MOMENTUM COUNTRY AND GLOBAL LEADERSHIP

Strategic Planning Advisors for Education and School Health in Africa: Desk Review of School Health and Nutrition in Malawi

MOMENTUM Country and Global Leadership

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MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

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Cover photo: Teacher-led malaria diagnosis and treatment through "Learner Treatment Kits" approach in Malawi. Photo credit: Save the Children.

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Acronyms

ASRH	Adolescent Sexual and Reproductive Health
CFP	Country Focal Point
DHS	Demographic Health Survey
DNCCs	District Nutrition Coordinating Committee
DNHA	Department of Nutrition, HIV, and AIDS
DSHNHA	Department of School Health and Nutrition, HIV and AIDS
DODMA	Department of Disaster Management Affairs
EMIS	Education Management Information System
FP	Family Planning
FRESH	Focusing Resources on Effective School Health
HIV	Human Immunodeficiency Virus
HPS	Health Promoting Schools
IDP	Internally Displaced Person
M&E	Monitoring and Evaluation
MHH	Menstrual Health and Hygiene
MNCH	Maternal, Newborn, Child Health
MoEST	Ministry of Education, Science, and Technology
MoH	Ministry of Health
MOMENTUM	Moving Integrated, Quality Maternal, Newborn, Child Health and Family Planning and Reproductive Health Services to Scale
NEP	National Education Policy
PTA	Parent Teacher Association
RH	Reproductive Health
SHN	School Health and Nutrition
SMP	School Meals Program
SPAESHA	Strategic Planning Advisors for Education and School Health in Africa
SRH	Sexual Reproductive Health
STH	Soil-Transmitted Helminths
STI	Sexually Transmitted Infection
USAID	U.S. Agency for International Development
VDC	Village Development Committee
WASH	Water, Sanitation, and Hygiene
WFP	World Food Program

Executive Summary

Malawi faces several priority health issues for school-age children: lack of WASH in schools, malaria and other infectious diseases, malnutrition, teenage pregnancies or sexually transmitted infections (STIs) including HIV, disabilities including poor vision or hearing, and physical and psychosocial safety problems in and around schools. Several of these health issues are exacerbated by climate change-related disasters.

In Malawi, an integrated school health and nutrition (SHN) policy came into effect in 2017 and expired December 31, 2022. The Ministry of Education Science and Technology (MoEST) found the start-up of the MOMENTUM Country and Global Leadership (MOMENTUM) Strategic Planning Advisors for Education and School Health in Africa (SPAESHA) timely, because it will play a critical role in informing the review of the national policy and the development of a new policy for the next five years. The MoEST created a Department of School Health and Nutrition, and HIV and AIDS (DSHNHA) to implement the SHN policy. The department also has reporting lines under the Department of Nutrition HIV/AIDS (DNHA) in the Ministry of Health.

The MOMENTUM/SPAESHA activity identified some barriers to school health policy implementation in Malawi, through a policy audit desk review and some interviews with policymakers:

1. WASH in schools has not improved, and climate disasters have exacerbated poor sanitary infrastructure.
2. School health and nutrition services are not consistent nationwide, particularly regarding malaria control. The presidential taskforce for the COVID and cholera outbreak has not achieved nationwide coverage. Both malaria prevention and improved access to treatment could reduce school-age mortality and morbidity and improve learning outcomes.
3. School safety (both building infrastructure as well as psychosocial protection) standards are inconsistent.
4. There is a lack of monitoring of the SHN policy, particularly its impact on girls, orphans, and children with special needs.
5. Teenage pregnancies are very common, and the life skills curricula is debated.
6. The policy dissemination process had limited funding and no follow-up at the district, local, and school level. The strategic plan for the policy was never approved.
7. Budget allocations for the SHN policy implementation by the MoEST have been very low and unclear by other involved ministries.
8. Technical working groups at district level, called District Nutrition Coordinating Committees or DNCCs, implement some SHN activities, but health services in schools are not consistent nation-wide.
9. Local adaptations of the policy are needed, based on local epidemiological data of health issues of school-age children, particularly around infectious disease control.

MOMENTUM/SPAESHA will collect qualitative data on these gaps during the field assessment, which includes direct observation, focus group discussions, and key informant interviews. Based on this current report in combination with the field assessment, MOMENTUM/SPAESHA will make specific recommendations as to improve the quality of SHN in Malawi.

Introduction to Strategic Planning Advisors for Education and School Health in Africa

Moving Integrated, Quality Maternal, Newborn, Child Health and Family Planning and Reproductive Health (MNCH/FP/RH) Services to Scale (MOMENTUM) Country and Global Leadership (MOMENTUM) is a five-year global project funded by the U.S. Agency for International Development (USAID) to provide targeted MNCH/FP/RH technical and capacity development assistance to countries to facilitate countries' journeys to self-reliance. MOMENTUM also contributes to global technical leadership and learning, and USAID's policy dialogue for achievement of global MNCH/FP/RH goals through support to globally endorsed MNCH/FP/RH initiatives, strategies, frameworks, guidelines, and action plans. Through the Strategic Planning Advisors for Education and School Health in Africa (SPAESHA) activity, MOMENTUM works with ministries of education and health, as well as global, regional, and local school health partners to strengthen school health and nutrition (SHN) systems for the health and well-being of school-age children.

Schools provide an extensive platform to reach children with health services that contribute to learning and being healthy throughout their lives. Contextually appropriate school health interventions will improve children's health status, increase attention and concentration, and result in improved academic performance. Schools provide a cost-effective and efficient platform to reach children at scale and are essential for creating equitable and inclusive education pathways for girls and boys to learn and reach their full potential.

Unfortunately, the continued effects of endemic diseases like malaria, and outbreaks such as Ebola and COVID-19, and inadequate water, sanitation, and hygiene (WASH) in schools highlight the prolonged underinvestment in school health within education systems.[1] A recent global WHO-UNICEF Joint Monitoring Program survey found WASH coverage in sub-Saharan Africa to be generally low: 10 out of 19 countries surveyed had fewer than 50 percent schools with sanitation coverage and 47 percent of schools across 17 countries in the region had no water service.[2] Globally, at the start of the pandemic, in the 60 countries (40 of which were on the African continent) at highest risk of health and humanitarian crisis due to COVID-19, one in two schools lacked basic water and sanitation services and three in four lacked basic handwashing services.[3] Climate change further reinforces the need to act, as growing evidence suggests that some of the greatest health impacts due to climate change will be on the emergence, re-emergence, and spread of infectious diseases, which is already affecting the prevalence of mosquito-borne pathogens, particularly malaria and dengue.[5,6]

As school closures threaten to reverse historic education gains, the United Nations and multilateral agencies are renewing commitments to school health across varying sectors due to the essential role they play in children's health, nutrition, protection, and learning potential, disrupting intergenerational cycles of health and social inequalities. Renewed attention to health in schools offers an opportunity to leverage government commitments to school health and to strengthen the operationalization of school health policies. School health frameworks currently exist to inform policy and implementation but have been unevenly applied and monitored by ministries of education around the world and specifically in sub-Saharan Africa. Multi-sectoral collaboration and coordination between ministries of education and health will be critical to sustainable change. There has always been a need for comprehensive approaches to health policies and planning within the education sector; COVID-19 has only exacerbated the existing gaps and demonstrated the need to make the education system more resilient to future infectious disease epidemics.

While governments recognize the value of comprehensive, integrated SHN programming, the current challenge is how to make it more scalable and sustainable moving forward. The cross-sectoral nature of SHN lends itself to variations across countries regarding how it operates, where it resides within ministries, and the relevant ministries involved in policy and programming. Ministries of education, health, gender, water and environment, and social welfare often contribute their expertise and inputs into SHN via the health curricula, health services for school-age children, and the quality of the school environment. This can also

make the impact, scale, and reach of SHN initiatives less visible or difficult to measure.

Recognizing the global underinvestment and poorly targeted investment in school health, as well as its potential to foster health and education outcomes that better position children to survive, thrive, and countries to build stronger future economies,[7] USAID's Africa Bureau and JSI/Child Health Task Force jointly commissioned a 2021 report to identify pathways for advancing school health and nutrition programming in Africa. In this 2021 report, 10 African Missions were solicited to understand their contexts and optimal points of entry for optimizing existing resources. For many of the countries that were solicited, a number of strengths and opportunities were identified for better targeted investments alongside multi-sector school health coordination.[8] Kenya, Malawi, Senegal, and Uganda were identified as countries well-suited for this pilot.

Kenya, Malawi, Senegal, and Uganda were selected using the following criteria:

1. Existing national School Health Policies
2. Links to other USAID education or health initiatives (including linkages with the Child Health Task Force school health activities) taking place in that country that affect school-age children (basic education transitions, numeracy and literacy, neglected tropical disease (NTDs), school feeding, adolescent sexual reproductive health, under 5 nutrition and health, etc.).
3. MOMENTUM partner country offices' interest and capacity to engage and advocate, with strong government relationships.
4. Receptiveness of the Ministry of Education, Ministry of Health, and USAID Mission to the project.
5. Previous school health programming or similar work.

MOMENTUM/SPAESHA will identify the major barriers to school health policy implementation in Kenya, Malawi, Senegal, and Uganda, focusing on the different elements of the school health system, processes, and platforms to create a realistic and context specific policy strengthening plans.

Malawi was selected as an MOMENTUM/SPAESHA country due to its strategic location in Southern Africa and potential to provide context to the broader sub-region. The Government of Malawi is keen to identify high-impact interventions to support quality and equally accessible education. Additionally, inclusive education is a priority for the MoEST, as is evidenced by long-standing SHN interventions rooted in school meals, and recent innovations in school-based malaria treatment, as well as a center-based community feeding and nutrition program, all of which have demonstrated positive contributions to educational outcomes and gained government buy-in. A National Integrated School Health and Nutrition Policy was released in 2017 that guides the inclusion and realization of health and nutrition issues in education institutions from preschool to secondary school. It aligns with and amplifies the intent of the national policies for agriculture, nutrition, gender, early childhood development, water, and environmental health, and of the national education sector plan and Malawi Growth and Development Strategy. It also links with the Sustainable Development Goals that seek inclusive and equitable "quality education" for all, "zero hunger" for school children, and "good health and well-being for school-going children." It also further linked to the Constitution of the Republic of Malawi, National Education standards of 2015, Education Act of 2013, and the Education Sector Implementation Plan 2-13/2014-2017-2018.

This report builds on what we know about Malawi's school health and education context, takes a deeper dive into the policy history and the known and emerging health needs of school-age children, and will inform MOMENTUM/SPAESHA work plan activities to establish contextualized deliverables related to policy strengthening. This desk report is the first of several products, with the goal to contribute to the global and regional evidence on school health. This activity is important for Malawi because it will facilitate implementation of the National School Health and Nutrition policy and other related policies and provide direction for development of comprehensive SHN programs.

Methodology

This desk review report includes the result from two key activities: a SHN policy audit and a rapid literature review. The theoretical foundation of the desk review draws from three globally accepted frameworks used to design school health and nutrition policies and programs: FRESH[9] (Focusing Resources on Effective School Health), Systems Approach for Better Educational Results (SABER),[10] and, most recently, Health Promoting Schools (HPS)[11]. The primary framework reference for the desk review was the HPS standard on government policies and resources because it is a more recent framework that incorporates and maintains key aspects from the predecessor frameworks, FRESH and SABER. The aim of HPS is to ensure whole-of-government commitment to and investment in HPS are reflected in laws, regulations, policies, strategies, resource allocation, intersectoral collaboration, collaboration and engagement with school and local communities, with a sustainable system of monitoring and evaluation (M&E).

Thematic areas and pillars are referenced throughout each report and standards are set by each framework. Their prominence in each SHN policy, or related polices, will vary. For the purposes of this report, "thematic areas" refer to the health issues covered in the policy and may include: children with special needs; deworming; disaster risk reduction/emergences; education for sustainable development; general life skills/social and emotional learning; HIV and AIDS; hygiene, water, and sanitation; malaria; school feeding; nutrition; oral health, immunization/vaccines in school; vision and hearing; physical activity; prevention and response to unintentional injury; sexual and reproductive health; substance abuse; and violence in the school setting. New challenges or re-emerging challenges include COVID-19, climate change-related increase of natural disasters (such as tropical storms and consequent flooding) and, derived from those, cholera epidemics.

Combined with the health thematic areas, four core pillars, or components, form the basis of an effective school program:

1. Health-related school policies and links with parents and the school community.
2. Safe, supportive school environments, including access to safe water, adequate sanitation, and a healthy social and psychosocial environment.
3. School-based health and nutrition services, including deworming, micronutrient supplementation, school feeding, dengue prevention, and psychosocial counseling.
4. Skills-based health education, including curriculum development, life skills training, and learning materials.

Policy Audit

The first level of policy assessment utilized an online questionnaire structured by each HPS global standard. Country Focal Points (CFPs) read all related policy documents and operational guidelines to assess the extent to which each country's policies and practices met each standard. In cases where policies, strategies, and guidelines were unclear or unavailable, CFPs met with government partners to understand policy documents and directives (Table 1). This report uses both government documents and conversations as sources for understanding the school health and nutrition policy environment.

In Malawi, all available policy documents across nine sectors were reviewed. The CFP conducted eight informational interviews(see Table 1 below).

TABLE 1: INFORMATIONAL INTERVIEWS CONDUCTED FOR SPAESHA MALAWI DESK REVIEW AND POLICY AUDIT

No.	Name	Ministry Division	Main Responsibility
1	**Mrs. Maureen Maguza-Tembo, Deputy Director for SHN**	Department of School Health and Nutrition HIV/AIDS, MOEST	Responsible for the implementation of the SHN policy
2	**Mr. Edwin Kanyoma, Deputy Director for Education Planning**	MOEST	Responsible for all issues to do with education planning
3	**Mr. Albert Saka, Chief for School Health, Nutrition, HIV & AIDS**	MOEST	Strategic role in the implementation of SHN interventions
4	**Mr. Hans Katengeza, National Program Officer for Adolescents and Youth SRHR Program**	Ministry of Health	Responsible for adolescents and youth sexual reproductive, health and rights programming
5	**Late Mr. Lazarus Juziwelo, Program Manager for Schistosomiasis & Soil Transmitted Helminths (STH) Control Program**	Ministry of Health	Responsible for all control programs for schistosomiasis and soil-transmitted helminths
6	**Mrs. Mercy Zimpita, Deputy Director for Nutrition, Department of Nutrition HIV & AIDS**	Ministry of Agriculture	Responsible for nutrition programming under the Ministry of Agriculture
7	**Mrs. Grace Chinamale, Chief Nutrition, HIV / AIDS Officer**	DNHA, Ministry of Health	Strategic role in the implementation of SHN interventions
8	**Mr. Alick Kafunda, Technical Advisor (Policy and Monitoring, Evaluation, Research & Learning)**	MOEST	Responsible for policy monitoring, evaluation, research, and learning

Rapid Literature Review

To complement the policy audit, CFPs of each country conducted a rapid literature search to understand the health status of school-age children, and potential emerging issues that many not have been documented or present at the initial development of school health policies and strategies. First, CFPs received 48 global resources from their Technical Advisors. An additional 78 global resources were suggested by SHN experts on our Global Advisory Committee to provide the CFP with a good foundation of research, global initiatives, and policy reform. The Malawi CFP reviewed 48 Policy documents and research papers specific to Malawi. The search for policy documents was completed on government websites using key words provided by the Country Technical Advisors such as school health, malaria, and nutrition.

Some documents included policies under various ministries that support implementation of SHN interventions alongside the Ministry of Education. The policies that were sourced and used during the desk review were those policies that supported the development of the Integrated School Health and Nutrition Policy, including strategic plans, standards, education plans, and guidelines. Apart from the numerous policy documents, research papers were sourced from PubMed, PLos One, Google Scholar, BioMed Central, and government and ministry websites.

The policy audit and literature review provide a critical foundation for understanding historical decisions and designs of school health policies, as well as potential development and evolution. Findings from this report will inform a field assessment, which will in turn incorporate school observations and discussions with various stakeholders involved in the operationalization of school health or who benefit from SHN initiatives. The intention is to have a clear understanding of the theory and intentions of school health policies alongside their perceived application and implementation. Analysis of these activities will allow for informed and prioritized opportunities for school health policy strengthening. It will also provide concrete case studies to the global and regional SHN practitioner community and interested governments who wish to replicate or learn from this exercise.

Country Background and Context

The current government structure in Malawi has its headquarters in Lilongwe, where all government ministries operate. There are four administrative regions in the country but six education divisions (see Table 2).

TABLE 2: ADMINISTRATIVE REGIONS AND EDUCATION DIVISIONS

Administrative Region	Education Division
Central	Central West
	Central East
Southern	South West
	Shire Highlands
Northern	Northern
Eastern	South East

In the 28 Districts, District Councils or Assemblies are presided over by a District Commissioner, and there are directors for planning and development, finance, HIV/AIDS, youth, forestry, education, health, social welfare, and agriculture. Each district director relates to its respective national ministry. At the time of this review, Malawi runs 5,878 public primary schools.

Education and School Health Background

Malawi had its first formal Education Plan in 1973-1980, providing guidelines for education development on primary, secondary, and teacher education. The second Education Sector Development Plan (1985 to 1995) was affected by the introduction of Free Primary school (FP) policy in 1994, which also influenced the direction of the Policy Investment Framework in 2000 and the National Education Sector Plan 2008-2017. The first National Education Policy (NEP) was developed in 2013 and was reviewed in 2016.

NEP 2016 is intended to guide and provide a coordinated approach to the development of the education system for relevant knowledge, skills, competencies, and values that are necessary for the socioeconomic development of the nation.[12]

The National Education Policy has seven priority areas:

1. Quality, accessible, and equitable basic education;
2. Accessible and quality secondary education;
3. Quality teacher education (primary and secondary);
4. Quality and equitably accessed technical, entrepreneurial and vocational education and training;
5. Quality and equitably accessed higher education;
6. Quality and equitably accessed open and distance learning;
7. Enhanced science, technology and innovation in education.[13]

Specific statements related to school health are presented in four priority areas of NEP 2016: 1, 2, 3 and 5.

Under Priority 1 "Quality, accessible and equitable basic education," there is a mention of a "sustainable and effective school health and nutrition program including HIV/AIDS."

Under Priority 2 "Accessible and quality secondary education,"

Under Priority 3 "Quality teacher education (primary and secondary),"

Under Priority 5 "Quality and equitably accessed higher education," there is a mention of "a comprehensive response to HIV and AIDS is coordinated and sustained."

Sixteen percent of children of primary school age are out of school in Malawi, while at secondary level, the proportion is one third (34 percent). At all levels, the rates of children out-of-school are much higher for the poorest children than the average across Malawi. Only 3 percent of children belonging to the richest quintile of school at primary level are out of school, compared to 10 percent of the poorest children at the same level.[14]

Educational attainment was measured by the 2015/2016 Malawi Demographic Health Survey (DHS).[15] Overall, 86 percent of females and 92 percent of males aged 6 and over have ever attended school. Only 5 percent of females and 9 percent of males have completed secondary school or gone beyond secondary school. Fourteen percent of females and 8 percent of males have never attended school. Median educational attainment is slightly higher for males (3.9 years) than for females (3.1 years). Ninety-four percent of girls aged 6-13 attend primary school compared to 93 percent of boys. The net attendance ratio drops in secondary school: only 18 percent of girls and 17 percent of boys aged 14-17 attend secondary school.

The most vulnerable children in Malawi include orphans and children living with a disability. According to the DHS almost half (48 percent) of the population of Malawi is under age 15. Among children under age 18, 12 percent are orphans (one or both parents are dead) and one in five is not living with either biological parent. Caretakers of 28.7 percent of children aged 2-9 reported at least one functioning problem or disability: cognitive, speech, or motor development delays, hearing difficulty, vision problems, and/or seizures being most often mentioned.

Priority Health Issues for School-Age Children

Malawi faces several challenges affecting the health of school-age children. According to the Institute for Health Metrics and Evaluation, in 2019, the top five health issues most affecting Malawian girls and boys 5-14 years old, measured in disability-adjusted life years and in order of severity, included HIV/AIDs and STIs, nutritional deficiencies, neglected tropical diseases & malaria, enteric and respiratory infections, and tuberculosis.[16]

HIV/AIDS and Reproductive Health

In 2016, Malawi's adolescent birth rate was 141 births per 1,000 adolescents ages 15-19. This was well above the global adolescent birth rate of 44 and the sub-Saharan African rate of 102.[17] While HIV/AIDS prevalence has decreased (from 11.8 percent in 2004 to 9 percent in 2011), the state of sexual and reproductive health leaves much to be desired. Pregnancy accounts for a large proportion of the dropouts in higher primary school classes. Almost half of girls in Malawi are married or in union before the age of 18.[18] Furthermore, 65 percent of girls and 35 percent of boys report experiencing some form of abuse and violence during their lifetime. In part due to the impact of HIV/AIDS in the country, 28.3 percent of children in Malawi are either orphaned or growing up without parental care. Most of these households are vulnerable to food insecurity.[19] According to the 2016 DHS, the median age at first sexual intercourse is 16.8 years for women aged 25-49. Nineteen percent of women aged 25-49 have first had sex before age 15, and 64 percent before age 18. By age 20, 85 percent of women have had sexual intercourse. Twenty-nine percent of women aged 15-19 have begun childbearing; 22 percent have had a live birth and 7 percent are pregnant with their first child. Teenage childbearing generally declined between 1992 (35 percent) and 2010 (26 percent) before increasing slightly in 2015-16 (29 percent). It is estimated that adolescent births make up 25 percent of all births in the country,[20] and that both adolescent pregnancy rates and child marriage increased during COVID-19 shutdowns.[21]

A study from two southern districts — Mangochi and Zomba[22] — revealed that despite introduction of compulsory Life Skills education in primary schools, teenage pregnancies and child marriages continue to rise. The study explored the barriers faced by teachers in delivering sexual and reproductive health education in 10 primary schools. It revealed that, "there is over-emphasis on abstinence, an unconducive learning environment, existence of sexual practices linked to coming of age rites, peer pressure, lack of sexual and reproductive reinforcement by parents, and inadequate training for teachers."

Malawi has a youth-friendly health strategy and offers youth friendly health services in most health centers and hospitals. The Ministry of Health trains youth-friendly health services providers. The focus is to deliberately target youth with comprehensive adolescent sexual and reproductive health ASRH services to increase access and uptake of ASRH among youth.

A situation analysis conducted by UNESCO[23] through formative research on comprehensive sexuality education for out-of-school young people living with disabilities and young people living with HIV, revealed that "YPLD and YPLHIV are marginalized groups and that they face stigma and discrimination, are more vulnerable to abuse warranting comprehensive sexuality education CSE that addresses their needs. The study revealed that they are often left out of sexuality education such as school-based programs due to early dropouts and out of school programs." The study further revealed that in cases where they are able to access sexuality education, there is not much evidence that such sexuality education is designed to address their needs.

Menstrual Health and Hygiene

A study conducted to assess acceptability of menstrual products interventions among women and girls in Malawi revealed that most women and girls prefer re-usable menstrual pads. The study further revealed that service providers bemoaned the poor coordination and lack of national standards to regulate the quality of menstrual products that are distributed at national level. The study advocated that there is need to deliberately include males and health workers to enhance sustainability of programs.[24]

In a study conducted by the Red Cross/Water Aid[25] in 2011 in seven primary schools in Lilongwe, three themes that emerged and kept recurring. The study observed that sanitation facilities and infrastructure were inadequate in every school they visited. Six out of the seven schools failed to meet the WHO suggested toilet/student ratio of 1:30. The study also revealed that cultural beliefs affect menstrual health and hygiene (MHH) because parents do not talk to their children about menstruation. Menstruation is seen as a strictly secret issue and girls are just told to stop playing, talking or chatting with boys. The study also revealed that there is ignorance about menstrual issues not only among schoolgirls but among communities as a whole.

Hunger and Nutrition

According to the Malawi Global School-Based Health Survey conducted in 2009,[26] the overall self-reported prevalence of hunger within the last 30 days was 12.5 percent: considerably higher (18.9 percent) in rural than in urban areas (8.3 percent), and slightly higher for female (12.5 percent) than for male (11.9 percent) children.

Short-term hunger contributes to several educational challenges in primary schools, as many children do not have a meal before heading to school, or parents keep them home on days when they cannot provide them breakfast before school. A lack of energy, combined with walking long distances to access school, means that children often arrive with low energy and cannot concentrate in class.

Poor nutrition in adolescents (10-19 years) remains a public health challenge. Approximately 35 percent of adolescent girls 15-19 years are anemic while 31 percent are underweight.[27] School-age children and younger adolescents (6-14 years) also face nutritional challenges with anemia affecting 22 percent, zinc deficiency affecting 60 percent of this age group. In the 2016 DHS, 89.7 percent of households were using iodized salt, which leaves 10.3 percent of school-age children at risk for iodine deficiency.

Infectious Diseases

Malaria

Malaria in Malawi remains one of the leading causes of morbidity and mortality, with an estimated 2.1 million cases per year in the 5–14-year age group and is the third highest cause of death in the same age group.[28] Studies estimate an average of 60-74 percent of school-age children are living with *Plasmodium falciparum*,[29] the type of malaria that is most likely to result in severe infections.[30] A study in three districts in Southern Malawi revealed that school-age children are a significant reservoir of *Plasmodium falciparum* and yet are least likely to receive malaria treatments or to sleep under bed nets.[31]

Another study from 50 schools in Zomba District in Southern Malawi revealed that 60 percent of the children in these schools were infected with *Plasmodium falciparum*, 32.4 percent were anemic, and only 32.4 percent reported sleeping under a mosquito net the previous night. The high burden of malaria highlights the need to tackle malaria among school children.[32] There is a high risk of *Plasmodium* infection and a high prevalence of asymptomatic infection among primary school children. In this population, malaria infection can lead to morbidity, reduced school attendance, and delayed cognitive development. According to the 2017

MIS, prevalence of malaria in urban areas and rural areas is 4 percent and 30 percent, respectively.[33]

Malawi's progress in malaria control has reversed, with a 37 percent increase in incidence, from 5.2 million cases in 2019 to 7.2 million in 2020.[34] Potential factors include widespread insecticide resistance of Anopheles vector mosquitoes,[35,36] and limited adoption of effective interventions by key population groups, such as school-age children. Poor health system factors include long waiting queues at health facilities, frequent stock outs of medical supplies, and long distances to health facilities. In addition, there is inadequate access to effective malaria control interventions by population groups that perpetuate transmission. Most school-age children and their parents fear malaria tests due to cultural barriers and beliefs associated with witchcraft.[37] COVID-19 also contributed to lack of treatment for malaria and testing for fear of being tested for COVID and HIV/AIDS, which are deadly diseases.[38] Interventions that support school-age children from accessing malaria prevention messages and treatment are required in Malawi to reduce cases of malaria. Similarly, school-age children need access to prompt diagnosis with malaria rapid diagnostic tests, and prompt treatment[39] to improve the effective control of malaria in Malawian communities.

Schistosomiasis

Schistosomiasis (both subspecies, mansoni and haematobium) is endemic in Malawi, and the disease is widely distributed in all regions, causing considerable morbidity. In 2009, a study revealed that Schistosomiasis is a public health problem in Malawi. Out of 1,139 school children that were enrolled in the study who submitted urine, the eggs of Schistosoma haematobium were detected in 10.4 percent. The child's knowledge of an existing open water source in the area, history of child's urinary schistosomiasis in the past month, distance of less than 1 km from school to the nearest open water source, and age 8-10 years compared to those 14 years or older were all associated with infection. In this population, children who attend schools close to open water sources were at an increased risk of infection.[40] A later study conducted on the southwestern shores of Lake Malawi revealed that Schistosoma haematobium was prevalent among 23.7 percent of school children living in that area, with re-infection rates of about 30-40 percent.[41]

Tuberculosis

As a low-income country, Malawi has several risk factors for high incidence of tuberculosis, such as undernutrition, high HIV/AIDS prevalence, and slums or overcrowded housing in urban areas. In 2021, Malawi reported 132 cases per 100,000 people of all ages.[42] According to WHO,[43] there are 2,000 school-age children with TB estimated in the country, but only 42 percent of males and 37 percent of females have been diagnosed, notified, and started treatment. Suspicion of TB in a school-age child often relies on the schoolteacher, who may be more easily made aware of typical danger signs.

Impacts of Disasters, Climate Change and COVID-19 on Child Health and the Education Sector

When the SHN policy was developed in 2017, COVID-19 was not yet an issue and cholera was not affecting the country, hence, they were not included. These will be included as emerging issues during the upcoming policy review.

In Malawi, epidemics and climate change have had a significant impact on the education sector. Disasters result in destruction of schools and infrastructure, student and teacher illness, and school closures. A large proportion of the population live on subsistence farming, rely on rain-fed agriculture, have limited crop diversity, and lack of disaster risk management infrastructure and systems. During food and nutrition emergencies caused by such disasters, the risk of illnesses and poor health among learners increases significantly, leading to absenteeism and, potentially, dropout. Furthermore, those driven from their homes by floods often seek shelter in schools; this disrupts learning and leads to dangerous sanitary conditions.[44] One interviewee stressed that during such times, children are likely to be abused, they are vulnerable, lack basic needs, require nutritious meals, and are susceptible to infectious diseases including malaria, diarrhea, and water-borne diseases like cholera. In addition, some children have lost their relatives, parents, and their homes.

Recent Cyclones

Malawi has experienced one or two tropical cyclones every year since 2019, all of them affecting the Southern Region.[45] The worst was Cyclone Freddy on March 11, 2023. Crops, houses and schools were all damaged. People lost their livelihood. According to OCHA Flash Update No. 9 on Malawi: Tropical Cyclone Freddy, 653,771 internally displaced people were residing in 577 camps. As of March 25, 2023, 511 deaths were reported, at least 1,724 were injured, and 533 people are still missing according to Department of Disaster Management Affairs (DODMA). The cyclone damaged or destroyed 547 schools—484 primary schools and 63 secondary schools—affecting at least 273,388 learners and 586 teachers. Of the schools still standing, 726 classrooms are currently providing shelter for cyclone survivors. Four hundred twenty-six temporary schools are currently functioning in camps.[46] The cyclone also affected people's livelihoods, with more than 285,500 livestock affected and at least 204,833 hectares of crops submerged or washed away. As of March 21, 2023, DODMA reported that at least 139,929 learners (74,117 girls and 65,812 boys) from 484 schools were affected. Out of these, 23,066 were learners with special needs. As of March 22, 2023, 22 learners (18 boys and 4 girls) and one male and one female teacher were reported dead. There were 238 schools with Internally Displaced Persons (IDPs) occupying 762 classrooms. Education was interrupted in all the 15 affected districts. All these schools are now in operation despite most of the infrastructure, including sanitary facilities, being damaged.[47,48]

When the cyclone hit, the Ministry of Education suspended learning in all schools in the Southern Region for about one month due to unsafe conditions and the use of schools that withstood the cyclone as temporary shelters. This was also to ensure there was adequate time for cleaning classrooms for safe return to schools by all children.

Meanwhile, children who are out-of-school in Malawi miss out on all the school health and nutrition interventions that are targeted only to children in school. In addition to this, children who were affected by Cyclone Freddy and Tropical Storm Ana in January 2022 were at a disadvantage compared to other children who were not affected by the cyclones.

Malawi failed to achieve equity for these children because even as the children were in camps, with learning suspended, the Malawi National Examinations Board did not change their National Examinations Calendar. Children who missed classes for some time took the Junior Certificate of Education Examinations and Malawi School Leaving Certificate of Education Examinations together with other children who were not affected by the cyclones. The examination results showed that the districts that did not perform well were those that were affected by the cyclones. Provision of school health and nutrition interventions for these children was also disrupted.

Climate Change

In 2023, Save the Children conducted a feasibility study to understand how climate change was affecting the health and well-being for rural communities in six districts: Balaka, Ntcheu, Machinga, Mangochi, Phalombe and Zomba. Findings revealed implications for health, education, and livelihoods. First, extreme heat and heat waves were not only resulting in heat stroke and exhaustion but were exacerbating other health problems. Diarrheal diseases, cholera, scabies, and malnutrition were prevalent in communities in Balaka District because of extreme temperature changes, unlike the other districts that had not been experiencing these changes. Similarly, when floods hit in all the six districts, crops and livestock were washed away, resulting in household food insecurity and further contributing to malnutrition. Children in these districts failed to attend school, and teachers who lived far away could not get to schools because the roads or bridges were washed away. Episodes of extreme heat were suspected to contribute to school absenteeism, mostly because many children learn outdoors and are exposed to extreme weather conditions. The study also revealed an increase in pregnancies and STIs in camps where populations were displaced after the climate shocks.[49]

COVID-19

The COVID-19 pandemic has hit Malawi in four waves: a small one in July 2020, and three consecutive stronger waves in February, July, and December 2021. Overall, 88,986 cases and 2,686 deaths have been reported.[50] The country is in recovery from the disruption caused by the COVID-19 pandemic. Malawi is planning to vaccinate 70 percent of the population, and schools have been considered a platform for outreach and service provision. The Ministry of Health instituted a presidential taskforce on Coronavirus, responsible for making strategic decisions in response to the pandemic. Through the health cluster that usually meets every fortnight, the country updated stakeholders about the status of pandemic in the country as well as the response and funding gaps. The Ministry of Education was also very vigilant, taking the first step of closure of schools when the spread of the virus worsened to protect learners, teachers, and community at large. The MoEST put in place distance learning programs through radio for learners to follow lessons in their homes.

While all the other preventive measures were done through the Ministry of Health and development partners, the Ministry of Education also developed Guidelines for the Re-Opening of Primary and Secondary Schools, Teacher Training Colleges During COVID-19 Pandemic. The guidelines provide key measures and actions to prevent COVID-19 and ensure quality of learning and also contain actions on ongoing disease prevention through school health and nutrition as well as the preconditions for opening schools stipulating public health guiding principles and education guiding principles. This includes key measures and actions to prevent COVID-19 and ensure quality learning upon the opening of schools, encompassing preparing for the reopening of schools and ongoing disease prevention through school health and nutrition, and ensuring quality learning, additional requirements, and financing. Additionally, there was an overview of roles and responsibilities of stakeholders and M&E focusing on school-level M&E (school self-assessment) and District-level assessment and evaluation.[51]

Schools are still enforcing COVID-19 preventive measures including regular handwashing with soap. In addition, when the Ministry of Health (MOH) introduced the Pfizer vaccine for adolescents, the MoEST worked with the MOH to mobilize learners' to access the vaccine. The MoEST also worked with communities to ensure teachers and all education stakeholders and community members were vaccinated, while also implementing preventive measures. Communities were trained on the production of reusable face masks, and the government also introduced shift learning to ensure large numbers of children were not crowded into classrooms.

The country also introduced a socio-economic recovery plan that includes schools offering remedial classes and adjustments to the school calendar to maximize school days and advance learning. The government recruited additional teachers and is in the final stages of establishing Education Radio stations, and eventually Education Television channels to advance learning and in cases of future outbreaks.[52]

During the COVID-19 pandemic, the Ministry of Education leveraged District Education Clusters to respond to the pandemic, however the quality of the response and details regarding the interventions conducted are unknown.

Cholera

WHO states that climate change drove an "unprecedented" number of larger and more deadly cholera outbreaks around the world in 2022, underpinning an important acknowledgment of the link between climate change and increased infectious disease.[53] A cholera outbreak started in Malawi in March 2022, following an abnormal and intense rainy period, and has persisted up to the publishing of this report. As of July 24, 2023, the disease has spread to all 29 districts of Malawi, with 58,944 cases and 1,766 deaths. More than 14,000 children have contracted cholera, and at least 219 have died.[54]

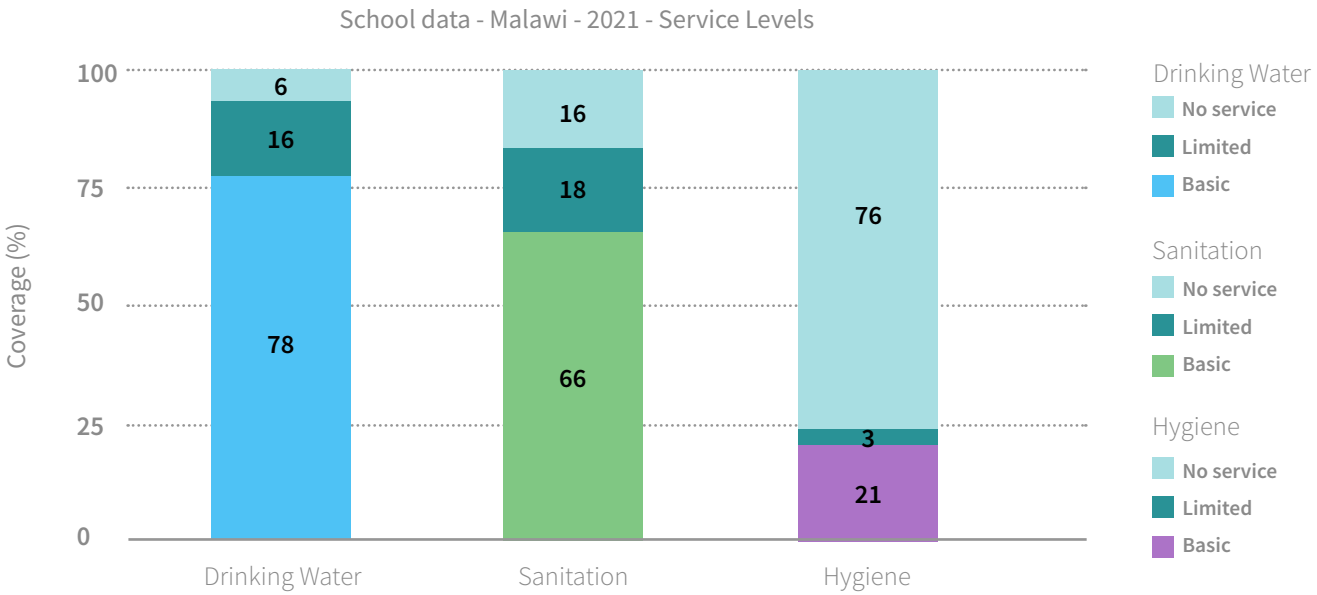
When the cholera outbreak was declared, and when cases surged to their worst in the two largest cities of Lilongwe and Blantyre, the Presidential Taskforce on Coronavirus and Cholera Outbreak directed that all schools close for two weeks and that a determination would be made after two weeks to re-open the schools. Meanwhile the Ministry reverted to distance learning where lessons were offered through radio. At the same time, the Ministry of Education developed Cholera Prevention Standard Operating Procedures for schools and education institutions. These included information on what cholera is, its symptoms and transmission, and food safety and hygiene practices.[55]

School WASH

School WASH is considered a key element for the continued well-being and safety of learners. The SHN Policy explicitly states that "WASH facilities and services are provided in schools to promote positive health outcomes." Unfortunately, WASH in schools continues to be a challenge and is not fully implemented at the school level. Many schools do not have complete WASH facilities with safe water, handwashing facilities, and sanitation facilities that meet the needs of the school population (i.e., sex segregated and proper learner to toilet ratios).

Only about 45 percent of primary schools have protected water sources (boreholes or piped water) and 40 percent have permanent latrines. On average, one latrine is shared by 140 learners. WASH data from Education Management Information System (EMIS) in 2021 shows that the lowest service coverage is for basic handwashing facilities. In addition, school curricula have inadequate content on sanitation and hygiene promotion. The combination of these issues is a major contributor to the poor health status of school-age children.

FIGURE 1. WASH SERVICE LEVELS IN MALAWI SCHOOLS, 2021[56]



Informational interviews revealed concern that girls cannot easily manage their menstrual periods to prevent stains or leaks, as there are few if any changing rooms, sanitary napkins, or adequate WASH facilities. In some schools there are limited toilets and in others, girls and boys may share latrines. While there are some local organizations that support girls to make homemade sanitary napkins, when there are no toilets, napkins do not suffice. According to one informational interview, girls who are in primary schools with boys may feel extra shame if they have leaks and may prefer to miss school for several days. This was considered a huge issue, but there are no specific plans for how to deal with it. Girls are still learning to take care of themselves, and schools do not support them to wash themselves or practice proper hygiene.

A feasibility study for climate resilient health and well-being closely examined school WASH facilities in six districts and found that they are inadequate. What was available was in poor condition, forcing children to use the nearest bushes or walls of the toilets. The study indicated that food is sometimes sold nearby, making it susceptible to contamination and increasing the risk of cholera outbreak. The shortage of toilets affects teachers as well, who have to use student facilities.[57]

District Education Management in Balaka District revealed that all schools there have separate girls' and boys' toilets, however, the toilet to student ratio is high. During the rainy season, some of the pit latrines collapse, forcing smaller children use nearby bushes as toilets, and older girls' attendance declines as sanitary facilities are not suitable for changing menstrual pads.[58] The district was allocated COVID-19 response funds to construct boreholes in 17 schools but the project was not successful in seven schools as they could not find ground water.

Diarrheal diseases are still leading killers in children under five (Integrated SHN Policy 2017:1). Handwashing with soap can help reduce the transmission of a range of infectious diseases such as acute respiratory infections, cholera, Ebola and COVID-19. Nonetheless, some schools still do not have any sanitation and less than 5 percent of schools provide handwashing facilities with soap. Access to water is quite encouraging at 81 percent, but children from 19 percent of schools drink from unprotected water sources.[59] According to the 2020 Education Management Information System, 578 primary schools and 35 secondary schools in Malawi do not have potable water. As many as 4,378 primary schools and 587 secondary schools do not have supplies such as soap. This situation affects more than 3.6 million children in the country.[60]

Malawi still has a high prevalence of soil-transmitted helminths (in some areas, up to 20 percent of children are affected), as well as lymphatic filariasis.[61]

Evidence from two case studies that were conducted in Uganda and Malawi on policy and provision of school WASH services for children with disabilities revealed that there is a robust policy environment in these countries, however provision of services and facilities are low and focus primarily on sanitation.[62]

Investing in sustainable and resilient WASH services for schools in Malawi requires joint and coordinated commitment from all stakeholders including Malawi government, development partners, community leaders, parents, schools, NGOs and donors.

School Meals

Malawi's SHN policy has its roots in the first School Meals Program in Dedza, implemented by World Food Programme (WFP) in 1999, as an emergency response. The Dedza district was heavily affected by hunger and drought, and there were higher school dropout rates and lower classroom attendance than other districts in the country. WFP started a school meals program that provided learners porridge before starting classes, which demonstrated that a hot meal was a strong incentive for learners and families, increasing school enrolment and regular attendance, as well as reducing school dropout.[63] These results made clear to the MoEST that there was direct relationship between education and nutrition, because where learners were fed, they were attentive and school enrollment increased. In 2007, the Cabinet Directive for a Universal School Meals Program mandated all primary schools to have a school meals program. Unfortunately, due to financial constraints, the program still only reaches roughly one third of the 6,000 schools.

Through UNICEF's weekly supplementation with iron and folic acid (IFA) in 1,788 schools, 70 percent of 10-14 year old girls and 36 percent of 15-19 year old girls were reached with weekly supplements.[64] Through the Nutritional sensitive Agriculture Program,[65] there were steady improvements in adolescent girls meeting dietary diversification standards.

Since the Cabinet declaration on the Universal School Meals Programme (SMP), Malawi has continued expanding the school health and nutrition initiatives. Starting from the original centralized model, Malawi has progressed to three different models (see Table 3). The large international development partners that support the SHN interventions in Malawi include Mary Meals, Nascent Solutions, Save the Children, WFP, and Welt Hunger Hilfer. Currently the SHN program implements a number of interventions in addition to school meals, including de-worming, vaccinations, nutrition supplementation, malaria screening, menstrual health and hygiene, WASH, first aid, preventive treatment, health screening, mental health and psychosocial support, nutrition, and violence prevention.

TABLE 3: OVERVIEW OF FOUR MALAWI SCHOOL MEAL INTERVENTION MODELS AND THEIR REACH

Model	Components	Implementing Partner	No. of Schools Reached
Centralized	• Likuni Phala locally purchased (corn soybean blend) and stored centrally. • Distribute to schools for consumption or from the "warehouse" to "schools" • School volunteers or paid cooks prepare meals in school	Mary's Meals	948
Home Grown (community production)	• Communities provide land and labor, and schools provide inputs (fertilizers and seeds) and storage space • School volunteers or paid cooks prepare meals	Government of Malawi/MoEST	801
Home Grown (school grants)	• Provider (WFP) provides funds through council to school account, similar to school improvement grants • Schools contract local farmer organizations to supply food commodities and pay by cheque • School volunteers or paid cooks prepare meals	World Food Programme	170
School Canteen	• Service provider outsourced to independently prepare meals and sell to learners or schools	Used only in tertiary institutions	

As at the time of this desk review, the SMP reaches 35.8 percent of schools and coordinates with several other ministries. School meals are included in the Malawi National Social Support Program under Pillar 1 (Consumption), which connects with the Ministry of Agriculture through school gardens, tree planting, and farmer cooperative development. In 2017, MoEST put in place a Multisectoral Nutrition Policy and Integrated School Health & Nutrition Strategy that provides a framework and operational plan for scaling up school nutrition (meals) to all schools in Malawi (SHN Department Presentation Slides 3-7). The number of schools reached by SMP has dropped over the years, with GIZ pulling their support. Mary's Meals, who provide school feeding programs, have been reducing the number of schools they support due to rising costs in running the school feeding programs. DoDMA also supports DSHNHA in implementation of school meals programs with centralized procurement of produce that is then distributed to participating schools. Support is also through schools growing food crops or being provided with funds to source produce locally in coordination with MoEST. This increases the number of schools participating in the school meals program and also brings together several ministries, including the Ministries of Agriculture, Education, and Gender, among others.

Health Services in Schools

The MoH coordinates health service provision such as deworming, WASH, Human Papilloma Virus vaccination and schistosomiasis control interventions including health awareness and education, mass drug administration of Praziquantel to school-aged children in affected areas, and chemotherapy to symptomatic people at health facilities.

Mangochi District has an active SHN program through the MoEST and MoH in partnership with various stakeholders. This program provides annual deworming and schistosomiasis preventive chemotherapy. There are also local charity and community-based organizations along the Lake that provide Praziquantel regularly to communities.

The MoH/National Malaria program's prevention and treatment interventions include distribution of treated mosquito nets, residual indoor spraying and larvicidal fumigation of stagnant water to reduce the incidence of malaria from 386 per 1000 population in 2015 to 193 per 1000 by 2022; and to reduce malaria deaths from 23 per 100,000 population in 2015 to 12 per 100,000 by 2022 (as of 2022, incidence was 219 per 1,000). Malaria and its causes are taught in school, however children are not adequately supported at home to put knowledge into practice.

Teacher-led malaria diagnosis and treatment through a Save the Children initiative called "Learner Treatment Kits" trained primary school teachers to make proper diagnosis and provide basic treatment before referring complicated cases for further medical care. This program started in 2008 and has been rigorously studied.[66,67] Malawi introduced malaria case management in schools in Zomba and Machinga. Currently Save the Children has secured another funding source and has scaled up the intervention from 78 to 108 primary schools for more than 300,000 learners. The MoH provides all the medical supplies including malaria rapid diagnostic tests, thermometers, Artemether/Lumefantrine (first line malaria drug in Malawi), iodine, methylated alcohol, Paracetamol, and latex gloves. Save the Children provides technical expertise around capacity strengthening for teachers to be able to conduct malaria tests, and provide correct dosages and referral where necessary. The program is currently administered by Save the Children in collaboration with the MoH, which has obtained funding from the Global Fund for 2024 to expand implementation.

The Malawi School Health and Nutrition Policy

International Commitments to School Health

Malawi's SHN Policy[68] closely aligns with Sustainable Development Goals 2 (hunger and nutrition), 3 (health and well-being), 4 (education), 5 (gender equality), and 6 (water and sanitation). It clearly recognizes school health as a means of achieving the National Education Policy priorities, stating:

> ***"Underlying reasons for dropout, repetition, and poor performance include: poor learning environments (including inadequate sanitary arrangements for girls); malnutrition and frequent sickness; household food insecurity; domestic demands on learners' labor, in particular for girls and orphan heads of households; early pregnancies and marriages. It is the government's mission to help young people – and in particular girls – to make greater academic progress, and achieve better health and nutrition, with related life skills and habits. This would have a direct positive impact on the health and nutritional status of the community in general and on children in the future. It is thus a crucial element in breaking the cycle of hunger and malnutrition. Retaining children, especially girls, in school for a longer time would achieve higher levels of education, and it would also contribute to reducing the fertility rate, helping to slow down population growth."***

With COVID-19 exposing the fault-lines of education systems globally, at the September 2022 UN Transforming Education Summit, more than 130 countries committed to rebooting their education systems and accelerating action to end the learning crisis.[69] The summit acknowledged the role of education in achieving all the Sustainable Development Goals and emphasized the need for innovations in education to prepare the learners of today for a rapidly changing world. Each country made commitments that aligned with their contextual needs and priorities.

Malawi made several commitments to transforming education, as illustrated below.

> **Track One >> define and equip all existing and new education institutions with an integrated minimum priority package comprising school health, nutrition, WASH, inclusive education, mental health, and online safety[70]**
>
> All key policy interventions are covered in the commitments. Nutrition is linked to Priority 1 of the policy; school health and WASH are linked to Priority 2 of the Policy.
>
> Track One of the commitments of the Transforming Education Summit includes strengthening child protection, ending gender-based violence, and operationalizing school governance bodies. Child protection and gender-based violence is linked to Priority 3 of the Integrated School Health and Nutrition Policy. Operationalizing school governance bodies is linked to Priority 4, which focuses on institutional set-up (coordination, integration, and linkages).

> **Track Five >> allocate at least 15-20 percent of national expenditure, and at least 4-6 percent of the GDP for domestic financing of education**
>
> The country also committed to enact and enforce legislation to end corruption and free resources to augment education financing.[71] The minimum priority integrated package fits very well with what is stipulated in the five priority areas of the Integrated School Health and Nutrition Policy. This commitment is important as may translate to increased funding for SHN.

However, budgets are under more strain than ever, and contributions from bilateral and other donors are often dropping due to competing priorities. This exacerbates inequalities between and within countries and stifles progress to achieve the Sustainable Development Goals.[72,73] According to a February 2021 briefing by Development Initiatives (2021), bilateral donors have decreased aid commitments by 36 percent between 2019 and 2020 (over the same January to November period). Of the 13 bilateral donors considered in this analysis (covering 97 percent of 2020 bilateral commitments by value), seven have seen total ODA commitments fall, with four seeing drops of 40 percent or more.[74] The global trend for funding, plus increasing populations, means that there is less money available, even as MoEST plans get more ambitious.

Education Policies Related to School Health and Nutrition

The Malawi National Education Standards outlines all standards that the MoEST will use to ensure that children in schools remain healthy, thrive, have access to good nutrition, learn in safe environments, and perform to their best potential under well qualified teachers in good classrooms with all the necessary amenities available to support them in their education. This is reflected in the broader National Education Policy, as SHN is recognized as a core element of quality education provision, requiring "a sustainable and effective school health and nutrition program including HIV/AIDS education services."

Malawi's first formal Education Plan, in 1973-1980, provided guidelines for education development on primary and secondary levels and teacher education. A National Education Policy was developed in 2013 with seven priority areas, and school health is mentioned in three of these priority areas.

The national Education Sector Implementation Plan describes how the MoEST will support SHN programming at different levels including at primary school, teacher education, and in the curriculum. The Multi Sector Nutrition Education Communication strategy stipulates how nutrition issues will be communicated at different levels including primary schools, and the National Social Support Policy clearly stipulates the type of school nutrition programs that will accompany the communication strategy, including school meals and cash transfers, while working with the MoEST. The National Gender Policy outlines how child protection, psychosocial support, gender-based violence and mental health issues will be tackled at different levels including in schools, communities, homes, health facilities, etc. The National Strategic Plan for HIV and AIDS committed to strengthen multi-sectoral coordination in the implementation of adolescent girls and young women interventions in alignment with their strategy. It also specifies increasing access and coverage of biomedical HIV and SRH interventions for young people and implementation of Youth Friendly Health Services while expanding and intensifying existing life skills modules and SRH and HIV education for in-school and out-of-school youth under strategic interventions within Objective 1.4.1.

The MoEST's first objective is to improve equity and access to education in Malawi, however, it learned from the very first school meals program that health and nutrition are among the factors that affect teachers and learners from accessing education services. This gap is what led the MoEST to create DSHNHA to manage learners and teachers' health, HIV, and nutrition services. To ensure DSHNHA operates an integrated nutrition and HIV/AIDS service with MoH, staff working in this department are seconded from the MoH's Department of Nutrition HIV & AIDS.

Content of the National Policy

The Government of Malawi released the National Integrated School Health and Nutrition Policy in 2017. It is called an "integrated" SHN policy because it is implemented in coordination with the Ministries of Education, Health, Gender, and Agriculture and links directly with their policies and strategies.

Prior to the development of this policy, a situation analysis was conducted to provide an overview of the health problems that schools and school children face in the country, affecting their well-being and eventual performance in class.[75]

The analysis described in detail how health problems affect education outcomes in the country and informed the five priority areas of the Integrated School Health and Nutrition Policy:

Priority Area 1 - school nutrition including school meals;

Priority Area 2 - school health, hygiene and sanitation;

Priority Area 3 - child protection;

Priority Area 4 - institutional set-up – coordination, integration, and linkages;

Priority Area 5 - mainstreaming of cross-cutting issues.

The policy describes severe malnutrition, poor sanitation, limited access to potable water, adolescent pregnancies, food insecurity, micronutrient deficiency including Vitamin A deficiency, anemia, iodine deficiency, and malaria as key health issues to be addressed in schools.[76]

The analysis identifies areas of inequity, deprivation, and marginalization, and notes that poor health effects are more severe on girls, orphans, and children with special needs. These are exacerbated by cultural prejudice and practices and economic challenges that hinder girls from completing their primary let alone secondary education. Pregnancy was noted as resulting in high dropout rates for girls, and issues of food insecurity resulting in chronic under-nutrition among children who are orphaned by HIV/AIDS.

The SHN Policy was a five-year policy and expired on December 31, 2022. For this reason, MoEST found the start-up of the MOMENTUM/Strategic Planning Advisors for Education and School Health in Africa (SPAESHA) project to be timely, as it will play a role in informing the review of the national policy and development of a new policy for the next five years. The Deputy Director of the DSHNHA noted that though the policy exists as a standalone document, its development was informed by several other policies to make it an integrated document (see Table 4).

One of the Malawi government's core strategies is to ensure universal and equal access to school for all children. It also has an obligation not to expose learners to an increased risk of illness while they learn, and schools are an excellent channel to reach young children with direct health interventions.

In view of this, the Ministry developed five policy statements:

1. Learners stay in good health at school;
2. WASH facilities and services are provided in schools to promote positive health outcomes;
3. Learners seek and acquire health promoting skills, attitudes, and habits;

4. Teachers are trained to identify basic health issues including mental health, provide first aid, address some identified issues and refer others to more specialized services and provide guidance and counselling on health matters including HIV/AIDS;

5. Health workers periodically conduct health interventions/health campaigns at school as necessary.[77]

Within the five priority areas, the policy covers the thematic areas of WASH, nutrition, physical activity, menstrual health and hygiene, health screening, vaccinations and preventive treatment, first aid, skills based health education, mental health and psychosocial support, and violence prevention and response.

TABLE 4: MALAWI POLICIES AND STRATEGIES CONTRIBUTING TO THE NATIONAL INTEGRATED SCHOOL HEALTH & NUTRITION POLICY

NR	Sector	Policy Name	Start	End	Does this Fund SHN Initiatives?
1	**Education**	National Education Sector Implementation Plan	2011	2015	
2		Free Primary School Policy	1998		
3		National Education Sector Investment Plan	2020		
4		National Integrated School Health and Nutrition Policy	2017		Yes
5	**School Health**	Universal School Meals Program			
6		SHN Guidelines 2009-2018	2009	2018	
7		SHN Strategic Plan 2017-21			
8	**Health**	Multi-Sector Nutrition Policy	2018	2022	
9		National Nutrition Policy 2013 - 2018	2013	2018	
10		Integrated Management of Child Illnesses Approach			
11		Policy for Accelerated Child Survival and Development 2006	2006	2010	
12		Sexual and Reproductive Health and Rights Policy and Strategy	2017	2022	
13		National HIV/AIDS Policy 2012	2012	2017	
14		National Strategic Plan for HIV/AIDS Strategic Plan 2015 – 2020	2015	2020	
15	**Environment**	National Water Policy 2005	2005	2010	
16		National Sanitation Policy			
17		National Social Support Policy	2012	2016	
18		National Disaster Risk Management Policy 2015 - 2020	2015	2020	
19		National Agriculture Policy 2011 - 2015	2011	2015	
20		Agriculture Sector Wide Approach; 2011 - 2018	2011	2018	
21		National Environmental Health Policy 2010	2010	2015	

The Health Sector Strategic Plan III mentions providing a health benefits package to all, including health interventions like deworming and schistosomiasis mass treatment, which are provided in schools. The Strategic Plan also specified strengthening epidemic preparedness and response, evidenced when the MoH worked with the MoEST on COVID-19 preparedness and response strategies. The current cholera response in schools is also a collaborative effort between the MoH and MoEST.

In terms of other services, the National Water Policy stipulates provision of safe water to schools. School gardens and nutrition interventions are outlined in the National Agriculture Policy and the National Multi-Sector Nutrition Policy.

Equitable School Health Policies

The Integrated SHN Policy promotes equity and inclusion throughout its five priority areas, mainstreaming cross-cutting issues like gender, child protection and HIV/AIDS prevention, the specific mention of school meals, take-home rations and cash vouchers for vulnerable families, the assessing and managing learners with special needs, and the need for WASH facilities that meet the needs of menstruating girls.

It highlights the health priorities of school-age children and the need to support marginalized children (including girls, orphans, and children with special needs).[78] It outlines strategies to increase the enrollment and attendance of vulnerable groups, in particular girls, orphans, and vulnerable children. From early childhood education (ECD) to secondary school, the policy uses take-home rations, school meals, and conditional cash transfers for vulnerable families, and times of emergency to affected households. The policy also committed to identifying learners with special needs through regular assessment of the extent their needs and determining appropriate accommodations, with the goal of full integration into normal school life and learning through campaigns to overcome prejudice. The National Gender Policy and the National Social Support Policy have included ways these will be supported through the District Social Welfare Offices under the Ministry of Gender, Children, and Social Welfare. Currently youth interventions are under the Ministry of Gender.

Despite the detailed evidence of health problems and needs of school-age children, child-headed households have not clearly been mentioned or targeted in the SHN Policy, rather their support is detailed in the National Gender Policy and the National Social Support Policy. The SHN Policy is also silent on how it will support the attainment of good health for children living with HIV/AIDs, including adherence to treatment for learners who have HIV, even though issues of protection from contracting HIV are mentioned.

Equity in the policy approach can be further approved through guidance for local adaptation of SHN polices, to respond to local priorities and the needs of all students, including access and respect, and equal treatment for children with disabilities. Additionally, schools are expected to create their own plans to adhere to the national policy, but the extent to which they align across all core standards is unknown.

Safe Learning Environment

The Ministry has developed a full program of child protection, positive discipline, and safe school infrastructure, under the safer schools program. However, the minimum indicators at the school level to qualify for a “safer school” are lacking.

Physical Environment

MoEST interviews indicated that the lack of a framework led to inconsistencies in implementation, rollout, and especially school construction. This was particularly concerning for schools constructed by local communities, which pull together local resources but may not meet safe building standards. Due to poor financing, one interviewee indicated that “it is believed that the safer school program is not reaching all schools.”

Psychosocial Environment

The policy is explicit regarding the social-emotional safety of learners in Priority 3, stating that schools should be inclusive and participatory places where cases of child abuse or violence can be detected and reported. In theory, each school is supposed to consider the safety issues of learners and to be a safe and conducive place where any student who needs special attention can get support. The government reaffirmed that this policy was to address child protection from two angles: firstly, that schools ensure children are not excluded in any way from participating in schooling and secondly, schools are an important detection point outside home where cases of child abuse, violence etc. are detected.[79] There are three policy statements under this: that the policy will ensure "all children, including vulnerable groups, access education at all times; school environments are conducive to the participation and protection of all children in normal times and during crises; and teachers and other school staff provide enhanced protection, care and support for vulnerable children against violence and abuse,"[80] which would include a positive and safe school culture for children with no corporal or humiliating punishment.

However, informational interviews suggested that psychological issues are not fully dealt with in schools, and issues of discrimination still exist that require psychosocial support.

Skills-Based Health Education

Through the MoEST, comprehensive sexuality education is introduced through the life skills subject. The subject is compulsory to ensure that there is access to information on life skills for learners to be able to understand themselves and make informed decisions.

Under Priority Area 2 - school health, hygiene, and sanitation, the Policy requires learners seek and acquire health promoting skills through the integration of health topics in the curricula and teacher training. The Policy mentions that issues of nutrition, health, hygiene and sanitation, and child protection are included in the life skills curriculum.[81]

Priority Area 5 explains how content is integrated into the curricula and provided via training:

1. Identify jointly with the Government and other stakeholders the relevant learning to be integrated into primary and secondary school curricula;
2. Based on this, identify the relevant learning to be integrated into teacher training curricula (content and methodologies practically involving learners). Such learning should empower future teachers to integrate academic teaching with practical involvement and experience to achieve optimal learning (e.g., involve higher classes in the preparation of school contingency plans);
3. Ensure that the above is well integrated into school and teacher training curricula;
4. Ensure that existing teachers have access to the relevant training modules, e.g., through regular refresher courses and continuing professional development;
5. Consider additional ways of strengthening teachers' capacity to keep up to date in mainstreaming the identified cross-cutting issues into their teaching, e.g., the provision of a national helpline; establishment of a peer network among teachers (Integrated SHN Policy page 15, 2017).

Teachers are also trained to identify basic health issues, provide first aid, refer children to health centers, and provide guidance and counselling on health matters. The policy also stipulates that teachers must occasionally conduct simple health interventions and campaigns at schools.[82] One challenge to teacher training is their ad hoc implementation, as trainings are provided by several government departments or partner organizations and there has been no consistent nationwide coverage. Additionally, such trainings are usually short term and mainly focuses on content of the issues rather than how to teach them in a participatory way, including basic nutritional messages, basic health messages and skills, gender and protection, and how to achieve resilience to threatening disasters, in particular droughts and floods. There are three policy statements that focus on life skills and cross-cutting issues accompanying standard educational curricula. These policy statements focus on learners' acquisition of relevant knowledge, skills, attitudes, and habits in nutrition, sanitation and hygiene, health and cross-cutting issues such as gender and protection, HIV/AIDS prevention, disaster risk management, and resilience. Finally, the policy was intended to ensure that teachers acquire required knowledge, attitudes, and skills to teach learners in an adequate way through classroom lectures and exercises that are age appropriate and that they act as role models.[83]

A key informant interview revealed that though issues of school health are integrated in the curriculum, there is a lack of capacity for teachers to deliver the content. The teacher who is selected to be the SHN focal point may not necessarily have an educational background in any of the health issues they are expected to teach or promote. This has resulted in poor nutrition education and may be contributing to a lack of sexual and reproductive health (SRH) education implementation in schools.

The topic of SRH in schools has been strongly debated between the MoH and MoEST. In writing, the coordination and collaboration between the ministries on SRH is thoroughly considered and well aligned. Comprehensive sexuality education is part of primary school curriculum for ages 6 to 13, and is an elective subject in secondary school for ages 14-17; at both levels it is examined. MOEST and MoH have established linkages to ensure SRH services target learners. Referral of students to SRH, HIV, and other social services is conducted by MoEST, while MoH and its partners conduct health and sanitation sessions and campaigns in schools. MoH has a policy on provision of SRH services, with schools expected to provide information on where to access such services including counseling and referral, but restricts service providers from distributing condoms and contraceptives on school premises.[84] The content of life skills education curriculum is targeted at the needs of young people and addresses public health objectives such as reducing teenage pregnancies, HIV infections, and STIs in a culturally appropriate manner. However, an analysis conducted by UNESCO in 2019[85] stated that the program falls short by emphasizing abstinence and not providing details on the knowledge and skills needed to address gender-related issues and decrease STIs and unwanted pregnancy, such as limiting sexual partnerships and using contraceptives including condoms. Interviews with MoH stakeholders raised this topic and expressed that SRH is not well covered in the curriculum. Representatives from the MoEST do not agree with the report, and feel that the foreign influence and pressure is unwelcome and will not lead to culturally appropriate comprehensive sexuality education in schools.

UNFPA, the Malawi Girl Guides Association, and other NGOs have teamed up to enhance the capacity of mothers' groups around each school to counsel girls on menstrual hygiene. Girls are trained to sew their own menstrual pads, and mothers' groups encourage schools to reserve pads for emergency use. The government, with support from development partners, is promoting construction of girls' change rooms to ensure girls attend classes even when they are menstruating. During cyclones, various partners provided dignity kits to adolescent girls as part of promoting menstrual health and hygiene, however main challenges were poor disposal of used pads and lack of privacy as the girls used the same rooms with other families.

SHN Policy Dissemination and Adaptation

MoEST disseminates policies at three levels: national, district, and school/community. At the national level, the MoEST disseminates policies to relevant government departments. At the district level, the District Assembly Executive Chair disseminates to all relevant government departments, which represent the national structures through a District Executive Committee meeting and community structures like Area and Village Development Committees. At the school level, school management and teachers disseminate policies through school assembly announcements, club activities, delivery of the curriculum, meetings with the learners' council, School Management Committees, and Parent Teacher Associations (PTAs). Usually, dissemination is done at divisional levels.

Informational interviews with the Deputy Director for School Health and Nutrition and HIV/AIDS and the Technical Advisor (Policy Monitoring, Evaluation, Research, and Learning) revealed that the SHN policy and strategy have been disseminated to approximately half the local governments in the country. It is noteworthy, however, that there is no formal mechanism to disseminate the Policy. There was instead a national dissemination event, and national officers travelled to the districts to disseminate the policy through meetings with the relevant district level officers. Thereafter the policy documents were left at the district education manager's office for further distribution to schools. Government officials expressed concern that "dissemination" may have been confused with distributing copies of Policy documents to the districts, when in actual fact, district-level dissemination would be evidenced by the districts' ability to integrate SHN issues into the districts' implementation plans.

SHN policy dissemination to schools was reported to have been partially done by District SHN Coordinators, though reports on that dissemination were not available to see. At school level, SHN teachers are responsible for further disseminating the Policy to other cadres including Village Development Committees, Area Development Committees, School Management Committees, PTAs, and learners. In the schools where dissemination of the SHN Policy occurred, only parents were targeted — through school structures such as mothers' groups, PTAs, and School Management Committees — not students. Dissemination to all schools would be evidenced by SHN school plans reflecting what is in the policy and students experiencing indirect dissemination of the policy through the delivery of the curriculum by teachers through classroom teaching as well as participation in School Health Clubs, receiving health services, and the status of their school environment. Field assessments following this report will help inform the overall quality of this experience and verify these assumptions. According to informational interviews, the key cause for the incomplete dissemination of the SHN Policy across the education levels was resource constraints.

The national policy on SHN does not specifically recommend local- or sub-national adaptation, though it provides broad guidance on the implementation arrangements for SHN at these levels, as outlined in the SHN Strategic Plan 2017-21. However, though the strategic plan was developed to be used together with the Policy, it was neither finalized nor approved, leaving the strategic plan as more of a guide than a mandate.

At the national level, the MoEST hosts the Directorate of SHN and HIV/AIDS and liaises with the Ministries of Gender, Health, Agriculture, and Nutrition in the provision of school health interventions for all age groups. A Technical Working Group and Steering Committee on SHN made up of public and private entities provides overall policy direction.

District SHN Coordinators report to the District Education Manager and engage with District Councils to include SHN interventions in their plans when they are developing District Development Plans or program-based budgets. An interview with the Deputy Director for SHN in the MoEST confirmed that SHN plans for district education offices are aligned to the central plans. Priorities for the district are included in the District Development Plans. These are developed in consultation with communities via community structures and sectoral heads for government departments and district level. The Director of Planning and Development and District Councils work with sectoral heads to compile their priorities in the District Development Plans and submit them to Lilongwe.

There is no development of aligned policies at school level. Rather schools are expected to adapt what is in the national policy to their school-level improvement plans. Copies of the school plans were not available for reference during this desk review process but may be an important verifiable data source for the field assessment portion of this project.

Institutional Set-Up – Coordination, Integration, and Linkages

"The policy addresses the shortfalls of policy fragmentation and weak institutional ownership. It seeks to achieve comprehensive action in SHN by all actors. The policy seeks to see all SHN actors both in the education sector and outside joining forces around clear strategies, aligning their activity plans and securing resources. The policy recognizes that this cannot be achieved if actors' coordination roles are not clearly defined, mandates are not clear in respect to institutional action plans and budget preparation." (Integrated SHN policy 2017:9)

There are three policy statements under this that include the following: "structures and procedures are in place to ensure that minimum education standards as well as adequate measures to promote school health and nutrition are implemented in a concerted, efficient and effective way at all levels; relevant stakeholders have an opportunity to discuss and agree on coherent intervention strategies, and clear action plans are developed and executed for effective SHN interventions." (Integrated SHN policy 2017:9)

There is a multisectoral coordination committee — named Multisectoral School Health and Nutrition High Level Coordinating Committee and is also known as the SHN Technical Working Group — has formal terms of reference and levels of expected commitment. The committee is comprised of members from the entities shown in Table 5, including government.

TABLE 5: NATIONAL MULTISECTORAL SCHOOL HEALTH AND NUTRITION HIGH-LEVEL COORDINATING COMMITTEE MEMBERSHIP, MALAWI

Government/Ministries	Civil Society	Academia	Bilateral Agencies and Donors
Ministry of Health, DNHA – Chair	Mary's Meals	Lilongwe University of Agriculture and Natural Resources	UNICEF – Co-chair
Ministry of Education – Secretariat	Welthungerhilfe		World Food Programme
Ministry of Local Government	Nascent Solutions		GIZ

The terms of reference stipulate the roles and responsibilities of the Chair and the secretariat, but not the roles of the other members of the committee. The chair (Director of Nutrition, HIV, and AIDS) provides leadership, leads the flow of information to and from the committee, and leads the committee in annual reviews, and acting as required. The chair is supported by a co-chair, currently a UNICEF representative. The secretariat of the committee, the Ministry of Education Deputy Director of School Health and Nutrition, is responsible for preparation and circulation of agenda and meeting minutes (Multi-Sectoral School Health and Nutrition High Level Coordinating Committee, pages 3-5).

Interviews with the Deputy Director for School Health and Nutrition HIV and AIDS revealed that MoEST is responsible for ensuring the curriculum covers nutrition issues across sectors, with the MoH supporting the integration of other health topics and providing health services in schools. The Ministry of Agriculture enforces the procurement of locally produced foods for school meals. The Ministry of Information ensures that information is disseminated to citizens through different schools. An informational interview with the Deputy Director for Nutrition in the Ministry of Agriculture revealed that despite the coordination committee being present, SHN work remains disjointed. There is need for strong collaboration among the key ministries who have a mandate to support implementation of the policy. However, a heavy burden rests on the MoEST for implementation as the requirement of budgetary allocations within each of the key ministries who have a mandate on the implementation of SHN has not occurred.

At the district level, District Nutrition Coordinating Committees (DNCCs) coordinate some SHN interventions under the leadership of the MoH (DNHA). These DNCCs include members from the MoEST staff (DSHNHA), but also the Ministries of Agriculture, Forestry, Water, Nutrition, Planning, and Social Welfare. DNCCs are key to the coordination of SHN implementation because that is where the greatest potential for local multisectoral coordination exists. Districts that have weak DNCCs also have weak multisectoral coordination.

One of the effects of limited resources is a decreased ability to hold coordination meetings. Another is that the mandated operations associated with a decentralized government structure are not yet fully understood. School health is broad, and it needs to feed into several committees. It is important to set aside support for the operation and monitoring of structures like DNCCs. If they are not supported and monitored, their functionality and effectiveness is unknown. This is true at the national, district, and community levels.

Key informant interviews noted that another barrier to proper SHN implementation and coordination is a lack of specialized public health and nutrition personnel. Administrative arrangements are needed from the district level up to school level to build SHN capacity across sectors in order to ensure the implementation of the policy. National planning should collaborate with health to dedicate funding to SHN and reserve funds to monitor WASH. The SHN department in MoEST should be able to monitor whether the planned school health implementation activities have proper budget allocations.

Resource Allocations for School Health

The National Education Investment Plan, its associated implementation plan, the Ministry's Human Resource management plan, and annual national budget for the MoEST include plans for SHN and funding human resources. At the time of this desk review, we could not document the funding amount or set percentage allocations for SHN policy initiatives. However, the 2020-2030 National Education Sector Investment Plan stipulated that the DSHNHA would have a total five-year budget of USD 284,758 to invest in promoting gender mainstreaming, girls' education, SRH, and rights in primary schools. Additionally, there are explicit statements on expected contributions from other ministries within the Institutional Arrangements section of the policy. Each ministry that is supposed to contribute to SHN implementation is listed, with its mandates clearly articulated. The institutional arrangements include what should happen at the national, district, and community levels.

A review of the National Education Policy revealed that there are annual resource allocations across Ministry documents and policy. There is also evidence of plans to diversify and equitably distribute the resources for basic education across the nation. The Ministry also committed to mobilize resources from development partners and the private sector and ensuring that those financial resources are spent according to the Public Financial Management Act, Treasury Instructions, and other agreed conditions. In addition to this, Policy Objective Number 2 stipulates enhancing quality assurance and quality of secondary education.[86]

Several policy statements mandate continuous human, information, or financial resources (see Table 6).

TABLE 6: POLICY STATEMENTS IN THE NATIONAL EDUCATION INVESTMENT PLAN

Reference	Policy Statement
Human Resources	
Policy Objective 11, 5.2.12	Strengthen capacity development in primary education
5.2.12.1 xv	Build capacity of primary school teachers including those in special needs education
5.2.12.1 xvi	Establish education personnel promotion that is performance based
5.2.12.1 xxi	Develop career path for the teaching profession
5.2.12.1 xxii	Establish schoolteacher positions in accordance with prevailing pupil/teacher ratio
Strategies 1	Equitably deploy qualified teachers
Informational Resources	
Policy Objective 7	Ensure that teaching and learning materials are available to all learners
5.2.8.1 Strategies 1	Provide national curriculum textbooks on the market for the public and private sector
5.2.8.1 Strategies 2	Provide adequate ad relevant teaching and learning materials to public primary schools
Financial & Operational Resources	
5.2.12.1 xxiii	Review teachers' establishments at school level
5.2.8.1 Strategies 3	Align the supply chain of primary school textbooks to Procurement Act and Donor Partner's procurement guidelines

There is evidence and justification for annual resource allocations across ministry documents and policy including "diversify and equitably distribute resources for basic education across the nation; mobilize resources from development partners and the private sector spend financial resources in accordance with the Public Financial Management Act, Treasury Instructions, and other agreed condition." In addition, "Policy Objective 2: Enhance quality assurance and quality of secondary education 5.3.2.1. Reinforce efficient and effective mechanisms for resource management in primary education." (National Education Policy 2016:35)

During the desk review, MOMENTUM/SPAESHA was not granted access to the SNH budget. However, key informant interviews revealed that the funding base is usually not enough to meet the needs of the Ministry, and this is true at all levels for school health. This leaves several key questions unanswered regarding budget and implementation of the SHN policy, which MOMENTUM/SPAESHA will investigate in the field assessment phase.

1. What percentage of the education budget is expected to be spent on school health programs and initiatives?
2. What contributions are supposed to be made by other sectors and ministries?
3. How are funds distributed between national, sub-national, and local-level education platforms (including schools)?
4. What determines the percentage of funding allocated to SHN policy and interventions?
5. When budget allocations are insufficient, how are budget priorities and interventions established?
6. What guidelines are schools given for how they spend their budget and how to adhere to them? Similarly, when the funds are insufficient how do schools manage this?

Monitoring and Evaluation of School Health and Nutrition

The SHN Operational Guidelines outline the need for systems for monitoring school health. Among the monitoring systems is an Annual School Census whose output is:

1. Education Statistics Bulletin;
2. Comprehensive Sexuality/School Health and Nutrition Census;
3. School Mapping;
4. Cohort Tracing.

The Education Management Information System (EMIS) collects annual census data for decision making at the primary and secondary level, sex disaggregated where relevant. School health data includes WASH in schools information such as the number of toilets/latrines by type, number of handwashing facilities with soap and water, and water sources. The EMIS also tracks information on children with various special needs and vulnerable and orphaned learners. At the secondary school level, the EMIS tracks availability of changing rooms for girls and incinerators for menstrual waste. Additionally, the EMIS includes four types of indicators related to access, quality, and efficiency that pertain to enrollment, teacher to student ratios, grade repetition and promotion, completion of primary school, and transition to secondary. EMIS indicators and status are published in two reports: Education Statics Report/ Bulletin and the Comprehensive Sexuality/School Health and Nutrition - Education Report.

The Comprehensive Sexuality/School Health and Nutrition Census collects information on:

1. HIV/AIDS-related guidelines;
2. Life skills-based HIV and sexuality education;
3. Life skills-based HIV and sexuality education: orientation process for parents and guardians;
4. Education: free basic support for orphans and vulnerable children;
5. Psychosocial support;
6. Nutritional support;
7. Water and sanitation and infrastructure.

Conclusions and Recommendations

The Integrated SHN Policy is a comprehensive policy that includes all four recommended core pillars to promote the health and well-being of students, their families, and school staff. During the policy audit, informational interviews, and desk review, several gaps and assumptions regarding the implementation of the policy were identified, which SPAESHA intends to investigate further during a field assessment in order to provide more detailed recommendations.

The evidence or problem is stated in bold font.
SPAESHA's next steps during the field assessment are stated in italic font.
SPAESHA's preliminary recommendations are underlined.

1. **WASH in schools has not improved, rather climate disasters have exacerbated poor sanitary infrastructure.**
   - Field research will dive deep into the issues of WASH, menstrual hygiene, COVID-19, and effects of climate change so that the next report provides an update recommendation on how the revised policy should address these issues.

2. **School health and nutrition services are not consistent nationwide, particularly malaria control.**
   - Both malaria prevention and improved access to treatment, could reduce school-age mortality and morbidity and improve learning outcomes.

3. **The presidential taskforce for the COVID-19 and cholera outbreak has not achieved nationwide coverage of all schools.**
   - SPAESHA will learn how national- and district-level task forces translate to local initiatives and the realities that learners and schools faced. Best practices, future initiatives, and opportunities for improvement will be captured during field assessment activities.
   - Pandemic preparedness, prevention, and control of infectious diseases should foster an increased partnership between the MoEST and the MoH. During crises, school health and nutrition interventions must respond to the immediate needs, including psychosocial/mental health support AND prevent outbreaks of infectious diseases. In addition, the government is advised to consider alternative shelters for affected people to avoid interrupting learning for longer periods. Finally, as the proportion of out-of-school children increases during crises, any health and nutrition intervention needs to be redesigned to reach all children.

4. **School safety (both building infrastructure as well as psychosocial protection) standards are inconsistent.**
   - The Comprehensive School Safety framework links to many of the same priorities as School Health and Nutrition. MOMENTUM/SPAESHA recommends that the MoEST lead SHN stakeholders in a process that would: 1) Integrate evidence-based strategies from the existing CSS Framework into the Integrated SHN Policy to ensure that safety is adequately addressed. OR 2) Ensure coordination with Safe Schools national and sub-national structures to ensure safety is adequately covered in SHN plans and policies.

5. **The SHN policy fails to describe specific needs and monitor the impact on the most vulnerable children: girls, orphans, and children with special needs.**

- MOMENTUM/SPAESHA will investigate the issue with key informants and determine whether the topic should be included in school visit focus group discussions.
- In the short-term, the MoEST DSHNHA, and MoH Department of Nutrition, HIV, and AIDS is advised to lead SHN stakeholders in incorporating sections on child-headed households, supporting good health for learners with HIV including HIV treatment adherence at all levels of education. Optimally, this process would be done in coordination with the Department of Nutrition HIV and AIDS, DNHA, and the Ministry of Gender, Children, and Social Welfare.

6. **Teenage pregnancies are very common, and the life skills curricula is debated.**

- SPAESHA will work with MoEST and MoH to determine how this assessment can help uncover details and gaps regarding legislation and SRH curricula provision in schools that would assist both ministries to determine their own resolutions on the issue. We will also investigate if the construction of secondary schools through PEFAR/SEED may provide an advocacy opportunity for comprehensive sexuality education.
- Age- and culture-appropriate puberty education, as currently recommended by UNESCO, should be included at the primary level.

7. **The policy dissemination process had limited funding and no follow-up at the district, local, and school level. The strategic plan for the policy was never approved.**

- Field research will assess the degree to which district and school level structures (District Education Committees, SMCs, PTAs integrated and conducted SHN interventions). A review of annual school plans will be included in data collection.
- Together with the next iteration of the policy, MoEST should develop and approve an accompanying strategic plan that addresses some of the challenges uncovered through recent years of implementation and the SPAESHA assessment.

8. **Budget allocations for the SHN policy implementation have been very low by the MoEST and unclear by other ministries involved.**

- SPAESHA will discuss the realities of decision-making processes regarding budgets for SHN initiatives, including contributions from other ministries, to assess how to better prioritize SHN needs and ensure a transparent process for budget allocations.

9. **Technical working groups at the district level, called "District Nutrition Coordinating Committees" DNCCs, implement some SHN activities, but health services in schools are not consistent nationwide.**

- MOMENTUM/SPAESHA recommends that health interventions in schools (deworming, screening, vaccinations, etc.) should be standardized nationwide. This would increase the visibility of schools as a platform for achieving various strategy and policy objectives, and the need to invest in initiatives from across the ministries, ensure supporting ministries are fulfilling their financial obligations to the SHN policy.

10. **Local adaptations of the policy are needed, based on local epidemiological data of health issues of school-age children, particularly around infectious disease control.**

- In alignment with Malawi's information devolution policy, the MoEST and its SHN stakeholders should endeavor to accommodate flexibility in adapting the policy at the divisional level in accordance with the predominant health challenges of the division. Given limited resources and no clear prioritization method, local adaptation may be critical to meaningfully improving health and education outcomes.

Endnotes

1. Schultz, L., Shors, L. 2021. Operationalizing Health & Education Coordination: Recommendations Surfaced Through Interviews with Africa Bureau Missions [Internet]. Washington DC. www.childtaskforce.org
2. Sarr, et al. The Evolution of School Health and Nutrition in the Education Sector 2000-2015 in sub-Saharan Africa.
3. UNICEF, World Health Organization. 2020. Progress on drinking water, sanitation and hygiene in schools. Special focus on COVID-19. https://data.unicef.org/resources/progress-on-drinking-water-sanitation-and-hygiene-in-schools-special-focuson-covid-19/
4. Wu, X., Lu, Y., Zhou, S., Chen, L., Xu, B. 2016. Impact of climate change on human infectious diseases: Empirical evidence and human adaptation. Environ Int; 86:1423. doi:10.1016/j.envint.2015.09.007 pmid:26479830
5. Ghiteko, A.K, et al. 2000. Climate Change and Vector-Borne Disease: A Regional Analysis. World Health Organization Bulletin. 78(9):1136-47.
6. Ogden, N. H., Lindsay, R. 2016. Effects of Climate Change on Vectors and Vector-Borne Diseases: Ticks are Different. Trends in Parisitology. 32 (8) 646-656.
7. Schultz, L., et al. 2018. Maximizing Human Capital by Aligning Investments in Health and Education.
8. Schultz, L., et al. 2021. Operationalizing Health & Education Coordination: Recommendations Surfaced through Interviews with Africa Bureau Missions
9. Focusing Resources on Effective School Health (FRESH) is an international framework that provides guidance on the development and implementation of school health programs. Launched by UNESCO, WHO, UNICEF, and the World Bank in 2000, it recommends that government and schools must ensure policies for school health, school-based health services, a safe and supportive school environments and skills-based health education.
10. Systems Approach for Better Educational Results (SABER) is a World Bank initiative to help countries systematically strengthen their education systems in order to ensure education for all.
11. Health Promoting Schools (HPS) is defined by the World Health Organization as those that constantly strengthen their capacity to promote healthy living, learning and living conditions. Making every school a health-promoting school: global standards and indicators for health-promoting schools and systems. Geneva: World Health Organization and the United Nations Educational, Scientific and Cultural Organization; 2021. License: CC BY-NC-SA 3.0 IGO.
12. NEP 2016:13
13. NEP 2016:14
14. UNICEF. 2022. Malawi Education Fact Sheets. Analyses for Learning and Equity using MICS data
15. Malawi DHS 2015-16. 2017. The DHS Program. https://dhsprogram.com/publications/publication-fr319-dhs-final-reports.cfm
16. GBD Compare. 2019. The Institute for Health Metrics and Evaluation (IHME)
17. Adolescent fertility rate (births per 1,000 women ages 15–19) United Nations Population Division, World Population Prospects; www.worldbank.org
18. Integrated SHN Policy 2017:12
19. Integrated SHN Policy 2017:1-2
20. Malawi Demographic and Health Survey Health Survey 2015–16. 2017
21. UNICEF. Better late than never: Enifa finally goes back to school. 2021. https://www.unicef.org/malawi/stories/better-late-never
22. Likupe, G., et. al. 2020
23. Mhango, P., Malata, M.P., Chipeta, E. et al. Barriers to accessing malaria treatment amongst school-age children in rural Malawi. Malar J 22, 258 (2023). https://doi.org/10.1186/s12936-023-04695-z
24. Kambala, C., Chinangwa, A., Chipeta, E. et al. 2020. Acceptability of menstrual products interventions for menstrual hygiene management among women and girls in Malawi. Reprod Health 17, 185. https://doi.org/10.1186/s12978-020-01045-z
25. Enzler, D. M. 2018. Knowledge, attitudes and practices concerning Menstrual Hygiene Management (MHM) of adolescents in rural primary schools in Malawi. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.isglobal.org/documents/10179/7339333/MFP+Daniel+Enzler/4565e949-c2d2-48d9-b1c5-52fb30571a39
26. Mwambene JB, Muula AS, Leo JC. (2013). Prevalence and correlates of hunger among primary and secondary school children in Malawi: Results from the 2009 Global School-based Health Survey. Malawi Medical Journal; 25 (2): 45-49. https://www.researchgate.net/publication/257465321_Prevalence_and_correlates_of_hunger_among_primary_and_secondary_school_children_in_Malawi_Results_from_the_2009_Global_School-based_Health_Survey/link/56e2baf108ae41daff31b79f/download
27. National Statistics Office. 2017
28. Institute for Health Metrics and Evaluation
29. Mathanga, D.P., Halliday, K.E., Verney, M., Bauleni, A., Sande, J., Ali, D., Jones, R., Witek-McManus, S., Roshnick, N., Brooker, S.J. 2015. The high burden of malaria among primary schoolchildren in southern Malawi. American Journal of Tropical Medicine and Hygiene 93(4). https://www.researchgate.net/publication/281141929_The_High_Burden_of_Malaria_in_Primary_School_Children_in_Southern_Malawi
30. Centers for Disease Control and Prevention. https://www.cdc.gov/
31. Waldof et al. 2015.
32. Mathanga, D., et.al 2015
33. National Malaria Control Programme - NMCP/Malawi and ICF. 2018. Malawi Malaria Indicator Survey 2017. Lilongwe, Malawi: NMCP/Malawi and ICF. https://www.dhsprogram.com/pubs/pdf/MIS28/MIS28.pdf.
34. World Health Organization. 2021. World Malaria Report 2021. Geneva.
35. Riveron, J.M., Chiumia, M., Menze, B.D., Barnes, K.G., Irving, H., Ibrahim, S.S., et al. 2015. Rise of multiple insecticide resistance in Anopheles funestus in Malawi: A major concern for malaria vector control. Malar J;14:344.
36. Mzilahowa, T., Chiumia, M., Mbewe, R.B., Uzalili, V.T., Luka-Banda, M., Kutengule, A., et al. 2016. Increasing insecticide resistance in Anopheles funestus and Anopheles arabiensis in Malawi, 2011–2015. Malar J. 2016;15:563.
37. Malata, et al. 2023.
38. World Health Organization. 2021 World Malaria Report 2021. Geneva.
39. Mhango, P., Malata, M.P., Chipeta, E. et al. 2023. Barriers to accessing malaria treatment amongst school-age children in rural Malawi. Malar J 22, 258. https://doi.org/10.1186/s12936-023-04695-z
40. Kapito-Tembo, A.P., Mwapasa, V., Meshnick, S.R., Samanyika, Y., Banda, D., Bowie, C., Radke, S. 2009. Prevalence Distribution and Risk Factors for Schistosoma hematobium Infection among School

Children in Blantyre, Malawi. www.ncbi.nlm.nih.gov/pmc/articles/PMC2614474/

41. Kayuni, S., Peeling. R., Makaula, P. 2017. Prevalence and distribution of Schistosoma haematobium infection among school children living in southwestern shores of Lake Malawi. Malawi Med J. https://pubmed.ncbi.nlm.nih.gov/28567191/
42. World Bank Group. Incidence of tuberculosis (per 100,000 people) – Malawi https://data.worldbank.org/indicator/SH.TBS.INCD?locations=MW
43. Stop TB Partnership. Tuberculosis situation in 2020 – Malawi. https://www.stoptb.org/static_pages/MWI_Dashboard.html
44. National Integrated SHN Policy 2017:2
45. World Data. Cyclones in Malawi. www.worlddata.info/africa/malawi/cyclones.php
46. OCHA Flash 46 No.9 Update 2023:1
47. UNICEF. 2023. Boosting sanitation and hygiene in Cyclone Freddy affected schools: UNICEF's humanitarian response in Malawi. https://www.unicef.org/malawi/stories/boosting-sanitation-and-hygiene-cyclone-freddy-affected-schools#:~:text=As%20of%20the%20end%20of%20March%2C%20at%20least,139%2C929%20learners%20impacted%20in%20primary%20and%20secondary%20schools
48. Save the Children. 2023. Nearly half a million children in Malawi unable to attend school due to Cyclone Freddy. https://www.savethechildren.net/news/nearly-half-million-children-malawi-unable-attend-school-due-cyclone-freddy
49. Save the Children 2023:64
50. Worldometers. Coronavirus Cases – Malawi. https://www.worldometers.info/coronavirus/country/malawi/
51. Ministry of Education. 2020. Positive Discipline for Safe Schools: National Training Manual
52. Transforming Education Summit National Statement of Commitment - Malawi
53. United Nations News. 2022. Global cholera surge likely accelerated by climate change, warns WHO. https://news.un.org/en/story/2022/12/1131787
54. UNICEF. 2023. Responding to the Cholera outbreak in Malawi: Saving lives from a preventable disease. https://www.unicef.org/malawi/responding-cholera-outbreakmalawi#:~:text=The%20disease%20has%20spread%20to,and%20over%20219%20have%20died.
55. Ministry of Education, Science, and Techonology. 2022. Cholera Prevention Standard Operating Procedures for Schools and All Education Institutions
56. WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP). https://washdata.org/data/
57. Save the Children 2023:65
58. ibid.
59. WaterAid. Education: Malawi. https://www.wateraid.org/mw/education#:~:text=The%20status%20of%20water%2C%20sanitation,provide%20handwashing%20facilities%20with%20soap
60. UNICEF. 2020. Reimagining Water, Sanitation and Hygiene for every child: Hand hygiene for all. https://www.unicef.org/malawi/stories/reimagining-water-sanitation-and-hygiene-every-child
61. Global Atlas of Helminth Infections. https://www.thiswormyworld.org/maps/distribution-of-soil-transmitted-helminth-survey-data-in-malawi
62. Erhard, L., Degabriele, J., Naughton, D., Freeman, M.C. 2013. Policy and Provision of WASH in schools for children with disabilities: A case study in Malawi and Uganda. Policy and provision of WASH in schools for children with disabilities: a case study in Malawi and Uganda. National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/24156778/
63. Unpublished data, information from a slide deck shared by Ministry of Education, Science, and Technology
64. Matonga, D., Nyirenda, K., Chigamba, J., Kang'ombe, D. 2022. A multi-sector approach for nutrition in school-age children and adolescents in Malawi. FEX 66 Digest. www.ennonline.net/fexdigest/66/nutritioninschoolagedchildrenmalawi
65. Matonga, D., Nyirenda, K., Chigamba, J., Kang'ombe, D. 2017. Integrated Multi-Sector Approach to improve the nutritional status among school-age children and adolescents in Malawi. www.ennonline.net/fex/66
66. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4596600/10.1186/s12936-016-1587-9
67. Chinkhumba, J., Kadzinje, V., Jenda, G., Kayange, M., Mathanga, D.P. 2022. Impact of school-based malaria intervention on primary school teachers' time in malawi: evidence from a time and motion study. Malaria Journal. https://malariajournal.biomedcentral.com/articles/10.1186/s12936-022-04324-1
68. National Integrated SHN Policy. 2017:3
69. UN Sustainable Development Goals. 2022. Closing Transforming Education Summit Press Release: Over 130 countries heed call to reboot education systems, offering new hope to world's children for a better future. https://www.un.org/sustainabledevelopment/blog/2022/09/closing-transforming-education-summit-press-release-over-130-countries-heed-call-to-reboot-education-systems-offering-new-hope-to-worlds-children-for-a-better-future/
70. Malawi National Statement of Commitment 2022:1
71. ibid.
72. OECD. 2022. Global Outlook on Financing for Sustainable Development 2023: No Sustainability Without Equity. OECD Publishing, Paris. https://doi.org/10.1787/fcbe6ce9-en
73. Martin, M. 2023. Policy Briefing June 2023, Development Finance International. https://policycommons.net/artifacts/4944977/policy-briefing-june-2023/5773891/ on 01 Nov 2023. CID: 20.500.12592/qtgj4q.
74. van der Hoeven, R., Vos, R. 2022. Reforming the International Financial and Fiscal System for Better COVID-19 and Post-pandemic Crisis Responsiveness. In: Papyrakis, E. (eds) COVID-19 and International Development. Springer, Cham. https://doi.org/10.1007/978-3-030-82339-9_2
75. Confirmed during informational interview with Deputy Director for School Health, Nutrition, and HIV/AIDS
76. Integrated SHN Policy 2017; 19
77. Integrated SH Policy 2017:8
78. "Orphans" include child-headed households, and "children with special needs" include children/youth living with HIV
79. Integrated SHN Policy 2017:9
80. ibid..
81. Integrated SHN Policy. 2017:7
82. Integrated SHN Policy. 2017:8
83. Integrated SHN Policy 2017:10
84. Ministry of Health. 2017. National Sexual and Reproductive Health and Righs (SRHR) Policy 2017-2022. https://malawi.unfpa.org/sites/default/files/resource-pdf/Malawi_National_SRHR_Policy_2017-2022_16Nov17.pdf
85. SERAT. 2019
86. National Education Policy 2016:35

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