Republic of Zambia

Ministry of Education

Final Draft

National School Health and Nutrition Policy

Lusaka
March, 2006
The School Health and Nutrition Policy is based on the National Education Policy, “Educating our future”, which partly states that one of the aims of education is to foster healthy living, physical coordination and growth of the child. The School Health and Nutrition Programme is the sum total of all health and nutrition activities that go into promoting the physical, social and the mental well-being of the child. Poor health, due to diseases among learners, retards their physical and mental development. This leads to absenteeism from school and reduction in active learning capacity.

The guiding principle of this policy is that optimum health and nutritional status of children is a determining factor for effective learning. Therefore, this policy will attempt to address and promote the health and nutrition status of learners through the strategies outlined herein.

The outlined objectives and strategies will be subject to regular reviews in order to keep abreast with new trends in health and nutrition. The current HIV and AIDS situation adds to the complexity of health and nutrition issues in education. Its impact is devastating to children, teachers and communities and touches all aspects of their lives.

Realizing the important role that partner line ministries and other stakeholders play in the provision of education services, this policy will promote collaboration with relevant institutions.

Hon. Dr. Brian Chituwo, MP.
Minister of Education
March, 2006
ACKNOWLEDGEMENTS

The development of this policy has been a collaborative effort between the Ministry of Education and Ministries of Health, Community Development and Social Services, Sport Youth and Child Development, Agriculture and cooperatives, The National Food and Nutrition Commission, Zambia National Union of Teachers, CHANGES and other stakeholders.

I acknowledge the contributions made by various experts in education, health, community development, nutrition, agriculture and other fields.

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Lillian Kapulu
Permanent Secretary
Ministry of Education
March 2006
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREWORD</td>
<td>1</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>2</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>6</td>
</tr>
<tr>
<td>CHAPTER 1</td>
<td>8</td>
</tr>
<tr>
<td>1.0 BACKGROUND AND RATIONALE</td>
<td>8</td>
</tr>
<tr>
<td>1.1 BACKGROUND</td>
<td>8</td>
</tr>
<tr>
<td>1.2 RATIONALE</td>
<td>9</td>
</tr>
<tr>
<td>CHAPTER 2</td>
<td>11</td>
</tr>
<tr>
<td>2.1 SITUATION ANALYSIS</td>
<td>11</td>
</tr>
<tr>
<td>2.1.1 Health Status</td>
<td>11</td>
</tr>
<tr>
<td>2.1.2 Environmental Health</td>
<td>12</td>
</tr>
<tr>
<td>2.1.3 Sexual and Reproductive Health</td>
<td>13</td>
</tr>
<tr>
<td>2.1.4 HIV and AIDS</td>
<td>13</td>
</tr>
<tr>
<td>2.1.5 Malaria</td>
<td>13</td>
</tr>
<tr>
<td>2.1.6 Communicable Diseases</td>
<td>14</td>
</tr>
<tr>
<td>2.1.7 Non-Communicable Diseases</td>
<td>14</td>
</tr>
<tr>
<td>2.1.8 Control of Childhood Diseases</td>
<td>15</td>
</tr>
<tr>
<td>2.1.9 Health Education and Promotion</td>
<td>15</td>
</tr>
<tr>
<td>2.1.10 Nutrition Status</td>
<td>15</td>
</tr>
<tr>
<td>2.2 INSTITUTIONAL FRAMEWORK</td>
<td>17</td>
</tr>
<tr>
<td>2.2.1 Ministry of Education</td>
<td>17</td>
</tr>
<tr>
<td>2.2.2 Ministry of Health</td>
<td>18</td>
</tr>
<tr>
<td>2.2.3 Ministry of Community Development and Social Services (MDSS)</td>
<td>18</td>
</tr>
<tr>
<td>2.2.4 Ministry of Sport, Youth and Child Development</td>
<td>18</td>
</tr>
<tr>
<td>2.2.5 Ministry of Local Government and Housing</td>
<td>18</td>
</tr>
<tr>
<td>2.2.6 Ministry of Agriculture and Cooperatives (MACO)</td>
<td>19</td>
</tr>
<tr>
<td>2.2.7 National Food and Nutrition Commission</td>
<td>19</td>
</tr>
<tr>
<td>2.2.8 NGOs, CBOs and other Community Agents</td>
<td>19</td>
</tr>
<tr>
<td>2.3 LEGAL FRAMEWORK</td>
<td>19</td>
</tr>
<tr>
<td>CHAPTER 3</td>
<td>21</td>
</tr>
<tr>
<td>3.0 VISION, OBJECTIVES AND POLICY STATEMENTS</td>
<td>21</td>
</tr>
<tr>
<td>3.1 Vision</td>
<td>21</td>
</tr>
<tr>
<td>3.2 Policy Objectives</td>
<td>21</td>
</tr>
<tr>
<td>3.3 POLICY STATEMENTS</td>
<td>21</td>
</tr>
<tr>
<td>CHAPTER 4</td>
<td>24</td>
</tr>
<tr>
<td>4.0 LEGAL FRAMEWORK</td>
<td>24</td>
</tr>
<tr>
<td>4.1 Education Act Cap 234 (1966)</td>
<td>24</td>
</tr>
<tr>
<td>4.3 Public Health Act CAP 295 (1995)</td>
<td>25</td>
</tr>
<tr>
<td>4.4 The National Food and Nutrition Commission Act (1967)</td>
<td>25</td>
</tr>
<tr>
<td>4.5 Day Nurseries Act, CAP 313 (1994)</td>
<td>25</td>
</tr>
<tr>
<td>CHAPTER 5</td>
<td>26</td>
</tr>
<tr>
<td>5.0 INSTITUTIONAL FRAMEWORK (MAJOR PLAYERS)</td>
<td>26</td>
</tr>
<tr>
<td>5.1 Ministry of Education</td>
<td>26</td>
</tr>
<tr>
<td>5.2 Ministry of Health</td>
<td>26</td>
</tr>
<tr>
<td>5.3 Ministry of Community Development and Social Services</td>
<td>27</td>
</tr>
<tr>
<td>5.4 National Food and Nutrition Commission</td>
<td>27</td>
</tr>
<tr>
<td>ACRONYMS</td>
<td>Meaning</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune-Deficiency Syndrome</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>BESSIP</td>
<td>Basic Education Sub-Sector Investment Programme</td>
</tr>
<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
</tr>
<tr>
<td>CBoH</td>
<td>Central Board of Health</td>
</tr>
<tr>
<td>CHANGES</td>
<td>Communities Supporting Health, HIV and AIDS, Nutrition, Gender</td>
</tr>
<tr>
<td></td>
<td>and Equity Education in Schools.</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistical Office</td>
</tr>
<tr>
<td>DEC</td>
<td>Drug Enforcement Commission</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>EMIS</td>
<td>Education Management Information Systems</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organisation</td>
</tr>
<tr>
<td>GRZ</td>
<td>Government of the Republic of Zambia</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Virus</td>
</tr>
<tr>
<td>IDA</td>
<td>Iron Deficiency Anaemia</td>
</tr>
<tr>
<td>IDD</td>
<td>Iodine Deficiency Disorders</td>
</tr>
<tr>
<td>MACO</td>
<td>Ministry of Agriculture and Cooperatives</td>
</tr>
<tr>
<td>MCDSS</td>
<td>Ministry of Community Development and Social Services</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MLGH</td>
<td>Ministry of Local Government and Housing</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSYCD</td>
<td>Ministry of Sport, Youth and Child Development</td>
</tr>
<tr>
<td>NFNC</td>
<td>National Food and Nutrition Commission</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Governmental Organisations</td>
</tr>
<tr>
<td>PEM</td>
<td>Protein Energy Malnutrition</td>
</tr>
<tr>
<td>PTA</td>
<td>Parent Teachers’ Association</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SHN</td>
<td>School Health and Nutrition</td>
</tr>
<tr>
<td>SEP</td>
<td>Special Education Programme</td>
</tr>
<tr>
<td>SIP</td>
<td>Sector Investment Programmes</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children’s</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Agency</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development Fund</td>
</tr>
<tr>
<td>VAD</td>
<td>Vitamin A Deficiency</td>
</tr>
</tbody>
</table>
GLOSSARY

1. **Abortion** - termination of pregnancy or expulsion or extraction of embryo or foetus before 24 weeks of gestation or below 500gm weight of foetus by natural or forced means.

2. **Adolescent** - is a person aged 10 to 19 years.

3. **AIDS** – a collection of different types of diseases that attack the body due to HIV infection.

4. **Anorexia** – Loss of appetite

5. **Anorexia nervosa** - Psychological malaise of young girls who have loss of appetite for fear of becoming obese

6. **Antigens** - Substance that induces antibody production and interacts with it in a specific way.

7. **Ante Natal Care** - care provided to pregnant women from conception to onset of labour.

8. **Antibodies** – Protein substances produced on challenge by an antigen.

9. **Communicable diseases** - these are diseases which can be transmitted directly or indirectly from one person to another e.g. measles, tuberculosis and whooping cough.

10. **Non communicable diseases**: Diseases which can not be transmitted directly or indirectly from one person to another such as cancer, high blood pressure, mental and problems of the heart and liver.

11. **Cholera** – Profuse watery diarrhoea and vomiting with dehydration caused by vibrio cholerae

12. **Cognitive development** - capability of thinking or reasoning positive /sound mind

13. **De-worming** - Administering of a drug to remove intestinal worms

14. **Diarrhoea** – Frequent passage of unformed watery stool due to inflammation, **irritation**, retention, emotion etc.

15. **Dysentery** – Inflammation of the mucosal lining of the gastro-intestinal tract with passage of blood, pus and mucus stool.

16. **Food security** – access to enough quality food all year round by an individual and/or families.

17. **Malaise** – General discomfort of the body due to illness

18. **Goitre** – Enlargement of the thyroid gland

19. **Human Immuno Virus** – The germ that causes AIDS
20. **Helminths** – Earthly worms

21. **Immunisation** – The process of rendering a person immune by active (Toxoid, inactivated, killed organisms) or passive process.

22. **Immunity** – state of being protected against disease either by previous infection or by a vaccine.

23. **Malaria parasitaemia** – Presence of the malaria parasite in the body.

24. **Micronutrient deficiencies** - lack of small substances found in foods, which are necessary for proper growth and mental development.

25. **Nutrients** - Nutritional components of food e.g. vitamins, minerals, proteins.

26. **Protein Energy Malnutrition (PEM)** – Condition due to inadequate energy intake or disease factors.

27. **Psychomotor coordination** – Coordination of physical and mental activities.

28. **Psychosocial distress** - slowness of the mind in terms of social interaction

29. **Psychotropic substances** - Drugs of dependence.


31. **Retention of pupils** - Ensuring that registered pupils remain in school and complete their education.

32. **Parasitic infestations** - Presence of worms in the intestines.

33. **Sero-convert** – Development of antibodies after the vaccine is introduced in the body

34. **Stunting** – Inadequate height for age.

35. **Supplementation** – Giving of extra nutrients in form of food or drugs for prevention or treatment.

36. **Vitamin A Deficiency (VAD)** – Disorder due to intake of Vitamin A.

37. **Wasting** – Inadequate weight for height
CHAPTER 1

1.0 BACKGROUND AND RATIONALE

1.1 BACKGROUND

At independence in 1964, the Ministry of Health (MoH) provided comprehensive school health services that included physical examination, referral and treatment of ailments, provision of immunization, environmental health and food supplements. In addition, the MoH established the office of the School Health Specialist within Maternal and Child Health (MCH). Every hospitals and health centres were obliged to provide school health services in their respective catchment areas. Those schools that lay outside the catchment areas of health institutions were serviced by mobile teams. The provision of drugs, equipment and supplies was provided to all institutions. The school health services decline in the past decades is attributed to institutional structural changes with personnel shortages and resource short falls compounding the scenario. This is one of the reasons why the education sector was thought to be the best option to provide SHN.

In 1985, the Ministry of Education (MoE) adopted the Child-to-Child Programme as a tool to provide health information to school-going children and through them, to the community. The implementation of Child-to-Child Programme was done on pilot basis and later expanded to some schools but was not evenly spread among rural and urban schools. The MoE also re-introduced Production Units in schools to enable children to learn about food production as well as benefit from the food they produced. The policy on school food production units was not effectively implemented in most schools. Other activities which were implemented in schools by teachers included regular checks of sanitation and children’s personal hygiene.

In the last two decades, SHN services have declined in terms of accessibility, availability and quality. Rarely are learners physically examined, treated and/or referred. Food supplementation ceased in the early 1970s due partly to an insufficient understanding and appreciation of the role that health and nutrition contributes to learning achievements. This decline has been worsened by a misconception that SHN is the prerogative of the MoH alone rather than being regarded as a multi-sectoral development issue. Generally, the health and nutrition status of learners has continued to deteriorate. Government has acknowledged this. It is against this background that the MoE introduced the SHN programme as one of the components of the Basic Education Sub-sector Investment Programme (BESSIP, 1998 -2002). The BESSIP was one of the Sector Investment Programmes (SIP) that Government of the Republic of Zambia (GRZ) has implemented to improve the social status of its nationals through economic and public sector reforms. As the cornerstone plan for educational reforms, the BESSIP was organized to achieve the goal of improving access, quality and
The relevance of education in nine key mutually reinforcing areas of interventions. These are:

a) Overall management  
b) Infrastructure  
c) Teacher Development, Deployment and Compensation  
d) Education Materials  
e) Equity and Gender  
f) School Health and Nutrition  
g) Curriculum Development  
h) Capacity Building and Decentralization  
i) HIV and AIDS

Further, BESSIP was intended to optimise the use of resources and reinforce the decentralisation of education system management to local service delivery points. Limited available data suggests that learners are burdened with chronic micronutrient deficiencies, protein-energy malnutrition, helminths, malaria and HIV infections that are, in turn, associated with low academic achievements.

In view of the above it was imperative that a SHN programme be put in place to commit Government and other stakeholders to undertake activities that would assist improve the health and nutrition status of the learners, thereby improving on enrolment, retention and learning achievements. Further, considering the importance and the magnitude of the programme it was felt that a policy is put in place to guide the stakeholders on its implementation.

1.2 RATIONALE

Ensuring that children are healthy and able to learn is an essential component of an effective education system. This is especially relevant to efforts to achieve “Education for All” in the most deprived rural and urban areas. At present more of the poorest and most disadvantaged children have no access to school and many of these are girls. It is these children, who are often the least healthy and most malnourished, who have the most to gain educationally from improved health and nutrition.

Good health and nutrition are not only essential inputs but also important outcomes of quality basic education. On one hand, learners must be healthy and well nourished in order to fully participate in education and gain its maximum benefits. Thus, programmes which improve health and nutrition can enhance the learning and educational outcomes of learners. On the other hand, quality education, including education about health, can lead to better health and nutrition outcomes for learners and, especially through the education of girls, for the next generation.

The SHN Programme, supported by policy and strategies, is critical in improving not only the health and nutrition of learners, but also enhancing academic
achievements and acquisition of life skills. Lack of a SHN policy, harmful traditional practices and poor sources of water and sanitation compound problems of school enrolment, retention and learning achievement.

Vitamin A and Iron Deficiencies are endemic among children in Zambia. The national baseline survey (Luo et al. 1997 – 1998) found that 66% of children were Vitamin A deficient (VAD), while 22% were anaemic. It is well known that iron deficiency anaemia (IDA) affects almost all children. A recent survey of 1,427 Zambian Children (Luo et al., 1998) showed that 14.5% were severely anaemic and 22.2% had malarial parasitaemia. It is also estimated that Iodine Deficiency Disorders (IDD) affect between 50% and 80% of the general population.

Parasitic infestations due to unsafe drinking water, poor sanitation have contributed to the worsening health and nutrition situation among learners. Currently, checks of pupils’ personal hygiene are minimal and occur in very few schools. Parasitic infections in learners can result in diarrhoea and general malaise. Learners heavily burdened with worms eat less even when food is available and their absorption and retention of certain nutrients is impaired. This diminishes children’s learning capacity and their ability to pay attention and concentrate. Growth and cognitive development also diminish.

In Zambia today, some schools have become unsafe places where diseases are transmitted due to inadequate water supply and sanitation facilities and inadequate hygiene education promotion. With special reference to girls, it is already harder for girls to attend and complete school. This is more for order girls who have reached puberty. The presence of user friendly and separate sanitation facilities, equipped with hand washing facilities for both girls and boys that can be kept clean would offer privacy, and protect girls from sexual harassment.
CHAPTER 2

2.1 SITUATION ANALYSIS
In 1999 the population of Zambia was estimated at 10.8 million. Children aged 0 to 15 months comprised 45% of the total population (DHS: 1996). This implies that Zambia has a significantly young population.

The study conducted in Zambia on SHN has highlighted many health and socio-cultural problems affecting school age children. The social-cultural problems include early marriages, teenage pregnancies, and some aspects of traditional practices, child labour and substance abuse. The health problems include poor water supply and sanitation, reproductive health and poor school environment. Among the diseases that were prevalent were malaria, diarrhoea, Acute Respiratory Infections (ARI), eye/ear diseases, STIs/HIV and AIDS, fever, headache, worm infestations, Vitamin A Deficiency and anaemia (Luo et al. 1997/1998, UNICEF 1997).

The school Health and Nutrition activities were piloted in Eastern Province from 2001 to 2003 supported by CHANGES (USAID) on behalf of the Ministry of Education in collaboration with the Ministry of Health. The pilot included a longitudinal biomedical and cognitive research on a sample of pupils in 80 schools in Chadiza and Chipata districts. The pilot also developed a model of interventions.

Although there are no specific surveys on STIs / HIV and AIDS among learners, the magnitude of these problems is high. Data from the sentinel surveillance (CSO, 1998) reveals that HIV prevalence among the 15 to 19 year old is 15 to 16%. This entails that learners are sexually active and therefore sexuality education programmes for learners should be promoted in order to reduce the rate of morbidity and mortality due to STIs and HIV and AIDS (Kinsman et al., 1999).

These problems have not been attended to for many years. The schooling system does not have adequate technical skills and resources to handle the adolescent stage. The health system is not specific in the provision of adolescent services. Besides, there are more learning institutions that are far away from health institutions.

2.1.1 Health Status
Most people believe that young people are healthy because they are a very active group. However, a large number of them are vulnerable to preventable diseases. The problems that young people face as they go to school are many and varied. The integrated school curriculum together with the teaching and learning materials do not adequately address the quality and relevance of health issues for behaviour formation and change of individuals.
It is apparent that more than 80% of learners do not meet the desirable health status for healthy living. This has a negative impact on the physical, psychological, and social development of the child. As children grow, they develop physical, psychological and social needs that need to be addressed. The social changes in Zambia have displaced the child from the intimate traditional systems. The transition from childhood to adulthood is one such problem. The parents and schooling system are ill equipped to handle these traditional childhood changes. Adolescents are therefore more prone to physical, social and psychological health problems.

2.1.2 Environmental Health

Environmental health and sanitation are real problems in learning institutions. Learners are often exposed to poor physical environment such as poor infrastructure and furniture, which has deteriorated through heavy use and lack of maintenance or is absent. This has affected the enrolment and retention rates for most learners, especially girls. Environmentally related diseases such as malaria, cholera and dysentery are also widespread in school communities. These pose a challenge for environmental health and hygiene in relation to clean safe drinking water and good sanitation practices. Outbreaks of preventable water borne diseases such as dysentery, cholera etc have resulted into frequent closures of schools.

WHO (2000) indicates that over 53% of house holds in Zambia have access to clean water, compared to 50% in 1991. Further more, 85% of households in urban and 27% in rural had accesses to clean water. It is further observed that there was a decrease in access to clean water from 90% to 85% in urban areas and an increase from 29% to 37% in rural areas.

The CSO 1991 indicate that 23% of households in Zambia drink water from a river or lake, 12% from a protected well, 25% from unprotected well, 19% from a public tap, while 19% drink water from their own tap. There are remarkable differences between urban and rural access to clean water. This, if not handled can precipitate outbreaks of water born diseases. Therefore learning institutions require to be provided with safe clean water.

The Demographic health Survey of 2000 indicate that water and sanitation related diseases such as diarrhoea, dysentery, cholera, worm infections and other infections, despite being preventable, account for a large proportion of out patient visits and admissions to health institutions and deaths especially among children. This contributes to causes of poor health sicknesses, high curative health costs; increased production looses and decreases school attendance. Hygiene education – means all activities aimed to change attitudes and behaviour in order to break the chain of disease transmission associated with inadequate hygiene and sanitation.
2.1.3 Sexual and Reproductive Health

Urbanisation and the transition from traditional to modern culture have given rise to new patterns of sexual behaviour among young people, leading to risk-taking on the basis of insufficient and incorrect information on sexuality. As a result, they are prone to STIs/ HIV and AIDS, teenage pregnancies, and these are more likely to jeopardise learners’ potential careers. It has been observed that the majority of girls in Zambia become mothers before reaching the age of 20. Three out of ten teenagers in Zambia have either already had a child (24%) or are pregnant with their first child (7%). On the other hand, only 12% of women aged 12 to 19 years started using contraception before they had a child (DHS, 1996). Similarly, large proportions of the youth are sexually active. According to DHS (1996), in Zambia 70% of women aged 20 to 49 have had sexual intercourse by the age of 18 whilst 90% of men aged 22 have had sexual intercourse by the age of 16. However, there is the “Window of Hope” for ages 5 to 14 that require protective interventions. Comparatively the DHS (2002) shows a slight increase in the median age at first birth for women aged 15 to 40 years at 18.7 years against 18 years in 1996. Three in ten teenage women (age 15 to 19) had begun child bearing with 26% having had a child (DHS 2002) compared to 24% (DHS 1996). This is a slight increase of 2% from the previous study.

2.1.4 HIV and AIDS

The current HIV and AIDS situation adds to the complexity of health issues in education. Although the rate of HIV and AIDS among young people is low compared to those of adults, girls suffer disproportionately as victims.

The impact of HIV and AIDS is devastating to learners and teachers; it touches all aspects of their lives. Specifically, children experience psychosocial distress, increased malnutrition, and loss of health care (including immunization), fewer opportunities for schooling and exposure to HIV infection. A further dimension of the HIV and AIDS problem is the fact that teachers fall within the age group that is most vulnerable to infection.

The increasing numbers of orphans due to AIDS poses further problems in the education system. The number of orphans was estimated at 520,000 in 1999 and is projected to be over 895,000 by 2009 (HIV and AIDS MoH 1999). As at 1996, 64% of orphaned children had a deceased father, 22% had a deceased mother and 14% were double orphans, 13% of all Zambian children were orphans, (Orphans and Vulnerable Children: Situation Analysis Zambia 1999). A high proportion of these orphans are likely to experience low standards of living and high levels of morbidity and mortality. For economic and health reasons, many of them may be unable to attend school or drop out of school.

2.1.5 Malaria

Malaria continues to be a major public health problem in Zambia. It is the leading cause of death, especially among pregnant women and children under five years of age. It is estimated that every year, more than 3.5 million clinical cases and 50,
000 deaths are attributable to malaria. In addition, to the direct illness and death, malaria exerts a large economic burden on families, communities and the entire nation.

Recently, there have been significant changes in the tools and strategies used to fight malaria. Zambia has a new malaria drug, a new package of interventions to reduce malaria in pregnancy, a new weapon against the mosquitoes (Insecticide Treated Mosquito Nets (ITNs)).

Decisions regarding malaria and HIV are amongst the most important decisions students will make in their lives, and in the lives of their families. Just as youth are being empowered to take control of their lives with regard to HIV and AIDS, they can also be agents of change to take control of their lives, and their families’ lives with regard to malaria. Rolling back malaria in Zambia requires a united effort across our entire society. Youths are agents of societal change, and the key to change is learning. Schools shall therefore play an essential role in our national efforts to roll back malaria.

2.1.6 Communicable Diseases
Children who begin grade one are normally in the age range of 6 to 7 years. These children are vulnerable to various infectious diseases whether they were vaccinated or not. Most children are missed during routine immunization, hence are at risk of contracting some of the childhood diseases.

In the past, learners have been victims of preventable diseases. Outbreaks of measles, meningitis, tuberculosis, whooping cough, and other infections have been very common among learners. Furthermore, poor water and sanitation facilities in most schools put children at risk of suffering from diarrhoea, dysentery, intestinal parasites, bilharzia, skin and eye problems.

2.1.7 Non-Communicable Diseases
Most young people abuse psychotropic substances like alcohol, tobacco, marijuana and other drugs of dependence. Because of the statutes that provide for substance abuse as arrestable offences, young people do not report their dependence problems. Only extreme cases are brought to the attention of the class teacher and head teacher. This kind of scenario poses a great risk for children who are not yet substance dependent because they can easily be hooked on psychotropic substances through peer pressure. This can lead to increased risky behaviour such as absenteeism, vandalism, violence and dropping out of school. Substance abuse also leads to physiological and psychological illnesses such as cancer, high blood pressure, liver and mental problems. Moreover, appropriate counselling services are often lacking and most teachers do not have skills on how to recognize early signs of substance abuse problems.

The Drug Enforcement Commission (DEC) and Non Governmental Organizations (NGOs) have initiated clubs in learning institutions although they do not cover all.
Their impact on child behaviour towards psychotropic substance is not verifiable. The efforts in school interventions are difficult to quantify in terms of impact on learners’ behaviour towards psychotropic substance dependence.

2.1.8 Control of Childhood Diseases
Over many years the health care services have tried to make available antigens against common childhood illnesses. The coverage for under-fives in most antigens has been in the range of 50 to 80 per cent. There is an apparent increase in the number of fully immunised children from 67% to 70% (MoH 2002). This means that 20 to 30 per cent of the Zambian children are not effectively protected against common childhood illnesses. It is also evident that 15 per cent of children who are apparently immunized will not sero-convert. Cumulatively these children will enter the schooling system without the anti-bodies that can protect them from common childhood illnesses. Rampant malnutrition among learners weakens the body’s ability to withstand infections, making them vulnerable to common preventable childhood illnesses. The HIV and AIDS epidemic has also rendered some children vulnerable to preventable childhood illnesses. These factors call for the urgency for children to receive a comprehensive service that limit the child’s chances to succumb to preventable childhood illnesses.

2.1.9 Health Education and Promotion
Since independence the MoE has strived to provide personal health skills to learners who pass through the formal schooling process and many children have benefited. However, during the 1970s and 1980s it was observed that the schooling system had short-falls in health education and teacher exposition skills. In a majority of cases teachers were ill equipped to provide effective health education and health promotion to pupils. The Ministries of Health and Education collaborated in initiating the Child-to-Child programme. This had instituted the integration of health education and health promotion into the school curriculum as well as the teacher-training curriculum has also integrated health education. Efforts were made to develop teacher skills for health education. Teacher training lecturers have been trained and sensitised to provide health education to trainee teachers. Post-service seminars were held to provide the necessary skills to teachers in the field. The Child-to-Child approach was piloted and has been fully integrated in SHN. Currently the Health Promotion Schools programme is being implemented in basic schools in collaboration with MOH with support from WHO.

The impact of various health education and promotion programmes is difficult to quantify. This is due to the fact that behaviour and personal skills take a long time to be visibly apparent. Besides, various negative socio-economic factors affect the disposition of children to health behaviour.

2.1.10 Nutrition Status
Young people, particularly learners, are the most affected by nutritional problems, due to the high demand for nutrients required for growth and development. Additionally, children are prone to many diseases such as diarrhoea, worm
infestations, malaria, measles, and respiratory infections through which important nutrients necessary for their growth and mental development may be reduced.

The major nutritional problems of public health concern in Zambia are protein-energy malnutrition (PEM) and micronutrient deficiencies (VAD, IDA and IDD). Approximately 12% of babies are born with low birth weight, 53% of children are stunted and 20 to 30% of hospital admissions were due to malnutrition. Hospital records further revealed that 30% of child mortality in 1994 was attributed to malnutrition while about 56% of orphans and 49% of non-orphaned children were stunted (USAID / UNICEF/ SIDA 1999, FAO 2000, UNICEF 2000).

Food insecurity and high levels of poverty in the country has brought about increased levels of malnutrition among learners. According to the Demographic Health Survey (DHS, 1996), malnutrition contributes to over 50% of all infant and child deaths in Zambia. A recent study (Luo, et. al. 1997) reveals that out of 1,427 children screened, 14.5% were severely anaemic and 22.2% had malaria parasitaemia. It also stated that iodine deficiency ranges between 50% to 80% of the general population and VAD is endemic in most children.

DHS (2002) shows a marginal reduction in malnutrition among Zambian children from 50% in 1996 to 47%. It further indicates that over 75% of children were supplemented with Vitamin A, and over 80perce households consumed iodated salt.

a) **Protein Energy Malnutrition (PEM)**
Protein Energy Malnutrition is caused by not eating enough nutritious foods due to poverty or disease factors such as diarrhoea, measles and malaria. The effects of PEM among learners are varied but the most common are poor growth, slow psychomotor coordination, slow learning and poor social development. The most common forms of PEM are: Stunting (Inadequate height for age) as a result of chronic malnutrition, Wasting (Inadequate weight for height) due to acute malnutrition, and underweight (weight for age) as a result of severe malnutrition.

b) **Micronutrient Deficiencies**
The most common micronutrient deficiencies of public health concern in Zambia are VAD, IDD and IDA.

Vitamin A deficiency has been linked to impaired growth and development, vision and effective functioning of the immune system, especially among young children and women. In extreme cases, VAD leads to blindness and death. The 1997 national survey (Luo et.al. 1997) reveals that 6.2% children had night blindness while 11.7% and 65.7% had deficient serum retinal levels (Below 10ug/dl) and low or deficiency serum retinal levels (Below 20ug/dl) respectively. The FAO (2000) and UNICEF (1997) studies also reveal that 23% and 25 to 50% of children aged 6 to 72 months had low retinol levels respectively.
Iron deficiency anaemia affects lives of millions of Zambian women, infants, learners and adolescents. It poses a major threat to lowered resistance to infection, poor cognitive development and decreased capacity to work. Anaemia prevalence is widespread in Zambia particularly among young children and women in childbearing age, prevalence rates of 65% among children 0 to 5 years and 46.9% among women in childbearing age have been documented in the 1997 national survey (Luo et.al.1997). The study by FAO, 2000 indicate that Fifty per cent of pregnant women who attend ANC are usually found to be anaemic, and this results in bearing children who are already mentally retarded. Preventable infections and parasitic diseases such as malaria, worm infestations, diarrhoea when compounded with poor diet contribute to high IDA amongst learners.

Goitre is the common form of IDD in Zambia, severe cases of IDD could result into reduced mental development, growth retardation and cretinism, which could lead to delayed enrolment of children, poor attendance and performance in class, high repetition and drop out rates in the early years of school. In 1993, a total of 2505 pupils from 25 schools were surveyed from iodine deficiency disorders while in 2002 a total number of 2504 pupils from the same or near by schools were surveyed. The overall goitre rates remained unchanged over this period. In 1993, the overall prevalence rate was 31.6 %, compared to 30.2% in 2002. Statistically, this means that there is no difference. The 2002 survey reviewed that only 4% of the surveyed population were at risk of mild IDD, while 96% were at minimal or no risk of IDD compared to 72% who were at risk of mild to severe IDD. The results indicate adequate delivery of iodine in the proxy population of learners, and by implication in the adult population. Therefore strongly suggests the virtual elimination of IDD in Zambia. (Lumbwe 1993 and 2002)

2.2 INSTITUTIONAL FRAMEWORK

The following are key stakeholders in the provision of SHN services;

2.2.1 Ministry of Education

The SHN programme was under the Directorate of Standards and Curriculum in the Ministry of Education. The Directorate of Standards and Curriculum at national level was responsible for policy formulation and direction on SHN activities as well as collaborating with other departments in the MoE, line Ministries and cooperating partners. It was also responsible for monitoring and evaluating SHN activities at provincial and district levels. The Directorate had the capacity to carry out this mandate. However, at provincial and district levels, there were no Focal Point Persons to interpret SHN policies and to facilitate implementation, monitoring and collaborating with other stakeholders. At school level, there was also need to have a coordinator to implement SHN activities. Currently, the SHN is being implemented in the Directorate of Planning and Information as one of the special issues.
2.2.2 Ministry of Health
This Ministry provides promotive, preventive and curative services to the Zambian population. The policy of the health sector is to provide quality health services as close to the family as possible. To this end, one of the cardinal services provision is that directed at learning institutions. The Ministry, therefore, is charged with the responsibility to provide the necessary quality technical support to ensure that the health of learners is promoted, maintained and sustained. To ensure that there is a close collaboration between the Ministry of Health and Ministry of Education, a Memorandum of Agreement was signed.

The strengthened collaboration between the Ministry of Education and Ministry of Health can be proven with the revision of malaria in the curricula; expansion of school clubs to integrate malaria; provision of free ITNs to boarding schools under the Roll Back Malaria School Health Program.

2.2.3 Ministry of Community Development and Social Services (MDSS)
This Ministry provides social welfare services to the poor and vulnerable. It also provides life coping skills and attempts to integrate culture into the developmental process through literature, drama and fine arts. However, officers to carryout SHN activities from headquarters to sub-centre levels need orientation.

2.2.4 Ministry of Sport, Youth and Child Development
This Ministry offers skills training to unemployed youth, provides child advocacy programmes and support systems to ensure the rights and well being of the child are protected and fosters the development of sport. Nevertheless, their structure ends at provincial level, and there is no collaboration and coordination between the MoE / SHN at district level.

2.2.5 Ministry of Local Government and Housing
This Ministry is involved in the provision of essential social services such as public health and education, water and sanitation. However, their provision of safe water and sanitation has been inadequate.
2.2.6 Ministry of Agriculture and Cooperatives
The Ministry is mandated to facilitate and support the development of sustainable and competitive agricultural sector that assures food Security at national level and household levels. One of the Ministry's responsibilities is providing technical training in agriculture production, nutrition, including processing, preservation and utilisation.

The advantage of the Ministry is that the structure goes down to the camp or village level.

Over the years, efforts have been made to incorporate nutrition components with some success, but the

2.2.7 National Food and Nutrition Commission
The Commission is mandated to provide technical advice and guidelines on issues related to nutrition. However, inadequate resources have reduced its ability to handle nutrition issues.

2.2.8 NGOs, CBOs and other Community Agents
The organisations and agents referred to here are involved in the delivery of education, health and nutrition programmes. The Ministry of Education recently began closer collaboration with Zambia Malaria Foundation, which is the umbrella body for all NGOs involved in the fight against malaria and Zambia Scouts Association to facilitate better coordination. However, there is inadequate coordination amongst these agencies and the MoE and other stakeholders.

2.3 LEGAL FRAMEWORK
The following pieces of legislation have been used to govern the implementation of the SHN programme: -

(a) The Education Act, Cap 234 (1966)

(b) The Health Service Act, of 1995

(c) The Public Health Act, Cap295, Laws of Zambia, 2000

(d) The Day Nurseries Act and;

(e) The National Food and Nutrition Act, Cap 41, 1967

However, there are limitations to these Acts. They do not address SHN issues adequately.

In conclusion the socio-economic problems largely affect learners and mothers as indicated by the deteriorating health status, increasing levels of poverty,
malnutrition, micronutrients deficiencies and disease burden. The combined effects of these problems lead to reduction in learners’ capacity and motivation to learn, delayed enrolments, absenteeism, high repetition, dropout and push out rates.
3.0 VISION, OBJECTIVES AND POLICY STATEMENTS

3.1 Vision
To promote and provide quality and cost effective health and nutrition services to all learners in order to improve learning.

3.2 Policy Objectives
a) Promote and improve nutrition status of learners in order to enhance and sustain their physical, social and mental well-being.

b) Promote and maintain the health status of learners through the initiation of effective health promoting activities.

c) Improve collaboration among line ministries in planning and implementation of SHN interventions.

d) Strengthening school and community based health and nutrition activities.

e) Provide health and nutrition education and promotion of activities at all levels of the education system.

f) Promote and sustain a safe and healthy learning environment.

g) Ensure capacity building among stakeholders.

3.3 POLICY STATEMENTS

3.3.1 Health
In order to promote knowledge and skills on healthy living, the Government shall ensure that:

a) a regular physical examination, treatment and referral systems in all learning institution are re-established and sustained;

b) all eligible learners are immunized;

c) guidance and Counselling services are strengthened;

d) appropriate protective clothing is provided to learners;

e) appropriate facilities for learners with Special Education Needs (SEN) are provided;
f) physical Education in all learning institutions is strengthened;
g) adequate clean and safe water is available;
h) regular personal hygiene inspections on learners are carried out;
i) appropriate and adequate sanitary facilities are available;
j) the school environment and structures are safe, clean and maintained;
k) family Life and Sexuality Education is promoted in all schools;
l) initiatives aimed at controlling, preventing and mitigating the spread and impact of STIs/HIV AND AIDS on the school community are established and strengthened;
m) preventive and control measures against communicable and non-communicable diseases are instituted;
n) school based anti-substance abuse programmes in all schools are intensified; and
o) collaboration and partnership with relevant stakeholders are promoted and strengthened;

3.3.2 Nutrition
In order to improve nutrition levels the Government shall ensure that:
a) health and nutrition education is institutionalised at all levels of the school system;
b) eligible learners receive micronutrient supplements;
c) a school de-worming programme is established;
d) food production units are revitalised in all learning institutions;
e) the school feeding services are initiated and communities are involved; and
f) growth monitoring and promotion is institutionalised and implemented;
3.3.3 Institutional Framework
In order to ensure that SHN activities are well-coordinated and implemented at all levels, Government shall ensure that:

a) SHN focal persons at all levels in the MoE, MoH, MACO and MCDSS are appointed;

b) SHN monitoring and evaluating systems are established; and utilized;

c) partnerships with all stakeholders in SHN activities are strengthened;

d) SHN is institutionalised at all levels of the Education system;

e) a procurement and distribution system for drugs, micronutrients supplements and supplies is established; and sustained and;

f) networking and sharing information between learning institutions, districts and provinces is initiated and strengthened at all levels;

3.3.4 Legal Framework
The Government shall ensure that:

(a) SHN activities are implemented as provided for within the existing pieces of legislation.

(b) United Nations and the African Union Children’s Charters and any other relevant Charters are incorporated into SHN activities.
CHAPTER 4

4.0 LEGAL FRAMEWORK
The fact that SHN is an integral component of the education policy makes it compulsory for all schools to implement it within the provision of the Education and Health statutes. The following are the laws of Zambia that pertain to the SHN programme to which it shall conform in the implementation of the activities.

a) The Education Act, Cap 234 (1966);

b) The National Health Services Act, number 22 (1995);

c) The Public Health Act, Cap 295 (1995);

d) The National Food and Nutrition Commission Act ,Cap 41 (1967); and

e) The Day Nurseries Act, Cap 313 (1994);

f) The Local Government Act, number 22 of 1999;

g) The Water Supply and Sanitation Act, number 28 of 1997

4.1 Education Act Cap 234 (1966)
The Education Act in its current form does not adequately cover SHN issues. Since SHN is one of MoE programmes, it should be recognized and be given its important status as it contributes to the health and nutrition of children.

The following suggestions should be included in the Act:

a) the provision of school based health services;

b) the protection of teachers as they administer health and nutrition interventions;

c) the provision for infrastructure maintenance in schools;

d) acceptable standards for the learning environment;

e) accreditation of schools in terms of health and nutrition;

f) emergency preparedness and;

g) provision for MoE to inspect Pre - and Nursery Schools.
The National Health Services Act provides for the right of all citizens to quality health. The Act in its current form has gaps regarding SHN services. The following points should be considered:

a) The provision for functional expected outputs;
b) The provision for MoE to mobilize resources for SHN activities; and
c) The compelling provision for MoH to provide drugs, medical supplies, equipment and trained personnel for SHN Services.

4.3 Public Health Act CAP 295 (1995)
While the Act addresses issues of public health in general, it does not provide for the implementation of health and nutrition programmes in learning institutions. In this case, it is proposed to review and strengthen the law. The following suggestions should be included:

a) A provision compelling relevant ministries and agencies to implement SHN activities.
b) The provision for the community to take action when a school does not meet the required health and nutrition standards.

4.4 The National Food and Nutrition Commission Act (1967)
The National Food and Nutrition Commission (NFNC) Act (1967) makes provision for the right of children and adults to good nutrition and access good nutritional services such as micronutrient supplements and fortified foods.

4.5 Day Nurseries Act, CAP 313 (1994)
The Day Nurseries Act confers authority on the Commissioner for Juvenile Welfare who works through Juveniles Inspectors and the Local Authorities. The Act provides for registration and certification of Day Nurseries by the Local Authority and the inspection by the Commissioner for Juvenile Welfare or any person appointed by the Local Authority, usually an officer of the authority. It also provides for the closure by the magistrate if satisfied on the application of a Medical Officer or a Juveniles’ Inspector that the closure would be in the best interest of the children. However, the Act does not provide for the role of MoE. It is therefore proposed that the above gap, among others, be addressed so as to facilitate effective SHN programmes in these Nurseries as they have upper grades.

4.6 Local Government Act, number 22 of 1999 and Water Supply and Sanitation Act, number 28 of 1997
The Local Government Act gives the local authorities prime responsibilities for the provision of water supply and sanitation services to all areas within the local authority boundary. The local authorities have powers to set standards and guidelines on the provision of services.
CHAPTER 5

5.0 INSTITUTIONAL FRAMEWORK (MAJOR PLAYERS)

The SHN programme is an inter-sectoral initiative in which ministries and agencies will work collaboratively in the planning, implementation, monitoring and evaluation of activities. The provision of integrated health and nutrition interventions shall be implemented jointly with other ministries and organizations with MoE spearheading the programme.

The following is the structure and roles for each stakeholder Ministry and agency:

5.1 Ministry of Education

The central level will be responsible for policy formulation, guidance and monitoring and evaluation. The implementation of SHN activities will be coordinated in the Directorate of Planning and Information.

The Ministry of Education shall:

I. Establish inter-sectoral SHN Coordinating Committees at National, Provincial, District and school levels. Focal point persons shall be members of these committees at their respective levels;

II. Sensitize pupils, teachers and parents in SHN ensure their active participation, community ownership, replication and sustainability;

III. prepare annual work plans in collaboration with other stakeholders and;

IV. provide funding for SHN activities that relate to education outcomes in accordance with SHN component action plans.

5.2 Ministry of Health

The Ministry of Health will provide technical and other support services to various stakeholders on SHN issues at all levels.

The Ministry of Health shall:

I. Fund activities contributing to health outcomes such as immunizations.

II. Provide technical support on the implementation of core health and nutrition activities including procurement and storage of drugs, physical examination (screening), immunization, referral and treatment of ailments, environmental health services, health education and health promotion.

III. Ensure that the Public Health Act and other relevant health regulations are enforced.

IV. Ensure that communities fully participate in SHN activities;
5.3 Ministry of Community Development and Social Services
The Ministry of Community Development and Social Services shall in collaboration with the MoE provide social and community services in line with the SHN activities at all levels.

The Ministry of Community Development and Social Services shall:

I. identify vulnerable school age children in need of health care cost and other support services with a view to linking them to available services;

II. facilitate the participation of communities in SHN activities;

III. assist in sensitizing communities in SHN activities for community involvement to ensure ownership and sustainability;

IV. provide technical guidance in water and sanitation and other SHN issues for effective implementation; and

V. help in coordinating with other stakeholders in communities i.e. CBOs NGOs and line ministries.

5.4 National Food and Nutrition Commission
Among others, the Commission's duty is to promote and advise the Government of Zambia on food and nutrition matters. The role of NFNC in the SHN programme shall be to:

I. provide technical advice on nutrition matters

II. provide training on nutrition.

5.5 Ministry of Agriculture and Cooperatives (MACO)
The role of MACO in SHN Programme is to provide technical training and guidance in agricultural production, processing, preservation and utilisation of the produce. MACO in collaboration with MoE shall participate in planning, implementation, monitoring and evaluation of SHN agricultural activities.

5.6 Ministry of Local Government and Housing
The role of MLGH working through Local Authorities is responsible for provision of social services such as water supply and sanitation, education and public health services.

The role of MLGH in the SHN programme shall be to:

I. be instrumental in the provision of Water Supply and Sanitation (WSS) in all institutions of learning;
provide policy guidance on WSS and to coordinate WSS projects and programmes.

5.6 Other Stakeholders
Other stakeholders will contribute technical, financial, material, and other resources in the implementation of SHN. There shall be collaboration and partnerships in carrying out activities in their programmes as they relate to SHN.

5.7 Implementation of Policy
The provision of integrated health and nutrition interventions shall be implemented jointly with other ministries, organisations and agencies with MoE spearheading the programme.

The following are the strategies to be taken:

I. Capacity building at all levels;

II. Develop guidelines and implement SHN programme accordingly;

III. Mobilise resources and distribute to the implementers;

IV. Appoint Focal Persons in relevant ministries;

V. Monitor and evaluate activities;

VI. Establish committees at all levels;

VII. Develop a SHN strategic plan;

VIII. Review health and nutrition related activities and;

IX. Ensure that SHN issues are adequately incorporated in the curriculum.

X. Develop monitoring and evaluation instruments / tools.
CHAPTER 6

6.0 RESOURCE MOBILISATION, MONITORING AND EVALUATION

6.1 Resource Mobilisation

I. The Government shall create a budget line to finance the SHN Programme.

II. The Government shall ensure that line ministries commit resources towards the implementation of the SHN interventions.

III. The Government, organisations and other implementing agencies will mobilise resources for SHN activities.

IV. The Government shall train human resource for the implementation of SHN programme.

6.2 Monitoring and Evaluation

I. The Government shall ensure that monitoring and evaluation of SHN is integrated into education programmes.

II. Line ministries and other stakeholders shall jointly carry out monitoring and evaluation.

III. The capacity of all officers participating in monitoring and evaluation at all levels will be strengthened.

IV. Develop and integrate a comprehensive SHN information system with measurable indicators into existing Education Management Information Systems (EMIS).

V. The impact assessment of the SHN programme shall be carried out every three years.
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<th>Organization</th>
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