



**SUSTAINING
ADOLESCENT
HEALTH
SERVICE
DELIVERY
DURING
PROLONGED
SCHOOL
CLOSURES:
CONSIDERATIONS
IN LIGHT
OF COVID-19**



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“ THE COVID-19 PANDEMIC HAS ILLUMINATED HOW THE SCHOOL-BASED HEALTH DELIVERY MODEL NEEDS TO BE RE-EXAMINED IN PERIODS WHEN SCHOOLS ARE CLOSED AND STUDENTS ARE NOT IN ATTENDANCE. ”



COVID-19, SCHOOL CLOSURES, AND THEIR IMPACT ON ADOLESCENT HEALTH AND EDUCATION.



MORE THAN
192
COUNTRIES
MANDATED SOME
FORM OF SCHOOL
CLOSURES



IMPACTING
AT LEAST

1.6

BILLION
CHILDREN
AND YOUTH



As the Novel Coronavirus Disease 2019 (COVID-19) swept the globe, most countries took swift action in response to the pandemic, with most governments temporarily closing schools and businesses and mandating lockdowns to contain community transmission.

Despite the intent of lockdowns to slow the transmission of COVID-19, they have made accessing social services more difficult, particularly in the delivery and uptake of public health interventions, and especially so for those that depend on the education system as their delivery mechanism. In an effort to prevent community spread of COVID-19, more than 192 countries mandated some form of school closures, impacting at least 1.6 billion children and youth and an estimated 63 million teachers^(1,2).¹ The scale is unprecedented; in comparison an estimated 175 million children have their schooling interrupted by a disaster each year⁽³⁾. The impact of health emergencies on education, including the current health pandemic, is likely to be most severe in countries with low learning outcomes, high dropout rates, and low resilience to shocks.

Even before this shock, there was already a learning crisis in low- and lower-middle income countries. Periods of school closures result in learning loss, and prolonged absences from schooling will further exacerbate learning disparities and opportunity costs of schooling⁽⁴⁾.

The World Bank estimates that school closures from COVID-19 will reduce the average learning that a student achieves over their lifetime by more than half of a school year (from 7.9 years to 7.3 years). This will result in a 5 percent reduction in annual earnings each year, and a predicted 4.5 million or more students who may never return to school due to the income shock of the pandemic alone⁽⁵⁾. Negative impacts from school closures will be significantly higher for marginalized populations, such as adolescents with disabilities and those living in or forcibly displaced from fragile contexts. Efforts to engage children in remote learning instruction—such as delivering lessons over TV and radio, through SMS, and online instruction—are expected to mitigate anticipated loss in educational gains from schooling disruption, however, disadvantaged students are more likely to have inequitable opportunities to benefit from distance education⁽⁶⁻⁹⁾. Efforts to retain student enrollment once schools reopen will need to contend with the unique challenges presented by COVID-19, as some families may choose to avoid re-enrollment due to underlying conditions that make the student or a family member more susceptible to the effects of the disease.

¹The situation remains fluid, and even after periods of reopening, schools may close yet again. The most up-to-date information by country and region can be found at the World Bank Closure Database and Interactive Map: <https://www.worldbank.org/en/data/interactive/2020/03/24/world-bank-education-and-covid-19>



HEALTH AND EDUCATION

“ ADOLESCENTS ARE PARTICULARLY VULNERABLE TO A DOUBLE DISRUPTION IN HEALTH SERVICE DELIVERY, AS PROLONGED SCHOOL CLOSURES STYMIE ROUTINE SERVICE DELIVERY AND DISRUPTIONS FROM HEALTH EMERGENCIES CREATE CHALLENGES IN ACCESSING THOSE SAME SERVICES THROUGH THE TRADITIONAL HEALTH SYSTEM. ”

In nearly every country, schools also serve as a delivery platform for preventive health, nutrition, and hygiene services⁽¹⁰⁾.

These services can include, for example, interventions to promote physical health and nutrition (vision screening, HPV vaccination, intermittent iron and folic acid supplementation, school feeding, deworming, nutrition education and promotion), education to promote health (comprehensive sexuality education and life skills education), and infrastructural investments to promote health (menstrual health and hygiene, WASH, prevention of school-related gender-based violence).

The COVID-19 pandemic and its consequential school closures, however, has illuminated how this model needs to be re-examined in periods when schools are closed and students are not in attendance.

In the short term, the closure of schools largely eliminates access to the types of preventive services defined above, which, in the case of the COVID-19 pandemic, has already been shown to negatively affect the health and wellbeing of school-age children and adolescents^(4,11,12). As was documented during the Ebola epidemic, 76 percent of children in Sierra Leone reported not having enough to eat, underscoring the importance of identifying flexible approaches to keep students nourished during the pandemic⁽¹³⁾. The World Food Programme estimates more than 320 million children and adolescents who rely on school meals for their nutritional needs may be at risk of acute malnutrition following prolonged school closures⁽¹⁴⁾. Some countries continue to offer select health and nutrition services during planned school closures, such as the provision of meals to vulnerable students during the summer holidays. This suggests that the groundwork may already be in place in many contexts to reach vulnerable students through alternative platforms during unplanned and prolonged school closures.

Adolescents are particularly vulnerable to a double disruption in health service delivery, as prolonged school closures stymie routine service delivery and disruptions from health emergencies create challenges in accessing those same services through the traditional health system.

The combination of being out of school, socially isolated, and the loss of family and livelihoods may increase caregiving responsibilities, the likelihood of witnessing or suffering violence and abuse, early marriage, sexual exploitation, introduce or exacerbate the risk of mental health conditions, and increase the likelihood of unplanned pregnancies and transmission of sexually transmitted infections⁽⁵⁾. Additionally, adolescent girls

may experience supply- and demand-side barriers to accessing key health services as resources are shifted to address the health emergency, supply chains for essential commodities are disrupted, and/or avoidance of health centers due to concerns over disease transmission in these settings. Furthermore, local travel restrictions and/or non-availability of transport during periods of lockdown can limit access to care and family planning support. Lessons from the Ebola outbreak in West Africa offer a sobering reminder of the negative consequences that can arise as a result, as more women in Sierra Leone died of complications during childbirth than of the disease itself⁽¹⁵⁾. This is especially true in the case of COVID-19, where age is such an important determinant of mortality risk and is unlikely in and of itself to have severe health consequences for adolescent populations.

This brief provides an overview of approaches to sustain the delivery of school health and nutrition services described above and targeted to adolescents in periods of school closure, while presenting considerations for the resumption of school-based service delivery upon reopening.

This resource summarizes effective service delivery approaches that have been utilized by the health, education, and social protection sectors to respond to health and humanitarian crises, drawing from evidence from the Ebola epidemic and emerging evidence from the COVID-19 pandemic. The actions suggested within this brief are intended to complement the guidance developed by the UNESCO, UNICEF, World Bank, World Food Programme, and the World Health Organization as well as the Center for Global Development, International Federation of Red Cross and Red Crescent Societies, and among others⁽¹⁶⁻²⁰⁾ (see Annex 1). It should therefore be treated as a living document. Policymakers are encouraged to weigh the approaches highlighted within this brief against the national and sub-national capacity to respond to current and anticipated community and cluster transmission, emerging evidence of successful strategies applied in other contexts, and data generated by community engagement and monitoring.

This is the fourth brief in a series focused on adolescent school health and nutrition developed by the Global Financing Facility for Women, Children and Adolescents (GFF).

The other briefs in this series introduce: (i) a set of health and nutrition interventions that are relevant for adolescent populations and can be delivered through schools in low-resource settings; (ii) monitoring mechanisms for school health and nutrition service delivery; (iii) a costing tool for school health and nutrition services; (iv) country case studies; and (v) a decision tree to guide World Bank operations that include school-based adolescent programming.



“ SOME COUNTRIES CONTINUE TO OFFER SELECT HEALTH AND NUTRITION SERVICES DURING PLANNED SCHOOL CLOSURES, SUCH AS THE PROVISION OF MEALS TO VULNERABLE STUDENTS DURING THE SUMMER HOLIDAYS.

THIS SUGGESTS THAT THE GROUNDWORK MAY ALREADY BE IN PLACE IN MANY CONTEXTS TO REACH VULNERABLE STUDENTS THROUGH ALTERNATIVE PLATFORMS DURING UNPLANNED AND PROLONGED SCHOOL CLOSURES. ”

PIVOTING TRADITIONAL SERVICE DELIVERY IN RESPONSE TO COVID-19



In the context of a pandemic such as the one facing the world in 2020, decision makers must be complementary and opportunistic working across sectors to adapt service delivery to protect the health, education, and social protection needs of the population.

This is particularly true for adolescent populations who are both vulnerable and difficult to reach, even under normal conditions, and for which alternative mechanisms of delivery are used. Table 1 shows actions each sector can take to ensure the health, education, and social protection needs of adolescents are met during periods of school closure and school resumption. Populations who are at greatest risk of leaving school may be identified through school census (pre-crisis attendance records) and household surveys (economic status), however, program planners should anticipate that those in need of targeted support has likely increased as a result of the crisis.

HEALTH SERVICE DELIVERY DURING SCHOOL CLOSURE

In response to the global pandemic, actors at the national and local level can pivot service delivery to continue the provision of health services that were previously school-based to reach vulnerable populations.

At the national level, governments can stem the risk of unplanned pregnancies among adolescents by temporarily changing policies to enable self-administration of preventive, diagnostic, and therapeutic sexual and reproductive health medicines and devices⁽²¹⁾. At the local level, program implementers can pivot the delivery of school-based social safety nets, such as the delivery of meals to undernourished students. Program implementers have successfully pivoted their delivery approaches in various contexts; Thailand began to distribute long-life, shelf-stable ultra-high temperature milk to the homes of students who would otherwise receive meals in schools⁽²²⁾ and Guatemala has engaged Parent-Teacher Associations to deliver two-week lunch rations⁽²³⁾. The World Food Programme has piloted a number of approaches, including digital food vouchers, contactless cash transfers, and delivery of take-home rations to families⁽²⁴⁾. Separately, lessons gleaned from developed countries such as the United States show that practitioners from school-based health centers can continue to provide support during periods of school closure through phone-based counseling, referrals to alternative health providers, and dissemination of health behavior information to school families^(25,26). It is important to track how the degree to which these alternative delivery methods reaches intended beneficiaries. The mid-day meal program in India, the largest school feeding program worldwide, adapted its delivery mechanisms within each state in light of school closures, and despite these efforts, reaches only half of the pupils⁽²⁷⁾.

Students' temperatures are taken at Billy Town Public School, Liberia during the Ebola outbreak.
Photo: © Dominic Chavez / World Bank

“ IN RESPONSE TO THE PANDEMIC, ACTORS AT THE NATIONAL AND LOCAL LEVEL CAN PIVOT SERVICE DELIVERY TO CONTINUE THE PROVISION OF HEALTH SERVICES THAT WERE PREVIOUSLY SCHOOL-BASED TO REACH VULNERABLE POPULATIONS. ”



As countries consider alternative mechanisms for routine service delivery, program implementers are demonstrating that it is possible to leverage new delivery mechanisms to provide additional supplies to adolescents during school closure.

South Africa's Gauteng Province, for example, started providing masks and gloves alongside food distribution to students who relied on the school nutrition program⁽²⁸⁾. This approach could reasonably be expanded to include hygiene products, menstrual supplies, SRHR messages, and health and nutrition education. Similarly, countries are piloting multichannel remote learning strategies to mitigate anticipated loss in educational gains from schooling disruption. Virtual online learning platforms can also be effectively leveraged to disseminate age-appropriate and family-friendly health messaging⁽²⁹⁾, especially when broadcast through gender-neutral platforms, such as through SMS and radio⁽³⁰⁾. Countries can use pre-existing open content and support teachers, parents, and caregivers through tailored training⁽³¹⁾. The Ministry of Education in Ethiopia capitalized on this opportunity to broadcast messaging on physical activity, mental health, and hygiene and collaborated with religious institutions to further disseminate age-appropriate health messaging to a broad subset of the population⁽²³⁾.

MULTISECTOR ACTIONS TO REOPEN SCHOOLS

The successes and failures witnessed recently in reopening of schools indicates that the practice must have some fundamental elements to succeed: cross-sector efforts must be integrated into the country's overall response to coordinate measures for safety and learning; it must have the necessary resources to ensure the physical safety and mental wellbeing of children and communities once they are back in buildings; and it must take into account cultural and political context and engage key stakeholders (parents, teachers, community leaders) in the decisions to reopen⁽³¹⁾.

In cases where closures are caused by a public health emergency, health actors are tasked with supporting education decision makers to develop national school reopening guidelines that detail disease mitigation measures within the context of the school setting, as has been done in Burkina Faso⁽²³⁾. Examples include mechanisms to facilitate social distancing and holding lessons in well-ventilated areas. This may mean reducing class size, distancing desks, and/or splitting the days or timeframes

in which students are in school. Education authorities can also collaborate with their health counterparts to develop health promoting policies. These can include a "stay-at-home if unwell" policy, guidelines for symptomatic screenings, requirements on mask use, and development of health education and behavior change communication targeted to both teachers and students. Protocols may also detail the mechanisms to support public health authorities with contract tracing following localized outbreaks in school⁽¹⁸⁾.

Schools are tasked with fostering a health promoting environment to protect the safety of students, parents, and communities when schools resume after a public health crisis.

WHO guidance encourages schools to increase their hygiene infrastructure to enable and encourage regular handwashing by teachers and students. In areas with limited water, or where retrofitting existing infrastructure is not possible, the provision of alcohol-based hand rub is an effective and easily deployable alternative recommended by WHO. Health actors can also suggest low-cost environmental nudges to prompt behavior change among students towards more frequent handwashing⁽³²⁾ and social distancing. As a secondary benefit of these supply-side investments, greater attention to hand hygiene can reduce other common conditions that keep students out of school, such as diarrhea and helminth infections. Students can also serve as health ambassadors by modeling protective behaviors, such as regular hand hygiene and mask use, within their wider community to reduce infection transmission. Importantly, improved hygiene and sanitation infrastructure, such as separate latrines for female students, may also encourage adolescent girls to remain enrolled in school.

Reopening schools also requires broad coordination across line ministries to effectively target available resources, with cross-sector focal points identified at all levels of government.

The health sector can offer education counterparts valuable insight into the capacity of the primary health care system to quickly detect, respond to, and mitigate disease transmission. Well-organized health systems with investments in universal health coverage are better equipped to provide routine and emergency services in the event of an outbreak⁽³³⁾; however, responses to local transmission patterns and healthcare capacity may vary across regions and districts within the same country. As such, school reopening decisions and mitigation measures should be coordinated with identified actors at the national and sub-national levels. Lastly, cross-sector coordination can facilitate data sharing and improve coherence in strategies and messaging on reopening schools, relevant public health policies in schools, and safe care-seeking behaviors and settings⁽¹⁹⁾.



“ IN THE CONTEXT OF A PANDEMIC SUCH AS THE ONE FACING THE WORLD IN 2020, DECISION MAKERS MUST BE COMPLEMENTARY AND OPPORTUNISTIC WORKING ACROSS SECTORS TO ADAPT SERVICE DELIVERY TO PROTECT THE HEALTH, EDUCATION, AND SOCIAL PROTECTION NEEDS OF THE POPULATION. THIS IS PARTICULARLY TRUE FOR ADOLESCENT POPULATIONS WHO ARE BOTH VULNERABLE AND DIFFICULT TO REACH, EVEN UNDER NORMAL CONDITIONS, AND FOR WHICH ALTERNATIVE MECHANISMS OF DELIVERY ARE USED. ”



RESUMING SERVICE DELIVERY SAFELY ONCE SCHOOLS REOPEN

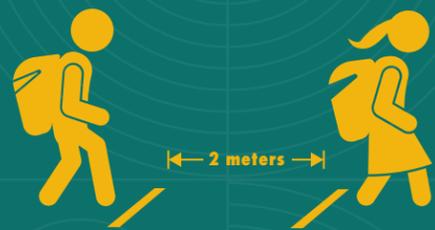
As the crisis shifts from response to reopening, decision makers are encouraged to engage communities in the planning process to garner public trust in the safety of resuming schooling and in highlighting the importance of continuing education.

Social and behavior change communication and demand generation campaigns may highlight the improved health, nutrition, and sanitation services and infrastructure as a mechanism to entice parents to re-enroll their children. Inclusive engagement in message generation and dissemination methodology is relevant beyond the reopening phase, as evidence suggests that community participation can improve school enrollment and attendance, reduce the risk of further marginalizing vulnerable populations, and reinforce health messaging delivered in schools. Community members can also be called upon to prioritize indicators to monitor and to engage in data collection activities to inform adaptive measures as the health and sanitation protocols are enacted⁽¹⁶⁾. As with any response, it is best practice to disseminate complementary messaging in local languages through multiple, credible channels. Household surveys can provide insight into which dissemination methods are best suited for different audiences⁽¹⁶⁾.

Collaboration across sectors should ensure that schools are prepared to support the broad spectrum of physical and mental health needs of school-age children and adolescents as they return to schools after periods of extended closure.

This may include a wide variety of activities to ensure that health and nutrition programs in schools effectively support increased student needs, such as ensuring that mechanisms between agricultural suppliers and food service distributors are prepared to immediately resume school feeding operations, and organizing school-based immunization catch-up programs to make up for disruptions in the supply and demand of routine health services. Additionally, evidence suggests that children and adolescents may require emotional and psychosocial support following periods of crisis and social isolation. Training programs focused on emotional support can better prepare school nurses, teachers, and other school staff to provide appropriate emotional support to students⁽³⁴⁾. Additional approaches, such as an emphasis on peer-to-peer socialization among adolescents are also seen as important interventions for student mental health.

“SOCIAL AND BEHAVIOR CHANGE COMMUNICATION AND DEMAND GENERATION CAMPAIGNS MAY HIGHLIGHT THE IMPROVED HEALTH, NUTRITION, AND SANITATION SERVICES AND INFRASTRUCTURE AS A MECHANISM TO ENTICE PARENTS TO RE-ENROLL THEIR CHILDREN.”



“GUIDANCE FROM THE WORLD HEALTH ORGANIZATION ENCOURAGES SCHOOLS TO INCREASE THEIR HYGIENE INFRASTRUCTURE TO ENABLE AND ENCOURAGE REGULAR HANDWASHING BY TEACHERS AND STUDENTS. AS A SECONDARY BENEFIT OF THESE SUPPLY-SIDE INVESTMENTS, GREATER ATTENTION TO HAND HYGIENE CAN REDUCE OTHER COMMON CONDITIONS THAT KEEP STUDENTS OUT OF SCHOOL, SUCH AS DIARRHEA AND HELMINTH INFECTIONS.”

Gender-specific and targeted social protection measures may be necessary to allow adolescent girls to remain enrolled when governments reopen schools and to sustain gains made towards their human capital formation.

Recognizing that adolescent girls are at higher risk of gender-based violence and transactional sex during periods of confinement, schools may wish to offer targeted empowerment programming when reopening. A program delivered to adolescent girls during the Ebola outbreak provided physical space away from men and was successful in reversing the drop-out rates seen among adolescent girls who did not have access to the program⁽³⁵⁾. Countries may also consider flexible approaches to school re-entry, particularly for adolescents who have become pregnant during school closures as was successfully piloted in Sierra Leone (see Box 1).

Relaxed conditionalities for cash transfer programs can help lessen the opportunity cost of re-entry into the education system.

Periods of crises can have deep economic impacts on household wealth, where a deterioration in economic opportunities and disruptions in food distribution can become a barrier to re-entry into the education system. Well-designed cash transfer or income support programs can reduce the need for adolescent girls to seek financial security through transactional relationships and may also reduce risk of intimate partner violence⁽¹⁵⁾. Similarly, scholarships and reduced or waived fees for schooling and exams are important financial incentives for families and girls to resume education when confinement ends. Burkina Faso is raising awareness about the importance of girls' education as part of its back-to-school campaign, which includes offering scholarships, school kits, and meals for the most vulnerable⁽³⁶⁾.

BOX 1

INNOVATIVE APPROACHES TO SUSTAIN ADOLESCENT ENGAGEMENT IN THE EDUCATION SECTOR DURING AND FOLLOWING THE EBOLA OUTBREAK IN SIERRA LEONE



ADOLESCENTS AND SCHOOL CLOSURES

Between 2014 and 2015, Sierra Leone, Liberia, and Guinea suffered from the worst recorded Ebola outbreak since the disease was first diagnosed in 1976 in the Democratic Republic of Congo. The education sector was severely impacted, with schools closed for the better part of a year to slow community transmission. Economic shocks coupled with forced and protracted school closures disproportionately put women and girls at risk for sexual exploitation and early marriage. Loss of household income increased the opportunity cost of staying in school, which in general, increases as children age, as families may encourage their children to support income generation efforts. One-quarter of secondary school-age students in Liberia did not return within a month of schools reopening, largely due to financial hardship⁽³⁷⁾.

Some estimates suggest that adolescent pregnancy increased by as much as 65 percent in some communities during the 2013-2016 Ebola outbreak⁽³⁸⁾. In 2016, following the epidemic, Sierra Leone saw a 16 percent drop in female enrollment once lessons resumed, with adolescent pregnancy and increased caregiving responsibilities among the reasons cited⁽³⁵⁾. The Government of Sierra Leone established a Task Force, with the Ministry of Education, Science, and Technology, development partners, and NGOs, to implement measures to sustain community engagement with the education sector⁽³⁹⁾.

A portrait of Ebola survivor Adam Fofanah in Freetown, Sierra Leone.
Photo: © Dominic Chavez/World Bank



SOCIAL MOBILIZATION

The Government of Sierra Leone launched a social mobilization campaign aimed at parents and communities to help disseminate information about returning to school and measures that had been taken to ensure the school grounds were safe. For example, schools that had previously been used as holding centers for suspected cases were disinfected and 36,000 hand washing stations were installed in schools. In addition, the government implemented social protection measures to encourage school return, including the provision of school feeding in primary schools and cash transfers and waived tuition for vulnerable households⁽⁴⁰⁾. The government also recognized the mental health impacts of the Ebola outbreak, and trained two teachers per school to provide psychological support.



CURRICULUM ADJUSTMENTS AND BRIDGE PROGRAMS

Following the increase in adolescent pregnancy during the Ebola epidemic⁽⁴¹⁾, the Government of Sierra Leone, with support from development partners, developed the Access to Education Programme for Pregnant Girls in response to a national prohibition on pregnant adolescents attending school. This accelerated bridge program taught core subjects from the national curriculum and included links to health services and social protection measures, with the intention of preparing adolescent girls to return to mainstream schooling following their delivery. 14,500 adolescent girls enrolled and nearly 9,800 girls left the programme to reintegrate into regular school over the course of the programme. A subsequent bridge program was developed, which includes a component on reintegrating out-of-school girls into the education system, including those who have dropped out due to adolescent pregnancy⁽⁴²⁾.

TABLE 1

RISK MITIGATION MEASURES BY SECTOR TO SUSTAIN HUMAN CAPITAL AND ESSENTIAL SERVICES



SCHOOLS OPERATING UNDER USUAL CIRCUMSTANCES	 HEALTH SECTOR	 EDUCATION SECTOR	 SOCIAL PROTECTION & JOBS
<p>GENERAL</p>	<ul style="list-style-type: none"> • Have an up-to-date emergency preparedness plan that outlines health sector actions to prioritize and deliver routine school-based health and nutrition services during school closures and localized disease outbreaks (e.g. SBCC to stimulate demand for services in health facilities; roadmaps to organize catch-up campaigns; agreements to coordinate with community-based food distribution to include health and sanitation products, etc.); revise annually to account for updated public health guidance • Coordinate with the education sector to deliver an essential package of school health and nutrition services 	<ul style="list-style-type: none"> • Have an up-to-date emergency preparedness plan that outlines contingency plans for education service delivery during school closures and localized disease outbreaks (e.g. distance learning plans and modalities; inclusion of updated health and nutrition education curriculum; etc.); revise regularly to account for needs of teachers, staff, and students 	<ul style="list-style-type: none"> • Have an up-to-date emergency preparedness plan that provides a roadmap for delivering school meals to vulnerable populations in the event of school closure and/or disrupted supply chains; update annually to reflect updated global guidance and emerging examples of best practices • Provision of school meals to the most disadvantaged populations (geographic targeting, means-based, provision during periods of seasonal hunger, etc.) • Cash transfers to encourage adolescent girls to remain enrolled in secondary school



TABLE 1

RISK MITIGATION MEASURES BY SECTOR TO SUSTAIN HUMAN CAPITAL AND ESSENTIAL SERVICES (CONT.)



SCHOOL CLOSURES	HEALTH SECTOR	EDUCATION SECTOR	SOCIAL PROTECTION & JOBS
<p>GENERAL</p>	<p>General actions to implement during prolonged school closures:</p> <ul style="list-style-type: none"> • Develop training protocol for teachers and school staff to support the expansion of essential school health services, such as for psychosocial support, once schools reopen <p>In cases of public health emergencies causing school closures:</p> <ul style="list-style-type: none"> • Issue guidance on health promoting behaviors, including targeted messaging for children and adolescents within national and subnational communication strategies • In tandem with disseminating health behavior messaging, include information on where to seek care and, if relevant, information on waived cost of testing and care for the current public health emergency • Inform parents and adolescents about altered schedules for school-based delivery of services, including for vaccines 	<p>General actions to implement during prolonged school closures:</p> <ul style="list-style-type: none"> • Education sector to issue guidance on distance learning measures for consistency in approaches used by teachers and principals within schools and across country • Establish agreements with media services (radio stations, mobile operators, telecommunication and internet companies, etc.) to broadcast lessons through gender-neutral platforms • Increase measures to close the digital divide such as promote access to digital resources, including making digital textbooks available for free and bolster internet connectivity in rural areas, as has been piloted in Indonesia and Kenya ^(43,44) and by creating zero-rate policies to facilitate download of learning materials onto smartphones ⁽⁴⁵⁾. • Implement measures to sustain continuity of education, such as through distance learning mechanisms that reach all students, ideally with a multichannel approach • Collaborate with the health and water sectors to disinfect schools and install/refurbish hand washing stations in preparation for reopening • Recalibrate and streamline the curriculum, allowing for more focused attention on select academic material to help students, particularly those furthest behind, gain equal footing when returning to school ⁽⁴⁶⁾ • Maintain teachers and school staff on the public payroll to retain existing talent and hire additional teachers and staff if required 	<p>General actions to implement during prolonged school closures:</p> <ul style="list-style-type: none"> • Relax conditionalities for cash transfers related to school attendance to sustain regular income support and mitigate risk of acute poverty and malnutrition ^(47,48); in contexts of food scarcity, consider switching support to food delivery • Expand social safety nets to include additional benefits and/or expand coverage to reach a wider subset of beneficiaries ⁽⁴⁸⁾ • Issue guidance on delivery of social safety nets, such as meals or food subsidies, to vulnerable populations; guidance may be best developed at the sub-national level and in collaboration with the education sector, where schools can still serve as distribution platform • Establish an accountability mechanism, such as a hotline or an Interactive Voice Response System, to ensure children are receiving meals ^(14,27) • Classify core child-protection services as essential to protect children and adolescents from violence, abuse, and exploitation ⁽²¹⁾



TABLE 1

RISK MITIGATION MEASURES BY SECTOR TO SUSTAIN HUMAN CAPITAL AND ESSENTIAL SERVICES (CONT.)



SCHOOL CLOSURES	HEALTH SECTOR	EDUCATION SECTOR	SOCIAL PROTECTION & JOBS
<p>CONTINUOUS ACTIONS</p>	<p>Continuous actions to implement during prolonged school closures:</p> <ul style="list-style-type: none"> • Train frontline staff on youth friendly services to ensure the continuity of essential health services for children, adolescents, and women • Establish telemedicine mechanisms for the provision of counseling on adolescent sexual and reproductive health • Use digital platforms to provide psychosocial support, identification, and management of mental health conditions to students who mainly rely on school-based services ⁽³³⁾ <p>In cases of public health emergencies causing school closures:</p> <ul style="list-style-type: none"> • Engage local communities in the dissemination of health promotion messaging to encourage adherence with public health and social measures • Disseminate messaging to parents and caregivers on containment measures in place at health facilities and at schools 	<p>Continuous actions to implement during prolonged school closures:</p> <ul style="list-style-type: none"> • Offer lessons through various communication channels, including streaming and on-demand content (synchronous and asynchronous remote learning modalities) • Provide targeted and tailored learning outreach for populations less likely to access digital resources, including use of SMS, printed material, offline platforms for teachers to assign work and provide instruction and feedback • Disseminate messaging to parents and caregivers through multichannel platforms on how to support students during school closures ⁽⁴⁵⁾ • Inclusion of relevant health education lessons within distance learning curricula, including on comprehensive sexuality education • Conduct rapid survey assessments of students and staff to gather critical feedback on methods to deliver remote learning and to inform return-to-school plans ⁽¹⁹⁾ 	<p>Continuous actions to implement during prolonged school closures:</p> <ul style="list-style-type: none"> • Organize dry take-home rations, vouchers or cash transfers to ensure vulnerable groups, including adolescent girls, have uninterrupted access to food during school closures; this may include extending benefits to school grades typically not covered by school meal programs, including provisions for cooking oil and other staples to facilitate meal preparation, and/or extending coverage to encompass weekends and school holidays ⁽²⁷⁾ • Explore options to use the meal delivery platform to continue delivery of other school-based health services (e.g. intermittent IFA supplementation to adolescent girls; HPV vaccines; hygiene kits and menstrual supplies, etc.) • Adapt adolescent girls' empowerment programs to a virtual format to reach girls in the context of confinement • Engage local communities to communicate changes in referral systems for gender-based violence <p>In cases of public health emergencies causing school closures:</p> <ul style="list-style-type: none"> • Adapt existing social programs to comply with social distancing guidelines; in remote areas, leverage partnerships, such as with the postal service, to deliver meals ⁽¹⁴⁾, and if distributing cash in person, offer larger, less frequent disbursements ⁽⁴⁸⁾



TABLE 1

RISK MITIGATION MEASURES BY SECTOR TO SUSTAIN HUMAN CAPITAL AND ESSENTIAL SERVICES (CONT.)



SCHOOL CLOSURES	HEALTH SECTOR	EDUCATION SECTOR	SOCIAL PROTECTION & JOBS
<p>GENERAL</p>	<p>General actions to implement following prolonged school closures</p> <ul style="list-style-type: none"> • Facilitate the development of a risk-based return-to-school approach with education stakeholders at the local level by offering standard operating procedures or checklists for schools, based on local conditions, epidemiology, etc. ⁽¹⁸⁾ • Collaborate with the education sector to resume delivery of essential school health and nutrition package of interventions, including the need for “catch-up services” lost during periods of school closures • Document adaptive health service delivery responses implemented during the period of school closures that should be sustained to reach out-of-school youth <p>In cases of public health emergencies causing school closures:</p> <ul style="list-style-type: none"> • Collaborate with the education sector to determine appropriate referral mechanisms and measures between schools and health facilities when cases are identified through schools • Collaborate with the education sector to integrate disease prevention and health behavior messaging into existing curricula • Collaborate with the education sector to introduce catch-up immunization programs using the school platform ⁽¹⁸⁾ • Revise safety procedures and emergency preparedness plan annually 	<p>General actions to implement following prolonged school closures</p> <ul style="list-style-type: none"> • Institute nationally directed, community-led campaigns to encourage school reenrollment, especially among vulnerable populations, including using role models/champions to communicate the safety of returning to school and benefits of education • Institute guidelines on revisions to school curricula to make-up for school closures and remedial learning programs such as teaching an accelerated syllabus, offering catch-up classes in preparation for final exams, and making individual learning plans for students with disadvantaged backgrounds • Document adaptive education service delivery responses implemented during the period of school closures that should be sustained to reach out-of-school youth <p>In cases of public health emergencies causing school closures:</p> <ul style="list-style-type: none"> • Organize school schedules to enable social distancing among teachers and students (ex. stagger attendance/double-shifts and/or organized blended learning, fewer children in classrooms, desk spacing, cancellation of extracurricular activities, etc.) with additional guidance on risk mitigation measures on travel to/from school; this may entail increasing the number of teachers to allow for fewer students per classroom • Collaborate with the health sector to train teachers on newly added health education curricula and on methods to screen for symptoms, such as daily regular temperature checks for teachers and students and/or symptomatic screenings and establish communication and disease mitigation protocols if students or staff feel unwell or are confirmed to be ill • Ensure sub-national education budgets include sufficient allocation for soap, alcohol-based rub, and disinfection supplies 	<p>General actions to implement following prolonged school closures</p> <ul style="list-style-type: none"> • Create contingency plans for the distribution of school meals in preparation for additional closure of schools ⁽¹⁴⁾ • Coordinate with the education sector to implement measures to overcome opportunity cost of schooling for adolescents, including cash transfers and scholarship programs to keep girls in school ⁽⁴⁹⁾, reducing fee barriers by offering subsidies or scholarships for school and examination fees and/or by removing requirements for uniforms • Document adaptive social protection service delivery responses implemented during the period of school closures that should be sustained to reach out-of-school youth <p>In cases of public health emergencies causing school closures:</p> <ul style="list-style-type: none"> • Provide masks for those who need them to adhere with national or local guidance ⁽⁵⁰⁾

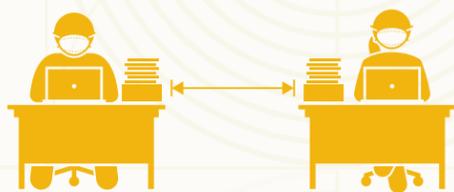


TABLE 1

RISK MITIGATION MEASURES BY SECTOR TO SUSTAIN HUMAN CAPITAL AND ESSENTIAL SERVICES (CONT.)



RETURN TO SCHOOL	 HEALTH SECTOR	 EDUCATION SECTOR	 SOCIAL PROTECTION & JOBS
<p>CONTINUOUS ACTIONS</p>	<p>Continuous actions to implement following prolonged school closures</p> <ul style="list-style-type: none"> Engage nurses, counselors, and/or teachers to provide psychosocial and emotional support to school-age children and adolescents as they return to school <p>Reopening following public health emergencies:</p> <ul style="list-style-type: none"> Engage local communities in the dissemination of health promotion messaging 	<p>Continuous actions to implement following prolonged school closures</p> <ul style="list-style-type: none"> Sustain parental engagement in school activities, including by engaging communities in reenrollment efforts, school monitoring activities, and by financing parent-teacher associations⁽¹⁶⁾ Teach health promotion within school curriculum Collect monitoring and evaluation metrics on learning data to inform needed curriculum adaptations going forward <p>Reopening following public health emergencies:</p> <ul style="list-style-type: none"> Conduct regular temperature checks for teachers and students and/or symptomatic screenings. The return-to-school approach could also include testing for the virus in advance of school return, as piloted in Benin⁽⁵¹⁾ Disinfect frequently touched surfaces daily Ensure sufficient soap and/or alcohol-based rub are available for all staff and students to use at school entrance and throughout the school environment Ensure adequate ventilation in classrooms and ensure heating and cooling systems are regularly maintained and cleaned⁽⁵²⁾ Engage local communities to disseminate school guidelines to maintain health promoting behaviors 	<p>Continuous actions to implement following prolonged school closures</p> <ul style="list-style-type: none"> Provide interventions focused on empowerment and well-being of adolescent girls, including offering safe space learning centers for pregnant adolescent girls⁽⁴²⁾ and/or establishing a 'buddy' program to link adolescent girls at-risk of dropping out with peers who have successfully returned to school⁽²³⁾ Provide tutoring camps and after school programming to further support remedial students⁽¹⁶⁾ Ensure school meals are available for all children as soon as schools reopen <p>Reopening following public health emergencies:</p> <ul style="list-style-type: none"> Promote optimal hygiene behaviors among food service staff/volunteers, school canteens, and food vendors on school perimeter in compliance with infection control protocols⁽¹⁴⁾





CONCLUDING MESSAGES



“ **SUCCESSFUL
CROSS-SECTOR
EFFORTS TO
REOPEN SCHOOLS
CAN SERVE AS
THE FOUNDATION
TO DELIVER
HEALTH SERVICES
THROUGH
THE SCHOOL
PLATFORM GOING
FORWARD.** ”

The COVID-19 pandemic has exacerbated many challenges, among them is the challenge with relying on the school platform to deliver health services to otherwise inaccessible or hard-to-reach groups, such as adolescent populations.

Schools can be significantly disrupted as a result of health emergencies, and/or following natural disasters, civil unrest, and humanitarian scenarios. In addressing this challenge, there is also opportunity to consider how school health and nutrition programming can be restructured to ensure continued service delivery to the targeted population, with lessons that can be taken forward in future periods of school closure.

In an effort to control the disease outbreak, mitigation measures, such as school closures, isolation measures, and reduced access to preventive health services have necessitated adaptations in routine service delivery. To meet the health and education demands of school-age children and adolescents in the current context, the education and health sectors will need to work closely to coordinate responses, including determining safe conditions for school reopening, agreeing on public health messaging and measures to employ, and sustaining coordination for contact tracing, establishing referral mechanisms, and delivering routine and catch-up health services.

Looking ahead, successful cross-sector efforts to reopen schools can serve as the foundation to deliver health services through the school platform going forward, particularly in areas where existing collaboration is weak. As the outbreak is brought under control, successful models for pivoting service delivery to adolescents during forced school closures may be worth exploring as platforms for reaching out-of-school adolescents, who are disproportionately female.



TITLE



ORGANIZATION



OVERVIEW

Considerations for School-Related Public Health Measures in the Context of COVID-19

WHO, UNICEF, and UNESCO

This document is an annex to WHO’s guidance on adjusting public health and social measures in response to COVID-19. This annex provides considerations for decision-makers and educators on how or when to reopen or close schools in the context of COVID-19. The guidance identifies the following considerations when determining whether to open or close schools: (i) Current understanding about COVID-19 transmission and severity in children; (ii) Local situation and epidemiology of COVID-19 where the school(s) are located; and (iii) School setting and ability to maintain COVID-19 prevention and control measures.

Guidance for COVID-19 Prevention and Control in Schools

UNICEF, WHO, and IFRC

This document provides guidance for safe operations through the prevention, early detection and control of COVID-19 in schools and other educational facilities.

Framework for Reopening Schools

UNESCO, UNICEF, World Bank, WFP, and UNHCR

This analysis will help decision makers and sub-national stakeholders to prioritize risk mitigation measures related to reopening schools.

Supplement to Framework for Reopening Schools: Emerging Lessons from Country Experiences in Managing the Process of Reopening Schools

UNESCO, UNICEF, World Bank, WFP, and UNHCR

This document compiles emerging best practices related to the four main dimensions of the Framework (safe operations, focus on learning, wellbeing & protection, and reaching the most marginalized) and highlights country examples

Planning for School Reopening and Recovery After COVID-19: An Evidence Kit for Policy Makers

Center for Global Development

This resource compiles a series of briefs that provide the best available rigorous evidence on five critical dimensions of school reopening and recovery:

1. Engaging communities in reopening plans
2. Targeting resources to where they are most needed
3. Getting children back to school
4. Making school environments safe
5. Recovering learning loss and building back better

What Have We Learnt? Overview of Findings from a Survey of Ministries of Education on National Responses to COVID-19

World Bank, UNICEF, UNESCO

As part of the coordinated global education response to the COVID-19 pandemic, UNESCO, UNICEF and the World Bank conducted a Survey on National Education Responses to COVID-19 School Closures. In this joint report, the results of the first two rounds of data collection administered by the UNESCO Institute for Statistics were analyzed. They cover government responses to school closures from pre-primary to secondary education.

World Bank and COVID-19 Education Tracker

World Bank

This open resource provides live information on countries with closed, open, or open with limitations schools. Additionally, it provides the number of students in closed and partially closed schools.

Education Policy Tracker

Center for Global Development

This live policy tracker provides up-to-date information on each country’s education policy response and reopening plans, as they emerge.

Mitigating the Effects of the COVID-19 Pandemic on Food and Nutrition of Schoolchildren

WFP, FAO, and UNICEF

This joint note provides government decision makers, school administrators/staff and partners with preliminary guidance on how to support, transform or adapt school feeding (in the short term) to help safeguard schoolchildren’s food security and nutrition during the COVID-19 pandemic. Specific recommendations are provided according to the various target groups involved in school feeding.

Maintaining Essential Health Services: Operational Guidance for the COVID-19 Context

WHO

This guidance recommends practical actions that countries can take at national, sub-regional and local levels to reorganize and safely maintain access to high-quality, essential health services in the pandemic context. It is intended for decision-makers and managers at the national and sub-national levels.

Continuing Essential Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health Services during COVID-19 Pandemic: Practical Considerations

WHO/SEARO, UNFPA, UNICEF

This document provides principles, strategic actions and a few examples of operational actions that countries have found useful for preparing plans to continue prioritized SRMNCAH services during the COVID-19 pandemic.

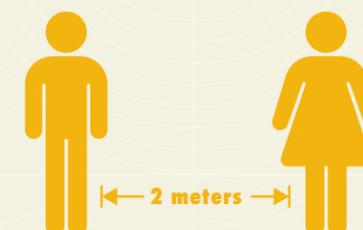
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Schools closed in Kenya.
Photo: World Bank / Sambrian Mbaabu

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