

# DETERMINANTS OF SUSTAINABLE IMPLEMENTATION OF THE COMPREHENSIVE SCHOOL HEALTH PROGRAM (CSHP) IN MARGINALIZED REGIONS OF KENYA: A CASE OF TANA RIVER COUNTY

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**Abstract:** The easiest way to provide health services to the young population in any country is ensuring that health programs are integrated into the education systems since majority of the young population in both developing and developed countries spend their lives and time in schools. Therefore, there was a need to establish the link between education systems in a country and the implementation of the CSHP. In this realization, the study was carried out. Therefore through the study it was the easiest way to provide health services to the young population in any country is ensuring that health programs are integrated into the education systems since majority of the young population in both developing and developed countries spend their lives and time in schools. Therefore, there was a need to establish the link between education systems in a country and the implementation of the CSHP. Out of the 218 questionnaires distributed, 150 were very useful for the study. The results indicated that there was a significant relationship between the various independent variables and the dependent variable as indicated by the Chi-Square test values. Therefore in the study, all the alternative hypotheses were adopted i.e: Capacity building has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya (calculated p value of 0.124 was less than 0.5 ( $p < 0.5$ ), at 95% significance level); support provision has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya (calculated p value of 0.221 was less than 0.5 ( $p < 0.5$ ), at 95% significance level); School infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya significantly (calculated p value of 0.003 was less than 0.5 ( $p < 0.5$ ), at 95% significance level); and government policies have a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya (calculated p value of 0.045 is less than 0.5 ( $p < 0.5$ ), at 95% significance level). The researcher suggested that a similar study should be carried out in the other remaining counties in the coast region or by extension in the whole of Kenya and beyond. Another study should be carried out to examine the influence of the CSHP on education performance in any given county in Kenya.

**Keywords:** capacity building, support provision, school infrastructure, government policies.

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## 1. INTRODUCTION

Basic life enabling components of any economy in the world that the governments ensure that the people access include: universal healthcare, universal education, food security, security, social protection and water and sanitation. All these components fall under the category of community programs, since their success has a direct impact to the lives of a given community members and influences the future population trends of the community plus to the socialization of the individuals in the community (Junko, Ngouay and Sachi, 2015). The various programs outlined interact to better the lives of individuals in the world, although their effective implementation has been influenced by a number of factors. These factors differ from one country to another and the factors depict themselves as challenges in majority of the developing countries in Africa and Asia as noted by World Health Organization (2015)

According to UNESCO (2017), the easiest way to provide health services to the young population in any country is ensuring that health programs are integrated into the education systems since majority of the young population in both developing and developed countries spend their lives and time in schools. Therefore, there is a need to establish the link between education systems in a country and the implementation of the CSHP. Junko, Ngouay and Sachi (2015) did a study in Vietnam and argued that there is a need for every school to ensure that the CSHP is adopted at all levels of learning. Thus there is a very crucial need to have the CSHP implemented in learning institutions as core idea. However, in the study, it was noticed that a number issues are influencing the implementation of the CSHP in Vietnam. For example, in Vientiane capital public schools, factors like policy processes, resources management, institutionalized monitoring cycle, management skills of school principals, effective training etc.

Idehen and Oshodin (2018) did a study in Nigeria and found out that the CSHP is very vital in Nigeria and it influences the performance of schools. The study equally showed that lack of health education teachers, lack of relevant health education textbooks, pamphlets and posters were factors central to the poor state of CSHP in Edo State secondary schools. Based on these findings, the research recommended that there is a need for an in-depth examination of other factors that influence the implementation of this program in the Nigeria and other countries in Africa. According to Macfarlane (2015), after recovering from the civil war that ran between 1994 and 1997, the Rwandese people embarked into reconstructing their country in the spirit of reconstructing their country, the government and other governing agencies identified key areas to throw their focus for equitable development. Notable areas were education, health, environment, peace and security etc. Education and health in Rwanda are intertwined (WHO, 2015). The concept of integrated CSHP was introduced in Kenya in the mid 1980's but it gained its momentum as the dawn of the new millennium approached (World Health Organization, 2014). Numerous studies by scholars, NGOs, government agencies and other independent research organs have shown that the periods between 1985 to late 2000, the Kenyan population was faced with numerous challenges; central among the challenges being poor health care, poverty and high rates of illiteracy (World Bank, 2014; Musembi, Celestine, and Andrea, 2016; Save the Children Kenya, 2016). Musembi, Celestine, and Andrea (2016) have a common view that Kenyans did not get a fair share of what other countries like Malaysia (their age mates) due to poor prioritization in the early nineteen sixties after independence. One blundered area is the poor link between health and education whereby lack of proper health systems were missing; exposing numerous infants and adolescents to deaths that could be protected and this led to reduced number of school enrolment; linked to poor progress in education institutions development across the country. When children and the youth die, the number of enrolment in basic educational institutions reduces, the future of the remaining kids is always affected due to trauma and other psychological associations (Save the Children Kenya, 2016).

National Council for Children Services, Kenya (2016) shares similar sentiments by arguing that CSHP plays a significant role in ensuring that the enrolments rates in schools is progressive in Nairobi's suburb areas, well-being of school children and academic performance of the learners. However, the report has gone further to show that the program is still faced by a number of challenges that range from: lack of enough qualified personnel to handle the program, poor schools management, poor implementation infrastructure and poor attitudes from the various stakeholders including the teachers and school management boards. It's in the same view that bodies like Global Communities (2015) have shown that Kenya needs to up its game in relation to CSHP implementation due to its importance and relevance in the modern ambitious

plans of the government like the Vision 2030. Jeropet *al* (2017) has a view that a critical examination of CSHP in Kenya needs to be done for better education performance since there is a close link.

## 2. RESEARCH PROBLEM

Less developed countries are faced with a number of challenges cardinals of them being poor access to health and productive education (World Bank, 2017). Majority of the developing countries are found in Africa where parents opt to keep their children out of schools to go and fetch food or look for medication in distance places besides fearing to take their children to schools where some diseases are perceived to be prevalent (WHO, 2017). Kent (2016) has indicated a number of issues that needs to be addressed for better educational performance in Africa. Central of these issues include: corruption and embezzlement, budgetary allocations, poor culture, lack of strategic practices like CSHP. This means that majority of the African children are not able to attend schools and translate to hundred percent transition from elementary education to secondary education (Jerop et al, 2017). Michael (2015) has a general opinion that the poor trend in education performance in Africa are tied to the failure of the government, research bodies and other strategists to critically analyze the importance of the integrated approach to health provision in schools through various comprehensive health programs and education outcomes and advice the various implementing agencies. From the above arguments, it can be generally observed that despite the fact that the CSHP is very important in educational performance in countries in Africa (Kenya inclusive) little is being done to examine the extent to which the CSHP influences the performance of education and the challenges facing the program's implementation and what affects this program; calling for such a study.

World Health Organization (2017) published a report about the state of the CSHP in Kenya's public primary schools since 2012 and the report indicated that the program is down dismally as compared to the neighboring countries like Rwanda and Tanzania. The program in Kenya is not yielding the intended results despite the fact that there is a very well laid plan for the same and the government is investing very many resources into the program. Second, the report has indicated that the country is affecting the general performance of the education in the marginalized countries since it is not allocating the adequate resources for the CSHP that include financial resources and trained personnel; a need for such a study.

Wasonga (2014) indicated that there is a need critical assessment on the influence of the CSHP and what challenges need to be addressed for its smooth implementation. Wasonga (2014) notes that Kenya Comprehensive School Health Policy is a critical document in the achievement of Sustainable Development Goals relating to child health, gender equality, universal education and environmental sustainability. He further notes that the comprehensive school health program increases students' enrolment, attendance and retention, factors that are very important in a country's human resources development. However, he has a general view that the program is not doing well as formulated in the policy papers due to a number of issues like lack of enough resources, research on its importance and coordination. Therefore the implementation requires allocation of enough resources, in-depth research of the importance of the program, involvement of all the stakeholders and coordination to bridge the gap between policy formulation and implementation. These recommendations are shared by other scholars like Albonico and Allen (2016); Oyaya and Rifkin (2016); Glennard and Maina (2017) etc. Oyaya and Rifkin (2016) for example have views that the Kenyan education system has not fully understood the importance of the CSHP and what it involves in its implementation making its implementation face numerous challenges; calling for such a study. This study shall therefore address a number of these issues surrounding the CSHP in Kenya. The research aimed at examining the determinants of sustainable comprehensive school health program implementation in Kenya's marginalized regions with a specific emphasis on River Tana County.

## 3. PURPOSE OF THE STUDY

The research was carried out with the aim of examining the determinants of sustainable implementation of the Comprehensive School Health Program (CSHP) in marginalized region of Kenya; A Case of Tana River County.

### 3.1 Objectives of the Study:

The study was guided by the following objectives:

- i. To examine the influence of capacity building on sustainable comprehensive school health program implementation in marginalized regions of Kenya

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- ii. To find out the influence of support provision on sustainable comprehensive school health program implementation in marginalized regions of Kenya
- iii. To examine the extent to which school infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya
- iv. To examine the influence of government policies on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

**4. RESEARCH QUESTIONS**

The study answered the following questions:

- i. What is the influence of capacity building on sustainable comprehensive school health program implementation in marginalized regions of Kenya?
- ii. What is the influence of support provision on sustainable comprehensive school health program implementation in marginalized regions of Kenya?
- iii. What is the extent to which school infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya?
- iv. What is the influence of government policies on sustainable comprehensive school health program implementation in marginalized regions of Kenya?

**4.1 Research Hypothesis:**

The study tested the following hypothesis alternative hypotheses at 95% level of significance

- i. **H<sub>A</sub>**: Capacity building has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya
- ii. **H<sub>A</sub>**: Support provision has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya
- iii. **H<sub>A</sub>**: School infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya significantly
- iv. **H<sub>A</sub>**: Government policies have a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

**5. SIGNIFICANCE OF THE STUDY**

This study shall be 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 contributes 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. The study also shall benefit the parents and other education sponsors since they will be able to get the insights in relation to the health issues surrounding the learners and how this can be improved to achieve universal education to Kenya learners. Finally the study shall benefit the future researchers in this field since it adds literature to the one that is already in existence.

**6. REVIEW OF LITERATURE****6.1 Comprehensive School Health Program:**

Numerous definitions have been put forward by various experts in relation to the CSHP in the 21<sup>st</sup> century. According to Albonico and Allen (2016), the comprehensive school health program is the procedures that are performed at school

aimed at understanding, maintaining and improving health care of the learners and school staff. Burk et al. (2014) delineates school health services as different health programmes or services implemented at schools. Glennard and Maina (2017) in their definition have an opinion the comprehensive school health programs have three major components that include: Health services conducted at school premises; Health education; and Healthy school environments.

In Kenya's policy framework, CSHP is defined as the programme that is provided to improve the mental, physical and social well-being of school going learners. The policy further indicates that health services should be provided only to learners whose parents or guardians have signed consent forms (Republic of Kenya, 2014). The Kenyan government has a general observation that comprehensive school health programme is a synonym for health promoting school. This health promoting school concept is defined under the origin of school health programme (Republic of Kenya, 2017a).

In their study in South Africa, James et al (2014) have tried to explain the origin of the Integrated School Health Programs. According to their work, school health program originated in the early 80s supported by the World Health Organization (WHO) and the International Union for Health Promotion and Education. In the 1980s, the WHO Ottawa Charter for health promotion introduced a new initiative called Health Promoting School (HPS) (UNICEF, 2016). The initiative served as an international policy framework for school health programme implementation.

USAID (2017) and UNDP (2017) have shown the rationale for the school health program. According to USAID (2014) children spend much time in classrooms learning which limits their visit to health facilities. It is for this reason schools have been considered as good settings for health programmes. The health and wellbeing of children internationally has been a great concern that led to new health developments such as implementation of health programmes at school (UNDP, 2017).

School health programme needs to be implemented so that positive health outcomes can be achieved such as reduction in all youth risky behaviors. The youth risk behaviors includes teenage pregnancy, drugs and substances abuse, depression, injuries and smoking (UNESCO, 2017). de Klerk (2016) specified that if health programmes are conducted at schools, student health could be improved and therefore learner absenteeism from schools could also be improved. It has also been indicated that implementation of health programmes at schools can lead to improved physical and mental alertness and ultimate reduction in the community health care burden (de Klerk, 2016).

#### ***6.1.1 Influence of Capacity Building on Comprehensive School Health Program Implementation:***

For effective implementation of the CSHP just like any other program run by the government or any other agencies, human resources are very crucial. Human resources in this case involves: well trained personnel to handle the various projects in the program (expertise), abundant labour, motivated labour, critical and creative individuals, healthy personnel etc. Well trained individuals or personnel on the components of the program, plus its individual projects and its perceived deliverables as outlined in the objectives influences CSHP implementation as noted by Albonico and Allen (2016).

Oyaya and Rifkin (2016) postulates that human capacity development has a very significant role in the implementation of the CSHP program in Kenya. This study that focused the Bridge International Academies that are run as social entrepreneurship organization all over the country, training of individuals in relation to what the CSHP entails in schools influences the whole program performance. Continuous training (induction and short courses), training on CSHP change management, training on the technical requirements, and comprehensive information on specific gender requirements influences the implementation of the program (Brynard, 2017).

In marginalized Kenya, the performance of the CSHP is relatively low as compared to the developed regions like Kiambu, Nairobi, Muranga, Nakuru due to a number of reasons (CARE International, 2015). Some of the reasons include lack of enough trained personnel to handle the program, poor government policies and differentiation of roles, poor program funding, poor school infrastructure and poor attitudes of various stakeholders towards the program. Wasonga (2014) shares similar findings by showing that the CSHP in slums and the ASALs region of Kenya (Wajir and Mandera) is dismally performing due to poor regional funding trends, lack of enough personnel, poor school infrastructure, poor policies and legislation from the government.

In eastern Kenya, the program implementation is tied to a number of factors (Musembi, Celestine, and Andrea, 2016; Mutia, 2015), including; capacity building, school environment, stakeholder's involvement, government policies, financial resources and program monitoring and evaluation. Migosi (2017) argues that capacity building at the individual level enables various individuals to be able to understand training on life skills. The understanding of life skills can easily enable the various people handling the health issues in the schools implement the CSHP effectively.

#### ***6.1.2 The Influence of Support Supervision on Comprehensive School Health Program Implementation:***

According to UNESCO (2017), children deserve decent education, protection from abuses like child labour, children deserve access to better Medicare, the same category of individuals deserve access to basic needs like food and shelter. Of the two mentioned, education and Medicare are components that involves many stakeholders that range from; the government agencies, NGOs, parents, the community, teachers, school management etc. therefore, the categories of individuals who form the stakeholders in education and health of the children influence the performance of various programs like the CSHP.

According to the USAID (2017), in the United States of America, the government plays a significant role in ensuring that the children access the universal healthcare through their various schools where they spend majority of their young life. The government has a strategic plan with clearly laid down rules and regulations governing the CSHP in the country that runs across the sphere by touching on financial resources, procedures and processes of running the program, monitoring and evaluation and many more. It is the responsibility of the government to take care of the health of its individuals by funding the various health initiatives, coming up with rules and laws that govern the whole process, by ensuring that all the deserving individuals access the Medicare equally and ensure that there is an enabling environment for the various health programs to be implemented; including the CSHP (WHO, 2015).

The school management plays a significant role in ensuring that the comprehensive school health program attains its objectives in South Africa (Republic of South Africa, 2017a). The government through the Ministry of Education comes up with various policies and strategies of running its programs-including the CSHP- but it's the work of the various individuals to take hold of the initiatives, break them into their various components and actualize them. In the school environment, the school management makes up the components that should actualize the vision and plans of the government's CSHP (Albonico and Allen, 2016).

Glennard and Maina (2017) have did a study and found out a clear relationship between the school management and the implementation of the CSHP in Kenya and Pretoria. In this comparative study, where the school heads, PTA chairpersons, and the various agencies from the government took place, a regression analysis performance indicated that the school head teachers, the PTA chairs, deputies and other people holding management in the various public schools significantly influence the implementation CSHP in the countries. This is confirmed by USAID (2017)'s findings indicating that the school managers including the PTA chair people, the deputies and heads influence the implementation of the CSHP.

Mbogo (2016) agrees that support supervision and school infrastructure are some of the factors that influence implementation of CSHP. Support supervision is a component that involves all the stakeholders like the teachers, medics for the program, parents, NGOs and other bodies and is restricted to throwing weight behind Disease prevention, Child rights and protection, Nutrition, Special Needs etc. National Council for Children Services, Kenya, (2016) has a report which was published in November 2016 which indicates that the various education stakeholders perform significant roles that are directly related to the implementation of the school health program. The stakeholders like the school heads, the parents, the school board managers, the health agencies and many more have a very special role in the implementation of CSHP and this is not limited to supervision. Supervision in this category includes: checking on the supervision of the whole process of diseases prevention, supervision of the whole process of child rights and protection, supervision of the nutrition and special needs of various learners.

School, parent and community partnerships have been described as the continuous planning, participation, and evaluation of activities that enhance the success of CSHP in Kenya's slums. Involvement of school staff, parents, students and community members will be required for a successful program. In many instances, parent volunteers operate school feeding programs for example. While keeping costs down, it has the added bonus of increasing community participation

creating a sense of ownership of the project (Boston Consulting Group, 2009). Programs that involve parents, staff and students in the operation and management often have greater success; however care must be taken to ensure that abuses do not occur. There have been instances where individuals have taken advantage of students (making them work in school gardens and selling the food for their own benefit) and have taken foodstuffs, equipment and materials for their own personal gain (Patton, 2010)

### ***6.1.3 The Influence of School Infrastructure on the Implementation of Comprehensive School Health Program:***

According to Michael (2015), the health infrastructure in schools is significant in the implementation of various school health programs. The health infrastructure in schools includes: children playing ground, water and sanitation structures, spacious and well-maintained classrooms, well equipped laboratories, school fences etc. As outlined in the Millennium Development Goals where countries were forced to adopt the universal basic education for all (EFA), the enrolment in schools increased between 2005 and 2015 (UN, 2017); meaning that facilities were overstretched.

UNICEF (2016) indicated that in Kenya, 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. According to AsDB (2017) there is a very considerably direct link between the school infrastructure and the improvement of school health in schools in Asia.

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 (Save the Children Kenya, 2016). The MOE, within the Kenya Education Sector Support Programme (KESPP), 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 (Republic of Kenya, 2017a).

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. The presence of water, hygiene and sanitation is influenced by a number of factors, among them being the school infrastructure. School infrastructure can be said to include clean and spacious classrooms, well erected buildings that don't put the child's health at risk, well-built latrines, clean water tanks and water storage facilities, health playing grounds among others (Brynard, 2017).

A study by WHO (2014) has linked the nutrition awareness component of the CSHP to the performance of learners in schools across the globe, Kenya included. Due to the importance of nutrition in schools, governments have been advised to adopt the enabling strategies for CSHP that carries the nutrition component. Kent (2016) argues that school infrastructure is a must consideration if schools have to achieve the various components of CSHP-where nutrition is included.

According to the United Nations Children's Fund (2017) there is a need for the government to allocate funds to the betterment of the school infrastructure for effective implementation of the CSHP in the marginalized regions of the country. In the marginalized parts of Kenya, malnutrition continues to affect a significant proportion of children and women. The report shows persistently poor nutrition outcomes with marginal increases in wasting (6.1%), stunting (33%) and underweight (20.2%). These figures communicate that there should urgent measures that should be undertaken to address the issue of CSHP in the marginalized Kenya; among them being the provision of funds for the construction of required infrastructure.

According to UNICEF (2016) a healthy school environment should include the structures that protect 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.

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 (UNDP, 2017).

#### **6.1.4 Government Policies and Sustainable Implementation of CSHP:**

For any program to succeed effectively and address the intended target, there must be well laid down rules and regulations. Majority of the projects that address the needs of the citizens in a given country subscribe to the country's rules and regulations as outlined either in the constitution, acts of parliament, municipal or county by-laws etc (SPARK, 2017). Laid down rules and regulations clearly determine the nature of services that should be provided to the citizens, which services should be left to the private investors and which ones should be handled by the national or regional governments, which services should be given priority, the type of services that should be funded more than others, which services that needs to be shared among various partners and which ones need to be free ( World Bank, 2016).

UNESCO (2017) has outlined the various components of the CSHP that is coordinated by the government through the Ministry of Education and that of Health in Australia and has indicated that the government policies significantly influence the performance of these components. The components include: Health education (Health education encompasses many topics, including alcohol and drug abuse, personal health and wellness, mental and emotional health, sexual health, and of course, healthy eating and nutrition. Students learn how to make health-promoting decisions and why those decisions are important); physical education; health services; nutrition services; counseling, psychological, and social services; healthy and safe school environment; health promotion for staff; family/community involvement. These components are influenced by the government policies that set an outline of what is to be handled first, what needs to be set aside for the various government agencies and the private sector (UNICEF, 2017).

According to USAID (2017), the government of Zimbabwe after realizing the need for Education For All (EFA) and the role of the educated population on economic performance and development, it came up with a very comprehensive policy that addressed the issue of CSHP and the overall result is increased enrolment in schools. The performance of the program in the schools increased between 2005 and 2015 and the general trend is still performing better. According to Idehen and Oshodin (2018) the policy provision of the government of Zimbabwe is to provide primary and secondary education system with an enabling environment for the provision of equitable, sustainable and quality health services for all learners; to ensure optimal health in the school environment through promoting and facilitating the equitable provision of quality, holistic school health programmes in all primary and secondary education institutions etc.

According to Jerop et al (2017) the government has a very significant role in influencing the performance of various programs in the country. The specific programs outlined are those addressing the needs of the community members in the marginalized regions. The concept of marginalization comes about when the governments fail to provide the basic needs that are meant to better the lives of the community people. Some of the major basic needs provided by the government to its citizens include: universal education, health, water and sanitation, nutrition and food security, protection and gender mainstreaming. The government policies influence the direction the various stakeholders take in order to achieve such objectives.



Migosi (2017) did a study that focused on the Secondary Education Quality Improvement Project (SEQIP): Vulnerable and Marginalized Groups Framework (VMGF). The research evidence shows that the most effective programmes for children and young people are carried out at the government level, supported by society in general, and promote national policies to decrease poverty and increase social equality. The second most effective interventions are coordinated government policies such as pricing, legislation and other policies. (E.g. the most effective interventions against tobacco use are increasing the price of tobacco, banning tobacco product advertising, banning smoking in public places and legislation prohibiting the sale of tobacco products to young people.) There is also evidence that simultaneous, multi-dimensional inputs at national, local and individual level increase the effectiveness of general health promotion campaigns. The health promotion interventions that are least likely to work are ones that deal with single issues, are 'negative in the message', and delivered at only one level of society.

## 6.2 Theoretical Framework:

This study is guided by the following theories:

### 6.2.1 The Theory of Planned Behavior:

According to Albonico and Allen (2016), 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 (Oyaya and Rifkin, 2016). This theory can be used to explain the ability and willingness of students to depict various behaviors like positive attitude variable since a person's behavior is highly influenced by their capacity to engage in a given behavior. If a learner and even teachers have limited information and awareness about the CSHP, they are least likely to actively engage in its implementation and depicting various behavior associated to the program. 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, learners and education official's 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 and later on affect academic performance in schools.

### 6.2.2 Resource Dependence Theory (RDT):

This theory was formally developed in 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 (Ursula et al, 2014). 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 (Wang et al, 2017). The theory is used in this study to explain the role of various stakeholders like the PTA chairpersons, the government, ministry of health partners, NGOs etc who must be willing to support the CSHP implementation. Besides implementation, these stakeholders should eliminate all the obstacles that could limit the proper functioning of the program thus enabling the students and learners access the services. Once the learners are exposed to a working health program, their performance in various sections can be said to have improved.

**6.3 Conceptual Framework:**

**Independent Variables**

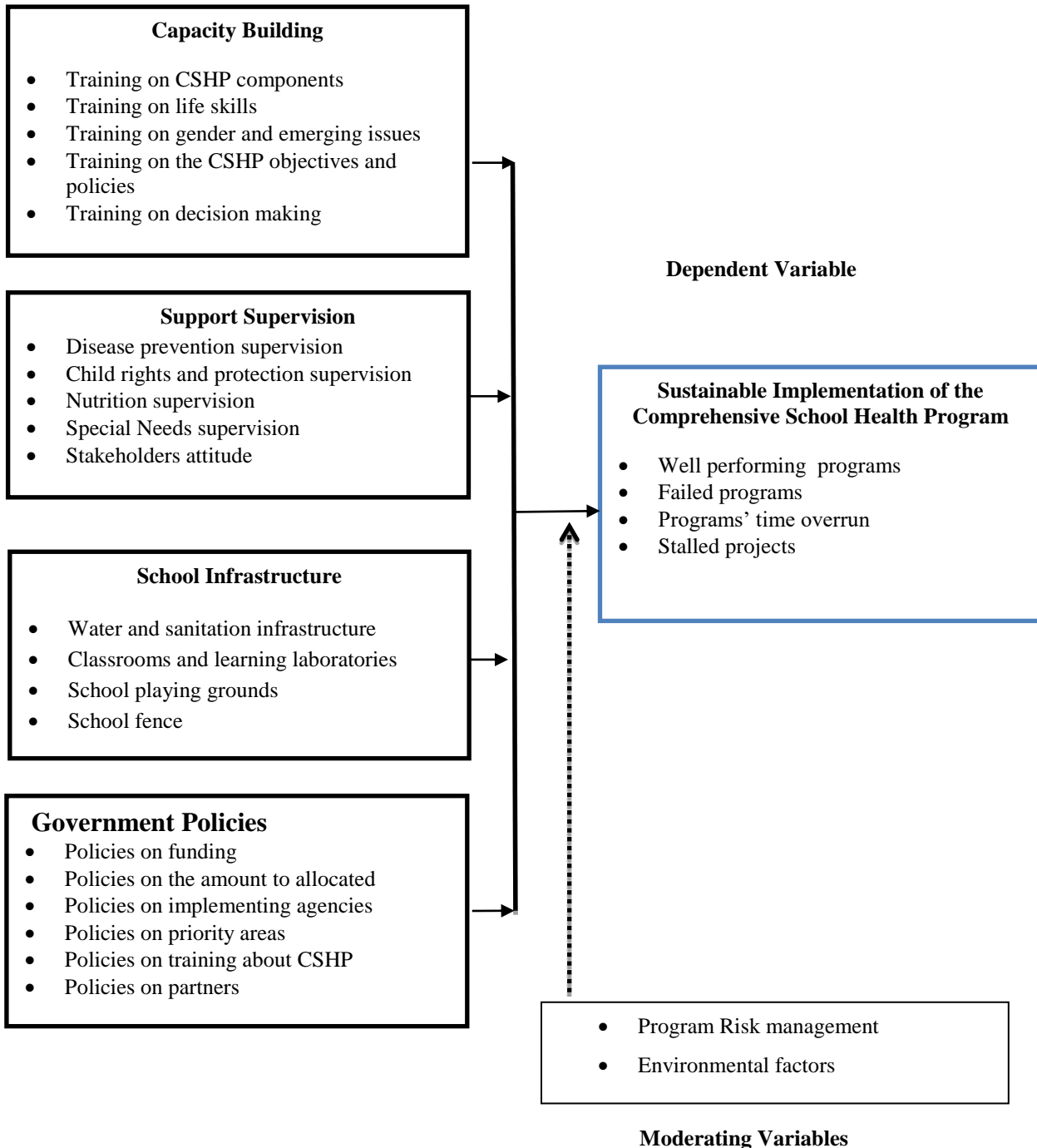


Figure 1: Conceptual Framework

**7. RESEARCH METHODOLOGY**

**7.1 Research Design:**

This research adopted a descriptive survey design. 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.

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### 7.2 Target Population:

According to the report in the education office at the county level, there were 174 registered public primary schools in Tana River County by the time of the study. Out of the 174 schools, 160 have been integrating the CSHP for over five years now and they were considered for the study since they were more likely to have much knowledge on the topic under discussion. Therefore 160 head teachers were picked for the study plus the corresponding 160 deputy head teachers and from each school the PTA chairperson was considered (160). This made the total target population to be 480 respondents.

**Table 7.1: Target Population**

Title	Frequency	Percentage
Head teachers	160	33.33
Deputy head teachers	160	33.33
PTA chairpersons	160	33.34
<b>Total</b>	<b>480</b>	<b>100.00</b>

*Source: (MOE Tana River County, September 2018)*

### 7.3 Sample Size and Sampling Procedure:

#### 7.3.1 Sample Size:

The Yamane formula of 1967 at 95% significance level given by:

$$N = \frac{N}{1 + n(e^2)}$$

Hence applying the above formula, the sample size shall be computed as:

$$N = 480:$$

$$n = \frac{480}{1 + 480(0.05^2)} = 218 \text{ respondents.}$$

Therefore, the study used a sample of 218 respondents.

#### 7.3.2 Sampling Procedure:

The study applied stratified sampling whereby the respondents were classified into the three strata and later on a simple random sampling was applied to 73 head teachers and 73 deputy head teachers were considered while the PTA chair were 72.

### 7.4 Data Collection Instruments:

The researcher used both secondary and primary data collection methods. In secondary methods, the relevant information was obtained through the literature review. In relation to primary data collection, the researcher used a structured questionnaire. The questionnaire was classified into two sections where section one sought the bio data of the respondents and section two contained the questions in relation to the objectives. Only the closed ended questions were considered for section two.

### 7.5 Data Collection Procedure:

A questionnaire was used to collect the primary data from the headteachers, deputy headteachers and the PTA chairpersons as outlined in table 3.1 of target population. The researcher obtained a letter of transmittal from the University of Nairobi Malindi and then proceeded to ministry of education offices at the county level to get permission to carry out the study. Later on the researcher visited the respondents, used research assistants to access some other respondents in remote school areas and e-mailed a questionnaire to some respondent who maybe were committed for one on one filling. Six research assistants were trained for five days prior to the research so as to conduct the research professionally. Drop and pick later method was also employed on other respondents were not reached immediately and did not supply their email addresses.

**7.6 Data Analysis:**

After gathering of information from the field, it was altered for zenith and steadiness. It was then examined utilizing SPSS rendition 22.4. Information was presented using illustrative insights containing relapse tables, rates, implies, standard deviation and tables to streamline and portray information and to outline the discoveries. Subjective information was examined utilizing the substance examination strategy. Hypotheses were tested by use of the Chi-square formula and interpretations given thereafter.

**8. RESEARCH FINDINGS AND DATA ANALYSIS**

**8.1 Capacity Building and Comprehensive School Health Program Implementation:**

The section required respondents to give their views in relation to the first question as outlined in the research questionnaire. The questions touched on the influence capacity building on the implementation of the CSHP program. Results were subjected to analysis by use of SPSS software and they indicated that:

**8.1.1 Support of Capacity Building and CSHP Implementation:**

In this first part of the question where respondents were asked whether they supported the idea that capacity building influences CSHP implementations, results indicated that

**Table 8.1: Support of Capacity Building and CSHP Implementation**

		Frequency	Percent
Valid	Yes	120	80%
	No	30	20%
<b>Total</b>		<b>150</b>	<b>100.0</b>

A higher percentage of the respondents who participated in the study (80%) supported the idea that capacity building influences CSHP implementation or performance.

**8.1.2 Degree of Support of the Influence of Capacity Building on the Performance of CSHP:**

Respondents were asked the degree to which they agreed or disagreed with the following statements that touched on capacity building and CSHP Implementation and performance. The means and std deviations were calculated as follows:

**Table 8.2: the Influence of Capacity Building on the Performance of CSHP**

Statement	1	2	3	4	5	Mean	Standard deviation
Training on the various components influences the implementation of the CSHP in the county	5	10	7	53	75	4.22	0.561
Training on life skills influences the implementation of comprehensive school health program in this county	10	5	15	50	70	4.10	0.786
Training on gender and emerging issues influences the implementation of comprehensive school health program in this county	10	0	0	75	65	4.26	0.812
Training on the objectives and policies influences the implementation of comprehensive school health program in this county	2	1	3	65	80	4.48	0.654
Training on decision making influences the implementation of comprehensive school health program in this county	5	2	3	70	70	4.36	0.76

The idea the training on the objectives and policies influences the implementation of comprehensive school health program in this county was more significant and favored as indicated by a mean score of 4.48 and std dev. 0.654. This was followed by arguments that: Training on the various components (mean=4.22, std dev= 0561); Training on life skills (mean=4.10, std dev= 0.786); Training on gender and emerging issues (mean=4.26; std dev=0.812); and Training on decision making (mean=4.36 and std dev=0.76) influences the implementation of comprehensive school health program in this county.

**Table 8.3: Testing of the First Hypothesis on Capacity Building**

Chi-Square Tests							
	Value	df	Asymp. (2-sided)	Sig.	Exact Sig. (2-sided)	Exact Sig. (1-sided)	
Pearson Chi-Square	1.950 <sup>a</sup>	1	.121				
Continuity Correction <sup>b</sup>	.881	1	.109				
Likelihood Ratio	2.121	1	.061				
Fisher's Exact Test					.124	.164	
Linear-by-Linear Association	2.111	1	.154				
<b>N of Valid Cases</b>	<b>150</b>						

**Tested null and alternative hypothesis:**

**H<sub>1</sub>:** Capacity building has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya: **H<sub>0</sub>:** Capacity building has no significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya

Since the calculated p value of 0.124 is less than 0.5 ( $p < 0.5$ ), at 95% significance level, the alternative hypothesis is considered. Therefore, Capacity building has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

**8.2 Support Provision and Comprehensive School Health Program Performance:**

Respondents were asked to indicate their views on the role of supervision provision on the performance of CSHP in the county and the results were given as discussed below

**8.2.1 Support Provision and CSHP Performance:**

Respondents were asked to indicate whether partners and stakeholders have an influence in supporting the comprehensive school health program in their area and the results were as shown below.

**Table 8.4: Support Provision and CSHP Performance**

		Frequency	Percent
Valid	Yes	135	90%
	No	15	10%
<b>Total</b>		<b>150</b>	<b>100.0</b>

Majority of the respondents (90%) supported the idea that support from the various stakeholders and partners has a significant influence on the performance of the comprehensive school health program in the county.

**8.2.2 Rated Responses of Support Provision and CSHP Performance:**

On a likert scale, respondents were asked to indicate the degree to which they agreed or disagreed with the following statements. Means were calculated to define the various ratings and std deviations to. The results were computed by use of SPSS software.

**Table 8.5: Rated Responses of Support Provision and CSHP Performance**

Statement	1	2	3	4	5	Mean	Std deviation
Supervision of diseases prevention by various stakeholders influences the implementation of CSHP	10	5	10	80	45	3.96	0.998
Child rights and protection supervision by the various stakeholders influences the implementation of the CSHP	10	10	5	100	25	3.80	0.765
Nutrition supervision by the various stakeholders influences the implementation of the CSHP	0	0	10	50	90	4.53	0.876

Special needs supervision by the various stakeholders influences the implementation of the CSHP	11	9	10	100	20	3.72	0.821
Stakeholders' attitude towards the CSHP influences its implementation in the county	0	2	1	42	105	4.6	1.23

The highest factor influence CSHP performance in the county can be said to be stakeholders' attitude towards the CSHP (mean 4.6, stddev 1.23). This is followed by the arguments that: Nutrition supervision by the various stakeholders (mean=4.53; stddev=0.876); Special needs supervision by the various stakeholders (mean=3.72 stddev=0.821), Supervision of diseases prevention by various stakeholders (mean=3.96; stddev=0.998); and Child rights and protection supervision by the various stakeholders (mean=3.80, stddev=0.765) influences the implementation of the CSHP.

**Table 8.6: Testing of the Hypothesis on Support Provision**

Chi-Square Tests								
	Value	df	Asymp. (2-sided)	Sig.	Exact Sig. (2-sided)	Exact Sig. (1-sided)		
Pearson Chi-Square	2.221 <sup>a</sup>	1	.201					
Continuity Correction <sup>b</sup>	1.113	1	.214					
Likelihood Ratio	3.112	1	.113					
Fisher's Exact Test					.221		.121	
Linear-by-Linear Association	3.098	1	.324					
<b>N of Valid Cases</b>	<b>150</b>							

**Stating the tested hypothesis:**

**H<sub>1</sub>:** Support provision has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya: **H<sub>0</sub>:** Support provision has no significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

Since the calculated p value of 0.221 is less than 0.5 (p < 0.5), at 95% significance level, the alternative hypothesis is accepted and null rejected. Therefore, support provision has a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

**8.3 School Infrastructure and the Implementation of the CSHP:**

On a likert scale, respondents were asked to indicate the degree to which they agreed or disagreed with the following statements. Means were calculated to define the various ratings and std deviations to. The results were computed by use of SPSS software.

**Table 8.7: School Infrastructure and the Implementation of the CSHP**

Statement	1	2	3	4	5	Mean	Std deviation
The various set ups of water and sanitation infrastructure influences the implementation of the CSHP in this county	5	7	3	120	15	3.89	1.021
The availability and conditions of classroom structures influence the performance of the school comprehensive health program	10	3	7	30	100	4.38	0.564
Availability of well-equipped laboratories for various activities influences the performance of the CSHP in this county	3	2	15	90	40	4.08	0.897
School playing grounds influence the performance of the CSHP in this county	12	8	10	100	20	3.72	0.877

The availability and conditions of classroom structures influence the performance of the school comprehensive health program as indicated by a mean of 4.38 and a stddev of 0.564. Also, School playing grounds (mean =3.72; stddev=0.877); The various set ups of water and sanitation infrastructure (mean=3.89; stddev=1.021); and Availability of well-equipped laboratories for various activities (mean=4.08, mean=0.897) influences the performance of the CSHP in the county.

**Table 8.8: Testing of the Hypothesis on School Infrastructure**

Chi-Square Tests	Value	df	Asymp. (2-sided)	Sig.	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.667 <sup>a</sup>	1	.120			
Continuity Correction <sup>b</sup>	1.113	1	.214			
Likelihood Ratio	3.112	1	.124			
Fisher's Exact Test					.003	.211
Linear-by-Linear Association	4.112	1	.444			
<b>N of Valid Cases</b>	<b>150</b>					

**Tested Hypothesis:**

**H<sub>1</sub>:** School infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya significantly; **H<sub>0</sub>:** School infrastructure doesn't influence sustainable comprehensive school health program implementation in marginalized regions of Kenya significantly

Since the calculated p value of 0.003 is less than 0.5 ( $p < 0.5$ ), at 95% significance level, the alternative hypothesis is accepted and null rejected. Therefore, School infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya significantly

**8.4 Government Policies and the Implementation of the CSHP:**

On a likert scale, respondents were asked to indicate the degree to which they agreed or disagreed with the following statements. Means were calculated to define the various ratings and std deviations to. The results were computed by use of SPSS software.

**Table 8.9: Government and the Implementation of the CSHP**

Statement	1	2	3	4	5	Mean	Std deviation
• Government policies on CSHP funding influences its performance in this county	5	4	2	50	89	4.42	1.09
• Government policies on the amount to be allocated to the various CSHP activities influences its implementation significantly	5	5	10	30	100	4.43	1.001
• Government policies on CSHP implementing agencies influences the whole process of CSHP implementation	10	6	14	50	70	4.09	0.954
• Government policies on priority areas influences the implementation of the CSHP	0	20	10	30	90	4.27	0.819
• Government policies on training about CSHP influences the implementation of the program	10	5	15	20	100	4.16	0.999
• Government policies on various partners for the program influences its performance	4	6	10	15	115	4.53	0.876

The influence of government policies on various partners for the program performance scored the highest with a mean of 4.53, and a stddev 0.876. Equally, higher percentage of respondents felt that: Government policies on CSHP funding (m=4.42, std=1.09); Government policies on the amount to be allocated to the various CSHP activities (m=4.43, std=1.001); Government policies on CSHP implementing agencies (m=4.09, std=0.954); Government policies on priority areas (m=4.27, std=0.819); and Government policies on training about CSHP (m=4.16, std=0.999) influences the implementation of the program.

**Table 8.10: Testing of the Hypothesis on Government Policies**

<b>Chi-Square Tests</b>								
	Value	df	Asymp. (2-sided)	Sig.	Exact Sig. (2-sided)	Exact Sig. (1-sided)		
Pearson Chi-Square	2.007 <sup>a</sup>	1	.211					
Continuity Correction <sup>b</sup>	1.456	1	.119					
Likelihood Ratio	2.221	1	.176					
Fisher's Exact Test					.045	.111		
Linear-by-Linear Association	3.021	1	.221					
<b>N of Valid Cases</b>	<b>150</b>							

**Tested hypothesis:**

**H<sub>1</sub>:** Government policies have a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya: **H<sub>0</sub>:** Government policies have no significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

Since the calculated *p* value of 0.045 is less than 0.5 ( $p < 0.5$ ), at 95% significance level, the alternative hypothesis is accepted, and null rejected. Therefore, government policies have a significant influence on sustainable comprehensive school health program implementation in marginalized regions of Kenya.

**8.5 Implementation of the Comprehensive School Health Program:**

Respondents were required to indicate the extent to which they supported the various independent variables vs the dependent variable and the results were rated on a likert scale as shown in table 8.11 below

**Table 8.11: Implementation of the Comprehensive School Health Program**

Statement	1	2	3	4	5	Mean	Standard deviation
Capacity building, support supervision, school infrastructure, and government policies have a significant influence on well performing comprehensive school health programs	5	0	15	40	90	4.40	.9748
Capacity building, support supervision, school infrastructure, and government policies have a significant influence on comprehensive school health programs failure	10	30	10	40	60	3.73	.673
Capacity building, support supervision, school infrastructure, and government policies have a significant influence on time overrun of comprehensive school health programs	12	8	10	50	70	4.05	0.986
Capacity building, support supervision, school infrastructure, and government policies are associated with stalled comprehensive school health programs in the county	4	6	20	50	70	4.17	0.889

The general trend indicates that all the four independent variables (Capacity building, support supervision, school infrastructure, and government policies) have an influence on the dependent variable (comprehensive school health program implementation). For example, majority of the respondents supported the idea that: Capacity building, support supervision, school infrastructure, and government policies have a significant influence on well performing comprehensive school health programs (mean=4.4, stdev= 0.9748); Capacity building, support supervision, school infrastructure, and government policies have a significant influence on comprehensive school health programs failure (mean=3.73, stdev= 0.673); Capacity building, support supervision, school infrastructure, and government policies have a significant influence on time overrun of comprehensive school health programs (mean=4.05, stdev=0.986); and Capacity building, support supervision, school infrastructure, and government policies are associated with stalled comprehensive school health programs in the county (mean=4.17, stdev=0.889).



## 9. DISCUSSION OF KEY FINDINGS

The first objective sought to examine the influence of capacity building on sustainable comprehensive school health program implementation in marginalized regions of Kenya. The results indicated that a higher percentage of the respondents who participated in the study (80%) supported the idea that capacity building influences CSHP implementation or performance. This is supported by Oyaya and Rifkin (2016) who postulates that human capacity development has a very significant role in the implementation of the CSHP program in Kenya. Also, results indicated that the various indicators of capacity building interact to influence the CSHP performance. This is supported by Brynard (2017) who has indicated that training of individuals in relation to what the CSHP entails in schools influences the whole program performance. Brynard (2017) adds that continuous training (induction and short courses), training on CSHP change management, training on the technical requirements, and comprehensive information on specific gender requirements influences the implementation of the program.

In relation to the second objective that sought to find out the influence of support provision on sustainable comprehensive school health program implementation in marginalized regions of Kenya, 90% of the respondents the idea. Also, it was found out that the highest factor influencing CSHP performance in the county can be said to be stakeholders' attitude towards the CSHP (mean 4.6, stddev 1.23). Mbogo (2016) is in agreement that support supervision and school infrastructure are some of the factors that influence implementation of CSHP. Support supervision is a component that involves all the stakeholders like the teachers, medics for the program, parents, NGOs and other bodies and is restricted to throwing weight behind Disease prevention, Child rights and protection, Nutrition, Special Needs etc.

The third objective sought to examine the extent to which school infrastructure influences sustainable comprehensive school health program implementation in marginalized regions of Kenya. The results indicated that the availability and conditions of classroom structures influence the performance of the school comprehensive health program as indicated by a mean of 4.38 and a stddev of 0.564. Also, School playing grounds (mean =3.72; stddev=0.877); The various set ups of water and sanitation infrastructure (mean=3.89; stddev=1.021); and Availability of well-equipped laboratories for various activities (mean=4.08, mean=0.897) influences the performance of the CSHP in the county. In agreement to these findings is Michael (2015) who has indicated that 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.

In a combined summary of results relating to the final objective that touched on government policies and CSHP, it was confirmed that, influence of government policies on various partners for the program performance scored the highest with a mean of 4.53, and a stddev 0.876. Equally, the results indicated that majority of the respondents supported the ideas that: Government policies on CSHP funding (m=4.42, std=1.09); Government policies on the amount to be allocated to the various CSHP activities (m=4.43, std=1.001); Government policies on CSHP implementing agencies (m=4.09, std=0.954); Government policies on priority areas (m=4.27, std=0.819); and Government policies on training about CSHP (m=4.16, std=0.999) influences the implementation of the program. A study by SPARK (2017) has indicated that for any program to succeed effectively and address the intended target, there must be well laid down rules and regulations. Majority of the projects that address the needs of the citizens in a given country subscribe to the country's rules and regulations as outlined either in the constitution, acts of parliament, municipal or county by-laws etc. The World Bank (2016) has a report indicating that laid down rules and regulations clearly determine the nature of services that should be provided to the citizens, which services should be left to the private investors and which ones should be handled by the national or regional governments, which services should be given priority, the type of services that should be funded more than others, which services that needs to be shared among various partners and which ones need to be free.

## 10. CONCLUSION AND RECOMMENDATIONS

### 10.1 Conclusion:

Based on the result findings, it can be concluded that capacity building has an influence on the performance of the CSHP. The components of capacity training that have an influence on the implementation of the CSHP should be considered. These components include: Training on CSHP components; Training on life skills; Training on gender and emerging issues; Training on the CSHP objectives and policies; and Training on decision making.

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Also, the researcher concludes that support provision influences the implementation of the CSHP significantly. The support comes from all the stakeholders and the more they are involved, the better the CSHP results are. The components of the support provision that have the influence include: Disease prevention supervision; Child rights and protection supervision; Nutrition supervision; Special Needs supervision; and Stakeholders attitude.

The researcher has the conclusion that the school infrastructure is the most significant determinant of CSHP performance in Tana River County. Coupled with the, figures achieved on individual indicators, it can be concluded that all the indicators have a significant influence. The indicators of school infrastructure that are very crucial include: Water and sanitation infrastructure, Classrooms and learning laboratories, School playing grounds, and School fence.

Finally, the researcher concludes that government policies scored second best as the most influencing determinant of CSHP. The programs have been found to be a blessing of the government since they have been carried out among the learners who are very sensitive and are crucial to economic development. The indicators of government policies that are very crucial include: Policies on funding; Policies on the amount to be allocated; Policies on implementing agencies; Policies on priority areas; Policies on training about CSHP; and Policies on partners.

### 10.2 Recommendations:

Based on the research findings, the study recommends for accelerated efforts towards identifying the various potential individuals who can handle the CSHP irrespective of the environmental challenges and give them thorough training. The training should also consider the relevance of the topics and the number of trainees per regions for centralized balance. The researcher also recommends for intensified efforts to bring all the stakeholders' ideas on board. The stakeholders have the power to determine the direction of programs and what resources should be pumped into the program; making them very crucial. They should be listened to and guided in case of any deviation. The researcher also recommends that before any step towards the implementation of any project that subscribes to the CSHP, the government agencies must be contacted to give their views. It is the government that makes policies that govern the services to be provided to their citizens and it's the government that is always in charge of the social welfare of its population. Therefore, the governments at all levels should be given first priority and be consulted at all level. Finally, the research recommends for concerted efforts that should bring all the stakeholders together, resources and even strategies to ensure that the various enabling infrastructure is provided.

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