Health Program. Additional meetings may be called as necessary.

6. Reporting :

The Technical Working Group (TWG) will report to the National School Health Program Steering Committee. Progress reports, meeting minutes, and any other relevant documents will be submitted to the Steering Committee for review and approval.

7. Duration :

The Technical Working Group (TWG) will be established for an initial period of [insert duration]. At the end of this period, the TWG will be reviewed for effectiveness, and its mandate may be extended as deemed necessary.

8. Secretariat :

The Secretariat for the Technical Working Group (TWG) will be provided by MOH. The Secretariat will be responsible for organizing meetings, preparing and circulating agendas and minutes, and providing administrative support to the TWG.

9. Amendment of the Terms of Reference (ToR):

These Terms of Reference (ToR) may be amended as necessary with the consensus of the members of the Technical Working Group (TWG) and approval from the National School Health Program Steering Committee.

10. Approval :

These Terms of Reference (ToR) for the Technical Working Group (TWG) for the National School Health Program of Ethiopia are hereby approved on the date by the National School Health Program Steering Committee.

Signature:_____

Name:_____

Position:_____

Date:_____

List of Contributors

Ministry of Health Ethiopia	Ministry of Education	Partners
Dr. Tegene Regasa Hailemariam Addissie (team lead) Yonas Hailu Abel Desalegn Chala Gari Martha Berhe Menbere Belay Kena Fikremariam Yewubidar Hirpa Abebe Anteneh Hareg Tadesse Yirgalem Mengstu Addisu Worku Yehualaw Getahun Ashenafi Birhane Animut Ayalew Eyob Getachew	Abebe Tilaye Berhanu Alemu Abdisa Roba Maru Yitayeh Tesfaye Mekonen Fekade Desalegn Teklay G/Michael Demelash Misigana Ashenafi Getachew Aleminesh Mekonen Alemtsehay Eniyew	Getinet Bayeh, WHO Wasihun, WHO Dr. Tewolde, WHO Bekele Ababiye, UNICEF Dr. Eshetu Girma, Addis Ababa University Kassahun Nigatu, FHI 360 Solomon Tesfaye, UNICEF Zenaw Tafere (Consultant), USAID Healthy Behaviors Activity/FHI 360 Dr. Getachew GebreSelassie, Amref Health Africa