

# An Evaluation of School Health Promoting Programmes and the Implementation of Child Friendly Schools Initiative in Primary Schools in Kenya

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**Abstract** This paper discusses the efforts related to school health that have been put in place in primary schools to promote learner friendly environments based on a study that was done in Uasin Gishu county, Kenya. The study was guided by the following objective: to assess the health promoting programmes that have been put in place and their effect on implementation of child friendly schools initiative. This study was anchored on resiliency theory as proposed by Krovetz (1998). Resiliency theory defines the protective factors in families, schools, and communities that exist in the lives of successful children and youth and compares these protective factors with what is missing from the lives of children and youth who are troubled. This study adopted a pragmatic approach to research and a mixed methods research design. From the 338 public primary schools in the county, a total of 103 schools were sampled to participate in the study which constituted 30% of the target population. A total of 103 headteachers and 103 class seven class teachers and 2,259 class seven pupils, who were grouped into 202 focus group discussions, participated in the study. Data was collected using questionnaires, interviews and focus group discussions. Data was analyzed using descriptive and inferential statistics as well as qualitative techniques. It was established that there is a significant positive relationship between school health promoting programmes and implementation of child friendly schools initiative. It was also noted that schools still experienced challenges in relation to provision of adequate nutrition, clean and safe drinking water as well as access to proper healthcare within the reach of children and communities. The study is significant to headteachers, parents, communities and the ministry of education in an effort to promote learner friendly schools.

**Keywords:** health promoting school, nutrition, child friendly schools, school programme, initiative

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## 1. Introduction

The quest to protect the interests of children is an issue that has attracted considerable attention across the world. According to National Centre for Early Childhood Education [15] a number of instruments provide for the rights of children in Kenya. This dates back to The Declaration on the Rights of the Child (Declaration of Geneva) of 1924 which is an international document that set down the fundamental principles for the rights and protection of the child. Although this document is non-binding, it reflects all the norms and values which all nations should aspire for in relation to the rights of the child.

Another document that was first drafted after the formation of the UN was the Declaration of Human Rights of 1948. This document recognized human rights to work, leisure, an adequate standard of living and education [16]. This declaration was in fact a major document devoted to the rights of the children. It introduced the principle of the 'the best interests of the child' to guide all those who

would be involved in the making of decisions that would ultimately affect the children. This reiterates that the child must be protected beyond and above all considerations of race nationality or creed [15].

The latest attempt in the protection of the interests of the child is the UNICEF's initiative to create learner friendly schools. The concept of Child Friendly Schools (CFS) as developed by the UNICEF has been experimented in countries with the sole aim of guaranteeing the children a right to quality education. According to Bellamy [2] a Child Friendly School is a rights based school, which actively identifies excluded children and gets them back to school; acts in the best interests of the "whole" child; is a safe gender sensitive environment that adapts to the needs of children; promotes active participation through interactive learner centred teaching methods and learning materials; assesses learners' progress continuously; consults children in the development of curriculum, lesson plans, materials and resources.; is well managed with children, families and communities actively participating in decision making and school management.

The idea of a “child-friendly” school grew out of efforts in the 1990s to link the concept of quality education with the Convention on the Rights of the Child (CRC). At the dawn of the new millennium, the concept continued to gain momentum in two continents. In Asia, representatives from 11 South and Southeast Asian countries participated in the UNICEF/Save the Children “Child-Friendly Learning Environments Workshop” in Chiang Mai, Thailand. In Sub-Saharan Africa, the 34 countries participating in the African Girls’ Education Initiative integrated child-friendly and girl-friendly initiatives into their programming and CFS related indicators into their programme evaluations. Since then, the CFS approach has continued to influence basic education programming around the world [2].

In the year 2010, students’ leaders in Kenya converged in several conferences countrywide to discuss on the issues that could render schools learner friendly. It is noteworthy that the involvement of students in decision making in schools is still at the minimal level.

### 1.1. School Health Promoting Programmes

Issues that relate to nutrition play a fundamental role in enhancing learner friendly school environment. Adequate nutrition is necessary for children to become fit and productive adults capable of fulfilling their responsibilities in life. People who are well-nourished and educated are more productive as they would consequently improve their own income and contribute positively to the national economy [21]. For instance, improvements in health and wellbeing of women and their families through better nutrition contribute to reducing their financial burdens and time constraints. Gained time and resources can be used for income-generating and productive activities or for participating in educational, health or social engagements from which women and their families can benefit (UN, 1970). Studies also indicate that implementation of essential public health programmes, including nutrition, health education and micronutrient supplementation, can reduce a considerable amount of the disease burden in low- and middle-income countries [25,30]. For example, using conservative assumptions, the benefits of investing in school feeding will far exceed the costs even if this could be one of the most expensive possible nutrition interventions [21]. In addition, nutrition interventions can contribute to reducing the substantial health care costs for nutrition-related chronic diseases and for productivity losses due to nutrition-related health problems.

Nutrition interventions improve children's health, learning potential and school attendance. Good health and nutrition are essential for concentration, regular school attendance and optimum class performance [13]. Existing research makes a convincing case that nutrition and health interventions will improve school performance [18,27]. For instance, studies in multiple countries show that the academic performance and mental ability of pupils with good nutritional status are significantly higher than those of pupils with poor nutritional status [25]. This and other evidence of the positive impact of good nutrition has been so convincing that the United Nations Sub-Committee on Nutrition recommends health and nutrition programmes among efforts to increase school enrolment and learning [21].

Schools are vitally important settings through which to promote good nutrition and provide nutrition interventions. Schools offer more effective, efficient and equal opportunities than any other setting to promote health and healthy eating. They reach young people at critical age of development in which lifestyles, including eating patterns, are being developed, tested and adapted through social interactions between students, teachers, parents and others [1]. In addition, schools have the potential to reach not only students but also staff, teachers, parents and community members, including young people not attending school. A Health-Promoting School provides a means to develop and manage nutrition interventions in collaboration with parents and communities.

Schools are an ideal setting that can promote health and healthy nutrition for several reasons. These include the need for schools to reach a high proportion of children and adolescents who may not otherwise access education. Schools should also provide opportunities for children to practice healthy eating and food safety. Schools can teach students how to resist unhealthy social pressures since eating is a socially learned behaviour that is influenced by social pressures. It is also recommended that schools should identify skilled personnel to provide follow-up and guidance – after appropriate training of students, teachers and other service personnel. Lastly evaluations can be used to show that school-based nutrition education can improve eating behaviours of young persons [4]. These recommendations show that school health and nutrition is a very important facet of learning that cannot be wished away if a child friendly school environment is to be achieved.

Evidence for many years has supported that well-managed nutrition education programmes can, at relatively low cost; bring about behaviour changes that contribute to improved nutritional well-being [32]. Additionally, school feeding programmes increase food availability to school children who need adequate food while promoting long-term development through support and education. While studies still continue, numerous evaluations of school feeding programmes have reported either significant increase in height and/or weight for participating children or in attendance and achievement [25]. School feeding programmes also contribute to decreasing hunger and hence helping children concentrate on their studies.

Furthermore, among the most cost-effective investments in health are programmes that include expanded micronutrient supplementation and increased knowledge about nutrition [30].

Studies also point out a relationship between education level and health. Educated girls are healthier than girls with no or little education. Educated girls and women seek appropriate prenatal care, give birth to healthier babies and bring them home to healthier environments [30]. Research evidence makes it clear that the single most important factor in determining a child's health and nutritional status is its mother's level of education. Malnourished mothers tend to have low birth weight babies, thus perpetuating the problem of malnutrition and ill health from one generation to the next [10]. For instance, a child's aptitude for formal education may be in jeopardy even prior to school enrolment if the mother suffered from maternal iodine deficiency during

pregnancy. Thus, educating young mothers and mothers-to-be is one of the best ways of ensuring the nutritional future of the next generation. In addition, the school system may be particularly useful in trying to supplement the diet of girls before puberty to ensure the remaining growth potential is fully achieved during this critical stage [21]. It is therefore notable that issues that relate to education and nutrition are intertwined and very fundamental in the quest to achieve quality learning outcomes. Schools should as such take into account this very important aspect of life and strive to provide adequate nutrition for all school going children.

Schools also provide a setting to introduce new health information and technologies to the community. For instance, the establishment of school canteens offering healthy food choices and practicing good food safety is a way to demonstrate how to improve facilities in communities. Furthermore, partnerships between schools, organizations and businesses can benefit both the school and the community, if the partnership is mutually beneficial.

In Dakar, Senegal in April 2000, the international community reaffirmed its commitment to achieving education for every citizen in every society. The *Dakar Framework for Action, Education for All 2000*, outlines goals and strategies for attaining that target by 2015. One important condition for fulfilling children's right to a basic education, the Framework notes, is "the creation of safe, healthy, inclusive and equitably resourced educational environments conducive to excellence in learning." Improving students' health and nutritional status can redress common sources of absenteeism, poor classroom performance and early school dropout, and thus boost the possibility of Education for All [20].

Recognising the importance and potential of a healthy school setting, four international agencies - each with decades of specialised experience working through schools to enhance learning and health - recently agreed upon a shared framework to strengthen school health, hygiene and nutrition programmes. Working together to Focus Resources on Effective School Health ("FRESH"), UNESCO, UNICEF, WHO and the World Bank recommends a core group of cost-effective components, as a common starting point for all schools. The components include: health-related school policies; provision of safe water and sanitation; skills-based health education; and school-based health and nutrition services [26].

When implemented and coordinated well, an effective school health programme can provide a strong foundation from which to build a "health-promoting school". For example, with the four common components firmly in place, a school can strive to foster health with all the measures at its disposal- the defining characteristic of a health-promoting school. This might include health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and many other health-related efforts. Similarly, FRESH lays groundwork from which to attain the five quality standards of a "child friendly school". They include quality of the learners and their experiences and needs, the relevance of the curriculum content and processes, the quality of the classroom and broader school environment, and the appropriateness of assessment and

achievement of learning outcomes in areas such as literacy, numeracy, knowledge, attitudes and skills for life.

It is also notable that safe drinking water and sanitation facilities are essential in promoting healthy learning environments. Ensuring private sanitation facilities and easy access to drinking water both at schools and at home, can enable children to remain healthy and enjoy a friendly school environment. Studies also reveal the importance of promoting school hygiene but little attention has been given to the role of school nutrition in the transformation of schools to learner friendly environments.

The success of school health programmes in Kenya demands an effective partnership between Ministries of Education and Health, and between teachers and health workers. The ministries must also coordinate and supporting local responses, so that programmes and services are appropriate to community requirements. Community support can make or break these programmes. The Kenya Education Sector Support Programme (KESSP) report [19] highlights that a significant number of school going children suffer from mild and moderate malnutrition while others also suffer from severe growth retardation. Other health problems are also experienced with intestinal parasitic infection and malaria. There is therefore a need to supply safe water to schools or install community water treatment plants near schools. If the government is committed to providing FPE then it must work hard in addressing other issues that would contribute to increased enrolment of children in schools. There is also a need to improve the standards of hygiene and environmental health. The government individual schools and other stakeholders should work to avert the dangers to relate to health and put in place corrective measures. This would in turn help improve the health of learners and so retain them in the schools.

But the Kenya government is working through the MOEST and Ministry Of Health (MOH) to undertake supplementary immunization activities against measles polio and also undertaking supplementary immunization activities of school-age girls of childbearing age with Tetanus -Toxoid in high risks maternal and Neonatal Tetanus disease districts [19]. Initiatives on Health Promotion Education include the following: immunization and vitamin A supplementation; schools competition through music and drama festivals using themes on health promotion and education; establishment and strengthening of school health clubs.

The challenge however is the fact that schools health and nutrition policies are scattered across a variety of ministries making them extremely difficult to access and implement. The MOEST and MOH and other partners should ensure that the policies and guidelines on schools health are implemented in all primary schools across the country.

## 2. Statement of the Problem

Education is recognized as a tool for achieving social equality and equity and so it should endow all individuals with skills and competencies geared towards a smooth progress from primary to secondary schools in Kenya. Since the inception of Free Primary Education in the year 2003 it is noteworthy that many children in Uasin Gishu

county in Kenya, are still unable to access education due to home or school related reasons. It is in this perspective that the Ministry of Education in Kenya and the UNICEF agreed to improve the learning conditions in schools in an attempt to promote child friendly schools. This study therefore was focused on assessing the health promoting programmes in an effort to promote the implementation of child friendly schools initiative.

### 3. Methodology

This study adopted a pragmatic approach in order to gain entry into the school health programmes and its influence on the implementation of the CFS initiative. CFS as a concept is solely aimed at enabling children to have meaningful learning experiences in schools and better the outcomes of school attendance. To a pragmatist, the mandate of science is not to find truth or reality, the existence of which are perpetually in dispute, but to facilitate human problem-solving.

The study therefore utilized the mixed-methods approach and a descriptive survey research design which involved a concurrent collection and analysis of both quantitative and qualitative data. Mixed methods approach was especially used at data collection stage to enable enriched findings. Principals of schools were interviewed while the teachers' questionnaires were used to collect data from teachers. Focus group discussions was used to collect data from pupils. Thus the study triangulated questionnaires, interviews and focus group discussions in order to best describe the health promoting programmes in schools and its influence on implementation of CFS initiative.

In this study the 338 primary schools were stratified into seven educational divisions, from which 103 primary schools were selected proportionately from the divisions. This represented 30% of the primary schools in the County. A stratified random sample is a useful blend of randomization and categorization, which enables both quantitative and qualitative process of research to be undertaken [3]. A sample size of 30% of the headteachers and class seven teachers and 10% of class seven pupils participated in the study. This agrees with Kerlinger [12] who noted that a sample size of at least 10%-30% is a good representation of the entire population. A total 103 headteachers as well as 103 class teachers were sampled to participate in the study. A total of 2,259 class seven pupils were grouped into 202 focus group discussions consisting of 11 pupils each. This is supported by Cozby [5] who notes that groups of between 6-12 members are recommended for focus group discussions.

### 4. Results and Discussion

#### Level of Health Promotion programmes and Child Friendly Schools Initiative

The study sought to establish the level of implementation of health programmes which is deemed to be an important component in boosting the implementation of child friendly schools initiative. The level of health implementation programmes was looked at by measuring the following variables: access to clean and

safe drinking water, health hygiene and life skills education, access to health services, community outreach services, recreation space and time for all learners, Maintenance of school compound. The respondents were asked to indicate their rating of these variables on a 5 point likert scale as follows: 5=excellent, 4=good, 3=satisfactory, 2=unsatisfactory, 1=poor.

#### 4.1. Access to Clean and Safe Water

The respondents were asked to indicate their opinions in relation access to safe and clean water for drinking and washing. Findings indicate that 31.1% (64) of the respondents said that this was unsatisfactory while 19.9% (41) rated it as poor. The cumulative percentage of children who were unable to access clean and safe water was 51%. It was also noted that only 15.5% (32) and 14.1% (29) observed that it was good and excellent respectively while the remaining 19.4% (40) noted that the rating of the water used was just satisfactory. It is therefore observable that availability of safe and clean water in schools is a challenge in most schools. This agrees with UNICEF [22] that points out that lack of access to safe drinking water contributes negatively to provision of education in sub Saharan Africa because a lot of time is wasted in search of potable water. For the county to effectively implement the child friendly schools process, it is important that teachers, pupils and their communities should actively participate to enable members' access clean and safe water for use in homes and schools. Lack of safe water for drinking and hand washing could expose children to waterborne diseases. Effective strategies that could be used can include child-to-child or child-to adult education on hygiene and safe water.

#### 4.2. Health Hygiene and Life Skills Education

The respondents were also asked to rate if 'Health, hygiene and life skills education is part of the curriculum and is regularly taught' It was revealed that 28.2% (58) of the respondents were in agreement that the regular teaching of health, hygiene and life skills education as part of curriculum was good. The rest of responses were: 23.3% (48) for unsatisfactory, 21.8% (48) noted that it was satisfactory while 17.0% (35) and 9.7% (20) rated the teaching as poor and excellent respectively. Most of the schools strive to include regular teaching of hygiene in their curriculum which ensures good health and hygiene. It is however observable from these findings, that there is still a need to impart skills based health education amongst learners especially those with diverse backgrounds and abilities. This would enable them to practice healthy habits and avoid unhealthy ones. Right now, in East and central Africa, millions of children are facing desperate hunger, disease and lack of clean water. These children also face reduced access to education and increased threats of violence and abuse as families' lives and livelihoods are put under such strain. The lack of rain and extreme temperatures have made crops fail and livestock die, causing the price of food to rise across the region, leading families to skip meals, pull their children out of school to help with family income, and sell-off valuable assets just to put food on the table. While this may ensure their survival today, in the long term it reduces families' resilience to drought and other threats

[24]. Based on the findings of this study it can be noted that skills based health focuses on changing specific behaviours in terms of knowledge, skills and attitudes. This will help the learners and parents to choose and practice healthy behaviours.

### 4.3. Access to Health Services

When asked to state their view on the provision of nutrition services such as deworming, school feeding, Vitamin A, Supplementation, it was noted that 27.7% (57) of the respondents said it was unsatisfactory, 25.7% (53) indicated poor while 20.9% (43), 18.9% (37) and 7.8% (16) rated the services as satisfactory, good and excellent respectively. It is notable therefore that nutrition services for primary school going children in the county are inadequate, a fact that could deteriorate their health. It is observable from the study that provision of adequate nutrition can be a very effective way of improving literacy rates and helping learners to break out of poverty. When school meals are offered, enrolment and attendance rates increase significantly. The schools can also work with other stakeholders such as the Ministry of Health to avert the dangers that relate to health and put in place corrective measures. This agrees with UNICEF, [23] that asserts that nutrition services provided to the children in most of the schools are not adequate and this could deteriorate the health of the children in the school. It is important for schools to come up with health and protection policies for schools to be transformed to child friendly status. This is echoed in UNICEF (2006) that for many years has contended that well-managed nutrition education programmes can bring about behaviour changes that contribute to improved nutritional well-being.

This would in turn help improve the health of learners and so retain them in the schools. Learners can also be encouraged to participate in monitoring their own nutritional status and in developing the school food policy and involving their parents and communities. The knowledge of parents and learners can be used to improve the school health programmes.

When asked to rate their level of access to health facilities or first aid, health educations 28.2% (58) rated it as unsatisfactory, 22.8% (47) saw it as good while 20.4% (42) rated it as satisfactory. Those who rated it as poor and excellent made a representation of 17.0% (35) and 11.7% (24) respectively. This implies that most of the schools do not have a good access to health centre and the health facilities. Studies in the United States also documented that carefully designed and implemented comprehensive health education curricula can prevent certain adverse health behaviours, including dietary patterns that cause disease [25].

### 4.4. Community Outreach Services

On the number of outreach activities done per term by the school to prevent HIV/AIDs, 36.9% (76) of the respondents rated it as unsatisfactory, 26.7% (55) indicated poor while 20.4% (42) saw it as satisfactory. A proportion of 12.1% (25) and 3.9% (8) indicated good and excellent respectively. More outreach need to be done to educate the children on the dangers of HIV/AIDS and how to curb the spread in the institution and in the community. It is very important to take a skills based approach to

management of HIV and AIDS to reduce the stigmatization of those affected by the disease. The crucial responsibility of schools should be to teach young people in communities and schools on how to avoid contracting the disease or transmitting to other people as well as development of HIV-related policies. Schools' health clubs or special anti-AIDS clubs can be useful for learners to learn how AIDS is spread and make a commitment to protect themselves and teach others how to prevent AIDS.

School policies can ensure a safe and supportive environment, both physical and psycho-social, for children and young people in a world with HIV/AIDS. At the national level, appropriate legislation and administrative actions can mitigate the impact of HIV/AIDS by ensuring the right of HIV/AIDS affected people to education, combating discrimination within the education sector and directing resources to strengthen recruitment, training, management and other elements of a nation's educational infrastructure. According to UNICEF [22] HIV/AIDS continues to pose a serious threat to education with a possibility of exposing teachers and learners to the disease. The study however further revealed how schools are playing a very minimal role of involving the community in mitigating the effects of HIV/AIDS by involving the members of the community through school community outreach programmes. This is in line with Kelder [11] who asserts that school health education interventions can be considerably strengthened by complementary community-wide strategies. According to WHO [25] schools can be the centre for community enhancement projects that include programmes to improve the health and nutritional status of the community. Schools also provide a setting to introduce new health information and technologies to the community.

### 4.5. Recreation Space and Time for All Learners

On the issue of recreation space and time for all learners, it was rated by 28.6% (59) of the respondents as poor. The study points out that the areas for recreation, time allocation and inclusion of learners with special needs in recreational activities was poor. This item was rated by 27.7% (57) of respondents as good. Those who rated it as unsatisfactory, satisfactory and excellent represent 19.9% (41), 16.5% (34) and 7.3% (15) respectively.

Any disadvantage that girls may experience in primary schools, is to some extent, a matter of judgment, but Kelly's (1988) conclusions certainly sustain the hypothesis that girls learn that they occupy an identifiable and different place in the educational system to that of boys. Again sex group membership and gender socialization are confounded. As a result, girls learn their place; they make fewer demands and are accorded fewer resources. Girls who pursue careers in science and technology or positions of leadership find themselves challenging the dominant view of femininity [14].

Putting all the learners on an equal playing ground requires conscious efforts of teachers and other staff within the school system. A better understanding, therefore, is needed of the difficulties, which face teachers who wish to help children to overcome their well-documented unwillingness to transcend the discriminatory

practices of culture. It has been argued that there are limits to what can be achieved through classroom interaction given the complexity of the problem [6]. Children develop firm ideas about their respective life roles at a very early age but there is no reason to suppose that schools cannot effect some change in attitudes and aspirations. Schools can have a substantial influence in modifying the effects of the disadvantaged [31]. Further, it is argued that there are schools where attempts are made to monitor teaching approaches and materials to guarantee equal opportunities. This has, however, not attained much progress and there is need for greater understanding of latent discrimination in schools- 'the hidden curriculum' – and of the differential treatment children appear to receive in the classroom [31]. According to a CFS manual (MOE, 2010) inclusive education goes beyond bringing children to the classroom set up. Although, primary and secondary head teachers in Nairobi, Kenya, are important ambassadors when it comes to implementation of the national school health policy, only 15 percent of schools in Nairobi have a comprehensive school health program. The Strengthening Evidence for Programming on Unintended Pregnancy (STEP UP) Research Programme Consortium wants to scale up this proportion to 50 percent by 2017. In order to achieve, an engagement with stakeholders will be required to understand the challenges schools face in implementing school health programs (MOH, 2015: <http://aphrc.org>).

An emphasis is actually placed on the need to use a variety of methods and activities to meet the needs of children with different learning needs. A challenge is therefore posed on teachers who use rote methods in teaching as they struggle to cater for the large classes.

#### 4.6. Maintenance of School Compound

Responses on the cleanliness and maintenance of the school compound showed that majority, 41.3% (85), of the respondents rated it as good, 20.9% (43) said it was excellent while 16.0% (33), 12.6% (26) and 9.2% (19) rated cleanliness and maintenance of the school compound as satisfactory, unsatisfactory and poor respectively. Generally schools had put an effort in regular maintenance of school facilities. This is in line with Day and Golench's (1997) suggestions that root causes of school violence go beyond the borders of school grounds and that the goal of school health and safety program should be to create and maintain a positive and welcoming school climate, free of drugs, violence, intimidation, and fear – an environment strongly supported by the community in which teachers can teach and students can learn. Schools should be safe and secure places for all students, teachers, and staff members without a safe learning environment, teachers cannot teach and students cannot learn.

According to Vaduganathan (2005), quality of education primarily resides within school facilities among other factors. Entwistle et al [7] also observes that a well desired educational facility is one that effectively meets the present educational and social needs of its occupants. In addition, such a facility should meet statutory regulations and other agreed health and safety equipments as well as provide adequate security against unauthorized access. Decaying environmental conditions such as peeling paint, crumbling plaster, non-functioning toilets, poor lighting and inadequate ventilation coupled with

unhealthy and insecure educational environments have all been too common a phenomenon the world over.

Determining what policies are needed requires the participation of all the stakeholders within the school and communities. Development of these, policies from the advocacy through consensus building, policy enactment to implementation and evaluation is a process of awareness raising and partnership building. Schools stand to benefit greatly by involving healthcare providers and community leaders.

#### 4.7. Hypothesis Testing

To establish whether there existed a relationship between health promoting programmes and child friendly schools implementation process in Uasin Gishu County, the researcher used Pearson Correlation Coefficient. The research question was stated thus:

**H<sub>01</sub>** There is no significant relationship between health promoting programmes and child friendly schools implementation process in Uasin Gishu County.

The rejection level was set at 0.05. The null hypothesis is rejected if the p-value or sig is less than or equal to 0.05 and if more than 0.05, then we fail to reject the null hypothesis. After testing hypothesis H<sub>02</sub>, the results were as follows:

**Table 1. The correlation coefficient between health promoting programmes and child friendly schools implementation process in uasin gishu county**

	health promoting programmes
Child friendly schools	$r = .765$ $p = 0.017$ $n = 206$

The results of Correlation Coefficient used for data analysis suggested that there is a significant positive relationship between health promoting programmes and child friendly schools implementation process in Uasin Gishu County at  $p \leq 0.05$  significance level ( $r = .765$ ) as shown in Table 1 above. This hypothesis was tested and  $r = .765$  (204) and sig ( $p$ ) = 0.017, two-tailed was found. This reveals that  $p < 0.05$ . Therefore the null hypothesis is rejected. This implies that there was a significant strong positive relationship between health promoting programmes and child friendly schools implementation process in Uasin Gishu County.

Interviews and focus group discussions were administered and some of the finding include the following: On an item on medication in case the pupils fell ill in school, the responses were as stated below:

*“when we are sick, we visit the local dispensary to get medicine from the nurses but when our condition worsens our parents are called to take us for more specialized treatment since there is no provision of medicine in the school”.*

The respondents advocated for an equipped dispensary with competent nurses. On the availability of school feeding programmes, the respondents retorted: “we have to walk back to our homes for mid day meals”. It is also notable that few respondents rejoined that “an attempt to provide porridge at 10.0 o'clock and Githeri (mixture of maize and beans) at lunch had been done”. Most of the respondents stated that they do not have school feeding programmes. This is the scenario in most public primary schools and especially those in the rural areas.

Nevertheless, this is not sufficient for a balanced diet for the children and it can result into malnutrition. It is important to note that no meaningful learning can take place in any school situation if issues of good diet and subsequently good health are not put in place. It was evident that most respondents were not happy with school feeding programmes. It would be very important if headteachers of learning institutions can come up with sustainable programmes that would promote good nutrition and good health amongst primary school children.

## 5. Conclusions and Recommendations

From the second objective on level of health in the school, it was observed that majority of the schools observed cleanliness because there was proper use and maintenance of the available latrines. However, nutrition services provided to the children in most of the schools are not adequate and this could deteriorate the health of the children. Schools, however, strive to provide clean water for drinking and include regular teaching of hygiene in their curriculum which ensures a child friendly environment.

Although, most of the schools have a reasonable access to health centres and measures on proper ventilation in the classrooms have been put into consideration there is need for more outreach activities to educate the children and the communities on the dangers of HIV/AIDS and how to curb its' spread. From the study it also noted that the schools should have well defined health policies that should be able to address the challenges faced by the pupils. This will enable the school and the community to have healthier children who are ready to learn. Some of the health policy programmes could include a sustainable school feeding programme which can be achieved through sustainable income generating activities. This would lead to schools that are friendlier to pupils and hence enhanced quality of teaching and learning. This would also improve knowledge, skills and attitudes amongst teachers and pupils.

In regard to school health it is recommended that the Ministry of Education should have a clear policy on schools' nutrition services. The Ministry of Education should also enhance its collaborative efforts on vitamin A supplementation and deworming programmes. This should aim at reaching all the children who require these services so as to enhance their health and subsequently the quality of education they receive from schools.

The school management should mobilize more resources through income generating projects to be used in the provision of adequate nutrition services to the children to enhance their health.

## References

- [1] Arnhold, Wolfgang (1997). *Healthy Eating for Young People in Europe: Nutrition Education in Health-Promoting School*. Draft. Ministerium für Frauen, Bildung, Weiterbildung und Sport des Landes Schleswig-Holstein, Europäische Kommission, 1997.
- [2] Bellamy, C. (2003). *The State of The World's Children 2004: Girls Education and Development*. New York: UNICEF.
- [3] Cohen, L, Manion, C and Morrison, K. (2011). *Research Methods in Education*. London; Routledge.
- [4] Contento, I.R., Manning A.D., Shannon B. "Research Perspective on School-based Nutrition Education," in *Journal of Nutrition Education* 1992, 24:247-60.
- [5] Cozby, P.C. (2001). *Methods in Behavioural Research* (7<sup>th</sup> Ed.). London: Mayfield Publishing Co.
- [6] Deem, J. (1980). *Schooling*. Great Britain: Routledge & Kegan Paul.
- [7] Entwistle, N. et al. (1990). *Handbook of Educational Ideas and Practices*. U.K.: Routledge.
- [8] Government of Kenya (2005). *Kenya Education Sector Support Programme 2005-2010: Delivering Quality Education and Training to All Kenyans*. Nairobi: Government Printers.
- [9] Government of Kenya (2005). *Sessional Paper No 1 of 2005: A Policy Framework For Education, Training and Research*. Nairobi: Government Printers.
- [10] Horwitz, A. (1983). "Why Teach Nutrition and to Whom," Chapter 31 in *Nutrition Intervention Strategies in National Development*. New York: Academic Press. <http://aphrc.org/are-nairobi-schools-implementing-the-national-school-health-policy/retrived> on 27th July 2016.
- [11] Kelder, S. (1995). "Community-Wide Youth Nutrition Education: Long-Term Outcomes of the Minnesota Heart Health Program," *Health Education Research* 1995, 10(2): 119-131.
- [12] Kerlinger, F.N. (1986). *Foundations of Behavioural Research*. New York: Subject Publications.
- [13] Levinger, B. (1996). *Nutrition, Health and Education for All*. Newton, MA: Education Development Center.
- [14] Lloyd, B. & Duveen, G. (1992) *Gender Identities and Education. The Impact of Starting Schools*. New York: Harvester Wheatsheaf.
- [15] National Centre for Early Childhood Education (2002). *Child Rights and Child Protection*. Nairobi: Kenya Institute of Education.
- [16] Ndani, M (2009). *Child Rights and Child Protection*. Nairobi: Longhorn publishers.
- [17] Pinstrup-Andersen, P. "Protein-energy malnutrition (PEM)" in *Disease Control priorities in Developing Countries*, D. Jamison, W.H. Mosley, J.L Bobadilla, A.R. Measham, eds. New York: Oxford University Press, 1993. -- quoted by Berg, A. (37, 279).
- [18] Pollitt, E. (1990). *Malnutrition and Infection in the Classroom*. Paris: UNESCO.
- [19] Republic of Kenya (2005). *Kenya Education Sector Support Programme (KESSP) 2005-2010; Delivering Quality Education and Training to all Kenyans*. Nairobi: Government Printers.
- [20] Republic of Kenya (2005), *Sessional Paper No. 1 of 2005: A Policy Framework on Education, Training and Research*. Nairobi: Government Printers.
- [21] UN/ACC/SCN. (1990). *Women and Nutrition*. Nutrition Policy Discussion Paper No. 6. October.
- [22] UNICEF (2009). *Child Friendly Schools: Emerging Practices in Southern and Eastern Africa*. Nairobi: UNICEF
- [23] UNICEF (2006). *The state of the World's Children: Excluded and Invisible*. New York: UNICEF.
- [24] Unicef (2016), *For Every Child in Danger* <http://www.unicef.org.uk>.
- [25] WHO (1996). *Promoting Health through Schools: The World Health Organization's Global School Health Initiative*. Geneva: WHO.
- [26] WHO (2000). *Preventing HIV/AIDS and related discrimination: An important responsibility of Health Promoting Schools*. Geneva: WHO School Health Information Series, <http://www.who.int/hpr/gshi/publications.htm>.
- [27] WHO/UNESCO/UNICEF. (1992). *Comprehensive School Health Education: Suggested Guidelines for Action*. Geneva: WHO, 1992.
- [28] World Bank (1990). *World Declaration on Education for All*. New York: EFA Programme for Action.
- [29] World Bank (2005): *Expanding Opportunities and Building Competencies for Young People: A New Agenda for Secondary Education*. Washington D.C: The World Bank.
- [30] World Bank. (1993). *World Development Report*. New York: Oxford University Press.
- [31] Whyte, J; Deem, R; Kant, L. & Cruickshank, M.(1985). *Girl Friendly Schooling*. London: Methuen & Co. Ltd.
- [32] Zeitlin M.F., Formacion C. S. (1981). "Nutrition Education," Chapter 5 in *Nutrition Intervention in Developing Countries*. Cambridge, Mass.: Oelgeschlager, Gunn & Hain Publ.