



Republic of Zambia
Ministry of General Education

Monitoring Guide and Checklist for School Health Programs



The FRESH (Focusing Resources on Effective School Health) APPROACH



RTS Learner Support & Services Series # 5



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It is also based on the Ministry of General Education (MOGE)’s School Health and Nutrition Policy and its guidelines, the Life skills education and the Guidance and Counseling Handbook.

BACKGROUND INFORMATION

*“Ensuring that learners are healthy, so that they can learn and are able to acquire healthy behaviours is essential for an effective school system”
(Monitoring and Evaluation Guidance for School Health, January 2013:1)*

“Efforts to improve school performance that ignore health are ill-conceived, as are health improvement efforts that ignore education.”

The Ministry of General Education launched the School Health and Nutrition Program in 1998 while the School Health and Nutrition Policy and the Policy Guidelines were produced in 2008. Although the policy is in place, it has not been fully institutionalized at school level. To this extent, it can be said to be non-operational. Schools are expected to develop their own school level policies in line with the FRESH Framework. Include that this will be coordinated through the G & C department

The FRESH (Focusing Resources on Effective School Health) supports efficient, realistic and results-oriented implementation of school health programmes to make schools healthier for children to learn and where children learn to be healthy. These programmes help ensure that children enroll and stay in school, learn more while in school and develop skills, knowledge and healthy behaviours that protect themselves and their future children from disease. School health programs contribute to the Education For All (EFA) goals to improve the quality of education and learning outcomes, while also indirectly contributing to the major health and development goals by promoting healthy behaviours amongst school children and their broader community in which they live. The FRESH recommends four pillars to be addressed in all schools:

1. Equitable School Health Policies¹
2. Safe learning environments²
3. Skills-based health education
4. School-based health and nutrition services

The development of this checklist is to assist school to accelerate the development of their own School Health and Nutrition Policies based on the national policy and for provincial and district officials to support schools to develop and monitor the implementation to ensure that schools are safe and secure for learners; skills-based education is provided; and school-based health nutrition services are provided. It is acknowledged that the school-level policy health policies will be effective in schools because Zambia has already got the policy and policy guidelines in place. Hence school-level policies will be supported by national policy framework which articulates expectations for schools across the country. For example, the school Health and Nutrition (SHN) policy recommends that all schools should have safe and separate water and sanitation facilities for girls and boys; that all children are dewormed at

¹ Originally referred to as “health-related school policies”. The word “equitable” was included to ensure that health-related school policies address issues of all children, including disadvantaged minorities

² Originally referred to as “safe water and sanitation”. This was broadened to a “safe learning environment” to include psychosocial aspects of the learning environment and other physical safety Issues besides water and sanitation.

least once a year and provided with vitamin A supplementation and that child health clubs are formed in every school to improve child participation in school health related activities. When developing the school-level policies, it is expected that all stakeholders, (community members, teachers, health care providers where they are available, social welfare officers and learners) are involved.

RATIONALE

The period prior to secondary school is the most crucial for shaping attitudes and behaviors. By the time students reach secondary school, many are already engaging in risky behaviors or may at least have formed accepting attitudes toward these behaviors.”⁵ Given that premise, *Schools and Health* provides a platform and a research base on which to build effective school health programs for the future. Therefore:

- ☞ All learners should receive sequential, age-appropriate health education every year during the lower, middle and upper primary grades and a minimum of a one-term health education talk from a health provider.
- ☞ All primary school teachers should receive substantive preparation in health education content and methodology during their pre-service college training.
- ☞ School health services should be formally planned, and the quality of services should be continuously monitored as an integral part of the community public health and primary care systems by the schools.
- ☞ Research should be conducted on school-based services, particularly on the organization, management, efficacy, and cost-effectiveness of extended services.
- ☞ Confidentiality of health records should be given high priority by the school, and confidential records should be handled in a manner similar to the way in which health records are handled in non-school health care settings.
- ☞ Established sources of funding for school health services should come from both Ministries of Health and education sector funds and new approaches to funding should be developed through PPP.
- ☞ Every school/district should establish a formal organization with broad representation to function as a coordinating committee for school health; this may subsume the Guidance and Counseling Committees.
- ☞ Individual schools should establish a school health committee and appoint a school health coordinator to oversee the school health program; this can likely be the Guidance and Counseling Teacher.
- ☞ An active research agenda on coordinated school health programs should be pursued and a major research effort launched to establish model programs and studies.
- ☞ Further study should be carried out in each of the components of coordinated school health programming.

FRESH APPROACH

1. Equitable School Health Policies

Each school should have a Health Policy in place: School level health policies are necessary to promote effective school health programming:

☞ At school level: school health-related policies set priorities, objectives, standards and rules to protect and promote the health and safety of students and staff. **School health policies should address physical safety issues such as ensuring that the school has adequate water and sanitation facilities as well as a safe environment to protect students and staff from abuse, sexual harassment, discrimination, and bullying.** School health policies **should respond to local priorities and needs of all including marginalised children.** For example, where teenage pregnancy is common, a school health policy may focus on inclusion of pregnant school girls and young mothers; and where child sexual abuse is a danger, a school health policy may prioritize the protection of children from the device. Policies regarding the health-related practices of teachers can act as positive role models for their learners and reinforce health education: for example, by teachers not smoking or drinking while in school.

2. **Safe Learning Environment:** the school environment refers to both physical and psychosocial environment, and aspects of the school or learning space that affects both the physical and psychosocial well-being of students.

☞ **Physical Environment:** the school should be a place where the students are free from danger, disease, physical harm or injury, where sufficient water and sanitation facilities are provided and where physical structures (buildings, courtyards, paths and latrines are around, welcoming and secure. The school environment can potentially damage the health and development of students, particularly damage the health and development of students, particularly if it increases their exposure to hazards such as infectious diseases carried by an unsafe water supply, and lack of hand washing facilities. They also help reinforce the health and hygiene education in schools allowing learners to practice what they learn. They also make the school welcoming and can increase school attendance and retention, especially amongst girls who require the privacy of single sex toilets with provision of water, whether flowing or in containers, particularly during their menses.

☞ **Psychosocial Environment:** the school should be a place where students are free from fear, exploitation, and where codes against misconduct exist and are enforced. When students do not feel safe inside or on their way to school because they are subject to violence, abuse or neglect, the consequences for children, staff, the school and the wider community are many: vandalism against school

community property increases, abusive behaviour toward school staff escalates, conflict among peer groups heightens and, in general, children are unable to learn, less likely to attend and more likely to eventually dropout of school. Preventing and stopping all forms of aggression (physical, sexual and verbal) is a first step to making children feel safe in responding to aggressive acts and ensuring that students, staff and parents are aware of and enforce these rules and procedures are essential.

- 3. Skills-based Health Education:** skills-based education uses participatory exercises to assist students acquire knowledge and develop the attitudes and skills required to adopt healthy behaviours. These skills developed can include cognitive skills such as problem solving, creative and critical thinking; decision making; personal skills such as self-awareness, anger management and emotional coping; and interpersonal skills such as communication, cooperation and negotiation skills. For example, skills-based health education can clarify students perceptions of risk and vulnerability, which can help them avoid situations of increased risk of becoming infected with HIV, malaria or other diseases, increase their understanding of the importance of washing hands after using the latrine or before eating, or realise their own role in the use of resources and their impact on the environment. Skills-based health education thus, has the potential to empower individuals to protect and improve their own and others' health, safety and well-being, which can in turn lead to better health and educational outcomes for children and their communities now and in the future.
- 4. School-based Health and Nutrition Services:** many common health problems which students face in schools can be managed effectively, simply and inexpensively through school-based health and nutrition services. Treatment services such as deworming and micronutrient supplementation are simple, easy, and safe and cheap to administer by teachers and can immediately improve children's health and nutritional status and consequently their ability to concentrate and learn in school. School-based counseling services can help identify and support learners and young people during difficult times and prevent school absenteeism and dropout. A strong referral system with health service providers, child protection services and community support groups are also essential to ensure that children with a more serious health problem which cannot be dealt with at school are referred to the appropriate services. While the school system is rarely universal, coverage is often superior to health systems, and it has an extensive skilled workforce with daily contact with children and community. It is therefore, in a unique position to address common health problems which are preventing children from attending and participating in schools in a prompt and cost effective manner.

5. What other Issues Should be of Concern? Cross-Cutting Issues:

- ☞ **Effective Partnership between Health Centres and the School:** health centres retain the responsibility for the health of children while the education sector retains responsibility for implementing and often funding school-based interventions. MOGE for example has a budget allocation to cross-cutting issues including school health and nutrition, gender, HIV/AIDS and SEN. It is therefore important that in their collaboration, schools and health centres identify and share responsibilities and present a coordinated action to improve health and education outcomes of the children. The starting point is usually establishment of cross-sectoral working groups in the school surrounding. Schools should ensure that each year learners are dewormed and provided with vitamin supplementation by the nearby health facility. They should also ensure that they collaborate with the local social welfare officers to ensure that needy OVC are supported with scholarships or home-grants. The schools should ensure learners are fed through the home-grown school feeding program particularly in drought stricken areas; that Immunization of learners takes place on an annual basis, that learners are free from worms, get lessons on malaria prevention and worm infestation, conduct screening on a regular basis for oral health, eye health and hearing.

- ☞ **Community Participation and Ownership:** this is achieved through effective community mobilisation strategies and strong partnerships between relevant stakeholders, which engender a sense of collaboration, commitment and communal ownership and build public awareness and strengthen demand. The community includes the private sector, women’s and men’s groups as well as youth groups, school management committees such as PTAs, local health care providers, village and religious leaders, and any community group interested and committed to.

FRESH Core Indicators for School Level:

FRESH Pillars	Core Indicators	Definition
Equitable School Health Policies	Percentage of schools that have comprehensive health related schools policies	<p>This indicator is assessed through monitoring a sample of schools in each district (at least a minimum of 10) to determine:</p> <ul style="list-style-type: none"> ☞ The extent to which health related policies exist in schools, along with procedures to monitor and enforce the policies ☞ The extent to which health-related policies that exist in schools, address priority health concerns (both in school and at community level) ☞ The extent to which health-related policies that exist in schools address the FRESH pillars ☞ The extent to which learners, parents and community leaders are aware of, and contribute to the policy

SAFE Learning Environment	Percentage of schools that meet the national school safety standards	<p>This indicator is assessed through collecting data during the monitoring visit of a sample of schools in the district to determine:</p> <ul style="list-style-type: none"> ☛ The extent to which schools meet the safe learning environment standards (physical and psychosocial) ☛ The extent to which the school leadership and staff are aware of and enforce the national standards for a safe learning environment (physical and psychosocial) ☛ Learners, parents and community perceptions of the school providing a safe learning environment (physical and psychosocial)
Skills-Based Health Education	Percentage of schools that provide regular skills-based health education sessions, as recommended in the national SHN Policy and Guidance and Counseling Handbook and Life skills curriculum	<p>This indicator is assessed through collecting data during monitoring and support visits to a sample of schools in the district to determine:</p> <ul style="list-style-type: none"> ☛ The extent to which curricular for school health includes specific skills-based pedagogical components ☛ The existence of quality of Teacher Group Meeting (TGM) and have access to necessary tools to help them teach the health topics using appropriate teaching approaches <p>The extent to which teachers are using participative skills-based approaches in teaching to teach health in schools</p>
School-Based Health and Nutrition Services	Percentage of schools with the minimum package of school-based health and nutrition services (as defined by the SHN Policy and guidelines)	<p>This indicator is assessed through collecting data during monitoring and support visits to a sample of schools in the district to determine:</p> <ul style="list-style-type: none"> ☛ The extent to which the minimum recommended package of school-based health and nutrition services and each element within the package are provided in schools ☛ Capacity within schools to deliver a minimum package of school-based health and nutrition services ☛ Students, parents and other community members views on the provision of school-based health and nutrition services

School-level Checklists:

School level checklists include questions for teachers, pupils and, in some cases, their parents and community members to ensure that the views of stakeholders, particularly the main beneficiaries of the programme (learners) are considered. During the monitoring and support visits, a group of learners can be assembled and asked some questions which are outlined in the checklists below. It is important to take note of the age-range in order to ask age appropriate questions.

A. EQUITABLE SCHOOL HEALTH POLICIES	
School-Level	
Core Indicator 1: Percentage of schools that have comprehensive health-related school policies ³ .	
PURPOSE	<p>To determine:</p> <ol style="list-style-type: none"> 1) The extent to which health-related policies exist in schools, along with procedures to monitor and enforce the policies. <ul style="list-style-type: none"> • Does the school have a written school health-related policy? (This may include school health related policies within a broader school policy.) • Are procedures in place to monitor and enforce the school health-related policy at school-level? 2) The extent to which schools address national and local health priorities, as assessed under Core Indicator 1, 2. <ul style="list-style-type: none"> • To what extent does the school health policy address national school health priorities? • To what extent are the local health priorities known and reflected in the school health policy? 3) The extent to which school health policies address the remaining three FRESH pillars. <ul style="list-style-type: none"> • Does the school health policy include a section on providing a safe physical and socio-emotional safe learning environment for students and staff? • Does the school health policy include guidance on teaching skills-based health education? • Does the school health policy include the provision of school-related health and nutrition services? 4) The extent to which learners know, understand and can contribute to the school health policy. <ul style="list-style-type: none"> • Do learners know that there is a school health policy? • Can learners describe what the school health policy is about? • Is there a mechanism for students to contribute to the design or development of a school health policy? 5) The extent to which health policies are known and understood by parents and community leaders. <ul style="list-style-type: none"> • Do parents and community leaders know if there is a school health policy? • Can parents and community leaders understand the school health policy? • Is there a mechanism for parents and community members to contribute to the design or development of a school health policy?

³ A school health-related policy is defined here as a set of principles and rules governing school activities and operations for the protection and promotion of children’s health and well-being at school.

RATIONALE	<p>Most schools around the world have school policies, defined here as a set of rules and principles that guide school-related activities and operations. School leadership, management committees, PTA members, staff, parents and students are all expected to agree, abide by and act upon these policies to ensure the school operates effectively and achieves its goal(s). Since children’s health and well-being (physical and socio-emotional) are an integral part of quality education, health-related policies are necessary to protect and promote children’s health and well-being at school. School health-related policies should reflect both the national school health policy and priorities, and the local health priorities which may differ between schools. For example, a school located near a busy road may include a policy which focuses on protecting schoolchildren from traffic accidents, whereas a remote rural school may focus on addressing short-term hunger as children walk long distances to school. This indicator assesses the extent to which schools have health-related policies, whether these policies address both national and local health priorities and whether they address all aspects of the three other FRESH pillars. The extent to which school health-related policies address local health priorities will depend in part on the level of participation from different stakeholders, particularly children (girls, boys and vulnerable children), but also parents and community leaders when developing the policy.</p>
DATA COLLECTION METHOD	<p>This indicator is assessed through a survey in a sample of schools representative of all schools in the district, including a review of school level policies and discussions with key informants.</p>

<p>B. SAFE LEARNING ENVIRONMENT School-Level</p>	
<p>Core Indicator 2: Percentage of schools that meet the national school safety standards (physical and socio-emotional).</p>	
PURPOSE	<p>To determine:</p> <ol style="list-style-type: none"> 1) The extent to which schools have capacity to meet the standards for a healthy and safe physical learning environment. <ul style="list-style-type: none"> • Can staff describe the standards for a healthy and safe physical learning environment? • Did staff receive training during the past two years to develop their awareness of the standards and, where relevant, how to implement and/or develop the standards? • What level of commitment and support do staff and/or other partners show towards providing, maintaining and developing a safe physical learning environment? 2) The extent to which the school have capacity to meet the standards for a protective socio-emotional learning environment. <ul style="list-style-type: none"> • Can staff describe the standards for a protective socio-emotional learning environment? • Did staff receive training during the past two years to develop their awareness of the socio-emotional standards and, where relevant, how to implement and/or develop the standards?

	<ul style="list-style-type: none"> • What level of commitment and support do staff show towards providing, maintaining and developing a protective socio-emotional learning environment? <p>3) The extent to which the school meets specific aspects of the school environment standards.</p> <ul style="list-style-type: none"> • Are sufficient numbers of latrines provided and maintained and are they used by/do they meet the needs of girls and boys? • Are there protocols to deal with bullying (by staff and students) and are they implemented? • How many of the minimum standards does the school comply with? <p>4) Learners' perceptions of the school providing a safe learning environment.</p> <ul style="list-style-type: none"> • Do learners feel that the school offers a physical environment that feels healthy and safe? • Do learners feel that the school offers a socio-emotional environment that feels healthy and safe? <p>5) Parent and community perceptions of the school providing a safe learning environment (physical and socio-emotional).</p> <ul style="list-style-type: none"> • Do parents and community members feel that the school offers a physical environment that feels healthy and safe? • Do parents and community members feel that the school offers a socio-emotional environment that feels healthy and safe?
RATIONALE	<p>While national standards may exist to guide schools and the education system on how to ensure children are safe and protected at school (i.e. Child Protection Guidelines by CAMFED, National Child Protection Policy), this does not mean that the standards will be reflected in schools across the country. In many cases, some aspects will be addressed and others not. Schools and the education system's ability to meet the standards depend on a number of factors, including staff and school leadership awareness of the standards, their commitment and capacity to implement the standards, which in turn depends on the education system, community or other partner's support (financial and technical) to help schools meet those standards. This indicator assesses the extent to which schools have a safe learning environment, from both a physical and socio-emotional perspective.</p>
DATA COLLECTION METHOD	<p>This indicator is assessed through a survey in a sample of schools representative of schools in the district (at least 10-15 schools per district).</p>
MEASUREMENT TOOLS	<p>The FRESH checklist 2 covers both the physical and socio-emotional aspects of the school environment and should be adapted to each context to reflect the national standards and program goals. Checklists collected in each surveyed school will need to be aggregated to generate the overall Core Indicator 2 and sub-indicators. These can then be disaggregated by district, school-level (primary and basic) and type of school (community or government), and used to identify higher and lower performing schools.</p>

C. SKILLS-BASED HEALTH EDUCATION

School-Level

Core Indicator 3: Percentage of schools that provide regular skills-based health education sessions, as recommended in the SHN Policy guideline.

PURPOSE

To determine:

- 1) The extent (frequency) health (all topics) is being taught in school.
 - How many distinct health lessons⁴ have been taught during the last school month?
 - How many health topics were infused into other lessons (such as math, language, and art, etc.) during the last school month?
 - How many health-related topics have been addressed in non-classroom school time during the last school month?
- 2) The extent to which each recommended health topic is taught across all the grades in the school in accordance with SHN guidelines and adapted to the local context.
 - Which of the recommended health topics (as per national guidance) are being taught this school year in a particular grade?
 - Was the selection of health topics OR the actual lesson content linked to the topic adapted by the teacher to fit local conditions and challenges?
 - Was the selection of health topics OR the actual lesson content adapted to fit students' ideas about the problems and challenges they face?
- 3) The extent to which teachers have received the appropriate training in skills-based health education.
 - How many teachers have received pre-service training in skills-based health education, including participatory teaching approaches?
 - How many teachers have received in-service training in skills-based health education, including participatory teaching approaches?
- 4) The extent to which teachers have access to necessary tools to help them teach the health topics using appropriate teaching approaches (such as recommended teacher guidance and student materials).
 - Which of the textbooks or curriculum guidelines that are based on skills-building approach or other evidence-based approaches are present and used in schools?
 - Do teachers use other materials to support teaching health lessons?
- 5) Teacher's views of the extent to which they are using participative,

⁴ Please note the distinction between lessons and topics. Several lessons can be used to teach a topic. The extent to which health is being taught requires that each school has provided for contact time on the school teaching timetable for the G & C teacher to teach these lessons. Participatory health teaching approaches like the ones used by REPSSI would be very appropriate for teachers to be trained in.

	<p>skills-based teaching approaches to teach health topics.</p> <ul style="list-style-type: none"> • To what extent are teachers focusing on developing students' skills during the health lessons? • Do teachers write down the skill(s) they wish to develop or strengthen in their students as a result of each health lesson in their lesson plans? • Do teachers ask the students open questions (i.e. questions you do not know the answers to) and/or give them an activity to do to practice a skill in most of their health lessons? <p>6) Learners' views of the extent to which teachers are using participative, skills-based teaching approaches to teach health topics.</p> <ul style="list-style-type: none"> • Which health topics have been taught in the last 12 months? • To what extent have students been engaged in discussions and other activities in class? • As a result of a health lesson, did learners feel they could do something new or better that will improve their own or another's health?
<p>RATIONALE</p>	<p>Skills-based health education can influence health behavior by equipping students with the knowledge, attitudes and skills they need to stay safe and healthy. Skills-based health education can clarify students' perceptions of risk and vulnerability to help them avoid situations of increased risk and empower individuals to protect and improve their own and others' health, safety and well-being, which can in turn lead to better educational outcomes. This indicator assesses the extent to which skills-based health education is being provided in schools.</p>
<p>DATA COLLECTION METHOD</p>	<p>This indicator is assessed through a survey in a sample of schools representative of schools in the district.</p>

D. SCHOOL-BASED HEALTH AND NUTRITION SERVICES	
School-Level	
Core Indicator 4: Percentage of schools where the minimum package of school-based health and nutrition services (as defined at program-/national-level) is provided.	
PURPOSE	<p>To determine:</p> <ol style="list-style-type: none"> 1) The extent to which the minimum recommended package of school-based health and nutrition services is provided in schools. 2) The extent of links between local health and nutrition services and schools. 3) Capacity within schools to deliver a minimum package of school-based health and nutrition services. <ul style="list-style-type: none"> • Have staff been trained during the last two years to deliver school-based health and nutrition services (delivery including referrals)? • Is there a support system for staff who are involved in the delivery of school-based health and nutrition services? 4) Learners', parents', and other community members' views on the provision of school-based health and nutrition services. <ul style="list-style-type: none"> • How many of the school-based health and nutrition services does the school provide? • Do the school-based health and nutrition services meet the physical health needs of learners? • Do the school-based health and nutrition services meet the socio-emotional health needs of learners?
RATIONALE	<p>This indicator assesses the extent to which the minimum package of school-based health and nutrition services (defined either at national- or program-level) is being provided in schools. The recommended package of school-based health and nutrition services may be determined at national-level (within the national school health policy) or at program-level. In either case, the package of school-based health and nutrition services should address national (and or local) health and nutrition priorities and be cost-effective. The package may include a range of services addressing both physical and socio-emotional health problems affecting schoolchildren and their participation and learning in school. Examples of school-based health and nutrition services include mass deworming and micronutrient supplementation as recommended by WHO in areas where prevalence of worms or anemia are high; school meals or snacks to address short-term hunger and improve attendance; school nurses or first aid kits; vaccinations (usually boosters); counseling of children and an effective referral system for more serious health problems. The services may be administered by teachers and/or health professionals, but are school-based, rather than health center- or community-based.</p>
DATA COLLECTION METHOD	<p>This indicator is assessed through a survey in a sample of schools representative of schools in the district.</p>
MEASUREMENT TOOLS	<p>The FRESH checklist 4 can be used to collect information on school-based health and nutrition service provision and inform the five sub-indicators listed in the Purpose above and the overall Core Indicator 8. It must be adapted to each context to reflect the recommended minimum package of school-based health and nutrition services (as determined at</p>

	<p>program- or national-level). Minimum standards for each school-based health and nutrition service should be provided alongside the checklist to clarify what a school should consider 'provision of a health and nutrition service'. Checklists from each school will need to be aggregated to generate the overall Core Indicator 8 and sub-indicators. These can then be disaggregated by district, school-level (primary and secondary) and type of school (government primary or community school), and used to identify higher and lower performing schools.</p>
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