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SPEAKING UP

A Human Rights Assessment Of Uganda's Draft School Health Policy



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A HUMAN RIGHTS ASSESSMENT
OF UGANDA'S DRAFT SCHOOL
HEALTH POLICY

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti-Retroviral Therapy
CSOs	Civil Society Organizations
HIV	Human Immunodeficiency Virus
HRBA	Human Right Based Approach
HTC	HIV Counseling and Testing
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance Planning and Economic Development
MoGLSD	Ministry of Gender Labor and Social Development
MoH	Ministry of Health
MOH	Ministry of Health
MOWE	Ministry of Water and Environment
NDP	National Development Plan
SH	School Health
SHEP	School Health Project
SHP	School Health Policy
SMCs	School Management Committees
SRHR	Sexual and Reproductive Health Right
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UBOS	Uganda Bureau of Statistics
UDHR	Universal Declaration of Human Rights
UPE	Universal Primary Education Policy (UPE)
UPHIA	Uganda HIV Impact Assessment
WASH	Water, Sanitation and Hygiene

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EXECUTIVE SUMMARY

This report presents the findings of the assessment of the Uganda's Draft School Health Policy. In 2018, the Uganda Ministry of Education and Sports, and Ministry of Health developed the Draft School Health Policy to ensure that health status and rights of school going children are respected and protected for better education outcomes and national development. In view of this, CEHURD assessed the Draft School Health Policy with the lens of Human Rights Normative and Comparative Approach.

The assessment utilized secondary data sources of information and key informant interviews. It focused on determining the extent to which the draft policy integrated Human Rights Based Approach (HRBA) principles (participation, accountability, non-discrimination (equality), indivisibility, rule of law) and components of AAAQ Framework (availability, accessibility, acceptability and quality). In addition, a comparative analysis of the between policy development pathway in Uganda and other countries including Kenya, Zimbabwe and South Africa was conducted.

The findings from the assessment showed that the draft SHP attempts to integrate different principles of the HRBA although this is not comprehensive and consistently reflected. While components such as availability, accessibility, acceptability and quality, and equity are reflected more in the draft policy, aspects of participation, indivisibility, rule of law and accountability are less reflected. Regarding its development process, the exact issue that prompted the current draft policy at this particular point in time is not clear. Information about whether there was systematic and transparent consideration evidence on likely impacts of the different policy options for school health is also lacking.

There is evidence of both visible and invisible actors that could actually have influenced the agenda setting for the school health policy. Further, comparative analysis of development pathway of the Uganda School

Health policy with that of Kenya, Zimbabwe and South Africa showed that Uganda followed more less the same process. However, the issues that prompted school health policies in these countries were clearer. For instance, in South Africa it was prompted by signing to the UN convention on the rights of the children and the subsequent presidential state of the nation address in 2010. Further, the development of the policy in Kenya and Zimbabwe was a joint undertaking by both the education and health sectors, where each sector was a signatory on the policy. Lastly, in Zimbabwe, the development process involved active participation of learners and parents and this was not the case in Uganda, South Africa and Kenya.

Since the policy still at a draft stage, the lacking elements regarding the integration of HRBA could addressed. The responsible ministries could also draw lessons from other countries highlighted in the comparative analysis to further improve on the current draft.

I. BACKGROUND

Uganda has a predominantly young population with over 56 percent of its population under the age of 18 and about half (48.7 percent) under the age of 15. These are school going children, spending up to 15 years of their formative life in school. However, the development of children and quality of their learning depends on a number of factors including their own health status and rights. The health status influences their ability to learn and complete school. Steven et al (2015) have demonstrated that children who are unhealthy are at higher risk of dropout than students who are free from health problems.

Despite significant progress made to promote school health through National legal and policy frameworks, children still face serious health related challenges. Overall, the number of children (aged 0–14 years) living with HIV remains high. According to the 2016 Uganda HIV Impact Assessment (UPHIA), the prevalence of HIV among children aged 0-14 years is 0.5 percent. This equates to approximately 95,000 children living with HIV in Uganda (MoH 2017a). Moreover, less than half (47 per cent) of the children (aged 0–14 years) living with HIV are on treatment. This reflects that the majority of children lack access to proper HIV care and treatment.

Furthermore, adolescents aged 10-19 years in Uganda face many challenges related to sexual and reproductive health rights. For instance, adolescent pregnancy rate remains high with 1 in every 4 adolescent girls aged 15-19 years either being pregnant or has already given birth (UBOS & ICF International 2012). This interferes with and undermines girls' ability to achieve high standards of health, education, and future economic well-being. Similarly, early sexual activity is a growing concern to adolescent development in Uganda. In the National Cross Sectional Study of Adolescent Health Risk Behavior in Uganda, almost 22 percent of adolescents reported some form of sexual activity (MoH 2016). Despite early onset of sexual intercourse among adolescents, contraceptive

use is low and many lack access to sexual and reproductive health-care services, including family planning information and comprehensive sexuality education (MoGLSD & UNICEF 2015).

Sexual violence meted out against this population is also rife with the nature of violence inflicted on children in learning environments taking the form of emotional, physical and psychological, and range from the subtle to the very explicit. In a survey conducted by the Ministry of Education and Sports, up to 78 per cent of primary school children and 82 per cent of secondary school students reported that they had experienced sexual abuse at school. In addition, 74 per cent of the children reported being caned by an adult in school, despite the ban on corporal punishments. Furthermore, 46 per cent of the pupils in primary school reported having been emotionally abused by a teacher and/or being bullied in school (UNICEF 2013).

The use of alcohol and other substances during adolescence (adolescence coincides with school going age) and early adulthood has become a serious public health problem in Uganda. According to the World Health Organization, Uganda has one of the highest alcohol and substance abuse rates in the World (WHO 2014). With over half of Uganda's population aged below 24-years, school going adolescents and young people are part of these statistics (Catherine Abbo, et al, 2016). It is noteworthy that this alcohol drug or substance abuse is followed by a myriad of psychosocial effects that require proper management including within the school setting. Further, there is wide spread concern that most of the schools do not provide safe and conducive environment. For example, the national standard of 1 toilet to 40 students are not met with the current ratio standing at 1 toilet to 71 children. More so, toilets lack garbage bins with lids, especially the girls' latrines for the proper disposal of used sanitary pads.

The poor nutrition status of school going children in Uganda continues to exacerbate the existing health challenges faced by children of school going age. Due to the increase in school enrolment through Universal

Primary Education, more children are entering primary school and the education system is now faced with challenging health nutrition problems (Acham Hedwig 2010). Micronutrient deficiencies like anaemia, iodine, zinc and Vitamin A deficiencies are the most common micronutrient deficiencies in Ugandan children.

Previously in 1980, the Government of Uganda had embarked on a process of developing and regulating school health programs when the Ministry of Education and Sports with support from UNICEF introduced the School Health project (SHEP). However, this effort ended in 1995 when the funding ended. This was later followed by introduction of health education programmes to ensure that health status and the rights of school going children are respected and protected. Currently, there is an over-arching legal and regulatory frame work provided by international, regional normative standards, national laws and policies, strategies and even ordinances developed at sub-regional level. Despite these efforts, Uganda continues to experience poor SRHR indicators with young people continuing to bear the brunt of the effects of negative SRHR indicators including teenage pregnancies, HIV/AIDS and other STIs, morbidity and mortality -related to pregnancy among others.

To address the persistent challenges, the Government of Uganda through the Ministry of Education and Sports has recently developed a Draft School Health Policy. Its goal is to enhance the quality of health in school communities in order to promote education for all. However, the process has been in the offing for the last 10 years without being concluded. In light of this, CEHURD assessed the Draft School Health Policy with the lens of Human Rights Normative and Comparative Approach to further inform the policy development process.

I.1 Overview of the Draft Uganda School Health Policy

Ministry of Education and Sports in collaboration with other key line ministries including Ministry of Health embarked on the Uganda Draft School Health Policy. Its goal is to enhance the quality of health in

school communities in order to promote education for all. The policy is guided by principles that include the rights-based approach, increasing access to health information for school communities, collaboration and partnerships, needs-driven programming, youth-responsive health services, gender equity, commitment of requisite resources (human and financial) and continuous capacity building of the key actors

The policy objectives are to: (i) promote the provision of universal equitable health interventions in order to prevent and control diseases in schools; (ii) enhance coordination in the provision of quality health interventions in schools; (iii) mobilize resources for delivery of school health interventions in a sustainable manner; (iv) promote the teaching of skill-based health education in schools; (v) promote a healthy school environment and; (vi) promote identification and management of the health needs of learners with special needs. In order to achieve these objectives, the policy recommends a minimum school health package, including health promotion and education, prevention of diseases disease, strengthening disease surveillance and response, age-appropriate sexuality education, referral and follow-up of minor health issues, safe water and sanitation provision, physical education and sports, healthy and safe school environment and other health interventions. The delivery mechanisms for the policy strategies proposed include: School medical facilities, School-based health clubs and safe spaces and improved monitoring and tracking of school health status and programming.

The implementation framework proposed details the roles and responsibilities of government stakeholders and non-government stakeholders in implementation of the policy. A national school health multi-Sectoral Committee (NSHMC) under the overall leadership of MoES and co-chaired by MoH is proposed as the overall policy-making body. Like other national policies, the draft school health policy has been developed through a participatory approach including external and internal consultations of the MOES and MOH regional consultations with education personnel, health officers, religious and cultural leaders, community development officers and CSOs, and other validation activities.

I.2 Study Objectives

The main objective of the study is, “to analyze the draft school health policy using a Human Rights Normative and Comparative Approach”.

The specific objectives of the study are:

- i. To develop an analytical framework grounded in normative international, regional human rights and national laws and policies
- ii. To undertake an assessment of Uganda’s draft school health policy using the developed analytical framework
- iii. To undertake a comparative analysis of best practices in development and implementation of progressive school health policies in the region
- iv. To make recommendations for the improvement and implementation of Uganda’s draft School Health Policy in light of the study findings

2. METHODS

2.1 Study Design

The assessment followed a stepwise methodological process involving desk review of documents including the Draft School Health policy, stakeholder mapping and analysis, key informant interviews and synthesis of the findings (Fig. 1). To ensure reliability and credibility of the data, validation meetings were conducted with a wide range of stakeholders. The assessment focused on determining the extent to which the draft policy integrated Human Rights Based Approach (HRBA) principles (participation, accountability, non-discrimination (equality), indivisibility, rule of law) and components of AAAQ Framework (availability, accessibility, acceptability and quality).

We also conducted a comparative analysis of development pathway of the Uganda School Health policy with that of South Africa, Kenya, Zimbabwe. We chose these countries because they are signatories to the Eastern and Southern Africa ministerial commitments signed in 2013.

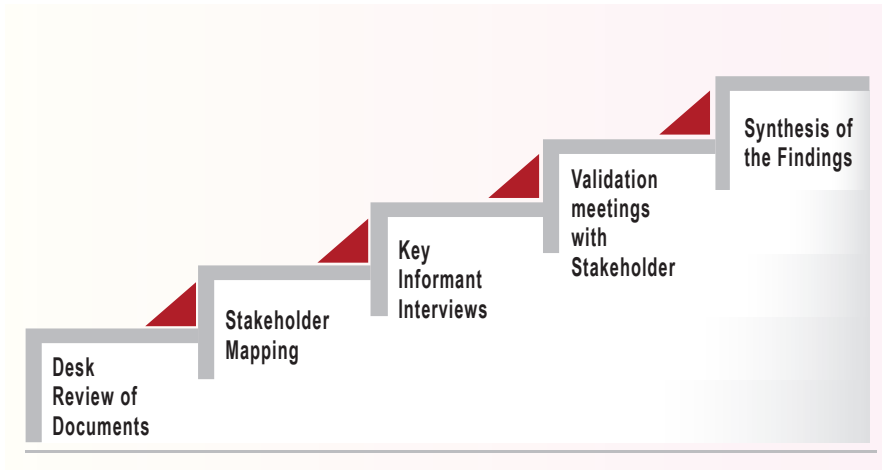


Figure 1: Study steps taken in the assessment.

2.2 The Analytical frameworks

The assessment of the draft policy utilized the lens of a normative human rights based approach. The HBRA was complimented with the Kingdon framework for agenda setting. The three Kingdon framework streams of Problem, Politics and Policy alternatives and their influence in the school health policy development were explored in relation to the principles of HRBA: We also conducted stakeholder mapping and analysis to determine their interest and influence, which relates to the HRBA principle of participation using the lens of the Kingdon framework “politics stream” for policy analysis.

3. FINDINGS

3.1 Assessment of the draft policy according to HRBA principles

We assessed the draft school health policy along the principles of Human Rights Based Approach and the findings are presented in Table 1. Generally, the draft policy attempts to integrate the HRBA Principles. However, in respect to:

- **Participation:** the policy is silent about the involvement and participation of learners in health-related decisions. It is not clear whether learners were consulted. In addition, the draft policy doesn't provide for addressing issues of consent and assent, which could lead to violation of children's rights.
- **Non-discrimination:** the policy doesn't provide for accessibility of WASH facilities especially for learners with disabilities. It also does not highlight strategies for identification and management of the health needs of learners with special needs and is silent about pregnant female learners.
- **Rule of law:** the policy doesn't provide for the conflict created by school rules and regulations.
- **Gender perspective:** the policy does not explicitly articulate deliberate actions to address gender based violence; teenage pregnancy, early and unprotected sexual activities.
- **Availability and accessibility:** The draft policy does not explicitly articulate deliberate actions to address availability and accessibility of family planning services and contraceptives, prevention services for STDs and
- **Quality:** the draft policy doesn't provide mechanism for Quality assurance

Table 1: Assessment of the draft policy according to HRBA principles

HRBA principle	Findings
Participation	<ul style="list-style-type: none"> • The draft policy recognizes the roles of key stakeholders in promoting a healthy environment for learning, teaching and living • The policy emphasizes the commitment and active participation of school communities as agents of change in transforming the lifestyles of the children and youth towards living healthy acquiring the desired learning outcomes and engaging in national development • The policy is silent about the involvement and participation of learners in health-related decisions • The policy is silent on issues of consent and assent, which could lead to violation of children’s rights.
Accountability	<ul style="list-style-type: none"> • Ministry of Education and Sports is responsible for providing accountability on policy matters to stakeholders • The Policy provides for periodical accountability to all stakeholders • There is provision for outcome and impact evaluation of the policy.
Non-discrimination	<ul style="list-style-type: none"> • The policy aims at provision of universal equitable health interventions in order to prevent and control diseases in schools • The policy doesn’t provide for accessibility of WASH facilities especially for learners with disabilities • The policy does not highlight strategies for identification and management of the health needs of learners with special needs. • The Policy is silent about pregnant female learners
Rule of law	<ul style="list-style-type: none"> • The policy doesn’t provide for the conflict created by school rules and regulations. This may compromise children’s rights at the expense of maintaining order in the schools (school rules Vs the rights of the child)

HRBA principle	Findings
Gender perspective	<ul style="list-style-type: none"> • The policy provides for integration of age appropriate sexuality and reproductive health information in curriculum at all levels • The policy proposes the provision of age-specific sexual and reproductive health counseling in schools • The policy does not explicitly articulate deliberate actions to address gender based violence; teenage pregnancy, early and unprotected sexual activities
The “AAAQ” framework	
Availability	<ul style="list-style-type: none"> • The policy provides for linkages, referrals and provision of health services and prevention of diseases • The policy aims at enforcing the prohibition of tobacco use as per Tobacco Control Act (2015) in all educational institutions but it does provide for control of alcohol, substance and drug use by children and youth • The policy recognizes provision of compulsory physical education and sports for cognitive, affective and psychomotor development at all levels of education but is silent on ensuring availability of the facilities where schools space is limited • Does not explicitly articulate deliberate actions to address availability of family planning services and contraceptives, prevention services for STDs.
Accessibility	<ul style="list-style-type: none"> • The policy aims at promoting access to safe and clean water, sanitation and hygiene at all levels of education, including promotion of effective menstrual health management solutions in all schools and institutions • The policy does not provide for access to quality SRH information and services • The policy does not explicitly articulate deliberate actions to address accessibility to family planning services and contraceptives, prevention of STDs by adolescents.

HRBA principle	Findings
	<ul style="list-style-type: none"> • The policy is silent on actions to ensure access to services for obesity, eye care, mental health and non-communicable diseases that are critical to the children's right to health • Accessibility to referrals for learners under chronic care is not clear • It is clear how health and safety equipment such as first aid kits, fire extinguishers will be accessible to all learners, teachers and non-teaching staff
Acceptability	<ul style="list-style-type: none"> • The development process involved consultations with key stakeholders including education personnel, health officers, religious and cultural leaders, community development officers and CSOs • There is no mention of consultations with learners the target beneficiaries, which has a bearing on their acceptability.
Quality	<ul style="list-style-type: none"> • The policy is silent about the quality of WASH services and facilities in schools • The policy doesn't provide mechanism for Quality assurance

3.2 Development pathway of the Draft Uganda School Health Policy

In addition to assessing the draft policy along the principles of HRBA, we also explored its development pathway with the Kingdon framework. Using this framework, we aimed to identify and understand the social, economic or political issue that prompted the policy (Problem stream). We also examined the policy options (the policy stream), politics at play (Political Stream) and how the three streams could have converged to create a window of opportunity culminating into the current Draft Policy.

3.2.1 The Problem Stream

The exact issue that prompted the development of the current draft policy at this particular point in time is not clear. However, the problem statement in the draft policy only highlights that learners in Uganda are not able to access and complete education without addressing the health problems. It is further notes that Ugandan school-going children and youth are affected by a number of common diseases including malaria (25.4%), diarrhoea (23%), skin infections (18%), cough (15.2%) flu (11.6%) and typhoid (6%). Also, that these diseases have significant negative impact on their educational attainment due to decreased school attendance, learning capacity and achievement.

3.2.2 The Policy Stream (Policy Options)

Whereas, there were consultations with key stakeholders including education personnel, health officers, religious and cultural leaders, community development officers and CSOs, the available evidence about the likely impacts of different policy options for school health was not systematically and transparently considered. The draft policy only provides delivery mechanism for policy strategies. It is critical to consider relevant evidence describing the problem, the impacts of options for addressing problem, barriers to implementing options and implementation strategies to address those barriers.

3.2.3 The Politics Stream

There is an acknowledgement of the contribution by United Nations agencies, particularly UNICEF and UNFPA and other development partners, civil society organisations and members of the Inter-Ministerial Taskforce. Other stakeholders acknowledged were the Technical Review Team, cultural and religious leaders. However, while key stakeholders for implementation of the policy were listed by name and their roles mentioned, UNICEF and UNFPA were not included in the list: they were lamped up as development partners. This underscores the presence of

both visible and invisible actors who actually set the agenda for the school health policy. In this study, we conducted stakeholder analysis to provide a better understanding of the key actors in terms of their influence and importance regarding the school health policy (Table 3) and suggested the engagement strategy (Table 4).

Table 2: Stakeholder Importance and Influence Matrix.

	Low Importance	High Importance
High Influence	<p>KEEP SATISFIED (A)</p> <ol style="list-style-type: none"> 1. Ministry of Finance Planning and Economic Planning 2. Ministry of Local Government 3. Ministry of information, communication and Technology 4. Ministry of Justice and Constitutional Affairs 5. Media Houses / Practitioners and artistes 	<p>MANAGE CLOSELY (B)</p> <ol style="list-style-type: none"> 1. Ministry of Education and Sports 2. Ministry of Health 3. District Local Government -Education Department 4. Parliament of Uganda 5. Civil Society Organizations 6. Uganda Parliamentary Forum for Children 7. Development Partners (UNICEF & UNFPA) 8. Faith-Based Institutions
Low Influence	<p>MONITO (MINIMUM EFFORT) - C</p> <ol style="list-style-type: none"> 1. Ministry of Public Service 2. Cultural Institutions 3. Institutions of Research and Higher Learning 4. Private Sector Companies 	<p>KEEP INFORMED (D)</p> <ol style="list-style-type: none"> 1. Ministry of Agriculture, Animal Industry and Fisheries 2. Ministry of Water and Environment 3. Ministry of Gender, Labour and Social 4. Target beneficiaries (Learners) 5. Uganda National Teachers Union (UNATU)

Table 3: Stakeholder engagement strategy.

Influence-Importance matrix	Stakeholders	Engagement strategy
<p>High Influence - High Importance stakeholders (Box B)</p> <ul style="list-style-type: none"> Key stakeholders to be managed and involved closely 	<ul style="list-style-type: none"> Ministry of Education and Sports Ministry of Health District Local Government -Education Department Parliament of Uganda Civil Society Organizations Uganda Parliamentary Forum for Children Development Partners Faith-Based Institutions 	<p>These must be regularly consulted and involved. For instance:</p> <ul style="list-style-type: none"> Could be invited to kick-off workshop at the beginning of the process and asked for ideas about the policy options Could be part of advisory board Could have participate in regular meetings to give an update on the process and ask for opinions and suggestions Keep informed
<p>High Influence - Low Importance stakeholders (Box A)</p> <p>These stakeholders may be a source of significant risk to implementation of the policy because of their high influence but little overlap of interests. They may not want to participate in the process but could jeopardize the efforts</p>	<ul style="list-style-type: none"> Ministry of Finance Planning and Economic Planning Ministry of Local Government Ministry of information, communication and Technology Ministry of Justice and Constitutional Affairs Media Houses / Practitioners and artistes 	<p>These stakeholders need to be kept satisfied.</p> <ul style="list-style-type: none"> Organize regular meetings to give an update on the process and ask for opinions and suggestions

Influence-Importance matrix	Stakeholders	Engagement strategy
<p>Stakeholders with Low Influence and High Importance (Box D)</p> <p>Require special initiatives to protect their interests because of their low influence.</p>	<ul style="list-style-type: none"> • Target beneficiaries (Learners) • Uganda National Teachers Union (UNATU) • Ministry of Agriculture, Animal Industry and Fisheries • Ministry of Water and Environment. • Ministry of Gender, Labour and Social Development 	<p>These stakeholders need to kept informed of the activities through.</p> <ul style="list-style-type: none"> • Regular updates of the process by e-mail • An article in a (local, company, professional) newspaper or magazine • Trainings on specific topics
<p>Low Influence - Low Importance stakeholders (Box C)</p> <p>Those stakeholders falling in Box C, are those that may need limited monitoring. They are unlikely to be the focus of the policy.</p>	<ul style="list-style-type: none"> • Ministry of Public Service • Cultural Institutions • Institutions of Research and Higher Learning • Private Sector Companies 	<p>These stakeholders need minimum effort</p>

3.3 Draft Uganda School Health Policy development compared to other countries

We comparatively analyzed the development pathway of the Draft Uganda School Health Policy with other countries guided by five (5) Questions: (a) When was the policy launched? (b) What prompted the policy? (c) What was the lead sector during the development of the policy? (d) Were there any consultations? If yes, what type of consultations? (e) Are there Implementation guidelines? (f) Was piloting of the draft policy done? (Table 2).

The analysis shows that Uganda more or less followed a similar process to that of South Africa, Kenya and Zimbabwe. This process involved policy initiation (identifying and understanding the issue), policy analysis to determine the various options, stakeholder identification and consultations. However, the events and issues that prompted school health policies in Uganda are not well articulated in the draft, whereas in Kenya, South Africa and Zimbabwe they were clearer. For instance, in South Africa the School Health Policy was prompted by signing to the UN convention on the rights of the children and the subsequent presidential state of the nation address in 2010.

In Kenya, it was upon realization that good health is essential for the success of the implementation of any educational program, and was part of a wider strategy to achievement of vision 2030, a policy road map to make Kenya a middle-income state by the year 2030. And in Zimbabwe, it was prompted by the 1999 report by the presidential commission of inquiry into education and training and was further influenced by a recommendation of the 1999 Health Commission report on the need for provision of health services for schools. Further, the development of the policy in Kenya and Zimbabwe was a joint undertaking by both the education and health sectors, where each sector was a signatory on the policy. While in Uganda, the draft policy is only signed by Minister of Education and Sports. In Zimbabwe, the development process involved active participation of learners and parents and this was not the case in Uganda, South Africa and Kenya. In Kenya, the policy was developed after a pilot and practical experience in 2 districts, while in Uganda and the other two countries there was no evidence of such the pilot.

Table 4: Comparative analysis of policy development pathways in Uganda and other countries

Guiding Questions	Uganda	Republic of South Africa	Kenya	Zimbabwe
a) When was the policy launched?	<ul style="list-style-type: none"> Still at a draft stage 	<ul style="list-style-type: none"> The integrated School Health Policy was launched in 2012 	<ul style="list-style-type: none"> The policy was launched in August 2009 	<ul style="list-style-type: none"> Was produced in March 2018
b) What prompted the policy?	<ul style="list-style-type: none"> No evidence of what exactly prompted the policy 	<ul style="list-style-type: none"> Signatory to the UN convention on the rights of the children and subsequent presidential state of the nation address in 2010. 	<ul style="list-style-type: none"> The policy came as realization that good health is essential for the success of the implementation of any educational program. Was part of a wider strategy to achieve vision 2030, a policy road map to make Kenya a middle-income state by the year 2030 	<ul style="list-style-type: none"> The need of the policy was prompted by the 1999 report by the presidential commission of inquiry into education and training. This was further influenced by a recommendation of the 1999 Health Commission report on the need for provision of health services for schools

Guiding Questions	Uganda	Republic of South Africa	Kenya	Zimbabwe
<p>c) What was the lead sector during the development of the policy?</p>	<ul style="list-style-type: none"> Being developed by Ministry of Education and Sports in consultations with MoH and other sectors No provision for MoH as a signatory to the policy. 	<ul style="list-style-type: none"> The department health took lead. Both Education & Health Sectors are signatories to the policy 	<ul style="list-style-type: none"> Joint undertaking by Ministry of Public Health and Ministry of Education. Both Education & Health Sectors are signatories to the policy. 	<ul style="list-style-type: none"> Produced by Ministry of Primary and Secondary in collaboration with Ministry of Health and Child Care. By inference doesn't cover higher education Both Education & Health Sectors are signatories to the policy
<p>d) Were there any consultations? If yes, what type of consultations?</p>	<ul style="list-style-type: none"> There were consultations with education personnel, health officers, religious and cultural leaders, community development officers and CSOs 	<ul style="list-style-type: none"> The draft policy was widely distributed for comments and inputs within both health and education sectors. Silent about consultations with learners 	<ul style="list-style-type: none"> Wide consultations with key stakeholders including religious leaders involving workshops, meetings, retreats and professional fora Silent about consultations with learners 	<ul style="list-style-type: none"> Development involved active participation of learners, parents and a wide spectrum of stakeholders including other sector ministries and non-state actors.

Guiding Questions	Uganda	Republic of South Africa	Kenya	Zimbabwe
e) Are there Implementation guidelines?	<ul style="list-style-type: none"> No implementation guidelines yet 	<ul style="list-style-type: none"> The implementation guidelines have been developed 	<ul style="list-style-type: none"> National School Health guidelines have been developed 	<ul style="list-style-type: none"> Implementation guidelines were developed after the launch
f) Was piloting of the policy done?	<ul style="list-style-type: none"> No evidence of piloting 	<ul style="list-style-type: none"> No evidence of piloting 	<ul style="list-style-type: none"> Developed after a pilot and practical experience in 2 districts 	<ul style="list-style-type: none"> No evidence of piloting and prior practical experience

CONCLUSIONS

The development of the draft policy made a good attempt to integrate the principles of the HRBA. Since this is still at a draft stage, lacking elements underscored in Table I could be addressed. The fact that there is a lack of evidence-based analysis of different policy options and the exact issue that prompted the development of the current draft policy is unclear, the three Kingdom streams of problem, policy and politics could not have converged to create a window of opportunity that culminated into the current Draft Policy. It is likely that the current state of the draft was largely influenced by politics involving both visible and invisible actors. The responsible ministries could draw lessons from other countries highlighted in the comparative analysis to improve on the current draft.

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