

HealthStart 2

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Report summary

HealthStart 2, the second iteration of Child.org’s HealthStart school health programme, was delivered in 25 schools in Kisumu County, Western Kenya between 2016 and 2018. It made schools stronger, more informed about the health of their pupils, and better equipped to tackle the health problems they encounter, impacting on the lives of 56,985 people, including children, parents and community members.

HealthStart 2 relied on active involvement by schools, their local communities, the Government ministries of Health and Education, and of course, Child.org’s implementing partners; Ogra and Omega. The programme was funded by Comic Relief.

We provided worming medication to 11,690 children, trained 625 as members of School Health Clubs, and gave out 1000 bed nets to protect those most vulnerable from malaria.

We published and distributed 200 School Health Training Guides, and issued 11,818 Health Cards to help families and schools communicate about the health of pupils.

And we did all this, over two years, at the cost of just £25 per child (total expenditure was £316,056).

HealthStart 2 was designed to help schools identify the health needs of their pupils and develop their own systems to address those needs. This report explains in detail how the programme was designed, how it was run, and how well it delivered on its strategic aims:

- Stronger systems
- Smarter health education
- △ Open communication
- ◇ Targeted interventions
- ◇ Knowledge through data
- ✓ Improve HealthStart

We impacted the lives of

56,985
people

To understand better what these aims mean, and how they make children healthier and better able to learn, read on...



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This report outlines the details of HealthStart 2, the second iteration of our HealthStart programme.

Results

Key areas of success

HealthStart 2 saw a range of successes, big and small, across all intervention areas. Based on our qualitative and quantitative results we found particularly good feedback around systems strengthening, health education activities and community engagement.

- **22% increase** in the percentage of Kenya’s School Health and Nutrition policy being implemented in HealthStart Schools
- **100%** of School Health Committee members with a functional knowledge of the national policy
- **87%** of School Health Club members feel that they are having a positive impact on the health of pupils
- **25%** of parents told us they had applied knowledge learned from HealthStart to improve the health of their families
- Improvements to hygiene practices witnessed in homes
- Caregivers reported improved knowledge on nutrition and communicable diseases
- **100%** of children receiving the recommended dose of deworming medication
- **42% increase** in pupils reporting they are given information at school about how to stay healthy and avoid sickness
- **94%** of older children knew how to protect themselves from unwanted pregnancies
- **Over 120 issues** reported from the pupils to the school boards that were **dealt with** by the schools
- **100%** of School Health Clubs that have a positive impact on the school community through the delivery of at least 2 new health initiatives
- **45%** of parents used the Health Cards to improve their knowledge of the health of their children
- Improvements to children’s confidence about reporting sexual harassment
- Reduction in proportion of girls missing school due to menstruation

“

This idea came at the right time. Pupils adopting hygiene practices at a tender age is a good thing. They will grow up knowing what is right and they will stick to that, educating other generations to come.

”

Caregiver,
HealthStart School ²

Improvements to delivery of School Health Education

- Stronger systems
- Smarter health education
- △ Open communication
- ◇ Targeted interventions
- ◇ Knowledge through data

The programme saw a range of successful changes around **improvements to the management of health in the schools**. Schools were audited using a tool based on the national audit but improved for the ease of use and interpretation. Schools were assigned points for performance against the eight different topics in the policy, including **life skills, gender and water and sanitation**, plus the level of **coordination with external stakeholders** including the government and community.

The schools were each given a percentage score based on their performance. The baseline average score across all 25 schools before the start of the programme was 44%. The schools were audited again at the end of the programme and the average score was 66%, therefore **performance had increased by 22%**. One school had improved by 54%. The topics that saw the biggest improvements were nutrition (improved by 31%), gender (24%) and child rights (23%).

The schools showed significant improvement in how they worked with stakeholders such as government ministries, the local administration (tribal leaders), community members and other NGO partners, with an improved score of 31%. The positive impact of such relationships were illustrated through various improvements we saw at multiple schools. Through HealthStart-facilitated dialogue sessions, school teams identified their priority needs and were enabled to work together to find their own solutions to problems faced. Some of the initiatives we saw were:

- Three schools built wells and created **new water systems**
- Five schools installed **hand-washing facilities**
- Four schools built additional **classrooms**
- Two schools built **fences** around the school grounds
- Two schools focussed on environmental protection and planted over **300 trees** between them
- One school fundraised from the local community to build **new latrines** for the pupils

None of these changes were funded by HealthStart; rather the schools identified their own solutions as a result of working together and applying to the government, the community or other organisations to help them to strengthen their weakest areas, as identified in our HealthStart school health audits.





Phylis: School Health Teacher

A CASE STUDY

Phylis has been implementing many of the changes at her school since the beginning of HealthStart 2. She has been helping to introduce clean drinking water for the pupils, maintaining the hygiene of the latrines, promoting the importance of handwashing and working with the School Health Club to encourage change.

Phylis is particularly proud to have purchased the school's first ever First Aid Kit. This means she can disinfect grazes the children get from playing in the rocky playground, and it also contains menstrual hygiene pads for her to give to girls when they need them. Phylis is thrilled that children with simple complaints can now be treated at school, whereas before she had no option but to send those children home.

These children are now able to get the most out of their education rather than having to go home for anything that could have been treated in school.

School Health Clubs
and Health Education

- Stronger systems
- Smarter health education
- △

Open communication

Based on our endline data and conversations with the pupils at HealthStart schools, we can evidence that HealthStart improved children’s knowledge and rights around their own health and wellbeing.

HealthStart **improved channels of communication** from children to school health leaders and from school health leaders to school management leaders. The aim of doing so was to empower children around issues affecting their health and to ensure their voices were being heard. **School Health Clubs** were set up where they didn’t exist and strengthened across all schools. These clubs are designed to give children opportunities around learning and leadership and were given content in the form of the **HealthStart School Health Training Guide**, packed full of valuable content and peer-to-peer activities.

Children were also empowered to identify their own observations of weaknesses of their school’s health facilities by performing their own school health audits and reflecting their reviews back to school health leaders. **All 25 schools delivered the child-led audit** and **all schools received three HealthStart-facilitated teaching sessions** using the School Health Training Guide as a learning tool.

By the end of the programme, 100% of the schools were able to demonstrate that the School Health Clubs had been able to communicate issues to health leaders. 100% of schools demonstrated that boards of management had acted upon health issues raised to them by health leaders by. Our records show that there were over **120 issues reported** from the pupils to the school boards and were dealt with by the schools, indicating that **HealthStart improved the opportunity for children to advocate for their needs and to influence decision makers.**



Zulea: a student advocate
for school health

Zulea is a Class 8 pupil at one of our HealthStart schools, and a member of her School Health Club. Zulea’s Primary School is in a very rural area and pupils often walk a very long way to get to school in the morning, but Zulea lives closer than many other students.

Teachers noticed that Zulea had taken it upon herself to help other girls out when they unexpectedly start their period at school, and that girls now come to her as somebody they can trust. She helps them tie a jumper around their waist, takes them to her Health Teacher to ask for sanitary towels, and then takes them back to her home during break time to wash any stained clothes before returning to school.

We asked Zulea what motivates her to help the girls. She said:

“
They just... feel shy. So I find it in my heart to help them.
”

Zulea’s work demonstrates that everyone in a HealthStart school can recognise need and deliver health interventions!

Community and parental involvement

- Smarter health education
- △ Open communication
- ◇ Knowledge through data

HealthStart promoted external community and parental involvement in school-based activities in a variety of ways to maximise health benefits to the wider community.

Community sensitization sessions targeted caregivers of children in project schools, bringing caregivers, school health committees and pupils together to discuss concerns and priorities of each group at the start of the project. These sessions introduced the project to caregivers, allowing them to offer perspectives on their preferences for the programme, to hear from pupils and to be invited to future sessions. Additional caregiver sessions were hosted throughout the life of the project and these provided a **platform for learning** about nutrition, sanitation, and infectious diseases. Caregivers were provided with signs and symptoms to look for in their families, prevention and management. **Partnering with Public Health Officers** from the government added value to the sessions and also increased the community’s understanding of Community Health Volunteer roles and how to access information for themselves.

Community ‘Baraza’ sessions were held in public spaces like markets to maximise reach into the local community. Information about the programme and supporting health information was provided to support the messaging within the schools.

As a result of community activity we saw **improvements to caregiver’s understanding of health practices** and witnessed **improved hygiene practices** in homes. Caregivers reported **improved knowledge on nutrition and communicable diseases** and 25% of parents told us they had applied knowledge learned from HealthStart to improve the health of their families.

The introduction of **Health Cards** in all HealthStart schools was designed to improve parental engagement with the health activities in their child’s school. The project exceeded targets with **45% parents reporting that they were using the Health Cards** to improve their knowledge of the health of their children.

Key areas of learning

Obviously not everything goes to plan when delivering complex development programmes and HealthStart 2 was no exception.

We met a variety of challenges that affected the delivery and impact of our work but all of which provided excellent learning opportunities, to inform the design of HealthStart’s next iterations.



There were two key areas that presented particular challenges to the delivery of the programme: **digital data collection and management**; and the **political environment**, both of which were compounded by the **short timescale** for delivery of the whole programme.



Data

- ◇ Knowledge through data
- ✔ Improve Healthstart

Having struggled with data collection and management in the HealthStart 1 pilot we allocated more resource to ensuring HealthStart 2 achieved better quality data. The initial plans involved the development and introduction of a new Child.org digital data collection platform. The intention was to then share any useful data with the Ministry of Health to contribute to the national health database.

Before the team were ready to build a new platform, we trialled an existing data collection application and through the trial we realised **the problem we were trying to solve was greater than we were able to solve within the scope of the project.** The monitoring and evaluation process for HealthStart required the collection of a huge amount of data; through interviews, surveys, focus groups and observations. We had accepted that the majority would need to be collected by hand but wanted to introduce a digital system to speed up the process and to reduce opportunities for error associated with collecting by hand and inputting into software later.



The ‘SnapStory’ app was trialled during a collection of anthropometric data: during the collection of **heights and weights of all 10,000 children** to assess nutritional status. During this collection it became clear that the app was slowing down our team and whilst in the field the team quickly reverted back to using their tried and tested method; writing the results down on paper. We managed to reach a compromise at later project sites by taking laptops and inputting directly into spreadsheets, therefore reducing the opportunity for error.

On reflection a number of factors contributed to the problems we had with data collection but to put it simply, we and our partners weren’t ready to make that change. Child.org were too ambitious in our thinking around designing and developing our own database when there are many packages available. We chose the anthropometric collection to trial the app because our partner, Ogra Foundation, were well versed in the process having completed the same data collection more frequently during the pilot. However, in practice this meant that they were used to using an existing system - so changing the process was actually more difficult.

We are happier with the quality of data achieved on this iteration of HealthStart than we were on the pilot. There was more oversight, better systems, higher expectations of our partners and an external evaluation this time around. However, we are currently **internally adopting a digital system used by the Kenyan Ministry of Health and investing more in training and developing the skills on the Child.org team** to ensure we can cascade that knowledge onto our delivery partners for future iterations of HealthStart and across all of our programming activity.

Political Environment

- ✔ Improve Healthstart

Despite being a relatively stable environment in Kenya, national events like elections can undermine stability resulting in significant unrest. The project ran into a number of challenges as a result of the political environment and this had a significant impact on the delivery of certain activities in schools and keeping to the project work plan.

In 2016 **the Ministry of Education went through a radical change in structure.** This impacted the project in a couple of different ways. The restructuring of the County office in Kisumu meant that the contacts we established and the authorisation we achieved at the commencement of the project needed to be re-established and re-sought at multiple points during the period of the project. This was time-consuming and disruptive. This became particularly frustrating at the time of a new directive that prevented partners working in schools during the exam term of the first year of operations. The programme had scheduled a deworming activity and a distribution of bednets in that term but because of the directive and new leadership in the ministry we weren’t able to deliver. Activities were pushed into the next term and that had a ripple effect on other activities scheduled later. Because the time period for delivering HealthStart 2 was short, our schedule was packed full of activity so delays such as this had a significant impact on the overall operations.

Another significant political issue faced was one of the biggest and most important elections in recent history for Kenya. Kisumu, where the project is based, is the stronghold of the leader of the opposition and historically political temperatures have heated significantly during elections. **The election in 2017** was particularly contentious and the initial vote in August was annulled. This resulted in international oversight, and a revote in October of the same year. Ballots were hosted in schools so access to those schools during those periods were limited and engagement in school health activity waned in those periods.



The time allocated to the delivery of a school health programme was short. A lot of the changes we would expect to see need time to evolve and establish meaning. There were multiple examples of changes becoming apparent by the time the project was closing. It would be preferable to consolidate the gains made in the schools by following up, but funds are unlikely to allow this to take place. Future iterations of HealthStart should ideally be longer to ensure changes have longer to take effect and to ensure that other factors beyond the control of the partners, such as political instability, can be mitigated against.

Programme design and delivery

Aims for HealthStart 2

All Child.org programme iterations are designed with two sets of aims. There are immediate aims to improve the lives of children through the delivery of this programme iteration, and programme development aims that should help us improve the delivery of the programme for the next iteration.



Immediate aims

Operating in the same region of Kenya as the HealthStart 1 Pilot, HealthStart 2 delivered a significantly reduced number of specific health interventions, and our focus became enabling schools to identify their own needs and find their own solutions.

The outcomes we aimed to deliver in these 25 schools were:

Stronger systems

Improve the delivery of Kenya’s National School Health Policy

Smarter health education

Improve access to health education

Open communication

Enable better channels of communication - from children to the school board of management

Targeted interventions

Improve access to the specific health interventions that are a priority for pupils in that school

Knowledge through data

Improve access to health data, enabling schools to identify their own needs

Programme development aims

We aimed to develop ways to do the above through improved data and by testing ways to build capacity, skills and structures in the schools.

Further outcome that focussed more on long-term learning, for ourselves and for the schools, were:

Knowledge through data

Improving access to health data, as above, would also help Child.org to strengthen our own decision making and optimise the programme impact in the future

Improve HealthStart

Identify obstacles and opportunities to improve HealthStart for our next iteration.

Our approach

Thanks to findings from HealthStart 1, the programme pilot, we knew that our strategy for HealthStart 2 needed to prioritise the development of community engagement and strong leadership. (See Evidence base for HealthStart 2, later in this report.) To achieve our aims, we would empower school leaders with the knowledge of the health of their children - enabling advocacy to the wider community, county government and other partners. This would make managing school health more effective.

To achieve this, HealthStart 2 focused on a range of activities that can be grouped into five key approaches:

1. Systems strengthening
2. Health Education
3. Community Mobilisation
4. Targeted health service delivery
5. Delivering data

1.

Systems strengthening

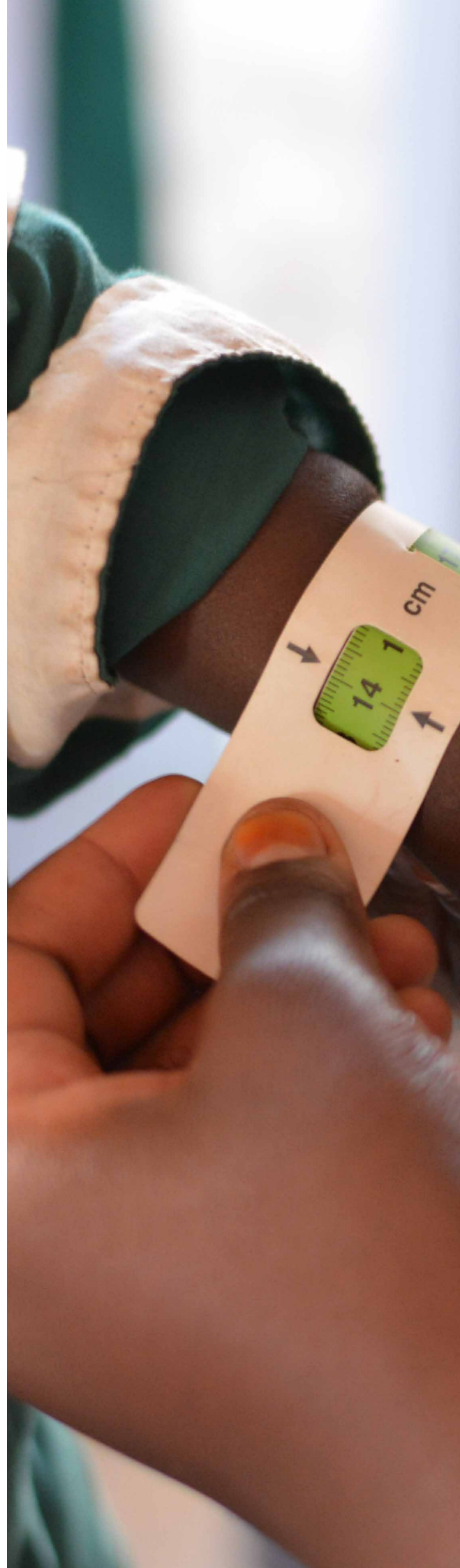
As outlined in the Kenyan National School Health Policy (2009), primary schools in Kenya are supposed to have structures in place that are responsible for the delivery of effective school health. However, we knew from our experience delivering HealthStart 1 that the support to enable such structures was poorly managed and underfunded.

HealthStart 2 improved and strengthened these structures through **governance training** for school Boards of Management. This ensured that school leaders understood their roles and responsibilities and were enabled to advocate for the needs of their school to the local education ministries.

Schools were then assisted in setting up and strengthening additional structures to manage health issues; through **School Health Committees** and **School Health Clubs**.

School Health Committees were made up of school health teachers, board members, parents and School Health Club members. They were designed to identify, manage and take prioritised needs to the boards of management. Ultimately these committees are designed to identify and solve issues around the health of pupils by ensuring funding is made accessible from Boards of Management.

School Health Clubs are pupil groups designed to oversee the health of pupils in school. During the HealthStart 1 pilot, Child.org found that many schools simply used these clubs to clean latrines. Little health information or other responsibility was awarded. HealthStart 2 worked with clubs to strengthen leadership structures and to provide greater autonomy over activities. Clubs were empowered to identify the needs of fellow school pupils and given the opportunity to represent those needs to influencers on the School Health Committees. Pupils were given Health Education Curricular and facilitated to perform school health audits, based on the national policy audits, to communicate their own needs to the school management.



2.

Health Education

HealthStart improved access to health information by providing **training and refresher training for School Health Committees** on the National Policy, focusing on key messages prioritised by the Government of Kenya.

Child.org produced the '**HealthStart School Health Training Guide**' as a training resource for school health teachers and School Health Club peer education sessions. The guide was context-specific to Western Kenya and highlighted weaknesses identified in many of the schools during the early stages of the programme. Content covered the subjects highlighted in the National Policy with a focus on sexual health and relationships. The Guide explained the importance of the School Health Clubs, the roles and responsibilities of the different positions and leadership. It encouraged active participation and facilitated pupils in running their own teaching sessions - providing learning outcomes, content and participatory exercises.

HealthStart also provided health education content to parents and caregivers through **open health forums** at the schools. Parents were invited to attend for free and to hear speakers discuss health topics pertinent to their children and communities. Topics included water and sanitation and nutrition, delivered in collaboration with nutritionists from the local Ministry of Health offices.



3.

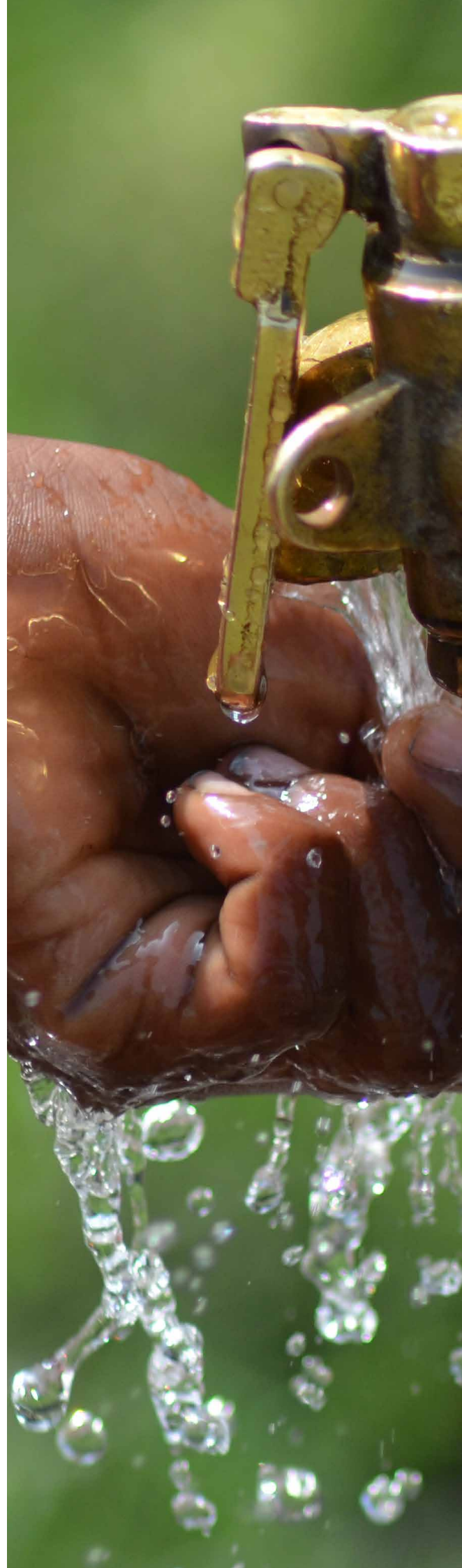
Community Mobilisation

The new roles, committees and Health Clubs within the schools created channels for pupils, teachers and school management to communicate about health issues and deliver solutions. But we also needed to create communication channels with the wider community.

By engaging beyond the confines of the schools, HealthStart 2 aimed to improve the long term benefits of the programme to the surrounding communities we work in. By **providing parents and caregivers with similar messaging to their children**, we made long-lasting positive health behaviour changes more likely, encouraging whole communities to stay safe and well.

HealthStart also aimed to improve caregivers' understanding of their children's health and engagement with the school through the introduction of **Health Cards**. These were designed to communicate personalised health issues and school-based activities into homes, encouraging parents to communicate to the schools if there were problems highlighted.

The strategy for community mobilisation aimed to strengthen the continuum of support for children from school to home, by **empowering parents, caregivers and wider community members to engage with health issues** and the potential for them to be managed in a school setting.



4.

Targeted health service delivery

HealthStart 2 provided schools with a package of interventions including **deworming**, **mosquito nets** for the youngest and the pupils who most needed them, **an assessment of each child's nutritional status** and **referral to local health care facilities**. The package was scaled back from the provision of the pilot to allow for flexibility based on the specific requirements of the schools. For example, the government had provided nets to some of the regions but we still encountered many children that were in need of nets to protect themselves from malaria.

The government runs a national deworming programme where all children in Kenya receive one dose of deworming medication per year. However, the government recommends more than one dosage for the specific regions we operate in because there are such high levels of soil-transmitted worm infections, so HealthStart **worked with the Ministry of Health** to ensure each child received the recommended treatment based on the prevalence of worms in the region.

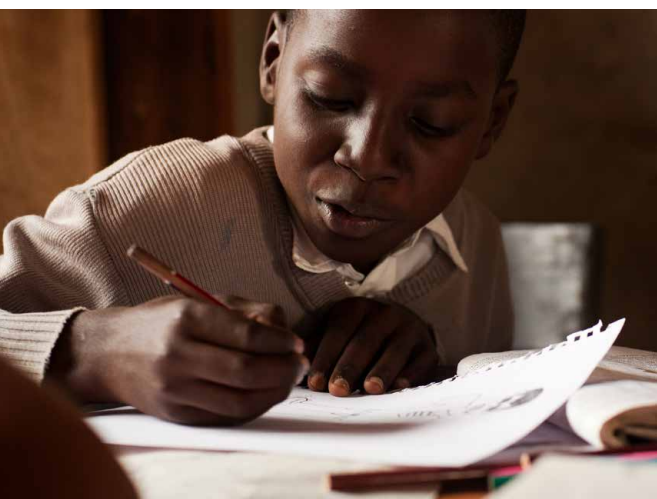
HealthStart also wanted to **assess the nutritional status** of the children in all 25 schools. Individual assessments were made of all children on an annual basis and this information was shared with parents through the Health Cards and with local health facilities to ensure that vulnerable cases were made known to the local nutritional services.



5.

Delivering data

Child.org aimed to improve data collection methods from the schools to enable better assessment of schools' performances against national policy, alongside health data of the pupils. Data were intended to be stored digitally and then shared with local ministries to contribute to a national database.



It became apparent very early on that investing in our own platform would be a waste of precious resources as so many 'off the shelf' collection platforms were available. It was decided to trial one to assess the digitisation opportunity so in 2017 a mobile phone application called '**SnapStory**' was adopted for the nutritional data collection process in schools.

Based on our findings, the strategy for this objective changed towards the end of the programme and funds were re-allocated to host a **sub-county forum** where qualitative and quantitative data were shared with Government of Kenya departments of health, education, nutrition and public health.

Location

HealthStart was designed for schools in Kisumu County, Western Kenya. Kenya developed a National School Health and Nutrition Policy in 2009, but the implementation was poorly funded and managed.

Kisumu County is a great place for HealthStart because children's health indicators are particularly poor. In Western Kenya, 53% of children are anaemic and most have had either malaria (49%) or a worm infection (42%) or both (21%)². The Kenyan HIV prevalence rate is 6% but in Kisumu County is 19%³.

Local delivery partners

Our HealthStart 1 pilot programme was delivered in its entirety by our partner; Kenyan NGO, the Ogra Foundation.

We engaged the same delivery partner, **Ogra Foundation**, to focus on the health delivery for HealthStart 2 and enrolled another partner, **Omega Foundation**, to form a HealthStart consortium of partners. Omega Foundation have expertise in working with communities to deliver long term change by investing in skills and behaviour change.

What did it cost?

HealthStart 2 was solely funded by Comic Relief (based in the UK).

The total spend on the programme was **£316,056**, coming in **under the projected budget of £324,028**. Funds were managed by Child.org and distributed to our partner organisations on a bi-annual basis.

**COMIC
RELIEF**

Spending summary

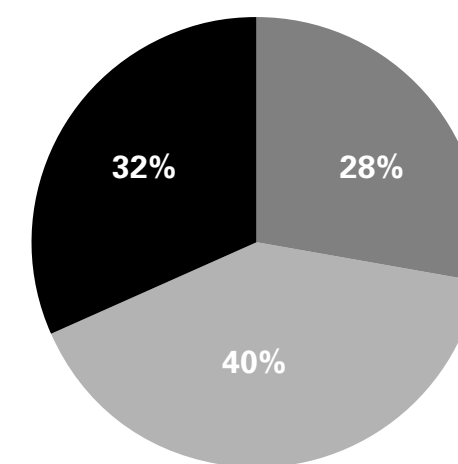
Spending on HealthStart generally went to plan and feedback from the external review was very positive about the financial management of the project. There were various over and under spends but these were generally managed by the partners without causing delay or disruption to the delivery of activities.

The largest expense on this project was the spending on staff. This covers all staffing expenses between three delivery partners and therefore the personnel associated with all activity (and all the other budget lines) is grouped together here.

The overall underspend of the project is attributed to the change of strategy on data collection alongside savings made on medications. Child.org realised part way through the project that the original plan for data collection and management was not appropriate for the context or achievable in the time remaining. Comic Relief agreed on a budget reallocation and Child.org shared findings in a forum. Ogra Foundation saved funds allocated to medication by fostering good relationships with the sub-county health teams who shared stocks of deworming and vitamin A medication, which HealthStart administered in collaboration with ministry staff.

At the end of the project period Comic Relief agreed to allocate savings to the design and development of the next steps for HealthStart.

Spending by partner



■ Ogra Foundation - £87,913

- Health Services
- Systems Strengthening
- Staff and Overheads

■ Omega Foundation - £128,125

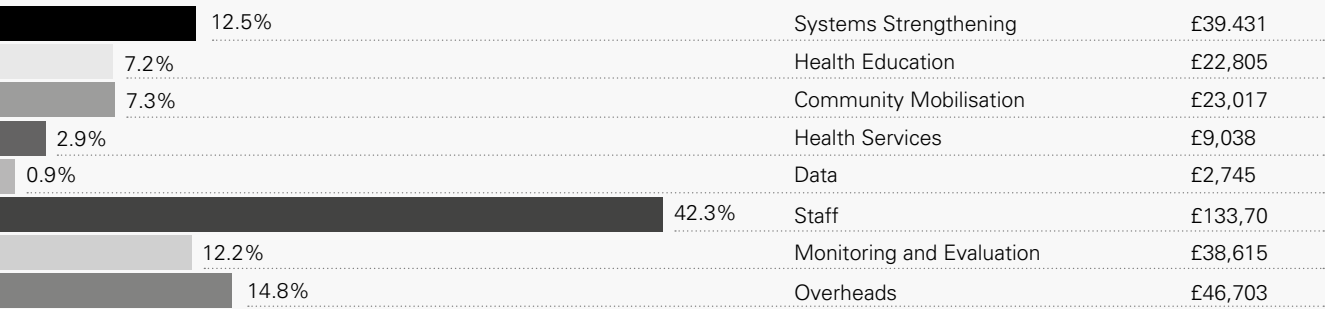
- Community Mobilisation
- Health Services
- Systems Strengthening
- Staff and Overheads

■ Child.org - £100,018

- Health Education
- Data
- Monitoring and Evaluation
- Staff and Overheads

Spending by activity

Figures below outline the total spend across the 30 month duration of the project.



Percentages represent the proportion of the total project spend on the specific activity.

Systems Strengthening

Includes spending on training for school boards of management and school health committees, developing accessible versions of the National School Health Policy, dialogue meetings including ministry representatives at each school and ongoing mentorship.

Health Education

Includes spending on the design and development of the School HealthStart Training Guide, additional health education materials, teaching sessions for the school health clubs and parents and caregivers.

Community Mobilisation

Includes spending on sensitisation sessions for parents/caregivers on school health and the purpose of the project, Health Card design and development, production and introduction to the community and ‘baraza’ sessions; community based activities to ensure support and awareness of the project.

Health Services

Includes spending on malaria net purchase and distribution, de-worming and vitamin A distribution and anthropometric data collection (to assess nutritional status).

Data

Includes spending on an assessment of usable data collection tools, assessment of national health database and a sub-county forum to share findings from the programme.

Staff

Includes spending from all three organisations on staffing for all activities outlined above, including project management, technical input, programme officers, data collection, programme delivery, human resource, monitoring and finance.

Monitoring and Evaluation

Includes spending on baseline data collection, monthly review meetings, project supervision, quarterly management meetings, mid term review, external endline evaluation and reporting.

Overheads

Includes spending on administration, governance and office overhead costs from each partner organisation and travel.

Travel

£17,560 - 5.6%

Admin and overheads

Rent, phone costs, stationary
£25,643 - 8.1%

UK Finance and governance

£3,500 - 1%

Background

Who are Child.org?

Child.org is an international Non-Governmental Organisation (NGO) with offices in London, UK and Nairobi, Kenya. We look for innovative solutions to problems faced by children in Kenya and beyond. We are passionate about reducing the barriers that children face to education, health and safety.

Child.org has a community-led approach; we work closely with communities to ensure our work creates lasting change and helping to reduce the impacts of poverty on as many people as possible. Every programme that we design at Child.org has two aims. It should improve the lives of children for the long term. It should also teach us how to work better; we’re dedicated to collecting evidence and testing ideas.

Our founders are medical professionals and our board comprises experts in Global Child Health and paediatric medicine.

Having worked in Western Kenya for over a decade, Child.org developed a plan to support whole communities, using schools as the vehicles for delivering health interventions, in a region where access to health was hugely limited due to poverty levels. In 2012 our board designed and developed a new school health programme to improve the health of primary-school aged children in western Kenya. We called it HealthStart.

Evidence base for HealthStart 2

Where did HealthStart 2 come from, and what evidence did we use to support our approach?

Healthstart was inspired by UNESCO’s FRESH (Focussing Resources on Effective School Health) Framework. Child.org developed our school health programme to combine a whole series of interventions, based on the suggestion from FRESH that combining interventions would be more effective in improving children’s health and impacting their academic attendance and performance.

What we learned from HealthStart 1 (pilot)

In 2012, Child.org set to work on testing whether designing and delivering a complex intervention based on the FRESH framework could positively impact such a range of complex issues. HealthStart 1, our pilot, was designed to test the efficacy of a FRESH approach, and ran in two schools in Kisumu from 2012 to 2015. HealthStart 1 delivered six key health interventions, identified as being particularly impactful on the health of children in these schools. Those interventions were:

- 1. A school lunch programme
- 2. Deworming
- 3. Vitamin A supplementation and micronutrient support
- 4. Bed nets for every pupil (mosquito nets, to protect children from malaria-carrying mosquitos at night)
- 5. Water and sanitation improvements
- 6. Health Education

HealthStart 1 was funded entirely by Child.org’s partner, Festival Republic, who made it possible to test out this method of working in schools.

The pilot resulted in a number of successes in nutrition and education. The proportion of children who were underweight almost halved (20% down to 11%). The prevalence of stunting reduced from 29.9% to 20%. There was an improvement in academic performance of around 30% in the number of children achieving satisfactory school grades⁴.



“

The food programme provides for those who wouldn’t otherwise be able to afford food. A lot of children come in without breakfast and go home to have no supper, so the lunch provided is their only meal of the day.

”

Senior Management
Rabuur ⁵

“

At home, they were told and they were taught. I was surprised as a parent, my child came and told me “...after getting out the toilet we have to wash our hands”. I learn from my children, because it was initiated in this school. They were taught, and they took it back.

”

Senior Management
Also a parent
Rabuur ⁵

HealthStart 1 showed us the impact that a comprehensive approach to school health could have a big impact, with some excellent results on children’s health and academic performance. It also taught Child.org and our partners a lot about the best ways to deliver these interventions.

We knew our goal for the next iteration of HealthStart would be to discover a way to scale the programme up to help more schools. To do this, we needed to make the programme cheaper, and more sustainable. HealthStart 1 identified two key strategies that would help us to do this successfully with HealthStart 2: Community Engagement and Strong Leadership.

Community engagement

There were concerns around the sustainability of the programme design of HealthStart 1, particularly around the feeding programme, due to the ongoing expense. Efforts were made to facilitate the schools to continue the feeding programmes following the withdrawal of support from Child.org, and one of the schools saw a continuation of lunch provision for the most vulnerable children, funded by the local community. This was possible because of this school’s strong community engagement, particularly with parents and caregivers.

We also found that stronger community stakeholder engagement could improve our opportunities for long-term sustainability by coordinating with other NGO and governmental activities happening at the same time. For example, a national programme for deworming had rolled out during the HealthStart 1 pilot, and the programme missed an opportunity to work together with the government.

Strong leadership

One significant difference between the two schools on the pilot was the efficacy and proactivity of the leadership. It was clear that the delivery of health interventions and the potential for uptake and long term change was greater with improved leadership or engagement from senior management.

HeathStart 1 demonstrated that each school environment is different; no two schools have the same needs or resources available to them. By strengthening leadership and systems within the schools, we felt there was an opportunity to allow schools to identify their own needs and source the interventions that are most needed for their pupils.

“

I feel the health education should be more on the parents because it is the parents who will practise these things in the homes where the children are.

”

Senior Management
Rabuur ⁵

What's next?

Planning HealthStart 3 and 4

Child.org have learned a huge amount from the most recent iteration of the HealthStart School Health Programme. We have already applied lessons from the previous two versions of HealthStart and we're looking ahead at how to make the next steps bigger and better.

The future of HealthStart is currently focused on two directions: adaptation of the programme to fit into a different Kenyan context (HealthStart 3: Narok) and scaling up, likely in Kisumu (HealthStart 4).



Adaptation

HealthStart 3: Narok

Our HealthStart 3: Narok iteration will redesign the programme, based on the learnings from the previous iterations, and adapt it to a new context. This means running HealthStart in a new location, in schools where children have different priority needs.

We have researched different regions of Kenya, looking at performance against school health policy, other school health activity and level of needs addressed by HealthStart. We identified Narok County as an ideal location.

Early marriage is the norm in Narok. Half of women 25-49 years are married by 19 years⁶. This is synonymous with early childbearing with 40% of girls in Narok pregnant by 19 years, twice the national level, and the highest age-specific adolescent fertility rate in Kenya⁶.

A quarter of 15-25 year old girls have undergone Female Genital Mutilation (FGM) compared to 12% nationally⁶. Access to health services is low, exacerbated by rural terrain. 70% of the population travel more than 5km to the nearest health facility⁷; and when they reach it they often find inadequate infrastructure, drugs or staff⁸. Schools are also not formally linked to their corresponding local primary health care services.

Based on these factors, and the differing needs of primary-school- aged children in this region, the programme has been redesigned to address these issues. HealthStart Narok aims to achieve similar outputs as HealthStart 2 but the activities have been streamlined and targeted towards the specific needs of schools in Narok. The programme aims to strengthen capacity and accountability for health, facilitate children's voices, improve access to reliable health information and differently for Narok, focus more heavily on improving gender-positivity.

Some of the methods of achieving these changes are similar, such as training school leaders, strengthening school health committees and clubs and training health teachers. New activities to improve gender relationships and child rights include the recruitment and training of School Mothers, involving the community in discussions around gender equity and training teachers and pupils in child rights and gender.

Based on a need identified during HealthStart 2, this next iteration will also aim to strengthen the links between schools and local health facilities. The involvement of community health volunteers and local health facilities will be a critical development to improve community involvement in the health of children and the recognition and acceptance of schools being positive vehicles through which to monitor the needs of children and to deliver health interventions.

We have recently submitted a second-stage application to UKAID for this next step and, should we be successful, this iteration will commence in June 2018.

Scale

HealthStart 4

Our next piece of work is to address how we might scale the programme in the Kisumu region. Our aim is to work more closely with County offices of Health and Education and to strengthen the collaboration of the two ministries. By working at this level, we intend to improve school health from a top down approach.

Working with government agencies to improve coordination will enable better implementation of the national policy and more evidence to supply Kisumu County with for advocating for change to the national government.

Some of the activities will be very similar to the adapted model, but instead of working directly with schools, we aim to work with government officials to train and invest in leadership, facilitating the cascade of training in schools. We want to work with all schools in a particular location, targeting approximately **200 schools** with an expected pupil population of **over 50,000 children**.

What can you do?

For further information please don't hesitate in getting in touch with the team to discuss the project.

To request any of the existing literature on HealthStart (listed in References), please email **programming@child.org**.

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Unrestricted funds allow us to develop and build our programming team, enabling Child.org to invest in the design and development of programmes like HealthStart, designed to impact large numbers of women and children in Kenya and Sierra Leone.

To donate, please visit **child.org/donate**.

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As HealthStart and our programming team grow, we're looking for partners from a wide range of sectors and fields of expertise.

If you think you could complement or add value to future school health programming with us, please email our Head of Programming, Martina Gant at **marti@child.org**.

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