

**FACTORS INFLUENCING IMPLEMENTATION OF  
COMPREHENSIVE SCHOOL HEALTH PROGRAM (CSHP) IN  
PRIMARY SCHOOLS: A CASE OF PUMWANI WARD,  
NAIROBI COUNTY, KENYA**

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**A Research Project Report Presented in Partial Fulfillment of the  
Requirements for the Award of Master of Arts Degree in Project Planning  
and Management of the University of Nairobi**

**2016**

**DECLARATION**

This research project report is my original work and has not been presented for the award of any degree in any other university.

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Signature

Date

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L50/73444/2014

This research project report has been submitted for examination with my approval as the university supervisor.

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## **DEDICATION**

I dedicate this study to my grandmother the late Ruth Gakiavi. It is through her guidance and council that I became who I am.

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## ABBREVIATIONS AND ACRONYMS

<b>AIDs</b>	Acquired Immunodeficiency Syndrome
<b>BOM</b>	Board of Management
<b>CBOs</b>	Community Based Organizations
<b>CRC</b>	Convention on the Right of the Child
<b>CSHP</b>	Comprehensive School Health Programme
<b>CWDs</b>	Children with Disabilities
<b>CWSNS</b>	Children with Special Needs
<b>DEH</b>	Division of Environmental Health
<b>DEO</b>	District Education Officer
<b>DMOH</b>	District Medical Officer of Health
<b>DSHCC</b>	District School Health Coordinating Committee
<b>ECDC</b>	Early Childhood Development Centre
<b>EFA</b>	Education for All
<b>ESACIPAC</b>	Eastern and Southern Africa Centre for International Parasite Control
<b>FBOs</b>	Faith Based Organizations
<b>FGM</b>	Female Genital Mutilation
<b>GBV</b>	Gender Based Violence
<b>GNC</b>	Global Citizens Network
<b>HIV</b>	Human Immunodeficiency Virus
<b>KIBHS</b>	Kenya Integrated Budget and Household Survey
<b>KIE</b>	Kenya Institute of Education
<b>KISE</b>	Kenya Institute of Special Education
<b>KNBS</b>	Kenya National Bureau of Statistic
<b>KNSPWDs</b>	Kenya National Survey for Persons with Disabilities
<b>NGOs</b>	Non-Governmental Organization
<b>NSHTC</b>	National School Health Technical Committee
<b>OVC</b>	Orphans and Vulnerable Children
<b>PEPFAR</b>	Presidential Emergency Plan For Aids Relief
<b>PLWD</b>	People Living With Disability
<b>STIs</b>	Sexually Transmitted Infections

<b>UN</b>	United Nations
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNICEF</b>	United Nation Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>WASH</b>	Water and Sanitation Hygiene
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization

## ABSTRACT

This study sought to find out the factors influencing implementation of comprehensive school health program (CSHP) in Pumwani ward, Nairobi County, Kenya. The study focused on primary schools within the target location. The government of Kenya has already developed and disseminated the National school health policy and the school health implementation strategy 2009. However, little is known about the implementation of the policy hence the need to conduct this study. The study was guided by three objectives which are capacity building, support supervision and school infrastructure in relation to how they influence implementation of Comprehensive School Health Program. The researcher used descriptive survey research design where factors influencing the implementation of Comprehensive School Health Program were described as they were. A sample size of 60 respondents was selected using stratified random sampling method from all the 10 primary schools within the location under study but only 50 respondents returned completely filled questionnaires. Qualitative and quantitative methods of data collection were used to generate the desired data through the use of a questionnaire comprising open and closed ended questions and an interview guide was used for triangulation. The findings were analyzed using descriptive and inferential statistics and presented descriptively and through the use of tables and figures. The study established that majority of the respondents had not been trained on Comprehensive School health Program and majority of the schools represented in the sample did not have access to clean water hence predisposing students to disease outbreaks. Most schools did not have school health committees and some had inactive school health committee which indicated that the schools did not have structures in place to implement Comprehensive School Health Program. The study also established that capacity building, support supervision and school infrastructure are some of the factors that influence implementation of CSHP and also established that there was a relationship between independent variables which are capacity building, support supervision and school infrastructure; and the dependent variable which is implementation of Comprehensive School Health Program. The findings of the study are expected to contribute to effective and efficient implementation of CSHP and strengthen the capacity of school health committee in dealing with school health. The study recommends training of teachers and BOM on CSHP, gender norms and life skills, collaboration of schools and health facilities and developments of child friendly facilities in schools to assure the safety and health not only of students but also those working within the school. The researcher suggests that more studies be done on engagement of parents in school health programs.

# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1 Background of the study**

The health of school going adolescents and children is a central development agenda and a key component of an effective education system from the view point of realizing the global goals of Education For All (EFA). Although parents have a great responsibility towards the health of their children, the schools, being the second home of the children also need to take their health very seriously. According to Means (1975), every child should be taught early in life, that, to preserve the lives and health of others and his own life and his own health, is one of the most important and constantly abiding duties. By observing certain laws or performing certain acts, his life and health may be preserved; by not observing, or performing certain other acts, they will both be destroyed. By knowing and avoiding the causes of disease, disease itself will be avoided, and he may enjoy live and health; by ignorance of these causes and exposure to them, he may contract disease, ruin his health, and die. Everything connected with wealth, happiness and long life depends upon health; and even the great duties of morals and religion are performed more suitably in a healthy than a sickly condition.

The ability for schools to provide more than mere academic preparation remains to be rediscovered, and today's renewed efforts in school health could be regarded as not new in concept but simply updated to reflect the needs of the times. An evaluation of history shows that for more than a century, schools have been called on to play an important role in addressing health and social needs due to their strategic capacity to reach children and families. There is a relationship, for example, between today's HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Syndrome) instruction and yesteryear's curriculum in physiology and hygiene, today's school-based clinics and today's family services programs and yesteryear's medical inspections, and previous years of visiting teachers' home visits to immigrants in urban settlements (Allensworth et al 1997). School health programming has grew into today's concept of a comprehensive school health program. Through continual reviews, It became clear that there were many descriptions about what a comprehensive school health program is and what

outcomes it is expected to produce. In its interim statement, the committee described the following set of ideal outcomes for Comprehensive school health programs (CSHPs), a vision of what these programs might be able to achieve. These optimal outcomes are categorized into three general areas: student outcomes, programmatic and organizational outcomes and community outcomes. According to Solloway et al. (1995), a CSHP refers to an overall school health program, of which school health education and school health services are each components. However, some use the term "comprehensive school health education" to refer to an overall program and consider school health services to be a component of comprehensive school health education.

### **1.1.1 The Eight-Component Model**

In the 1980s, a new model was developed to illustrate the different components of CSHP (Allensworth and Kolbe 1987). According to this model, a comprehensive school health program contains the following eight essential components: Health education comprises of a planned, sequential curriculum that addresses the physical, mental, emotional, and social dimensions of health. Physical education is a planned, sequential curriculum promoting activities that all students could enjoy and physical fitness and follow throughout their lives while health services focuses on prevention and early intervention, including the provision of emergency care, primary care, access and referral to community health services, and management of chronic health conditions. Services are provided to students as individuals and in groups. Nutrition facilities provide access to a variety of appealing and nutritious meals, an environment that promotes healthful food choices and support for nutrition instruction in the classroom and cafeteria. Health promotion for staff provides education, health assessments, and fitness activities for faculty and staff, and encourages their greater commitment to enhancing students' health by becoming positive role models. Psychological Counseling and social services include school-based interventions and referrals to community providers. Healthy school environment addresses both the physical and the psychosocial climate of the school and Parent and community participation engages a wide range of resources and support to enhance the health and well-being of students. In Kenya, the government has developed comprehensive school education policy and launched the strategic implementation plan for the same which aims to identify and mainstream key health interventions for improved education and school health. The strategy involves eight thematic

areas; these are: Values and life skills, Gender issues, Child rights, child protection and responsibilities, Special needs, disability and rehabilitation, Water, sanitation and hygiene, Nutrition, Disease prevention and control and School infrastructure and environmental safety. The strategy outlines critical issues on health and education linkages that are important towards the promotion of child health while in school (Republic of Kenya 2011)

Through this plan, the government hoped that the school environment will create an enabling atmosphere for emotional, cultural, social and well-being that promotes a healthy child friendly school. The strategy would ensure that positive changes in school environment are supported, reinforced and sustained through a school health policy; school health services and skills based health education. It envisaged that effective and efficient healthy school environment shall ensure retention, access, quality and equity in education. The national health policy focused on values, gender, life skills, adolescent youth and sexuality, prevention of early unprotected sexual activity, prevention of harmful practices, teenage pregnancy, adolescent relationships, child rights, and child protection, drug and substance abuse, STDs/HIV/AIDS, nutrition, malaria control, control of soil transmitted worms, bilharzias and other parasitic disease, water, immunization, control of non-communicable diseases, sanitation and hygiene, food safety, special needs, vector and vermin control, disability and rehabilitation, school infrastructure and environmental safety, physical education and training and in-serving of teachers.

According to Global Communities (2015), new HIV infection among girls and young women ages 10-24 years are on the rise. Moreover, young women are reporting increased cases of sexually transmitted infection and gender based violence. This backdrop forms the rationale of USAID initiating DREAMS project in Pumwani Ward through Global communities and; St. Johns Community Centre and Kenya Girl Guides association as the implementing partners. Pumwani Ward was singled out as one of the wards in Nairobi with the highest HIV prevalence rate of 6.7% compared to National HIV prevalence of 5.6% infection (KAIS, 2012). The DREAMS project recognized the centrality of schools in addressing the health of children and community as a whole and hopes to tap on the CSHP to promote community health and reduce HIV and GBV cases.

## **1.2 Statement of the problem**

According to World Health Organization (2003), a health promoting school is one that is constantly improving its capacity as a healthy setting for living, learning and working. Such schools foster healthy and learning environment. In addition, Means (1975) asserts that policy makers and educationists have ignored the central role of the learning institutions and school in protecting the health not only of learners but also of teachers and the community. This situation has in turn worsened the life and health of millions of school going children and adolescents faced by several livelihood, growth and environmental challenges.

In Kenya, children aged 5-19 years constitute 48% of the total population. This age group suffers varying but significant degrees health problems emanating from poor sanitation, hygiene, quality of water and other related factors such as a poor housing, HIV and AIDS, parasitic infections, macro and micronutrient deficiencies, infectious diseases and sexually transmitted infections. Furthermore, challenges encountered during adolescence such as sexual harassment, drug abuse and substance, unplanned pregnancies among others also contribute to poor health in children and youth (Republic of Kenya, 2009).

To address the fore mentioned challenges, the Kenyan government introduced the national school health policy and the implementation strategy plan of the same. Successfully interpreted and implemented, the policy was expected to lead to the improvement of the health status of school children. The policy also aimed at addressing issues related to equity and improvement on the learning environment for both boys and girls, including those with special needs. However other than development of the policy, little is known about the implementation of the program or the proportion of schools that are compliant with the school health policy. Furthermore, in Pumwani ward, HIV and gender based violence infection among school going girls age 10-24 is on the rise (Global Communities, 2015).

This study proposes to find out the factors influencing implementation of comprehensive school health program. The variables of interested include; capacity building, teachers attitude, support supervision and school infrastructure in relation to how they affect implementation of comprehensive school health program. The study was carried out in Pumwani ward, Nairobi County, Kenya.



### **1.3 Purpose of the study**

The purpose of this study is to investigate the factors influencing implementation of comprehensive school health program in primary schools in Pumwani ward, Nairobi County. Kenya

### **1.4 Objectives of the study**

The following are the objectives guiding the study;

1. To establish the influence of Capacity building on the implementation of comprehensive school health program
2. To find out the influence of support supervision on the implementation of comprehensive school health program
3. To find out the influence of school infrastructure on the implementation of comprehensive school health program

### **1.5 Research questions**

1. In what ways does capacity building influence implementation of comprehensive school health program?
2. How does support supervision influence implementation of comprehensive school health program?
3. In what ways does school infrastructure influence implementation of comprehensive school health program?

### **1.6 Significance of the study**

This study is beneficial to primary schools since it highlights the challenges they face in establishment of school health committee and recommend strategies of resolving them. It also contribute to effective and efficient ways of establishing and strengthening school health committees.

Through this study, the education officers will have a clear view of the missing link in regard to support supervision of comprehensive school health program. This study also recommends areas

of the policy that requires further supervision and training to ensure that the policy is implemented smoothly.

### **1.7 Limitation of the study**

The researcher encountered unwillingness from some respondents to reveal information especially sensitive information that portrays them negatively. To counter this, the researcher assured the respondents of confidentiality and informed them that the study is purely academic endeavor therefore the information given will not be used against them whatsoever.

### **1.8 Delimitations of the study**

The study focused on the factors influencing implementation of comprehensive school health program in Pumwani ward, Nairobi County. Further, the study was limited to three factors which are the independent variables of the study. These are; capacity building, support supervision and school infrastructure in relation to how they influence the implementation of Comprehensive School Health Program

### **1.9 Definition of significant terms**

The following is the definition of significant terms used in the study;

**Capacity building** – Formal or informal training of teachers, BOM or other school stakeholders in CSHP, gender issues and Life skills

**Comprehensive School Health Program (CSHP)** - an integrated set of planned school-based strategies, activities, and services designed to promote the optimal development of students and to improve the health of the community.

**Education official** – Any person working under the ministry of education or county education mandated to supervise or support implementation CSHP.

**School** – A formal or non-formal primary level learning institution that hosts learners aged between 8 years to 16 years.

**School health Committee** – A formal group of people comprising of a Head teacher, student, parent representative and others that meet regularly within a school to discuss the health status of the school.

**School infrastructure** – Basic facilities within a school which include toilets, running water, accessible and adequate classrooms within a school.

**Support supervision-** Any official visit, mentorship, training or advice given to a school by an education official in relation to CSHP and any material or technical, financial provided to a school by any person, organization or government to enhance the wellbeing of the school.

### **1.10 Organization of the study**

This study is organized into five. Chapter covers background of the study, statement of the problem, purpose of the study, objectives of the study, delimitations of the study, definition of significant terms and organization of the study.

Chapter two consists of literature review which is subdivided into subheadings concerning factors influencing implementation of comprehensive school health program in Pumwani ward, Nairobi County, Kenya. Chapter three covers research methodology divided into; research design, target population, sample and sampling procedures, research instruments, validity of instruments, reliability of the instruments, data collection and data analysis.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter examines the literature of the studies and policies that relate to Comprehensive School Health Program (CSHP). The chapter discusses general theoretical review of factors influencing implementation of CSHP. A conceptual framework is drawn and discussed to emphasize on the factors influencing implementation of CSHP.

#### **2.2 School Health Policy**

The school environment is one of the key settings for promoting children's environmental health and safety as explained in the National Health sector strategic plan as well as the Kenya education sector support programme. A national school health policy (2009) and national school health guidelines (2009) have been developed and disseminated.

This national school health strategic implementation plan aims to identify and mainstream key health interventions for improved school health and education. The strategy comprises eight thematic areas; these are: Gender issues, Values and life skills, Child rights, child protection and responsibilities, disability and rehabilitation, Special needs, sanitation and hygiene, Water, Nutrition, Disease prevention and control and School infrastructure and environmental safety. The strategy outlines critical issues on health and education linkages that are important towards the improvement of child health while in school.

#### **2.3 Capacity Building**

CSHP contemplates a situation where a school has adequate and able human resource to deliver key objectives of the program among these is addressing life skills education and gender issues. World Education Forum in Senegal-Dakar in April 2000 resulted in a Dakar framework for action 2000 which refers to life skills in goal 3. Life Skills Education are abilities which allows an individual develop adaptive and positive behavior so as to effectively deal with demands of everyday and life challenges. The main goals of the Life Skills approach is to enhance young people's ability to take responsibility for making choices, resisting negative pressure and

avoiding risky behavior. Where life skills education is well developed and practiced, it enhances the wellbeing of a society and healthy behavior promote and positive outlook. Life skills are classified into three broad categories namely; skills of effective decision making, skills of knowing and living with oneself, skills of knowing and living with others,

Values are beliefs, principles and ideas that are of worth to individuals and their communities. They help to define who people are and the things that guide their behavior and lives. People obtain values from families, friends, traditional culture, political influences, school environment, life experiences, religious teaching and economic experiences. Our values shape our behavior and a world view. For this program, health and education is intended to ensure that children are taught and assisted to acquire positive values (National school health policy 2009).

Ages 0-19 years are critical formative years for the development of behavior and skills in an individual. Learners in pre-school, secondary and primary school, face varied challenges, which are compounded by various factors. These include intra & interpersonal conflicts, lack of positive role models, negative mass media influence and unreliable and inadequate sources of information especially on human sexuality. Traditional education addressed the holistic view of human personality through the informal education system. However, due to historical reasons, educational and traditional family ties have largely broken down thereby leaving young people vulnerable. Therefore, there is need for the youth to be enabled to develop positive attitudes, values, skills and healthy behavior in order to help them effectively deal with the challenges of everyday life (WHO, 2003 – Skills for Health; UNICEF, 2005- The voices & identities of Botswana’s school children). Skill based health education supports the basic human rights included in the Convention on the Rights of the Child (CRC ) especially those related to the highest attainable standards of health Life Skills Education enables learners to develop and acquire skills such as critical thinking, problem solving, decision-making, interpersonal relationships, stress and anxiety management, effective communication, self-esteem and assertiveness. KIE has developed Life skills Education Curriculum for Secondary and Primary schools and disseminated for implemented on January 2009.

On gender, UNICEF 2003 defines Gender as the socially constructed roles, behavior, attributes and activities that a particular society considers appropriate for men and women. The distinct roles and behavior may give rise to gender inequalities i.e. differences between women and men

that systematically favors one group. In turn, such inequalities can lead to inequities between men and women in both health status and access to health care. There are several gender related issues that affects learning for both girls and boys. In the MDG's, MDG 2 Achievement of universal primary education by the year 2015 and Target 3( a )of MDG 3 emphasizes elimination of gender disparity in primary and secondary school education preferably by 2005, and at all levels 2015. Globally 150 million children currently enrolled in school may drop out before completing primary school- at least a 100 million of these are girls. Kenya secondary and primary schools have at least 1 million menstruating girls at least 3/5 or 872,000 of who miss 4-5 days of school per month, due to lack of underwear and sanitary pads combined with inadequate sanitary facilities in their schools(GCN and MOE, 2006).

The daily routine of a school is structured by formal and informal rules and ways of behavior. A 'gender regime' is manifest as part of this routine. Ways of relating and the type of interaction between students and boys, are part of this gender regime and serve to normalize certain types of behavior. This regime under which boys and girls interact is so 'naturalized' in schools that people don't see a need to intervene when this interaction may have negative effects. Some examples include; physical space that girls and boys have e.g. who gets to speak, roles that girls and boys play, how they contribute to the school, who cleans the classroom etc. These gender roles produce a gender hierarchy, which more often than not is one where the male hierarchy dominates. Boys tend to have more physical space such as in sport than girls. Peer pressure to tease, intimidate, hassle, exclude, and in some cases perpetrate physical violence, can become a part of the school environment. These gender roles within the school are reinforced by girls and boys themselves both of whom are protecting their space, but in a very gender stereotyped way. There are few if any alternatives put forward that suggest that gender roles could be otherwise.

Teachers themselves perpetuate gender inequalities. They are not trained on gender hence they do not see it as an issue. Instead they have internalized local norms and rarely question them. As a result, they do not intervene on gender, abuse issues in the classroom nor harassment. In addition discipline issues have been seen to be mainly male led, and boys are most often the subject of corporal punishment resulting in more school truancy and violence by boys. It has also been reported in media and some reports here in Kenya that transactional sex for good exam results is rampant. This sometimes leads to pregnancies and in most cases the girls are blamed

for becoming pregnant, leading to expulsion without option for re-entrance. This results in high drop out for girl, while the perpetrators are not punished. Sexual exploitation of both sexes is also rampant while there exists no mechanisms of addressing it.

The relationship between schools and community members in developing countries is often rife with power dimensions that transcend gender issues. In many contexts, many community members will not challenge a teacher or question their behavior and are not supported or listened to when they do e.g. in relation to impregnation of school children, and sexual harassment. However in Kenya there are opportunities like the constitution 2010, Children's Act (2001), and Sexual Offence Act (2006) which can be exploited in addressing this vice.

#### **2.4 Support supervision**

Schools require support from different stakeholders to enable them operate optimally considering the difficult circumstances that schools in Kenya operate under. Children are the most vulnerable members of our society by virtue of their stage of growth and age, their rights especially to health and education amongst others should be protected and safeguarded. It is important to ensure that health services and conditions for maintaining optimum health are accessible to all children. The CRC (1989) specifically mentions the special needs of children with a disability. Child survival strategies in Kenya endeavor to provide a comprehensive and integrated approach to address the needs of all children without discrimination. Vulnerable children constantly experience barriers to enjoyment of their basic human rights and to inclusion in society. The parents, communities, teachers and pupils should be sensitized on relevant laws regarding child protection (national school health policy & guidelines 2009)

Kenya Government has ratified several international and national conventions / treaties on the rights of the child. These include, the African charter on the rights of children (2000), the United Nations Convention on Rights of the Child (UNCRC) on July 30th 1990, and the disability act 2003 and welfare of the child, enactment of the Children's Act 2001, and the sexual offences Act 2006. These laws have since enhanced effective child protection in Kenya. Several other Acts with positive implication for protection of children were later passed. These include the Industrial Properties Act, Persons with Disabilities Act 2003 and Criminal law Amendment Act.

The constitution 2010 addresses issues of affecting children and guarantees for the Right of Children in various sections that include those with disabilities and vulnerable children. In line with the Child Rights and Millennium Development Goals (MDGs) the Ministry of Public Health and Sanitation and the Ministry of Education in collaboration with partners developed a National School Health Policy and Guidelines 2009. The two Ministries essentially have come up with a comprehensive School Health Programme addressing child protection, child rights, responsibilities, special needs, disabilities and rehabilitation among others.

Children in Kenya (0—18) years) constitute more than half of the 38million (Kenya national Census 2009) total population while 20% of the population is under 5 years of age. Since the introduction of free primary education in 2003, Primary school enrolment has increased from 77% in 2002 to 92% in 2007 with near parity nationally between girls and boys (National plan of action for children 2008-2012). Children with disabilities and those with special needs find themselves in difficult circumstances in accessing quality education and health equitably (KNSPDS 2007). Although the needs of vulnerable children are largely similar to those of other children in various aspects, they differ in that these children require additional support in enjoying and maintaining their rights as children (Child survival and development strategy Kenya 2008).

The ministry of education has developed a national Special needs education policy framework which is intended to improve the access and quality to education provided to children with special needs. It also addresses issues of improvement and equity of learning environment in all schools (The national special needs education policy framework 2009). It is in this regard that the ministry of Public health and sanitation and ministry of education intends to improve access to education and health care for children with disabilities and special needs through the development of this strategy.

The Kenya National disability survey 2007 reported that the disability prevalence in Kenya is 5.7%. PWDs are often marginalized and face difficulty as a result of their disability. Most have no access to health, employment, education, or rehabilitation. The majority experience hardships as a result of widespread social economic and cultural prejudices which results to stigmatization. Amongst children 0-14 years of age and 15 to 25 years of age only 55% of this target group is able to access health services when in need (KNSPWDs2007). Averagely 41% of children with



disabilities of school going age drop out due to various illnesses. On the other hand 39% of children with disabilities drop out due their disabilities (KNSPWDs).

The KNSPWDs also indicated that children aged 0-14 years those with hearing impairment were 22.9%, visual 14.8%, speech 9.5%, mental disability 12.4%, physical disability 20.4%, self-care 9.7% and others at 10.8%. For those aged between 15 – 24 years it was found that hearing impairment was 11.2%, speech 6.1% visual 29.2%, mental disability 14.4%, physical 23.9% and self-care 6.6% and other at 9%

It is evident that there is a growing number of children with special needs and disabilities whose requirements are not being met. The lack of awareness amongst community and school age going children is also a major barrier to the education and integration of children with special needs and disabilities. The interventions should include but not limited to; Screening and identification for disabilities and special needs, medical care, therapy and rehabilitation, provision of appropriate assistive and supportive devices / appliances, educational referrals and interventions, Vocational and skills training and social interventions and integration.

## **2.5 School Infrastructure**

The school infrastructure plays a crucial role not only in the health of students and those working in the school but also in terms of their wellbeing and enjoyment of conducive environment. For example, sanitation, water and hygiene are critical towards creating an improved learning environment. The government's commitment towards Education for All (EFA) has resulted in the over stretching of already inadequate water and sanitation facilities due to the dramatically increased enrolment and lack of adequate resources. Improving sanitation, water and hygiene in our learning institutions generates considerable benefits in terms of improved child-health, attendance, retention, performance, and transition of all learners including girls, boys and children with special needs. The aim for improving school Sanitation, Water and Hygiene (WASH) is reducing water-born and sanitation-related diseases e.g. cholera and other diarrheal diseases, worm infestation, skin infections, etc.

Learners are positive change agents within their communities, and instilling habits early is the most effective way to change current practice. Therefore, the multiplier effect of appropriate and positive messages on hygiene promotion will influence the larger communities. This influence

will translate in reduced ignorance and ill health and will ultimately result in a well-informed society. The MOE, within the Kenya Education Sector Support Programme (KESSP), is currently taking measures to better equip school managers, teachers and learners in Sanitation, Water and Hygiene promotion, knowledge and practices. Funding for recurrent costs, infrastructure and improved practice in water, hygiene and sanitation has been increased, and the government and development partners intend to adequately support the sector. Given the need to harmonize and coordinate support from the various providers within the sector, CSHP provides the MOE with the framework to do so.

The rapid increase in the number of children in the primary schools from 5.9 Million pupils in 2002 to 7.2 Million pupils in 2003 and currently at more than 8 Million pupils has resulted in straining hygiene and sanitation facilities in schools. Water, hygiene and sanitation are critical towards creating a child friendly environment in learning institutions. Improved water, hygiene, and sanitation in learning institutions generate considerable benefits in terms of improved child health, attendance, performance, retention and transition.

Provision of safe and adequate sanitation, water and hygiene services forms the basis of a sustainable solution to the threat of water, sanitation and hygiene related diseases among school children. The health benefits of safe and adequate water, improved hygiene and sanitation range from reduction in diarrhea, ecto-parasites, intestinal worms, infections and trachoma, to enhance psychosocial well-being afforded via such factors as the dignity that goes with using a clean toilet/latrine.

WHO estimates that between 25% and 33% of the global burden of disease can be attributed to by environmental risk factor. Globally causes of mortality, morbidity and disability for the age group 5-18 years conforms with this as it is shown that they are mainly due to cardiovascular disease, cancer, chronic lung diseases, violence, depression, substance abuse, nutritional deficiencies, injuries, HIV/AIDS/STI and helminthes infections and can be significantly reduced by preventing six interrelated categories of behavior, that are initiated during youth and fostered by social and political policies and conditions such as tobacco use, Behavior that results in injury and violence, dietary and hygienic practices that cause disease, Alcohol and substance use, Sedentary lifestyle and Sexual behavior that causes unintended pregnancy and disease

Worm infections are likely to affect children's cognitive development differently according to their levels of poverty, general health status and psychosocial stimulation. (Donald A. P. Bundy et al 2009). Two billion people are infected with intestinal worms. In many areas, the majority of school children are infected and the World Health Organization (WHO) has called for school-based mass deworming. Existing evidence indicates that mass school-based deworming is extraordinarily cost-effective once health, economic and educational outcomes are all taken into account, and it is thus unsurprising that a series of studies from the 1993 World Development Report to the recent Copenhagen Consensus argue that treatment of the most prevalent worm infections is a very high return investment.

In Kenya the documented causes of outpatient morbidity (Health facility service statistics-HMIS report, 2009) although different from above are also largely due to environmental factors. These are malaria, skin diseases, respiration system infections, diarrhea, accidents, rheumatism, pneumonia, urinary tract infections, eye infections, intestinal worms and dental disorders. However WHO has also shown that worm infestation is the greatest cause of morbidity in the age group 5-14 years. The resulting diseases give rise to much suffering and death. In addition, they contribute to perpetuation of poverty by impairing the cognitive growth and performance of children, and reducing the work capacity and productivity of adults and hence negatively impacting on national development.

The Kenya vision 2030 goal for the health sector is to provide affordable and equitable quality health services to all Kenyans. The vision also aims at restructuring the health care delivery system to shift the emphasis from curative to promotive and preventive health care. In addition, measures are being taken to control environmental threats to health as part of the effort to lower the Nation's disease burden. This is being implemented under the existing health legislations and policies.

Nutrition is the science that explains the role of food and nutrients in the human body during growth, maintenance and development of life. Good nutrition is essential to realize the learning potential of children and to maximize returns on education investments. Malnutrition affects a child's attentiveness, aptitude, concentration and overall performance. For these reasons, schools should provide an ideal setting to promote good nutrition as they reach a high proportion of

youth and children. Efforts should be made to promote good nutrition practices in schools by integrating nutrition interventions including micronutrient supplementation into school activities.

Poor diet and sedentary behaviors are among the major risk factors of chronic diseases which account for 59% of 56.5 million deaths annually and 46% of the global disease burden. There is clear evidence that high consumption of energy-sugar, fat-in and starch relation to physical inactivity is a fundamental determining factor of nutrition-related chronic diseases. Health diet and physical activity are key to good nutrition and necessary for a long and healthy life. Eating nutrients dense foods and balancing energy intake with the necessary physical activity to maintain health is essential at all stages of life. Consuming too much food high in energy and low in essential nutrients contributes to energy excess, obesity and overweight.

In Kenya, malnutrition continues to affect a significant proportion of children and women. The most recent countrywide study done in 2005/06 (KIHBS1, 2007) shows persistently poor nutrition outcomes with marginal increases in wasting (6.1%), stunting (33%) and underweight (20.2%) compared to 2003 data as shown below. The national micronutrient survey of 1999, found high levels of Vitamin A deficiency (VAD) among preschoolers, 61.2% moderate VAD, with 14.7% having acute and. Factors that were associated with this high prevalence include malaria infection, hookworm infestation and acute malnutrition. From the national micronutrient survey, Iron deficiency was also high with 43% of preschool children. Data on Iodine deficiency (ID) data from KEMRI (2004) indicate an improvement from 16% deficiency in 1994 to 6% in 2004, attributed to the consumption of iodized salt by a large proportion of Kenyan households 91% CBS/UNICEF Multi Indicator Cluster Survey or MICS 2000)

A healthy school environment should include the structures that protects pupils and staff but poorly designed school buildings and play areas may present serious health risks. Special construction techniques may be required to ensure safety particularly in areas prone to natural disasters. Schools should be designed to prevent temperature extremes inside classrooms. Poorly and cold damp ventilated classrooms provide an unhealthy environment for school children particularly poorly nourished and inadequately clothed pupils who are especially vulnerable to respiratory and other infections. Extremely warm conditions may reduce attention and concentration span and can lead to heart related illnesses, thermal stress, fatigue and heat stroke (WHO2003)

According to UN Convention on the rights of persons with disability (2007), appropriate measures should be put in place in schools to ensure an equal basis for children with disabilities to live independently and participate fully in all aspects of life. These measures shall include the elimination and identification of obstacles and barriers to accessibility to buildings, roads, transportation and other indoor and outdoor facilities including schools, housing, medical facilities workplaces.

Since children spend much of their day within the school environments during their critical developmental stages a healthy school environment is required to improve their health and effective learning and this will contribute to the development of healthy adults who will be skilled and productive members of society. In addition pupils who learn about the link between the health and environment will be able to recognize and reduce health threats in their own homes. (WHO 2003)

The Kenyan government's commitment towards Education for All (EFA) and the MDGs has resulted in the free primary education since 2003 and free day secondary education in 2007. This has resulted to increased enrollment from 5.9m in 2002 to 8.6m in 2010 of pupils in primary and students in secondary schools. This has over stretched the already existing inadequate water and sanitation and infrastructural facilities.

Primary education still continues to experience many challenges relating to access and equity, overcrowding, including overstretched facilities, and poor learning environments and lack of appropriate sanitation. Education opportunities for learners with special needs and disabilities are a major challenge to the education sector. There is need to link inclusive education with wider community based programs for persons with disabilities and special needs. Successful implementation of the CSHP's strategic plan would improve efficiency in resource allocation, improve the quality of education provided to Kenyans while also addressing gender imbalance and equity, improve the learning environment for both girls and boys including those with disabilities and special (Ministry of education strategic plan 2006 –2011).

## **2.6 Theoretical framework**

This section reviews the theories guiding the study. The researcher identified the theory of planned behavior and resource dependent theory as the key theories guiding the study and discussed these theories in relation to how they affect the variables used in this study.

### **2.6.1 The theory of planned behavior**

The Theory of Planned Behavior (TPB) was formulated by Ajzen and Fishbein as the Theory of Reasoned Action in 1980 to predict an individual's intention to engage in a behavior at a specific place and time. The theory was intended to explain all behaviors over which people have the ability to exert self-control. The key component to this model is behavioral intent; behavioral intentions are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome. The theory holds that intent is influenced not only by the attitude towards behavior but also the perception of social norms, the strength of others' opinions on the behavior and a person's own motivation to comply with those of significant others and the degree of perceived behavioral control.

This theory can be used to explain capacity building variable since a person's behavior is highly influenced by their capacity to engage in a given behavior. If a teacher has little knowledge regarding CSHP, they are least likely to actively engage in its implementation. The same can also be used to explain support supervision variable since the perceived degree of behavior control instilled by support supervision influence compliance or non-compliance. Therefore if those charged with support supervision do not do it, it is likely that the implementation of CSHP may be derailed.

Attitudes of teachers and education officials on CSHP can also be explained by this theory since attitudes are socially constructed and shaped by social norms, therefore depending on a person's attitude towards CSHP, efficiency and effectiveness of implementation may be affected.

### **2.6.2 Resource dependence theory (RDT)**

This theory was formally developed in the 1970s, with the publication of *The External Control of Organizations: A Resource Dependence Perspective* (Pfeffer and Salancik 1978). It holds that procurement of external resources is an important tenet of both the strategic and tactical

management of any organization. Resource dependence theory has implications regarding the optimal divisional structure of organizations, recruitment of board members and employees, production strategies, external organizational links, contract structure, and many other aspects of organizational strategy.

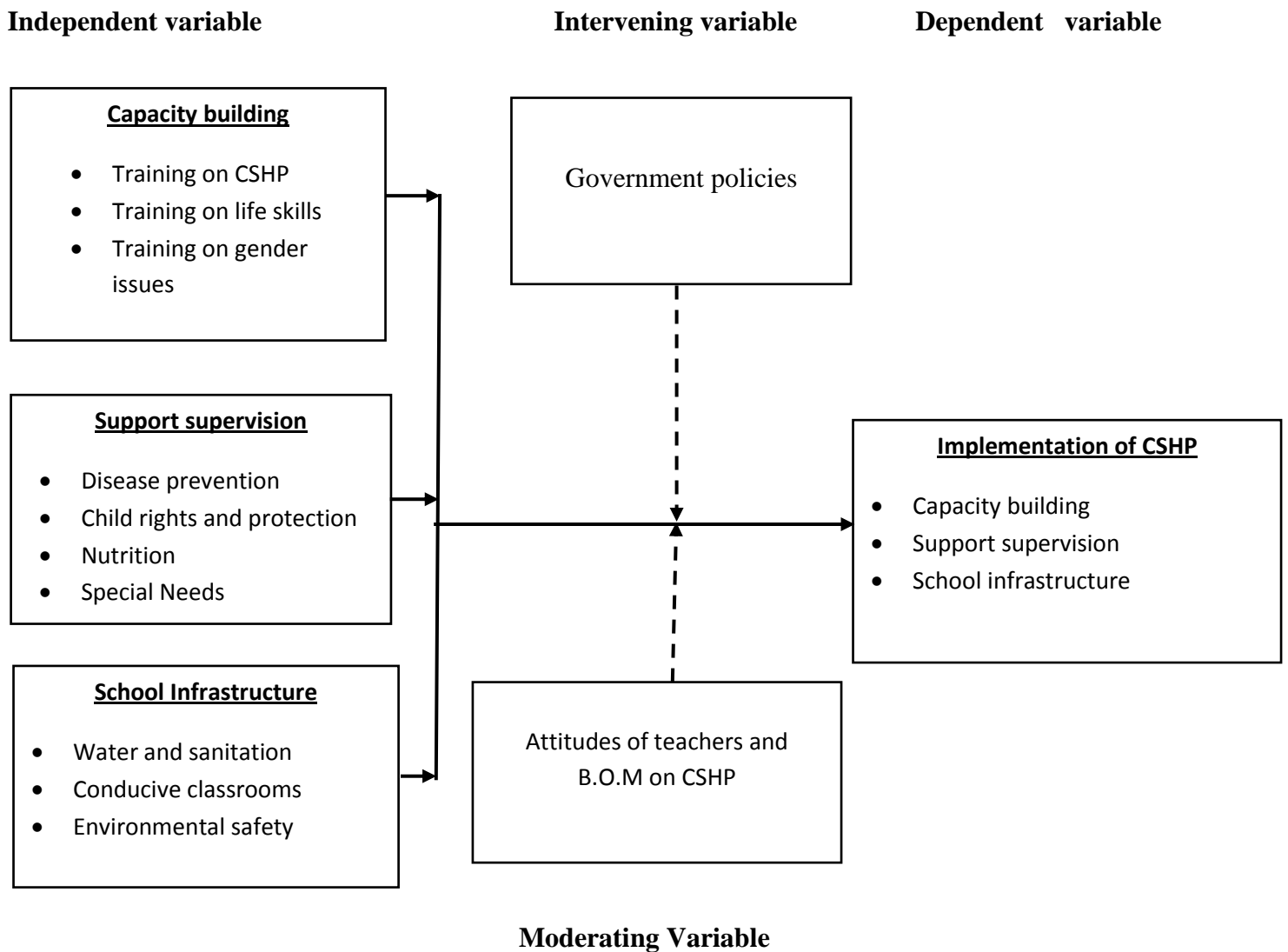
According to this theory, Organizations depend on multidimensional resources: labor, capital, raw material, etc. Organizations may not be able to come out with countervailing initiatives for all these multiple resources. Hence organization should move through the principle of criticality and principle of scarcity. Critical resources are those the organization must have to function. An organization may adopt various countervailing strategies—it may associate with more suppliers, or integrate vertically or horizontally.

This theory can be used to explain school infrastructure variable in relation to how it influences implementation of CSHP. If a school is not able to earn its own resources and those around it or within its reach, it may not be able to effectively implement CSHP. This therefore calls for partnership of purpose between schools' BOM, PTA, students, NGOs, government etc.

## **2.7 Conceptual Framework**

According to Peters et al. (2000), a conceptual model is a schematic presentation which identifies the variables that when put together explain the issue of concern. It is a set of broad ideas used to explain the relationship between independent and dependent variables. The researcher explains this study using the conceptual framework on Figure 1.

**Figure 1: Conceptual Framework**



From the above conceptual model, the independent variables which include school infrastructure, support supervision and capacity building would affect the implementation of CSHP. Specifically human resource capacity of a given school has an influence on how such a school implements the health program. On support supervision, it is expected that if a school has access to adequate support, then it enhances the implementation of CSHP and if there adequate infrastructure, the school stands at a better position in ensuring the safety and health of the students.



The researcher recognizes that the relationship between the independent variable may not be linear even in the best of conditions. Government policies and attitudes of teachers and education officials on CSHP comes in as the intervening and moderating variables respectfully since it may affect the relationship between the independent and the dependent variables.

## **2.8 Summary of the literature review**

The review of the literature on studies done on comprehensive school health indicates that a lot has been done in trying to understand and address health challenges faced by schools. However, such efforts have fallen short of exposing the outcomes of the strategies laid down such as the outcome of the implementation of CSHP. Literature indicates that despite the plans, school going children continue to face many health and other challenges in different parts of Kenya which compromises their performance in school. Since children spend much of their day within the school environments during their critical developmental stages a healthy school environment is required to assure their safety and optimal learning that accommodates children living with disabilities

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter describes the methodology that the researcher used to carry out this study. The researcher explains different components of research methodology adopted in this study. These include; research design, target population, sampling method, sample size, data collection instruments, validity of the instruments, reliability of the instruments and data analysis method.

#### **3.2 Research design**

Research design is the outline plan or structure that is used to generate answers to the research problem. It is the glue that holds the research elements and enables the researcher to gather accurate and reliable data (Kombo and Tromp, 2011). The researcher used descriptive survey research design for this study. This is a scientific method of investigation in which data is collected and analyzed in order to describe the current conditions, terms or relationship concerning a certain field problem (Mugenda and Mugenda, 2003). Descriptive survey research design seeks to establish factors associated with certain occurrences, outcomes, conditions or type of behavior. This design was appropriate for the study since the study involved assessment of human behavior which is highly diverse. In addition, the researcher aimed at getting the perceptions of the respondents regarding the issues under study hence this methodology was effective in meeting the objectives of the study.

#### **3.3 Target population**

Target population is defined as universal set of the study that includes all members of real or hypothetical set of people, events or subjects to which the researcher wishes to generate results (Mugenda and Mugenda, 2003). According to Kamukunji sub-county education office, there are 179 teachers and 127 members of BOM/PTA in the 10 primary schools within Pumwani ward.

**Table 3.1: Target Population**

Table 3.1 presents the target population of this study. The population is categorized into two groups, these are teacher and members of Board of Management (BoM) of all primary schools within Pumwani Ward, Nairobi County, Kenya.

NAME OF THE SCHOOL	POPULATION	
	Teachers	BOM
Muthurwa Primary school	25	16
Shauri Moyo Adventist	19	15
Heshima road primary	22	17
New Pumwani Primary	21	11
Our lady of Mercy primary	23	19
YMCA Shauri Moyo	15	9
Splash CBO Primary	13	8
Pumwani Udugu primary	14	12
Pumwani Child survival	15	10
St. Johns Community primary	12	10
<b>Total</b>	<b>179</b>	<b>127</b>

### **3.4 Sampling design and sample size**

A sample is a small proportion of the target population selected systematically to represent the entire population. Sampling therefore is the process by which a relatively small number of individuals, objects or events is selected and analyzed in order to find out something about the entire population from which the sample was selected. In this study the researcher used stratified proportional sampling to enable representation of all primary schools within Pumwani ward and

allow generalization of the results to the larger target population with a determinable margin error.

In total, 60 respondents were sampled. This represents 20% of the target population and above the recommended minimum sample representation of 10% according to Mugenda and Mugenda (2003).

### **3.5 Data collection instruments**

The researcher used both primary and secondary methods of data collection. For primary data, structured questionnaires and interview guide were used. The questionnaires had both open and close ended questions. For secondary data, books journals, manuals, magazines and newspaper and other documents related to CSHP were used.

### **3.6 Validity and reliability**

Reliability measures the extent to which a research instrument can produce the same results over and over again while validity describes the extent to which the instrument measures what it is purports to measure. The researcher conducted both validity and reliability tests to determine the suitability of the data collection instruments.

#### **3.6.1 Validity of research instruments**

Validity is the degree by which the sample of the test items represents the content the test is designed to measure. Content validity was adopted for this study and used to measure the degree to which data collected using a particular instrument represents a particular domain or content of a particular concept. To establish the validity of the research instruments the researcher sought the opinion of experts in the field of study especially the researcher's supervisor and lecturers which enhanced the development of appropriate instruments.

#### **3.6.2 Reliability of the research instruments**

Reliability refers to consistency of a measure, the ability of the instrument used in research to consistently measure the characteristic of interest over time (Ahmed et al, 1994). According to Mugenda and Mugenda, (2003) reliability is a measure of the degree to which a research

instrument yields consistent results or data after repeated trials. To ensure reliability, the researcher conducted a pilot study to 10 respondents.

To assure reliability, test re-test method was also be used where the same questionnaire was administered to same respondent twice within a span of two weeks and represented reliability coefficient of 0.91 which indicated that the instruments had excellent reliability.

### **3.7 Data Collection Procedures**

The researcher hand delivered the questionnaires to the respondents and allowed them a maximum of 24 hours to fill them and then the filled questionnaires were collected and checked for completeness. The researcher also used the interview schedule to interview the key respondents in the study and also for triangulation where data was collected through face to face interview between the respondents and the researcher.

### **3.8 Data analysis**

Data analysis procedures is the process of packaging the collected information, putting it in order and structuring its main components in a way that the findings can be easily and effectively communicated (Kombo and Tromp, 2011). In this study, data was analyzed using descriptive statistics and inferential statistics. Quantitative data was analyzed using descriptive statistics such as mean, standard deviation and percentages and presented descriptively and also through the use of tables. On inferential statistics, the researcher used multiple regression model to measure the relationship between independent and dependent variables.

### **3.9 Operationalization of variables**

This operationalization framework hypothesizes that there is a relationship between the school infrastructure, support supervision and capacity building; and implementation of comprehensive school health program. This section defines the variables in terms of measurable indicators. The independent and dependent variables are operationalized as shown on Table 3.2

**Table 3.2: Table of Operationalization of variables**

Table 3.2 explains how the researcher collected data and analyzed it on each of the variables used in this study. The researcher also shows the indicators used to measure the variables and specific measures used.

<b>Objectives</b>	<b>Variables</b>	<b>Indicators</b>	<b>Method of Data collection</b>	<b>Data analysis</b>
<b>To establish the influence of capacity building on the implementation of comprehensive school health program</b>	Capacity Building	<ul style="list-style-type: none"> <li>• Training on CSHP</li> <li>• Training on gender issues</li> <li>• Training on life skills.</li> </ul>	Questionnaire Interview guide	Percentages, frequencies,  Rank,  Mean
<b>To find out the influence of support supervision on the implementation of comprehensive school health program</b>	Support supervision	<ul style="list-style-type: none"> <li>• Disease prevention</li> <li>• Nutrition</li> <li>• Special needs</li> <li>• Child rights</li> </ul>	Questionnaire Interview Guide	Percentages, frequencies, Standard deviation,  Mean
<b>To find out the influence of school infrastructure on the implementation of comprehensive school health program</b>	School infrastructure	<ul style="list-style-type: none"> <li>• Access to water</li> <li>• Conducive classrooms</li> <li>• Environmental safety</li> </ul>	Questionnaire Interview Guide	Percentages, frequencies,  Standard deviation  Mean
<b>Factors influencing implementation of comprehensive school health program(CSHP)</b>	Implementation of CSHP	<ul style="list-style-type: none"> <li>• Capacity building</li> <li>• Support supervision</li> <li>• School infrastructure</li> </ul>	Questionnaire/ Observation  Interview guide	Percentages, frequencies,  Standard deviation  Mean, Regression analysis

### **3.10 Ethical considerations**

The researcher applied for a permit from National Council for Science and Technology to conduct research. The researcher also wrote an introductory letter to respondents informing them that the research was purely be for academic purposes. Respondents were assured of confidentiality and their participation in research is voluntary. Respondents were free to withdraw if they perceived the nature of questions as contrary to their value system. Respondents were also be informed that the findings of the study would be shared with any of the respondents who wished to know the outcome of the research.

## **CHAPTER FOUR**

### **DATA ANALYSIS, PRESENTATION AND INTERPRETATION**

#### **4.1 Introduction**

This chapter focuses on data analysis, presentation, interpretation and discussions. The researcher collected data through a questionnaire that was hand delivered to 60 respondents and collected by the researcher once completed and also through face to face interviews. Descriptive and inferential statistics were used to analyze data collected and the findings were presented descriptively; and through the use of tables.

#### **4.2 Response rate**

In this study, out of 60 respondents sampled, 50 returned fully filled questionnaires. This represents a response rate of 83%. According to Mugenda and Mugenda (2003) a response rate of more than 80% is more likely to give the researcher accurate findings.

#### **4.3 Background information**

The researcher sought background information from the respondents that relates to Comprehensive School Health Program and may affect the implementation of the program. Specifically, the researcher assessed whether the respondents represented private or public schools, whether they were trained on comprehensive school health program and their knowledge on thematic areas, their schools access to clean water and the status of the school health committees in their respectful schools. The researcher presents the findings of this assessment descriptively and through frequency distribution tables.

#### **Table 4.3: Private and public schools**

The researcher sought to find out whether the respondents represented public or private schools. 29(58%) of the respondents private schools while 21(41%) represented private schools. This findings are summarized on Table 4.3



<b>Category</b>	<b>Frequency</b>	<b>Percentage (100%)</b>
<b>Private schools</b>	29	58
<b>Public schools</b>	21	42
<b>Total</b>	<b>50</b>	<b>100</b>

**Table 4.4: Training on CSHP**

The study sought to find out whether the respondents were trained on Comprehensive School Health Program (CSHP). The findings are presented on table 4.4 below

<b>Category</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Trained on CSHP</b>	17	34
<b>Not trained on CSHP</b>	33	66
<b>Total</b>	50	100

From the finding, 17(34%) of the respondents indicated that they had been trained on CSHP while the majority 33(66%) indicated that they had not been trained on the program and among those who had been trained, 16(94%) knew at least four out of eight thematic areas of CSHP. This indicated that training was effective in promoting knowledge on CSHP. The findings also could indicate that implementation of Comprehensive school health program has been a challenge because the majority of the stakeholders are not trained on the program hence are not aware of the aims and overall strategy of the program.

**Table 4.5: Access to clean water**

The researcher also sought to determine whether the schools represented by the respondents had access to clean water always. The findings are presented on table 4.5 below

<b>Category</b>	<b>Frequency</b>	<b>Percentage (100)</b>
<b>Access clean water always</b>	15	30
<b>Access clean water sometimes</b>	35	70
<b>Never access clean water</b>	0	0
<b>Totals</b>	50	100

From findings in figure 4.3, 35(70%) of the respondents indicated that their schools accessed clean water sometimes while 15(30%) stated that their schools had access to clean water always. This information could indicate that some health problems faced by learners in school is as a result of lack of clean water all the times since the majority of respondents indicated that their schools only access clean water sometimes. However none of the respondents indicated that their schools never accessed water at all.

**Table 4.6: Status of school health committee**

The researcher enquired from the respondents on whether the schools they represented had school health committee and whether the committee in their school was active or not. The findings are presented on Table 4.6

<b>Status of school health committee</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Active</b>	16	32
<b>Inactive</b>	13	26
<b>Non existent</b>	21	42
<b>Total</b>	<b>50</b>	<b>100</b>

From the findings on Table 4.6, most of the respondents stated that there was no existent school health committee in their school 24(42%), while 13(26%) had inactive school health committees. Only 16(32%) of the respondents stated to have active school health committees. This could indicate that most schools do not implement Comprehensive school health because they do not have put implementation committees in place and where they have, the committees are inactive. In addition, 42(84%) of the respondents stated that their schools do not report on CSHP while 8(16) stated that they did not know whether their schools reported on CSHP. This could indicate that CSHP is not considered to be of importance in terms of reporting.

#### **4.4 Human resource capacity building in implementation of CSHP**

On human resource capacity building the researcher sought to get the perception of the respondents on whether capacity building influenced implantation of Comprehensive School Health Program. Specifically, the researcher enquired on training of teachers and BOM on Comprehensive School Health program, training on gender norms and training on life skills. The researcher examines each of the three capacity building areas and presents the finding descriptively and using tables. Interpretation of the findings is also provided.

**Table 4.7: Influence of Human resource Capacity Building in implementation of CSHP**

The researcher sought to determine whether training on Comprehensive School Health Program, training on gender norms and training on life skills have an influence on implementation of the Comprehensive School Health Program.

The perceptions of the respondents are presented on Table 4.7 below;

<b>Category</b>	<b>Strongly Agree (%)</b>	<b>Agree (%)</b>	<b>Uncertain (%)</b>	<b>Disagree (%)</b>	<b>Strongly disagree (%)</b>	<b>Total</b>	<b>Mean</b>	<b>sd</b>
<b>Training on CSH</b>	74	24	0	2	0	50	4.68	0.68
<b>Training on Gender norms</b>	52	28	8	12	0	50	4.2	1.03
<b>Training on life skills</b>	24	62	8	6	0	50	4.04	0.75

From the finding presented on Table 4.5, the majority 74% strongly agreed that training on school health influences implementation of Comprehensive School Health Program., 24% of the respondents also agreed while only 2% of the respondents disagreed. The findings reveal that School health is very important in influencing implementation of CSHP demonstrated by a mean rating of 4.68 points with a standard deviation of 0.68, this is despite majority 66% of the respondents stating that they had not been trained on school health.

On gender issues, the majority 52% strongly agreed that training on gender issues influenced implementation of comprehensive school health program, 28% agreed, 8% were uncertain while 12% of the respondents disagreed with an overall mean score of 4.2 points and standard deviation of 1.03. This indicates that respondents considered training on gender norms to be of importance in implementation of Comprehensive School Health Program. Most of the respondents 62% agreed that Life skills training was important with 24% strongly agreeing with the statement. 8% of the respondents were uncertain while 6% disagreed. Again this indicates that respondents considered life skills training as important in implementation of comprehensive school health program demonstrated by the mean of 4.04 points and standard deviation of 0.75.

Overall, training on school health ranked as the most important in human resource capacity building followed by gender issues training and then life skills training.

#### 4.5 Support supervision in implementation of CSHP

The study sought to determine the perception of the respondents on the influence of support supervision in implementation of Comprehensive School Health Program. Particularly the researcher focused on support supervision in Disease Prevention and Control, Child Rights and Protection, Nutrition and Special Needs. The researcher examines each of the four support supervision areas and the findings are presented in Table 4.8.

**Table 4.8: Influence of support supervision in implementation of CSHP**

The study sought the perception of the respondents on whether support supervision in Disease Prevention and Control, Nutrition, Child Rights and Prevention and Special Needs influenced implantation of Comprehensive School Health Program. The findings are presented on Table 4.8 below.

Category	Strongly Agree (%)	Agree (%)	Uncertain (%)	Disagree (%)	Strongly disagree (%)	Total	Mean	sd
<b>Disease prevention</b>	48	24	16	12	0	50	4.08	1.07
<b>Special needs</b>	34	46	0	20	0	50	3.94	1.08
<b>Nutrition</b>	22	60	18	0	0	50	4.04	0.64
<b>Child rights</b>	26	46	12	16	0	50	3.82	1.00

From the findings presented in Table 4.6, most of the respondents 48% strongly agreed on support supervision in disease prevention and control, 24% agreed, 16% were uncertain while 12% disagreed. Respondents considered support supervision in disease prevention and control as the most important with a mean of 4.08 points with a standard deviation of 1.07. This indicates that respondents considered support supervision in disease prevention as key in the implementation of Comprehensive School Health Program. On Special needs, 34% of the respondents strongly agreed, 46% agreed while 20% of the respondents disagreed. Support

supervision on special needs and rehabilitation got a mean score of 3.94 points and standard deviation of 1.08. Again, indicating that support supervision in special needs is important. Majority of the respondents 60% agreed with nutrition support supervision while 18% were uncertain. Support supervision on nutrition had a mean of 4.04 and standard deviation of 0.64. Also most 46% respondents agreed that support supervision on child rights and rehabilitation was necessary with 26% strongly agreeing; 12 % of the respondents were uncertain while 16% disagreed with support supervision in child rights, rehabilitation and protection.

#### 4.6 School Infrastructure in implementation of CSHP

On school infrastructure, the researcher was interested in getting the perception of the respondents on whether the school infrastructure influenced implementation of comprehensive school health program. Specifically, the researcher focused on water and sanitation, environmental safety, and conduciveness of the classrooms. The researcher examines each of the three school infrastructure facilities and presents the finding on Table 4.9.

**Table 4.9: Influence of school infrastructure in implementation of CSHP**

The researcher presents the findings in each of the three infrastructural facilities and also includes the mean and standard deviation.

Category	Strongly Agree (%)	Agree (%)	Uncertain (%)	Disagree (%)	Strongly disagree (%)	Total	Mean	sd
<b>Water and sanitation</b>	76	24	0	0	0	50	4.76	0.43
<b>Environmental safety</b>	14	54	32	0	0	50	3.82	0.66
<b>Conducive classrooms</b>	8	32	34	26	0	50	3.22	0.93

From the findings on Table 4.7, the study sought to establish whether access to water and sanitation influences implementation of Comprehensive School Health Program. 74% of the respondents strongly agreed with an addition 24% also agreeing, none of the respondents disagreed. On environmental safety, 54% of the respondents agreed with 14% strongly agreeing

while 32% were uncertain and none of the respondents disagreed. On whether conducive classrooms influenced implementation of the program, 8% strongly agreed, 32% agreed, 34% were uncertain while 26% disagreed. Overall, Conducive classrooms got the least rating in terms of influencing implementation of comprehensive school health program with the mean score of 3.22 points and a standard deviation of 0.93. Water and sanitation received the highest rating with a mean score of 4.76 points and standard deviation of 0.43 while environmental safety had a mean score of 3.82 points and standard deviation of 0.66.

#### 4.7 Factors influencing Implementation of CSHP

The researcher also examined the overall factors influencing implementation of Comprehensive school health program. This evaluation was based on the three independent variables of the study which are human resource capacity building, support supervision and school infrastructure. The researcher used descriptive statistics to determine the perception of the respondents on whether the independent variables influenced the dependent variable which is implementation of Comprehensive School Health Program. The researcher also employed inferential statistics to determine whether there was any relationship between the independent and the dependent variables.

**Table 4.10: Factors influencing implementation of CSHP**

This table presents the findings of each of the three independent variables in relation to whether they influenced implementation of Comprehensive School Health Program.

Category	Strongly Agree (%)	Agree (%)	Uncertain (%)	Disagree (%)	Strongly disagree (%)	Total	Mean	sd
Capacity Building	66	34	0	0	0	50	4.66	0.48
Support supervision	52	28	12	8	0	50	4.24	0.96
School infrastructure	48	32	14	6	0	50	4.22	0.91

From the findings on Table 4.8, majority of the respondents 66% strongly agreed that capacity building influences implementation of CSHP while an addition 34% agreed and none of the respondents disagreed. This indicates that capacity building plays a crucial role in the implementation of the program. On support supervision, 52% strongly agreed, 28% agreed, 12% were uncertain while 8 % disagreed. School infrastructure also got the approval of most respondents 48% strongly agreeing, 32% agreed, 14% were uncertain while 6% disagreed. Overall, capacity building had the highest rating with a mean score of 4.66 points and a standard deviation of 0.48, support supervision had a mean score of 4.24 points and standard deviation of 0.96 while school infrastructure scored 4.22 points and a standard deviation of 0.91. This indicates that majority of the respondents considered all the three independent variables as influential in the implementation of Comprehensive School Health Program.

#### **4.7.1 Respondents' opinion of implementation of CSHP**

The respondents indicated that lack of proper training of teachers and BoM on CSHP was the main challenge in the implementation of the program. For the program to succeed all the stakeholders need to be well informed about their role and how such roles will impact on improved health for pupils and those working within the learning institutions. They recommended training on the program and periodic updates and assessment to evaluate the progress of the program. They also highlighted the need for parents to be more engaged in school programs.

#### **Table 4.11: Multiple Regression Analysis**

The researcher sought to establish whether there was a significant relationship between the independent variables and the dependent variable. In this regard, the researcher used multiple regression analysis model to determine whether there was a significant relationship between the independent and the dependent variable.



The following Table 4.11 presents the findings of multiple regression analysis of various variables used in this study.

Model		Unstandardized Coefficient		Standardized coefficient	t	Sig.
		B	Std. Error	Beta		
Y=a+bx <sub>1</sub> +bx <sub>2</sub> +bx <sub>3</sub>	Constant	3.059	.621		4.923	.000
	Capacity building	-.421	.120	-.351	-3.716	.002
	Support supervision	-.365	.118	-.111	-1.114	.003
	School infrastructure	-.236	.117	-.089	-.918	.0035

**Dependent Variable:** Implementation of comprehensive school health program

From the configured multiple regression model

$$Y = a + bx_1 + bx_2 + bx_3$$

**Where:**

**bx<sub>1</sub>** is an independent or explanatory variable; human resource capacity building

**bx<sub>2</sub>** is an independent or explanatory variable; support supervision

**bx<sub>3</sub>** is an independent or explanatory variable; school infrastructure

**Y** = is the dependent variable; implementation of Comprehensive School Health Program

**a**= is a constant

**sig**= is the significance at 5% level of significance

**t= is** the test statistic value

Table 4.11 indicates that there is a high significant relationship between capacity building and implementation of Comprehensive School Health Program with (with t statistic p value  $<0.002 <0.05$ ). This indicates that capacity building has an impact on implementation of Comprehensive school health program. The findings also indicate that there is a significant relationship between support supervision and implementation of Comprehensive School Health Program (with t statistic p value  $<0.003 <0.05$ ). School Infrastructure variable was also found to have a significant relationship with the implementation of Comprehensive School Health Program (with t statistic p value  $<0.0035 <0.05$ ). Therefore in essence, human resource capacity building, support supervision and school infrastructure has an influence on the implementation of Comprehensive School Health Program.

## **CHAPTER FIVE**

### **SUMMARY OF THE FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter presents summary of the findings and interpretations as presented in chapter four, discussions of the results, conclusions and recommendations based on the findings. The researcher basis the conclusions and recommendations made on the findings of this study. The researcher also suggests related areas that requires further research.

#### **5.2 Summary of the findings**

The study established factors of implementation of Comprehensive School Health Program in primary schools: a case of Pumwani ward, Nairobi County, Kenya by studying the following factors; Capacity building, support supervision and school infrastructure.

The findings show that capacity building is very important in implementation of Comprehensive School Health Program. Ranking the perceptions of the respondents on the extent to which capacity building influences implementation of CSHP based on the basis of the mean; shows that training CSHP is the most influential with a mean of 4.68 points and standard deviation of 0.68, followed by training on gender issue with a mean of 4.2 points with a standard deviation of 1.03 and life skills training had a mean score of 4.04 points with a standard deviation of 0.75. However, the fact that all the three capacity building strategies had a rating of 4 and more points at minimal standard deviation, indicate that the respondents considered capacity building to play a crucial role in the implementation of Comprehensive School Health Program. The findings also reveal that majority of the respondents had not been trained on CSHP and this could explain the poor state of implementation of the CSHP in Pumwani ward.

The findings indicate that respondents consider support supervision to be crucial in the implementation of Comprehensive School Health Program. Majority of the respondents agreed that support supervision to schools on disease control and prevention, nutrition, special needs and rehabilitation, child rights and protection influenced implementation of CSHP. In order of priority, disease prevention and control had the highest rating with a mean rate 4.08 points with

standard deviation of 1.07, nutrition 4.04 points with a standard deviation of 0.64, special needs 3.94 points with a standard deviation of 1.0 and child rights 3.82 points with a standard deviation 1.08. Therefore majority of the respondents agreed that the four support supervision areas are key in the implementation of Comprehensive School Health Program.

Majority of the respondents agreed that school infrastructure influenced implementation of Comprehensive school health Program. In order of priority water and sanitation was ranked as the most influential with a mean score of 4.76 points and standard deviation of 0.43. This is despite the majority of the respondents 70% stating that the schools they represented did not have access to clean water always and only got clean water sometimes. Environmental safety had a mean rate of 3.82 points with a standard deviation of 0.66 while conducive classrooms had a mean rate of 3.22 points with a standard deviation of 0.93. This indicates that the respondents considered water and sanitation to be the most important infrastructure in the implementation of Comprehensive School Health Program.

Over all, the respondents rated capacity building as the most important factor influencing implementation of comprehensive school health Program with a mean rate of 4.66 with a standard deviation of 0.48. Support supervision had a mean score of 4.24 with a standard deviation of 0.96 while school infrastructure had a mean score of 4.22 with a standard deviation of 0.91. Other factors identified by the respondents were coordination and parental involvement. This indicated that the respondents considered all the three factors to be critical in the implementation of Comprehensive School Health Program. On inferential statistics, all the independent variables namely capacity building, support supervision and school infrastructure were found to have a significant relationship with the dependent variable which is implementation Comprehensive School Health Program. All the independent variables had a t statistic p value of less than 0.05 which indicated that there was a relationship with the independent variable at 5% level of significance

### **5.3 Discussions of the findings**

The researcher discusses the findings of this study and compares them with the findings of similar studies or literature conducted by other researchers. In doing this, the researcher is guided

by the three independent variables of the study which are capacity building, support supervision and school infrastructure.

### **5.3.1 Capacity Building**

The study sought to find out whether capacity building influences implementation of comprehensive school health program in primary school. The findings reveal that capacity building through training in CSHP, gender issues and life skills has high influence on implementation of Comprehensive School Health Program. This finding is in line with the finding of McLean et al. (2004) who studied health capacity building in schools and found that school systems are open and adaptive to small scale innovations such as introducing programs on individual health or social issues but resistant to large scale reforms that shift basic priorities away from their academic, vocational and accreditation functions towards their socialization or custodial functions through their loosely-coupled and bureaucratic structures. He recommended that key stakeholders be properly trained on new programs before rolling them out in schools to avoid resistance or perceived interruption from the learning path.

On gender issues, the findings reveal that gender norms training is crucial in the implementation of Comprehensive School Health Program. This findings are in line with the literature of Fiona Lean (2006) who argues that gender violence in and around school has been recognized in recent years as a serious global phenomenon. We have ignored for too long what goes on in the school environment. The sad fact is that schools are not always the child-friendly places we expect them to be. Violence can be perpetrated by pupils or teachers in or around the school, or by out of school youth and/or older men who demand sex in exchange for money or gifts. Acts of gender violence are disproportionately directed at girls, but boys and teachers can also be targets hence the need to reach all stakeholders on gender norms training. In addition, United Nations (2006) study on violence against children recommended implementation life skills education to enable students to build personal skills. Governments should ensure that rights-based life skills programs for non-violence should be promoted in the curriculum through subjects such as peace education, citizenship education, anti-bullying, human rights education, and conflict resolution and mediation; with emphasis placed on child rights and positive values such as diversity and tolerance, and on skills such as problem-solving, social and effective communication, in order to

enable girls and boys to overcome entrenched gender biases and to prevent and deal with violence and harassment, including sexual harassment. This is in line with the findings of the study.

### **5.3.2 Support supervision**

The study sought to find out ways in which support supervision influences implementation of Comprehensive School Health Program by studying support supervision on disease prevention and control, nutrition, special needs and child rights and protection. Majority of the respondents agreed that support supervision on these areas is key in the implementation of the program. This is in line with the findings of R. Govinda and Shahjahan Tapan (1999) study on support supervision in Bangladesh schools that found support of school programs by external personnel enhanced the performance of students and improved the conditions of the school.

### **5.3.3 School infrastructure**

The study also sought to find out the influence of school infrastructure on the implementation of Comprehensive School Health Program. The finding revealed that infrastructure is tied to the health of the pupils hence is key in implementing the program. This is in line with the finding of Sheets, M.E (2009) who studied the impact of school facilities on students and teachers and found that Poor facilities affected the health and productivity teachers and make retention of teachers difficult. On the academic side, a shift from the best facilities to the worst decreases student test performance by 3%. The study also found that the condition of school facilities has a measurable effect over and above socioeconomic conditions on student achievement and teacher experience/turnover. In addition, according to Schneider, M (2003) Schools play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behaviors. School health facilities can reduce the prevalence of health risk behaviors among young people. This argument is in line with the findings of this study.

## **5.4 Conclusion**

The study established that implementation of Comprehensive School Health Program is influenced by capacity building, support supervision and school infrastructure. Capacity building as a factor influences implementation of the program by equipping the stakeholders with

knowledge and skills on CSHP, gender norms and life skills training. The study established that majority of the respondents were not trained on these yet they identified these areas as key in the implementation of Program.

Support supervision was also found to be key in disease prevention and control, special needs, child rights and rehabilitation and Nutrition. This mainly requires additional expertise that may not be readily available within the school or on issues that keep changing over time and require technical assessment and control. Support supervision not only enhances the health of the students but also promotes academic performance and general school welfare.

Infrastructure also was found to influence implementation of the program since health of the students could be affected by the state of the infrastructure. The researcher established that the infrastructure play a crucial role in prevention of infections and diseases and cannot be ignored while implementing Comprehensive School Health Program.

## **5.5 Recommendations**

Based on the findings of this study, the researcher makes the following recommendations;

- i. All teachers and BOM should be trained on Comprehensive School Health Program, gender norms and life skills to equip them with the skills and knowledge required to implement the program.
- ii. Schools should work closely with other health related institutions such as hospitals, ministry of health among others for support in technical health issues that the schools may not have the capacity to handle.
- iii. All schools should be equipped with reliable source of clean water and child friendly facilities that cater for the need of children living with disabilities.

## **5.6 Suggestions for further Research**

From the findings of this study, the researcher suggests further study should be conducted on engagement of parents in school health programs to find out whether such engagement has an influence on health outcomes of students. Such research would help to redefine the role of parents in schools and extend healthy practices beyond the school.

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## APPENDIX I

### LETTER OF TRANSMITTAL OF DATA COLLECTION INSTRUMENTS

KENNEDY MBOGO  
P.O.BOX 686-60100  
EMBU.  
TEL: 0725686438

Dear respondent,

#### **RE: ACADEMIC RESEARCH PROJECT.**

I am a final year Masters of Arts students at the University of Nairobi, specializing in project planning and management. As part of my course, I am required to carry out research on “*factors influencing implementation of comprehensive school health program in primary schools:*” a case of Pumwani ward, Nairobi county, Kenya.

I will be grateful if you could spare sometime from your busy schedule and fill in the questionnaire. All the information provided will purely be used for academic purposes your identity will be treated with utmost confidentiality.

Thank you for your cooperation.

Kindly do not write your name anywhere on the questionnaire.

Yours faithfully,

**Kennedy Mbogo**

**L/73444/2014**

**APPENDIX II**  
**RESEARCH QUESTIONNAIRE**

This research is for academic purpose. You're kindly requested to provide answers to these questions honesty and precisely as possible. Responses will be treated with utmost confidentiality. Please tick [✓] appropriately or fill the required information on the spaces provided.

**SECTION A: BACKGROUND INFORMATION**

1. B.O.M/PTA  Teacher

2. School ownership

Private

Public

3. Have you been trained on Comprehensive school health program?

Yes

No

If yes, please write 4 thematic areas of comprehensive school health program

1) -----

2) -----

3) -----

4) -----

4. Have you been trained on Comprehensive School Health Program?

Yes  No

5. Does your school have access to clean water?

Always  Sometimes  Never

6. Do you have a school health committee in your school?

Yes  No

**SECTION B: CAPACITY BUILDING**

7. To what extent do you agree that the following capacities building interventions influence implementation of Comprehensive school Health Program? Please tick (✓) appropriately on each of the categories.

Category	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
Training on CSHP					
Training on Gender issues					
Training on life skills					

8. Have you been trained on CSHP?

Yes

No

9. In your opinion what how does capacity building influence implementation of Comprehensive School Health Program? .....

.....  
 .....

**SECTION C: SUPPORT SUPERVISION**

10. In the last 6 months, has your school been visited by an education official to assess/support CSHP?      Yes  No

11. To what extent do you think support supervision on the following factors influence implementation of comprehensive school health program? Please tick (✓) in rank (5 being the highest score)

<b>Category</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Uncertain</b>	<b>Disagree</b>	<b>Strongly disagree</b>
<b>Disease prevention and control</b>					
<b>Special needs and rehabilitation</b>					
<b>Nutrition</b>					
<b>Child rights and protection</b>					

12. In your opinion how does support supervision influence implementation of Comprehensive School Health Program? .....

.....

.....

.....

**SECTION D: INFRASTRUCTURE**

13. To what extent do you think the following school infrastructure influences the implementation of CSHP? Please tick appropriately

<b>Category</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Uncertain</b>	<b>Disagree</b>	<b>Strongly disagree</b>
<b>Adequate classrooms</b>					
<b>Friendly facilities for PLWD</b>					
<b>Water and sanitation</b>					

14. In your opinion how does infrastructure influence implementation of Comprehensive School Health Program?

.....

.....

.....

**SECTION E: IMPLEMENTATION OF CSHP**

15. To what extent do you agree that the following factors influences implementation of Comprehensive School Health Program? Please tick whether you strongly agree, agree, uncertain or disagree or strongly disagree on each of the categories.

<b>Category</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Uncertain</b>	<b>Disagree</b>	<b>Strongly disagree</b>
<b>Capacity Building</b>					
<b>Support supervision</b>					
<b>School infrastructure</b>					

16. In your opinion, what other factors would you add to the above?

.....  
 .....  
 .....

*Thank you for participating.*



**APPENDIX III**  
**INTERVIEW GUIDE**

1. Does capacity building influence implementation of Comprehensive School Health Program? .....  
.....  
.....
2. Does support supervision influence implementation of Comprehensive School Health Program? .....  
.....  
.....
3. Does school infrastructure influence implementation of comprehensive school health program? .....  
.....  
.....
4. In your opinion, how does school capacity building influence the implementation of CSHP? .....  
.....  
.....
5. In your opinion, how does support supervision influence the implementation of CSHP?.....  
.....  
.....
6. In your opinion, how does school infrastructure influence the implementation of CSHP?  
.....  
.....  
.....

**APPENDIX IV**  
**LETTER OF TRANSMITTAL**



**UNIVERSITY OF NAIROBI**  
**COLLEGE OF EDUCATION AND EXTERNAL STUDIES**  
**SCHOOL OF CONTINUING AND DISTANCE EDUCATION**  
**DEPARTMENT OF EXTRA-MURAL STUDIES**  
**NAIROBI EXTRA-MURAL CENTRE**

Your Ref:

Our Ref:

Telephone: 318262 Ext. 120

Main Campus  
Gandhi Wing, Ground Floor  
P.O. Box 30197  
N A I R O B I

19<sup>th</sup> July 2016

REF: UON/CEES//NEMC/23/519

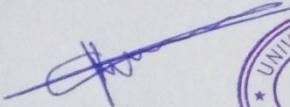
**TO WHOM IT MAY CONCERN**

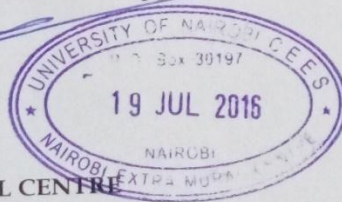
**RE: KENNEDFY KINYUA MBOGO -REG.NO.L50/73444/2014**

The above named has been a registered student at the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Department of Extra- Mural Studies pursuing Master of Arts in Project Planning and Management.

He is proceeding for research entitled "factors influencing implementation of comprehensive school health program (CSHP) in primary schools". A case of Pumwani ward, Nairobi County, Kenya.

Any assistance given to him will be appreciated.

  
**CAREN AWILLY**  
**CENTRE ORGANIZER**  
**NAIROBI EXTRA MURAL CENTRE**

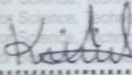



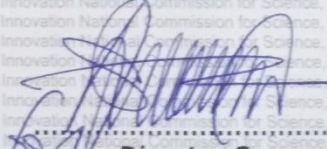
**APPENDIX V  
RESEARCH PERMIT**

**THIS IS TO CERTIFY THAT:**  
**MR. KENNEDY KINYUA MBOGO**  
**of UNIVERSITY OF NAIROBI, 686-60100**  
**embu, has been permitted to conduct**  
**research in Nairobi County**

**on the topic: FACTORS INFLUENCING**  
**IMPLEMENTATION OF COMPREHENSIVE**  
**SCHOOL HEALTH PROGRAM (CSHP) IN**  
**PRIMARY SCHOOLS: A CASE OF**  
**PUMWANI WARD, NAIROBI COUNTY,**  
**KENYA**

**for the period ending:**  
**29th July, 2017**



  
**Applicant's**  
**Signature**

  
  
**Director General**  
**National Commission for Science,**  
**Technology & Innovation**

**Permit No. : NACOSTI/P/16/35759/12721**  
**Date Of Issue : 1st August, 2016**  
**Fee Received :Ksh 1000**

**CONDITIONS**

- 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit**
- 2. Government Officers will not be interviewed without prior appointment.**
- 3. No questionnaire will be used unless it has been approved.**
- 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- 5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.**
- 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice**

  
**REPUBLIC OF KENYA**  
  
**National Commission for Science,**  
**Technology and Innovation**

**RESEARCH CLEARANCE**  
**PERMIT**

**Serial No. A 10407**

**CONDITIONS: see back page**