

**PARENTS' AND TEACHERS' PERCEPTIONS TOWARDS SCHOOL HEALTH AND
NUTRITION PROGRAMME IN SELECTED PRIMARY SCHOOLS OF MWENSE
DISTRICT, ZAMBIA**

By

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A dissertation submitted to the University of Zambia in partial fulfillment of the requirements for
the degree of Master of education
In Primary Education

The University of Zambia

Lusaka

2017

ACRONYMS

MOH	Ministry Of Health
MOE	Ministry Of Education
CHANGES	Community, Health and Nutrition, Gender and Education Support
MOGE	Ministry of General Education
SACMEQ	Southern African Consortium Measuring Educational Quality
SHAPE	Self Help Action Plan for Education
BESSIP	Basic Education Subsector Investment Programme
SHN	School Health and Nutrition
FNDP	Fourth National Development Plan
TNDP	Third National Development Plan
HIV	Human Immune Virus
AIDS	Acquired Immuno Deficiency Syndrome
USA	United States of America
WHO	World Health Organization
FRESH	Forum for Effective School Health
UNESCO	United Nations Education,Scientific and Cultural Organisaton
PTA	Parents Teachers Association

DECLARATION

I **Meleki Kabaso Chola** wish to declare that this document has been done by me and that the work recorded is my original work and neither in parts nor in full be submitted for an award of a master's degree at the University of Zambia or any other. In order to avoid duplication of other people's work the sources have been acknowledged.

Signed

Date.....

DEDICATION

The work has been dedicated to my wife Christabel Ilunga as well as my children, Mwansa Kabaso, Kabaso Suzen, Kabaso Mwewa, Kabaso Vincent Meleki, Kabasollunga and all my friends who had been very instrumental to encourage me pursue my studies.

APPROVAL

This dissertation of **Meleki Chola Kabaso** is approved as partial fulfillment of the award of master's degree of education in Primary by the University of Zambia.

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ACKNOWLEDGEMENTS

Special thanks go to my supervisor Dr. Mweemba, for working tirelessly as he went through my dissertation, and the advice he gave me to ensure I do the work with few difficulties. He could correct mistakes without getting frustrated despite there being too many of them.

I will be failing in my duties if I don't pay tribute to my administration and members of staff at Mulundu primary school where for their technical assistance and relentless effort in ensuring that the document meets the required standards.

I wish to thank Prof. Namafe and Dr. Akakandelwa who guided me in proposal writing. Further thanks go to Mr. Masatunya and Mr. Mukonko who went through my research proposal. Mwape Emmanuel, a student at the University of Zambia needs to be thanked for helping me with the knowledge on how to use a computer effectively; I never knew anything but he made me know some basics. I wish also thank Mr. Kasumpa for the special assistance he gave me in time of need. I still want to thank Esther Phiri who provided me with accommodation when I failed to secure one from the University of Zambia. My fellow students; Grace Shimishi, Mwila Mary and Rosemary Chalwe for their encouragement and assistance they rendered as I worked through my document.

My sincere thanks go to my brothers Mr. Kabaso Meleki Mpundu, Mr. Kapyia Meleki Kabaso, Mr. Stanley Kalasa, Mr. Chama Emmanuel, Mr. Besa Meleki and my sister Mumba Bupe Eunice who acted as key players in ensuring that I complete my master's degree programme.

I cannot forget to praise my wife and children for their patience to ensure that I excelled in my studies despite the little money they were given to use at home. They were very outstanding.

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ABSTRACT

The Zambian government introduced School Health and Nutrition Programme in order to address the issues of hunger and disease which interfered with learners' academic performance. Despite involving the parents and teachers to work with government, the issue of diseases and hunger has continued in Mwense District. In addition, the perceptions of parents and teachers over the matter were not understood. Therefore, this study was undertaken to determine parents and teachers perceptions towards School Health and Nutrition Programme in selected primary schools of Mwense District to bridge the knowledge gap. The objectives of the study were to: determine the perceptions of parents and teachers towards the School Health and Nutrition Programme, establish roles, attitudes and challenges towards the implementation of the School Health and Nutrition Programme. The study used descriptive survey design adopting the qualitative and quantitative approaches. Information was obtained from respondents by means of questionnaires and interviews. Thematic analysis was used to analyze qualitative data while excel was used for quantitative data. Five primary schools were selected randomly out of the total number of 40 in the district. A total of 100 respondents were selected which included 55 teachers, 5 head teachers, and 40 parents. This study used both probability and non-probability sampling. Purposive sampling was used in the selection of Head teachers because they had valuable information that the researcher required. Simple random sampling was used when selecting parents and teachers for equal chances of being picked. The findings of the study showed that generally parents and teachers had negative perceptions towards School Health and Nutrition Programme. Factors that led to negative perceptions were: respondents did not know the meaning of the programme, teachers did not pay much attention to the programme and low literacy levels among parents. The programme was neglected and looked down upon as something that initiates children into Satanism. The study concluded that the negative perceptions of parents and teachers were barriers to the programme. The study recommended that teachers and parents to work together to ensure the programme is effective. Sensitization to be done to dispel assertions that the programme is associated with Satanism which hitherto is unfounded myth. Future recommendations are that knowledge should be made available to communities before the programme is introduced.

CHAPTER ONE

INTRODUCTION

1.1 Overview

This chapter presents the background, statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, scope of the study, limitation of the study and definitions of key terms.

1.2 Background of the study

The high prevalence of diseases and low production of food have a negative effect on the people living in Mwense District. Ministry of Health (2002) revealed that the majority of the people live in absolute poverty and many children die of diseases. A survey conducted by Mwense Health Management Information system 2010 – 2014 revealed that 34 percent of children were affected by malaria, 31.5 percent had diarrhoea and 29.6 percent had bilharzia. From the health management information system of 2010 – 2014, malaria recorded the highest and was one of the biggest health problems affecting the old and the young especially those living along the river valley of Luapula.

Malaria is a fatal disease that is transmitted to persons through the bite by Anopheles mosquitoes which have malaria parasites. During the rainy season, malaria and other diseases affect the attendance and performance of learners, since affected children are absent from schools for a good number of days. High temperature, stagnant water and tall grasses around the surrounding areas during this season favour rapid breeding of mosquitoes (Ministry of Health, 2007).

Another challenge faced by the people of this region is the presence of diarrhoea causing agents which are frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta (Ministry of Health, 2008). Upon this realization, the government, through the Ministry of Health, instituted measures to help address the problem. As a result of these measures the regional incidence rate of these prevalent diseases continued to reduce (Ministry of Health, 2005). However, it was noted that there was still need for the

government through the joint operations of the Ministry of Health and education to address factors affecting people's perceptions towards health.

Another factor causing death among the people of Mwense District are diseases such as cholera, dysentery, tetanus, typhoid and measles. A research carried out by Kaluba and Mwale (1992) found that the attitude of people gathering in funeral places, drinking untreated water, eating contaminated food and attending religious conventions held alongside the river bank of Luapula allow the quick outbreak of cholera. A good example was cholera outbreak of 1991 which claimed a lot of lives. Schools remained closed for the period of more than two months hampering the learning process of children. The presence of HIV and AIDS and other related diseases also affect people living in the district. Despite several interventions, the disease burden has continued to soar.

Southern African Consortium for Measuring Education Quality (SACMEQ) III, (1995) indicates that common diseases and malnutrition were a serious problem affecting young children and had been a leading cause of death among school going ones. Generally, food availability in Mwense District is low and on the average insufficient to meet the body requirements. Fish serves both as a staple relish and also as a means of earning money. When fish is caught on small scale, they are shared among the family. If there is a surplus they are sold within the region at an exorbitant price. Since the production of food is low, malnutrition and deficiency diseases are common in children.

A comparative study done by Central Statistics Office (2000) found that children of this area have stunted growth due to insufficient food intake and malnutrition. For example, the study conducted by Southern African Consortium for Measuring Education Quality(SACMEQ) III (1995) on measurement of learners earlier on showed that 44 percent were stunted, 38 percent were underweight and 31 percent were undernourished. The important elements in the measurement and evaluation of the nutritional status of young children are the height and weight. Kelly (1991) noted that many primary school children have poor nutritional status and to make matters worse these children appear younger than their ages and are delayed to be sent to school on time until they are older and exceed in years. In most cases, children attain the age of 15 and above to graduate from the primary sector.

The School Health and Nutritional Programme was initiated after the Zambian government through the Ministry of Education and its stakeholders the World Health Organization (WHO) realized that poor health and nutritional status of school children in primary schools of Mwense District was having negative effect on learner performance. In 2002, Mwense District was selected to be one of the pilot districts for School Health and Nutrition Programme of Luapula province. The programme was initiated as one way to address issues of hunger and diseases which affected academic progress of school going children, this was done in a bid to reduce children absenteeism from school and therefore increase active learning.

It was a well-known fact that government alone could not address those problems without the involvement of parents, teachers and many other stakeholders. In order for government to involve parents in the school affairs, teachers needed positive attitudes to ensure that parents were well oriented on the kind of activities and materials needed to facilitate effective implementation of any programme including School Health and Nutrition Programme at school (Becker, 1984). Furthermore, to lay a solid foundation, parents and teachers had to conduct meetings to discuss the health and nutrition status of learners. According to the policy of the School Health and Nutrition Programme, parents and teachers were also mandated to mobilize the community and many other resources to ensure smooth running of the programme. Although the policy was put in place, it has not been fully implemented at school level. To this extent it is said to be non-operational. Schools were expected to develop their own school level policies in line with the FRESH Framework. (Castle, 1974; MOE, 2000).

Concerning the involvement of parents in the learning of their children, Annie and Neal (1976) argued that teachers also needed to recognize the roles of parents in the school system. Previously, parents were not taking part in school activities but with the introduction of Parent Teachers Association, parents became part of the school community. Therefore, Parental Involvement in the education of their children was a good solution to the success of the school programme. Ministry of Education (1996) alluded that the issue of community participation assumed special significance in the light of the fact that the first responsibility for education of children lies in parents and also in the wider community in which the family live. Hence, to enhance School Health and Nutrition Programme in selected primary schools of Mwense District, teachers and parents should work together in line with the Ministry of Education policy

statement that emphasizes the need to improve health and nutrition status of school-going children. Although the programme had to be introduced, the perceptions of parents and teachers were the determinant factors to the success or failure of any newly introduced programme in schools. For example, Self Help Action Programme for Education was introduced by World Bank (1997) in primary schools of Mwense District to give life sustaining skills at various grade levels. But the programme did not succeed with its mission of imparting skills in learners in the sense that teachers took advantage of getting tools distributed in schools to their homes. In the process tools started missing; slowly the programme became very ineffective and finally died a natural death. In the same way, from the time of inception, School Health and Nutrition Programme in primary schools of Mwense District have not been as effective as expected.

MOE (1992) further argued that parents and teachers tend to concentrate more on the academic performance than on the personal hygiene and immediate environmental health which usually affect learner performance. Even though teachers have concentrated on academic performance, very little has been done. Certainly, perceptions of this nature are the key factors to the negative or positive implementation of any programme in school. Excellence in academic performance could only be achieved if parents and teachers also consider good health and nutritional status of their children. According to Young (1985), the Zambian Government prioritised health and nutrition as a cross – curricular theme with a view to putting health and nutrition as key factors that promotes growth and psychological well-being of children which parents and teachers needed to embrace. Any negative attitude towards Health and Nutrition may have a negative impact on the children.

The perceptions of parents and teachers towards School Health and Nutrition Programme have been identified as one of the major factors that influence the success or failure of the programme. MOE (2000) adds therefore that parents and teachers perceptions could either facilitate or hinder the effective implementation of any programme in primary schools. On the other hand, perceptions of learners and any other concerned persons towards School Health and Nutrition Programme were essential in the sense that they might determine the success or failure of the programme. Furthermore, the perceptions of both parents and teachers can affect and shape the policies on School Health and Nutrition Programme either positively or negatively. Because of the importance attached to School Health and Nutrition Programme, the Ministry of Education

(1996) made it compulsory to all primary schools of Mwense District. Despite all the effort the Ministry of Education had put in place of ensuring that the programme is implemented, little is known on how the programme promotes learner academic performance. It is against such a background that this study sought to determine the perceptions of parents and teachers towards the effective implementation of School Health and Nutrition Programme.

1.3 Statement of the Problem

Kelly (1999) noted that due to hunger and high levels of poverty, learners' academic performance was negatively affected. CHANGES 2(2006) reported that the Zambian government together with the World Bank introduced School Health and Nutrition Programme in primary schools of Mwense District in an effort to address the issue of hunger and diseases which interfered with learners academic performance. The move by the government to work with parents and teachers in providing a conducive learning environment for learners was taken. Despite involving parents and teachers to work with government to facilitate good health and nutrition status of children, the issue of hunger and diseases among the people has continued in Mwense District. This constitutes a problem because hunger and diseases inhibit active participation when children are in class. On the other hand, schools experience large number of children drop out. MOGE (2015) goes on to say that parents and teachers need efficient and prompt measure to address the problems of absenteeism and high dropout resulting in high levels of illiterate. Therefore, it is not known what parents and teachers think about the effect of the School Health and Nutrition Programme on learners' academic performance. Since the School Health and Nutrition Programme was implemented in some schools, no studies have been undertaken to determine parent's and teacher's perceptions towards the programme. This study was undertaken to determine parent's and teacher's perceptions towards School Health and Nutrition Programme in selected primary schools of Mwense District.

1.4 Purpose of the Study

The purpose of the study was to determine parents and teachers' perceptions towards School Health and Nutrition Programme in selected primary schools of Mwense District.

1.5 Objectives of the Study

This research study was guided by the following objectives:-

1. To determine the perceptions of parents and teachers towards School Health and Nutrition Programme.
2. To establish roles that parents and teachers play towards the effective implementation of School Health and Nutrition Programme.
3. To determine the attitudes of parents and teachers towards School Health and Nutrition Programme in relation to learner performance.
4. To establish the challenges and solutions to the effective implementation of the School Health and Nutrition Programme.

1.6 Research Questions

1. What are the perceptions of parents and teachers towards School Health and Nutrition Programme?
2. What are the roles that parents and teachers play towards the implementation of School Health and Nutrition Programme?
3. What is the attitude of parents and teachers towards School Health and Nutrition Programme in relation to learner performance?
4. What are the challenges and solutions to the effective implementation of the Programme?

1.7 Significance of the Study

The importance of this study was to generate information that might be found very significant by the World Bank and the policy makers in the Ministry of General Education, School administrators, teachers and parents. To the World Bank and policy makers, the study might provide answers to some of the reasons why parents and teachers had negative or positive perceptions towards the programme. To the school administrators, this study might be very relevant to find suitable solutions aimed at correcting the perceptions of parents and teachers towards School Health and Nutrition Programme. To both parents and teachers, this research study would add new knowledge that would help them adhere to the conditions needed for the effective implementation of the programme.

1.8 Scope of the Study

This study was restricted to 5 selected primary schools in Mwense District namely Nsakaluba, Mulundu, Kankomba, Shichama and Kabundafyela.

1.9 Limitation of the study

The study was carried out within tight schedule of teaching. It called for patience, persistence and repeated visits in order to get responses from the respondents. Language barriers proved to be a negative factor especially to parents. Questionnaires and interviews were conducted and generated in English yet some could effectively express themselves in IChibemba so interpretations and translations were unavoidable.

Another limiting factor to the study was that only a few parents of learners targeted and teachers were interviewed because it was not possible to go to all the parents of pupils and teachers of the schools targeted in the study. Regardless of this limitation, the findings were consistent with the local and international literature. Therefore, the findings of the study might be generalized to communities in Zambia and elsewhere with similar characteristics as those in the study area.

1.10 Definition of key terms

- Hunger** Refers to the inability of an individual, family to provide three (3) Meals to a school going children per day which may determine the will to attend or not to attend.
- Parental Involvement** Refers to parents working together with teachers in helping their Children with school work through checking their health, ensuring Children attend school regularly and monitor their performance.
- Malnutrition** A condition in which one loses weight because of insufficient food intake resulting in the loss of weight.
- Health** This term is being used in the context to mean the well-being of the body or mind especially in terms of absence of illness, injuries or impairment.

- Perception** is the process by which individuals organize and interpret their sensory Impression in order to give meaning to their environment.
- Attitude** is defined as general enduring positive or negative feeling about somebody Or object or issues.
- Perceived benefit** refers to the patient's belief that a given treatment will cure the illness or Helps to prevent it or the effort somebody is making to prevent such a disease or illness.
- Perceived barrier** refers to a person's feelings on the challenges some people face to perform certain tasks. The barriers or impediments which lead to failure of any undertaking.

1.1 Organization of the Dissertation

The dissertation is arranged in six chapters. The first chapter comprises the introduction; chapter two consists of literature review while chapter three contains the methodology. The research findings are presented in chapter four. Chapter five discusses the findings of the study and chapter six presents' conclusions and recommendations.

1.1.2 Summary of chapter one.

In summary, this chapter has covered the following; background of the study. It also highlighted the statement of the problem , the purpose of the study which was to determine teachers and parents perceptions towards School Health and Nutrition Programme in selected primary schools of Mwense District, objectives of the study which were to determine parents and teachers perceptions towards school Health and Nutrition Programme, establish roles that parents and teachers play toward the implementation of the programme, determine the attitudes of parents and teachers towards the programme and establish the challenges and solution to the implementation of the programme. It also talked about the research questions, significance of the study, scope of the study, limitation of the study, definition of key terms, organization of the dissertation and summary of chapter one.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter presents a review of literature related to the study. It is structured as follows; the meaning of School Health and Nutrition Programme, School Health and Nutrition Programme across the world, in Africa and Zambia. Furthermore, it reviews literature on perceptions of people determinant factor of School Health and Nutrition Programme, roles of parents and teachers towards School based Health and Nutrition services, and challenges faced on the implementation of School Health and Nutrition Programme in primary schools. Finally, it ends with summary of literature review and the gap.

2.2 The meaning of School Health and Nutrition Programme.

According to MOE (2002) and MOE (2007), School Health and Nutrition Programme is the service offered within the school system to improve the well-being of children and in some cases to the whole families and the wider community. Monitoring and Evaluation Guidance for School Health (2013) explains that the key issue of the programme is to ensure that learners are healthy, so that they learn and able to acquire healthy behaviours essential for effective school system. Save the children (2017) outlined the main focus thus; (1) Increase access to good health and nutrition at school through deworming, feeding, micronutrients supplementation, control of malaria, as well as vision and hearing screening. (2) Increase access to safe water, sanitation and hygiene (WASH) in schools. (3) Promote lifelong health behaviour through skills-based health education, including HIV/AIDS prevention. (4) Ensures basic health-related school policies and support from individual schools and communities to the national level. MOESVTEE(2013) views health and nutrition of learners as one of the important component in the teaching and learning process. It goes on to say that if the health of the child is not well attended to, it will affect their performance, attendance and retention. To be healthy, the mind and the body require nutritional food.

2.3 Reasons for introducing School Health and Nutrition Programme

Literature by Jukes, et al (2008) indicated that poor health and Malnutrition prevent children from attending school and from learning while in class. The equivalent of more than 200 million school years are lost each year in third world countries as a result of ill health and the impact of learning and cognition is equivalent to a deficit of more than 630 million IQ points. Children with these points fail to progress to the higher grades. Hunger and malnutrition among children in developing countries continue to impair health, quality of life, and survival. Ahmed (2004) highlights the condition that children die in every six seconds from hunger and malnutrition related cause. He further goes on to say that one out of four children in developing countries is underweight. School-age children are vulnerable to under nutrition. Winick (1970) therefore noted that the problems of malnutrition and disease burden impair children's growth both physically in terms of height, weight, size and mental in terms of their ability to concentrate upon and to absorb learning. On the other hand, children with these problems risk higher chances of dying from severe illness. In order to alleviate these challenges, Meckel (2013) describes the positive effects of School Health and Nutrition Programme that it offers very good opportunity for school going children and enhances nutrition and improves school attendance and educational outcomes.

Adelman et al (2008) as well supported that School Health and Nutrition Programmes contribute to good health outcomes and are more effective for school access and completion. Following the positive effects the programme has, in April, 2000 UNESCO, UNICEF, WHO and the World Bank Launched the FRESH for School Health and Nutrition at the World Forum in Dakar Senegal as a way of global campaign to integrate School Health and Nutrition in the education sector (World Bank, 2000). The move taken to introduce School Health and Nutrition Programme was to address the problems of housing, nutrition among learners, environment, sanitation, water and prevention of endemic diseases.

There were other partners such as Education Development Centre, Education International, the partnership for child development, United National Education, Scientific and Cultural Organization and the World Food Programme; these partnerships recognized the need to introduce School Health and Nutrition Programme especially in low income generating countries. Further researches done by World Bank (2000), School Health and Nutrition Programme was found as one programme that plays positive roles on health and nutrition status of

school going children especially the poor and the disadvantaged one. UNESCO (1998) carried out the research and concluded that health issues were more pronounced in hospitals than in schools. This only favoured children who were coming from schools located in urban areas because it was easy for them to access big hospitals when they fall sick. Children in rural schools were more disadvantaged than those in urban areas. World Health Organization (1997) longed to strike the balance between the poor and the rich; this was done through effective donor aid to reduce poverty among the poor people. It went on to state that, the goals of the universal education could not be achieved when the health of the child remains poor.

2.2.1 School Health and Nutrition Programme in United States of America

A comparative study conducted by Meckel (2013) showed that by statistics many learners were behind in their studies only because of lack of good health and nutrition. In 1920, it was found that so many learners in the schools of Brooklyn, New York were compelled to repeat in the same grades twice or more resulting by the government in spending the average cost of 40 US dollar a term for each learner. Furthermore, 2000 US dollars were spent on other social amenities and these demanded the population of 100,000 people to be catered for, for effective medical aid to the school children. With these estimates, more than half of the populations were saved out of 252,000 school-children inspected in New York in 1919. However, 74% were found with poor sight, defective physically and defective teeth. Together Tuberculosis, heart failure and HIV/AIDS are common for the majority of people living in United States and these in turn have negative effect on young children capability to learn. When parents who are to look after them die of these diseases, they become homeless.

With such a huge expenditure, School Health and Nutrition services were proved to curtail those costs as a result the United States government embarked on developing the programme. Central guidelines were provided by making health academic better but each state and within that each school board had adopted its own specific methods. Making Health academics was a five year project funded by Curriculum Development Centre's division of adolescent. School health services were designed to enable all schools to co-ordinate School Health Programmes. The project was developed in such way that six preventable behaviours, mainly learned in childhood and youth, account for the most serious illnesses and avoid premature deaths. School Health and Nutrition service in Massachusetts from maritime state had a mission statement to foster the

growth development and educational achievement of learners by promoting their health and well-being.

2.2.2 School Health and Nutrition Programme in United Kingdom

Mickel (2013) carried out a research on School Health and Nutrition services and found that the health of children and youth in the United Kingdom is mainly the responsibility of the Nutrition Health Services. For example, the responsibility given to Nutrition Health Service were child health screening and giving advice to parents on overweight children. School based Health and Nutrition services were more pronounced in United Kingdom than in the United States. Since school based Health and Nutrition services are pronounced in the United Kingdom, the government has embraced the School feeding programme one component of the School Health and Nutrition Programme aims at increasing nutritional values among learners and increase educational outcomes in children aged 3, 6 and 10. Evidence from randomized controlled trials done by Ahmed (2004) shows that School Feeding Programme in the United Kingdom increase enrolment and reduce dropout rates. Girls who are better nourished are more attentive and involved in lessons during classes, and well-nourished boys exhibit improved classroom behavior and activity levels. School Feeding Programme has also demonstrated the potential for improved education attainment. Quite simply, school feeding keeps kids in school and supports learning by alleviating short-term hunger and improving health and cognitive abilities. On the contrary, however, White (2003) observed that these programmes have long-term implications for national development, social protection and growth productivity.

2.2.3 Nutrition, Sanitation and Water Challenge to School Health and Nutrition Programme in Asia, Eastern Europe and Developing countries

Inflation, sickness, malnutrition and poverty are widespread in developing countries. Malnutrition diseases like kwashiorkor and marasmus are among the top in many parts of the world especially in third world countries. According to a World Health Organisation (WHO) report of July 2001, "Malnutrition casts long shadows, affecting close to 800 million people in developing world." This means that 1 out of every 8 people in the world suffers from it. While the largest of the undernourished people are found in Asia mainly in the southern and central zones, the population with the highest percentage of the undernourished people is in Africa. Some developing countries in Latin America and the Caribbean are the next on the list. World Health

Organisation (2001) further reports that 11 million people who live in industrialized countries also suffer from malnutrition. An additionally 27 million undernourished people live in what are called transitional countries, especially ones in Eastern Europe and republics of the former Soviet Union. The direct cause of malnutrition is lack of food. But there are deeper social, economic, cultural, and environmental causes. Principal among them is poverty, which affects millions of people; particularly in African countries. The other contributing factor is poor eating habits. These poor eating habits include unequal distribution of food and discrimination against women. Women often eat last and least that is, after men and less than men. Women are also denied educational opportunities that would help them to care for their children better. Annie (1985) added that education has dual roles for women. Women need education in order that they may access better jobs, particularly in the areas of science and technology, raise standards of women's education that would benefit the whole community.

Economic decline has been the source of poverty resulting in heavy burden of diseases. In many countries, water is that scarce and very difficult to obtain which poses a challenge to human inhabitant. Diane (2000) in her book noted that 40 percent of the world's populations carry their water from wells, rivers, ponds, or puddles outside of their homes. In some countries, women may spend up to six hours fetching water for their families, lugging it home in containers that, when full, weigh more than 20 kilograms. Parents also send their children to distant places to fetch water and this result in children reporting very late to school. They become absent or lose concentration when they are in class because they are already tired. The fact is that over a third of the world's population is seriously affected by water and sanitation crisis. The problem is severe in Africa, where 6 out of 10 people do not even have proper toilets. According to World Health Organisation (2001), these problems contribute to the transfer of bacteria, viruses and parasites found in human excreta to water resources, soil and food. This is a major cause of diarrhoea, the second biggest killer of children in developing countries, and leads to other major diseases such as cholera, schistosomiasis and trachoma. According to Mark (1992), Immunization coverage in the developing world has been increased to approximately 80% in the last ten years. As a result three million deaths from vaccine preventable diseases are now prevented each year. However, further researches study done by Mwanza (2002) indicated that over 60% of the 12.9 million child deaths are caused by Diarrhoea diseases or vaccine preventable diseases. With these problems found in these regions, Save the children (2017) researched that across the

developing world, the problems outlined hampers the effective implementation of School Health and Nutrition Programme in primary schools and the whole entire communities.

2.2.4 School Health and Nutrition Programme in Kenya

Kenya is a low-income East African nation with a population of approximately 39 million people living in the country. The country is divided into eight provinces, which are subdivided into district which are further divided into division. About 80% of the populations, including three out of four poor people, live in rural zones. Lambar (2009) reports that School Health and Nutrition Programme in Kenya has traditionally been targeted to districts in the country with the lowest enrolment and attendance rates, as well as those with unequal gender ratios as compared with national average. Poverty, hunger, cultural values, and inadequate school facilities often keep children in these areas out of the classroom. Moreover, World Food Programme, working in collaboration with the Government of Kenya, has in recent years set up a new mechanism based on a weighted indicator that put into consideration education, poverty, food insecurity, water and sanitation in the country. The mechanism is well designed to make sure that proper targeting even reach to the needy districts, and lead to the handing over of more food secure districts to the government's Home Grown School Health and Nutrition Programme. This design is analysed annually in an effort to reach the most vulnerable populations. In the past, however, Kenyan schools have most of the time depended on emergency WFP assistance during drought or political instability.

2.2.5 School Health and Nutrition Programme in Morocco

Indicators of School Health in Morocco are troublesome. A recent article by the European institute of Health Science (2017) noted that 15% of school children in the country live in chronically medical conditions such as bronchial, asthma, allergies, diabetes, mellitus, anemia, epilepsy, congenital diseases and cancer. 10% to 15% of injuries to children occur while they are in school. 85% of infections occurring in school children are transmitted in school while 15% of school children suffer from an emotional or behavioural problem. One third of them will have serious dysfunction. Statistics about engagement of Morocco Youth in risky behaviours are alarming. School health services are traditionally provided by school nurses, but there is a severe shortage of qualified school nurses. The institute therefore proposes both a one year programme

nursing designed for registered general nurses and a one year for qualifying teachers in providing School Health.

2.2.6 School Feeding Programme in other African Countries

In addition, environmental factors cause a decrease in food production. Among these are natural disasters and civil wars. For example, press TV Aljazeera (2017) reported that about 2 million children in Nigeria are affected by malnutrition because of the terrorist attack caused by the rebel insurgents known as Boko Haram. Many people take refuge in neighbouring countries; they have no place where to establish permanent settlement for farming. Bishop (1989) earlier on alluded that early malnutrition in developing countries affect up to 20-30 percent of the world population. Although malnutrition is said to be declining in every part of the world, the nutrition status has dropped significantly or deteriorated tremendously, in much of African regions. The reason is that people in Africa feed on less healthy foods and lack knowledge of preparation. This has brought a serious challenge to children living in Africa. For example, in Burundi, Ethiopia, Madagascar, Malawi and Rwanda one half of all children are stunted in height for their ages. Literatures further reveal that in Ghana, Mali, Niger and Nigeria one child in ten is wasted (low weight for height). According to the South African Medical Research Counsel (1994), "Adequate nutrition is a basic human right and is essential for the development of an individual's full physical and intellectual potential. Under nutrition affects not only the growth and development of children, but also life cycle of each person.

In an effort to boost enrollment rates and ensure that school-age children are well fed Whiteside (1995) revealed that the Government of Ghana has initiated two types of feeding programs: 1) take home rations for girls in schools in deprived communities in three Northern regions and 2) provision of one hot meal per school day to primary-school children using locally-grown food products. The latter branch of the program originally provided lunches to over 975 primary schools and over 400,000 students. It was projected that by 2010 the program would serve 2,900 schools and approximately 1.04 million primary school children, however, recent estimates indicate that the program currently covers 656,000 students or about 22% of all pupils in public schools across the country. Seventy-five percent of primary school age children in Ghana attend school, though this number fluctuates dramatically by region. There is a continuous decline in enrollment at the junior high and secondary school level, especially among the poorest of the

poor. With few exceptions, such as Botswana, Cameroon and Zimbabwe are at least one fifth of children are underweight. Further researches by (World Bank, 1997) have been carried out and found that schools in Guinea and Gambia faced the same challenge of poor nutrition status of children. Micronutrient malnutrition inhibited learning process to both pre-school and primary school children from these countries. But with the introduction of School Feeding Programme in Guinea and Gambia, this dramatically improved the attendance and performance of learners in particular girls.

2.4 School Health and Nutrition Programme in Zambia

After 1964, Zambia was delighted with the fact that the Emergency, Transitional and First National Development Plan pressed much emphasis on health sector and this was done as well in the education sector at primary, secondary and tertiary levels. The strategy used in this regard was to strengthen health education as a way of addressing problems of diseases and malnutrition burden that were barriers to the Zambian people. Also to be taken note of is that education is useful to an extent that it is used to train people on health matters at different levels, carrying out researches on health problems, narrowing down health programme from health sector to schools and generally impart knowledge in both the young and adult on preventive measures rather than spending large amount of Money on curative measures. Some higher learning institutions have in recent years introduced courses on health so that students graduating carry the message of health to the wider community. Health attitudes cannot be attained only through the intake of medicine and public health independently, for many people believe that each person can get healed when he is treated through the use of medicine. But the most important aspect is to help people understand ways and means of preventing themselves from these diseases.

In early 1990's, the Zambian government proclaimed the urgent need to address hunger and diseases that seemed to be burden to the Zambian people through the implementation of health and nutrition programmes. For example, the Fourth National Development Plan (1980-1993) strongly recommended areas where much emphasis was needed. This included primary health care; environmental health programmes, nutrition and food supply, prevention and control of endemic diseases, child health services, the promotion of mental health, prevention of HIV/AIDs and other related diseases. In order to come up with positive results, the emphasis on preventive measures had to move side by side with curative measures which involved the expansion and

decentralization of medical services, rehabilitation of medical facilities, educational institution and improvement in the supply of drugs (FHDP 1980-1993).

In making the above health protection programmes succeed, it was important to ensure that parents were sensitized and understand the importance of giving their children selected food stuff with high levels of nutrition food contents. This was as well contained in the Third National Development Plan of 1979 which explained the need to meet government objectives to cover all areas, and in so doing, continue making health services accessible, efficient and available to all Zambian including those living in rural areas. This called for parents, teachers, pupils and every stakeholder to respond with a positive attitude and actually to look forward to make these programme succeed (Muzumara, 2008).

The introduction of School Health and Nutrition Programme in primary schools was seen as the only solution to problems of health and nutrition affecting the school going children. Before the onset of this programme, the government had to put several measures that would enhance the effective implementation of the programme. For example, during the period of 1970, government through the ministry of education was to inculcate values, norms and positive attitudes in teachers, and parents inclusively and had to see to it that they help in the promotion of children's health and nutrition. Schools had to remain places of hygiene at all the time. It was not only about knowledge and understanding the relationship between good hygiene standards and personal health but the school had a responsibility to influence attitude and behaviour change that might improve health among school going children. Hence learners, parents and teachers became key players in keeping the school environment clean (MOE, 2002).

In order to effectively facilitate cleanliness in schools, preventive maintenance was designed as one of the co-curricular activity which both the teacher and a pupil needed to respect. The first week of opening, learning was not taking place but general cleaning of the school surrounding had to be facilitated throughout the week. This was in line with Latham's view in his comments on an African child. He said that if education was to be preparation for life as it should be, then a considerable portion of school working week must be devoted to manual work. When learning resumed, cleaning of the school surrounding was done in the afternoon and teachers had to make sure that all pupils report back for work, failure to comply was punishable by rampant beating. Parents had no say on the rampant beating that was taking place. There was nothing like

childlabour or corporal punishment as it is today. However, hygiene had to be promoted to meet the objectives of schools. Moreover, in a school environment where fear prevails, hostile, and rejection relationship may eventually be reflected in the child who may feel very insecure to learn. As a result, many children may drop out from school. Snelson (1974) adds that there is a danger of attracting children to live in conditions that are educationally bad. It is evident that teachers' attitudes towards a learner affect their performance. Any negative attitudes on the part of the teacher indicating hostile environment have a strong influence on retention, access and enrolment of learners.

To enhance cleanliness in schools, wearing of school uniforms was compulsory even in rural ones like Mwenze District. Education was free to increase learner participation in the learning process. Teachers used to compose songs which were promoting cleanliness in schools. For example, "This is the way we wash our hand, wash our hands" This song was sung by children from grades 1 to 4. Such lyrics promoted personal hygiene among learners (MOE, 2002; Levinger, 1992). Production unit was among school co-curricular activity and teacher in – charge to manage were given extra duty allowances as entitlement. This was done to boost production unit in several schools in Zambia including the one in Mwenze District. The major task remained in the hand of the Ministry of Education to enhance School Feeding Programme and this included all aspects of distributing food to all learners. At Independence Day celebration tea and milk were given to learners. Educational Materials used to be available in schools for example, pencils, pens, erasers, crayons and books. Children in grade one used soft soil known as plasticine to mould different objects during creative activity.

Indeed a good learning environment with high quality education is unable to produce well intended educational outcomes when children are very unhealthy to learning. If such situation happens, then the education sector won't achieve its objectives (Kelly, 1996). In order to avoid children from learning in unhealthy environment, the Ministry of Health came up with comprehensive health services in schools which included physical examinations, referral treatment of ailments and inspecting of scars. Micronutrient supplementation was done through food supplementation mainly with milk and local buns. Between the period 1978 and 1980, the Ministry of Health in an effort to combat diseases in schools deployed nurses in many districts of Zambia to provide health services in local schools. The Ministry of Health was not able to provide

specific school services but only concentrated on occasions, outreach mission like vaccination and health campaign. Mark (1992) and MOE (2002) moreover added that other problems affecting children were cholera, teenage pregnancies, sexually transmitted diseases and substance abuse.

2.5 Perceptions of people towards School Health and Nutrition Programme

Bwalya and Simbeye (1997) noted that diseases which affect people in Zambia also affect people in many parts of the world. The perceptions of people responding to these problems affecting them differ from one region to another. An individual's perception towards School Health and Nutrition Programme account for one's behaviour or determines the performance of any programme either negatively or positively. For example, developed countries have responded with positive perceptions towards hygiene and cleanliness as a result malaria and diarrhoea have been eradicated. In Zambia; the poor perceptions of people towards hygiene and cleanliness have resulted into high incidents of malaria and diarrhoea. Black (2006) acknowledged that an individual's course of action towards certain diseases often depends on the perceptions of the benefits and barriers related to the health behaviour. Polit, et al (2007) further revealed that world over people die of prevalence diseases such as malaria, bilharzia, diarrhoea and other diseases like cholera, dysentery, typhoid, measles and tetanus. Mwansa the microbiologists at the University Teaching Hospital during School Health and Nutrition workshop quoted in Kochhar (2011) and revealed that the global statistics indicate that 76 countries are affected by Bilharzia and the population at risk is 652 million. The percentage in the African countries shows that it has 75 of the world population at risk and 165 million of the infected populations are in Africa.

2.6 Roles of parents and teachers towards School-based Health and Nutrition Services

Annie and Neal (1976) argued that teachers also needed to recognize the roles of parents in the school system. Headteachers, Guidance and Counseling teachers, and PTA members should be made aware about the need to collaborate with health centers in their areas for the provision of health services to learners as stipulated in the memorandum of understanding between Ministry of general Education and Ministry of Health. This was for the betterment of learners.

MESVTEE (2008) demonstrated that many common health problems which learners face in schools could be managed effectively, simply and inexpensively through school-based health and

nutrition services. Treatment services such as deworming and micronutrient supplementation are simple, easy and safe and cheap to administer by teachers and could immediately improve children's health and nutritional status and consequently their ability to concentrate and learn in school. School-based counseling services help and support learners and young people during difficult times and prevent school absenteeism and dropout. A strong referral system with health service providers, child protection services and community support groups are also essential to ensure that children with a more serious health problem which can be dealt with at school are referred to the appropriate services. While the school system is rarely universal, coverage is often superior to the health systems and it has an extensive skilled workforce with daily contact with children and community. It is therefore, in a unique position to address common health problems which are preventing children from attending and participating in schools in a prompt and cost effective way (MOE, 2000).

2.7 Re-introduction of School Health and Nutrition Programme in Primary Schools

According to Kerlinger (1984) attitudes are enduring and organized structures of social beliefs and predispose individuals to think, feel, perceive and behave selectively towards referent or cognitive or objects. Regarding attitudes, Kalabula (1991:21) argues that; "Attitudes are not immutable, they often change and new ones develop as individuals mature and widen their experiences in life." Because of different experiences parents and teachers have gone through, their attitudes may not be the same as they were sometime back. Furthermore, Kerlinger (1984) claimed that some people's attitudes are generally conservative (traditionally) who are too rigid to adapt to any change while other people's attitudes are liberal (progressive) meaning that they can accept any change in relation to education. To ensure that things run smoothly in the education sector, they accept orientation and make a lot of consultations. For example, during 1980, Kelly(1996) highlighted that the scenario in the education sector changed from bad to worse; there were low standards in the availability and quality facilities, dilapidated school infrastructure, inadequate water supply and sanitation, bear classrooms, insufficient seats and desks affected schools therefore, lower participation at all levels of national development. The government was failing to equally distribute learning materials to all schools in Zambia. Teachers used processed cassava as pieces of chalk to write on the chalk board. These negatively

frustrated teachers and in turn adversely affected learner performance; they did not want to succumb to these devastating situations (Kelly, 1991).

Free basic education was abolished in 1985 and wearing of school uniforms became the thing of the past. Poor parents struggled to cope with day to day pressure of living. As a result they found it difficult to provide their children with full basic needs. Children from poor families in rural districts in particular, Mwense walked long distance bare foot to get to schools. Teachers rarely carried out physical examination due to traditional believe that existed among traditional societies. Health and nutrition tremendously declined in terms of access, availability and quality. Food supplements were no longer anymore, parents and teachers stopped to appreciate the role played by government to ensure good health and nutrition in schools. However, the knowledge gap of the negative attitude that contributed to the decline of School Health and Nutrition Programme in primary schools was the poor perceptions of parents and teachers that the Ministry of Health was responsible to address the issues of health and nutrition and in this regard, health and nutrition continued to deteriorate. This was in contrast with the concept of health promoting environment that embarks on promoting healthy environment inculcating in children knowledge on issues related to health matters and improved classroom instructions for learners in regard to health and nutrition (MOE, 2007).

Good health and nutrition is not only essential input of education but also played a significant role for basic education of good quality. Take note that education is key to the future of young children. It is an important tool in the development of any country. The right to education is enshrined in article 26 of the Universal Declaration of Human Right to which Zambia has been a signatory since her independence in 1964. Therefore, Zambia to significantly fulfill this obligation, children must be healthy and well-nourished in order to fully participate in the learning process so as to receive quality education (MOE, 2002).

Of late, the Zambian government through the Ministry of Education had realized the immediate need to reverse the adverse attitude which hampered the learning process in primary schools for the period of 1980 – 2001. In 1996, the Ministry of Education produced a policy document “Educating our future”. This document emphasised the need to lower malnutrition levels and diseases that were affecting learners especially from poor families. Therefore, teachers were very much tasked to place much emphasize on the importance of diversified diet in promoting disease

resistant foods and general health. Hence, the School Health and Nutrition Programme located within the broader Basic Education Subsector Investment Programme were established with the mission to improve health and nutrition status of learners to increase retentions, enrolment and reduce absenteeism. The School Health and Nutrition Programme preceded with child to child programme an initiative which was used to give education on health and nutrition to schools and to the community at large. Among the information delivered in schools were also on reproductive health, HIV/AIDS and gender (MOE, 2003; MOE, 2002). This clearly demonstrated that the programme had a lot of issues related to health problems which needed to be addressed.

The Ministry of Health was not able to provide specific school services but only concentrated on occasions, outreach mission like vaccination and health campaign (Whiteside, 1995). The School Health and Nutrition Programme were then piloted in 40 schools in Chipata of Eastern Province. Lusaka and Central provinces were not exceptional but at the later stage the programme was extended to other provinces. The programme came at right moment when health and nutrition was very much needed.

2.8 Challenges faced in the implementation of School Health and Nutrition Programme

The Health Belief Model developed in 1950s by social scientists explains the failure to some people to adopt disease prevention strategies and suggest that a person's belief in a person threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood the person will adopt the behaviour. Hence, the perceptions of parents and teachers may determine the effective ways of responding to challenges or obstacles affecting each individual in the society. For the perceived benefit to be enhanced, School Health and Nutrition analysis was carried out and revealed that most schools in provinces of Zambia had major public health problems like malaria, bilharzia, diarrhoea, and cough, worm infection, eye disease, and skin disease. These were more common in school-going children. The older children in schools were also at risks of contracting Sexually Transmitted Diseases (STDs) like HIV/AIDS and further teenage pregnancy were also among the negative factor inhibiting progression rates among children. This was according to the survey carried out in recent years between 2006 and 2008 by the healthy management information system by province. The survey taken evidently showed that poor health and nutrition increase susceptibility to diseases and increase disease levels resulting in lower school attendance rates and poor

performance in schools. This clearly shows that disease and poor nutrition burden are all barriers of education.

Central Statistics Office (2003) further added that in Zambia, Vitamin A deficiency is also common among children. More than half of children less than 10 years are vitamin A deficient. In recent years a comprehensive analysis that was conducted by Ministry of Health (2005) revealed that deficiency is associated with low hemoglobin concentration. Anaemia is measured by low hemoglobin and this affects a third of all children especially in young ones.

Literatures further by Ministry of Health (2008) revealed that more than half of the children were infected with hookworm, but all infections were treated as light. For example, almost half of the children in Zambia were infected with urinary schistomias (Bilharzia) and a quarter was heavily infected giving rise to children developing ringworms and loss of appetite thereon resulting in marasmus and kwashiorkor. These were the common problems among children especially those coming from rural schools. The prevalence of Ascario (round worm), Trichuria (whipworm) and schistosomiasis Manson had been so low. Depending on the geographical variation such as environment determine the rate at which children are infected. In the analysis conducted by (MOH, 2007) there was a big variation between schools in the prevalence of iron deficiency (from 6% to 35%) anaemia (From 19% to 54%), infections with hookworm (from 29% to 75%), schristomiasis (from 15% to 69%), studying from 24% to 42% and underweight (7% to 3%). Even though, there had been such a variation depending on the geographical location, young children had been found prey of these factors and these had negatively affected enrolment and retention rate among learners (MOE, 2002; MOH, 2007). The School Health and Nutrition Programme was introduced to provide several interventions to end up disease and nutrition effect among children. MOE (2002) outlined that School Health and Nutrition Programme has faced major challenges such as drugs for deworming and treating bilharzias and iron tablets being administered were said to be harmful to children. The School Health and Nutrition Programme has also been affected by rumour mongers which parents and teachers have failed to stop. People in some traditional societies are being told that children undergo medical treatment through School Health and Nutrition Programme are initiated into Satanism and some children are abducted and taken to unknown places where parents cannot go. The cultural practices that some

Societies have such as, as soon as a boy is enrolled in the local cultural Nyau dances team of Eastern province, the boys' interest in education cools off.

2.9 School feeding Programme the component of School Health and Nutrition Programme in Zambia

The provision of education in Zambia has been liberalized in such a way that there has been a number of other providers who have come on board to work with the government in providing education at various levels in the country. The fact is that children cannot receive quality education without putting into consideration good health and nutrition. Therefore, School Feeding Programme located within School Health and Nutrition Programme was conducted under the auspices of the Ministry of Education, other service provider such as the Ministry of Community Development and Social Services were included as corporate partners to enhance feeding programme and carry out sensitization campaign and mobilize resources with the support from United Nations International Children Emergency Fund (UNICEF) and World Food Programme. One of the reasons why sensitization campaign was carried out was to make knowledge available to the general public that feeding promote good health and in turn improve learner academic performance. High levels of poverty and hunger have brought miseries on the life style of the Zambian people. A survey was conducted in schools by SACMEQ I and III (1995) in all provinces of Zambia and found that the problem of poor nutrition was common among the school going children. For example, regarding the number of meals children ate during SACMEQ II and SACMEQ III stood at the latter average of 10.5 while the former was 10.7.

Table 1 show the response given from each pupil on the meal ate during SACMEQ III and are tabulated according to the type of meals taken.

Table 1: Percentage of pupils who had morning meal

PROVINCE	2000								2007							
	Not at all		1 or 2 days per week		3 or 4 per week		Every Day	Not at all		1 or 2 days per week		3 or 4 per week		Every day		
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Central	9.1	3.17	12.1	2.76	13.8	2.68	65.0	5.32	14.7	3.148	9.92.78	13.8	2.99	61.5	61.5	6.98
Copperbelt	7.1	2.11	8.7	2.05	11.2	2.01	73.1	4.25	10.2	1.76	7.3	1.42	12.4	1.85	70.2	3.73
Eastern	10.5	3.48	20.8	4.34	13.8	3.42	54.8	6.78	20.2	4.15	14.2	2.22	10.4	2.07	55.2	4.14
Luapula	39.0	7.20	23.6	4.28	16.8	3.55	20.6	5.53	37.6	7.01	22.1	4.04	14.1	2.47	26.2	5.27
Lusaka	12.5	2.01	10.5	2.15	6.9	1.36	70.1	5.17	7.5	2.65	6.4	2.07	7.6	1.50	78.5	4.95
Northern	38.9	3.98	17.9	6.62	8.9	3.97	34.3	8.96	24.3	5.76	22.8	4.77	11.1	3.01	41.9	7.11
North – Western	16.3	4.11	21.4	4.35	12.4	3.37	50.0	7.58	27.8	4.50	15.5	2.48	13.3	1.65	43.4	5.61
Southern	7.9	3.34	13.2	3.04	6.4	2.54	72.5	5.34	27.4	5.89	11.3	2.27	9.0	1.87	52.3	6.15
Western	10.4	2.55	9.9	2.19	14.0	2.98	65.7	4.58	21.2	5.34	19.0	3.78	13.1	3.69	46.7	5.03
Zambia	16.2	1.74	14.0	1.29	10.5	1.04	59.3	1.89	19.9	1.54	13.4	1.02	11.5	0.82	55.2	1.95

Source: Examinations Council of Zambia- 2000 and 2007.

Due to high poverty among parents, the majority of pupils in 2000(97.5%) and in 2007 (87.6%) only took the evening meal compared to other meals of the day.

Table 2: Percentage of pupils who had Lunch

PROVINCE	2000								2007							
	Not at all			1 or 2 days per week		3 or 4 per week		Every Day	Not at all		1 or 2 days per week		3 or 4 per week		Every day	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	%	SE	
Central	2.9	1.97	1.6	0.68	2.2	1.26	93.2	3.09	1.5	0.73	6.0	1.57	6.0	1.44	86.5	2.97
Copperbelt	3.0	0.83	3.5	0.92	6.8	1.64	86.7	1.80	5.3	0.90	6.7	1.14	6.5	1.40	81.5	2.26
Eastern	2.2	1.23	3.7	1.84	1.1	0.63	93.0	2.77	7.1	2.42	5.3	1.67	5.3	1.26	62.3	3.39
Luapula	3.4	1.29	4.9	1.24	7.6	2.99	84.1	3.79	2.3	1.07	4.6	1.24	4.8	1.42	88.3	2.31
Lusaka	7.8	2.14	5.0	1.56	5.4	1.21	81.8	3.84	2.9	0.93	4.3	1.30	5.1	1.96	87.7	2.94
Northern	3.9	1.09	8.7	3.13	6.2	2.53	81.2	4.40	4.5	1.71	9.0	2.04	7.0	2.29	79.5	4.34
North – Western	1.1	1.13	3.7	1.21	4.5	2.19	90.6	2.76	7.9	2.62	11.3	2.71	6.0	1.35	74.8	4.22
Southern	2.3	1.07	4.9	1.57	2.7	1.50	90.2	2.77	3.6	1.01	3.5	1.29	6.3	1.54	86.5	2.48
Western	7.5	2.63	4.6	1.69	5.1	1.96	82.8	4.48	6.4	4.59	5.4	1.69	4.9	1.59	83.2	5.35
Zambia	3.9	0.52	4.7	0.66	4.8	0.63	86.5	1.16	4.4	0.54	6.1	0.54	5.9	0.58	83.6	1.11

Source: Examinations Council of Zambia- 2000 and 2007.

Analysis of perceived poverty by gender of head, of households' shows that more than half of single mothers headed household perceive themselves to be poor compared to households headed by men. In this case, the analysis was extended to both sexes to identify parents who provided children with only lunch.

Table 3: percentage of pupils who had evening meal

PROVINCE	2000								2007							
	Not at all			1 or 2 days per week		3 or 4 per week		Every Day	Not at all		1 or 2 days per week		3 or 4 per week		Every day	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	%	SE	
Central	1.7	0.79	0.7	0.47			97.6	0.94	2.1	0.90	1.5	0.72	4.0	1.20	92.4	1.98
Copperbelt	2.8	0.85	1.8	0.85	2.7	0.63	92.8	1.27	4.3	1.05	3.6	1.06	7.7	1.32	84.4	1.98
Eastern	4.0	1.87	0.6	0.41	2.0	0.84	93.4	2.15	5.2	1.79	3.0	2.61	5.3	1.33	86.5	3.88
Luapula	1.5	0.99	2.7	1.02	6.9	2.24	88.8	3.01	3.1	1.82	2.8	0.89	6.4	1.73	84.7	3.56
Lusaka	5.9	2.00	3.0	1.08	4.7	1.57	86.4	3.24	2.6	1.07	2.0	0.80	3.8	1.12	91.6	2.13
Northern	2.3	1.27	4.5	1.11	2.5	1.27	90.7	1.72	3.9	1.17	3.6	1.12	5.6	1.81	86.1	2.72
North – Western	0.9	0.75	1.2	0.82	1.3	0.83	96.6	2.32	9.2	2.37	6.4	1.26	5.7	1.57	78.7	2.87
Southern	1.6	0.76	2.4	1.07	3.5	1.42	92.6	2.23	2.6	1.63	1.3	0.51	3.0	1.00	81.1	2.73
Western	2.9	2.67	2.9	1.27	4.0	1.8	85.2	3.17	5.9	4.08	2.4	0.89	3.3	1.52	88.3	4.74
Zambia	3.1	0.47	2.4	0.39	3.0	0.45	91.5	0.79	4.4	0.52	2.8	0.42	5.2	0.49	87.6	0.93

Source:Examinations Council of Zambia-2000 and 2007.

Table 1 show the percentage of pupils who could not afford breakfast was more in rural areas than in urban province. Luapula province in 2000 recorded the highest and the percentage stood at 37.6 followed by North Western and Southern Provinces with 27.8 and 27.4 percent. The lowest was Lusaka Province, which is urbanized, at 7.5 percent and the percentage varied considerably from province to province.

Several devastating reasons were highlighted as to why most pupils did not take full meal in a day because parents had no enough food to give them. These were as a result of poverty in some homes; poor parents with poor educational background discourage children from eating morning meal basing on the wrong perceptions that when they take morning meal, they would lose concentration on lessons. Some families are living in isolated settlement; their children walk long distance to schools which require them to leave their homes so early. Parents also delay in preparing the meal as result children leave their homes without eating.

Kelly (1996) noted that seven of the 6 million total public school learners in the 2000-2007 school years benefitted from school feeding, though coverage varies at the provincial and school level due to reliance on local structures. Challenges to school feeding in Zambia include: lack of uniformity in programme implementation and meals components; resource shortages; lack of basic supplies and clean water; insufficient linkages to local agriculture/food vendors; and corruption and theft. Targeting is used to give priority to the poorest schools, particularly rural and farmschools, with certain provinces receiving a greater amount of funding. Variation exist between schools as to which grade levels are targeted for school feeding.

Seemingly, most families in Zambia like to eat an evening meal if they have insufficient foods in their storage. From the survey, it shows that most children came to school hungry and tired. They do not have sufficient food and often times; their nutritional values of the meals are low. Those that come from poor families do not have adequate food and often eat less nutritious food. The amount of food eaten also varies according to different seasons. For example, food becomes scarce in many rural societies of Zambia during the months of July to February. Climate change has also contributed to low rainfall and low production of food resulting in people developing poor attitudes towards farming (Kelly, 1991).

In the survey conducted by Central Statistics Office (2003), it was found that most families in Zambia are living in absolute poverty and hunger because parents cannot provide their children with full meals in a day. If the child has not been eating well balanced foods, many bad effect such as sensory impairment or other physically or mentally handicapping conditions may occur that can impede a child's moral to interact and losses opportunities to learn. The attitude of people having too many children is another determinant factor of hunger. Traditionally, Zambian people believe in having many children and they have strong point to defend themselves that

when they have few children, in case, these children die, none will care for them when they are old has been very misleading to many families in Zambia. This is the common language widely used by many Zambians especially those living in rural areas. Elderly people encourage many boys and girls at the tender age to enter into early marriages and there is no birth order when it comes to child bearing. Bearing of children is through trial and error method without planning.

Value of health and nutrition in both traditional societies and in schools is generally important. In this regard, health and nutrition influence the growth and the psychological wellbeing of a child. Kelly (1996) quoted in the third reading on the nutrition status in Zambia by GRZ – UNDP explaining that child nutrition is considered significantly as an indicator of general childhood welfare, especially in poor societies. During adolescent age, they fall prey to many chronic diseases which cause death. Hence, school feeding programme as an additive to health must be enhanced and properly be co-ordinate in schools. However, most Zambian people in rural areas regard health and nutrition as an option, somebody can accumulate a lot of money but he cannot buy enough food to sustain his life. He or she prefers putting money under the pillow claiming he has money but failing to utilize it in buying essential basic needs. Any negative attitude of this kind should quickly be addressed to avoid serious injuries to schoolgoing children.

2.9 School Health and Nutrition Programme in Mwense District.

Statistical analysis of the Annual Health Statistical Bulletin of 2008 on prevalence diseases, fortifiable diseases and the survey carried out by SACMEQ 11 and 111 on nutrition status of school going children showed that Luapula Province was among those facing the same challenges. A comprehensive situation analysis was undertaken in most primary schools of Mwense District. One of the districts found in Luapula province and found that school going children had poor health and nutrition status (MOE, 2005:5). Malaria, Diarrhoea, Cholera, Bilharzia and low production of food in the surrounding areas were also common. For example, the district has streams, dambo places and people drink, wash and swim from these pool of water which harbour snails that carry bilharzia parasites, thereby facilitating the spread of the disease. Bilharzia is water borne disease which mainly affects people who come into contact with water that is infected with bilharzia parasites. The rate at which the disease was spreading in Mwense District was the source of worry to the government and the community at large. According to the Ministry of Education policy document of 1992, focus on learning, states that, “Every Zambian

child carries a heavy burden of parasite like hook worms, whipworms and roundworms which cause bilharzia.” Children are at greater risks of getting the disease because they like playing in dirty water in the absence of parental control. A child infected with bilharzia performs badly at schooling the sense that the disease affects the child cognitive development. This could be the reason why Mwense District for the past five years recorded poor results at grade 7, 9 and 12 final examinations.

In Mwense, iodine deficiency affects between 50% and 80% of school going children. While almost half the young children are anemic with low hemoglobin. This has in recent years increased the chances of deaths resulting from measles, diarrhoea, and respiratory infections and has caused an irreversible blindness to the majority of people living in the district. Malaria and diarrhoea have also been the most prevalent illness that affects many school going children. Due to insufficient food stuff in the region, Malnutrition has been the most serious problem affecting young children in the district including the old men and women. On the other hand, children with these problems risk higher chances of dying from severe illness. The prevalence of stunting among children of Mwense District has been an indication of government long term failure to address child nutrition problems, since stunting is caused by perpetual and usually periodic conditions of insufficient food intake (Kelly, 1996). This is evident because the SACMEQ III survey gave a clear explanation that in Zambia particularly Mwense District, most families prefer having a single meal to having other meals if the resources are inadequate. Hence, the launch of School Health and Nutrition Programme on 28th March, 2006 by Honourable former Minister of Education. Dr. Brian Chituwo at Nsakaluba Primary School had been very overwhelming to address the issue of hunger and health related problems in primary schools of Mwense District. This was done to cushion the impact of malnutrition and the prime objective of these programmes was to promote and provide a well-balanced service in primary schools through the integration of health and nutrition.

Consequently, the Ministry of Education with its policy strove to put in place school – based health and nutrition intervention programmes to come up with the lasting solution that would address the health and nutrition concerns for learners of Mwense District. This was done in order to achieve education for all even in the most deprived areas. Thereby increase enrolment, retention, progression, reduce absenteeism, repetition and dropout. This measures work best if

parents and teachers put their heads together with the government to ensure that the programme exists within the framework of the education system. Although many parents and teachers appeared not to understand the importance of School Health and Nutrition Programme, they also had big roles to play to ensure health and nutrition status of children were improved. Though the programme was introduced in primary schools of Mwenze District, less effort was seen in its implementation because of numerous challenges. Therefore, this study wished the researcher to determine the perceptions of parents and teachers towards the effective implementation of School Health and Nutrition Programme in selected primary schools of Mwenze District.

2.11 Summary of literature review and identified gap

This chapter presented a review of literature considered relevant to the study on the perceptions of parents and teachers towards the School Health and Nutrition Programme in primary schools. It firstly reviews the meaning of School Health and Nutrition Programme. It also reflects on School Health and Nutrition Programmes across the world, in Africa and later on narrowed down to Zambia. From the literature reviewed, for example, United States of America and United Kingdom the programme had been doing so well but in Africa the programme was poorly coordinated. This suggested that the perceptions of people determined the success or failures of the programme in some countries. It also reviews literature on the negative effects of malnutrition, poor sanitation and poor water in primary schools. It reveals the importance of the programme in promoting learner academic performance in schools. It brings out perceptions of people towards School Health and Nutrition Programme, the roles of parents and teachers towards School based health and Nutrition services, Re-introduction of School Health and Nutrition Programme and lastly outlined challenges schools face in the Implementation of School Health and Nutrition Programme. From the reviewed literature it was concluded that the programme is vitally important to cognitive and academic outcomes. School Health and Nutrition Programme predicts higher learner academic performance, but parents and teachers have limited knowledge of how best the programme offers to the child. This suggests that all literatures reviewed had never addressed the perceptions of parents and teachers towards School Health and Nutrition Programme. It was under this background that this study sought to determine parent's and teacher's perceptions towards School Health and Nutrition Programme in selected primary schools of Mwenze District.

CHAPTER THREE

METHODOLOGY

3.1 Overview

This chapter presents the methodology employed in the collection and analysis of data for this study in order to realize desirable results. It describes the type of research design and its credibility to generate desirable data. It presents the research design and the population of the study. Furthermore, it outlines sample size, sampling techniques, research instruments, data collection procedure, reliability and validity of findings, data analysis and presentation of ethical consideration. The chapter ends with summary presentation.

3.2 Research Design

According to Orodho (2003), research design is defined as scheme, outline or plan that is used to generate answers to the research problems or planning of any scientific research from the first to the last step. A descriptive survey design was used for this particular study to determine the perceptions of parents and teachers towards School Health and Nutrition Programme in selected primary schools of Mwense District.

The descriptive survey method was used adopting qualitative and quantitative approaches to enable the researcher collect vital and reliable information about people's attitude, feelings, opinions and habits towards the programme (Kombo and Tromp, 2006; Kulbir, 2006). Best and Khan (2008) explained descriptive survey design that it is concerned with conditions or relationships that exist, opinions that are held, effects that are evident or trials that are developing. The survey method, on the other hand, gathers data from a relatively large number of cases at the particular time. Therefore, the descriptive survey design was chosen primarily because of its ability to assess the perceptions of parents and teachers towards the effective implementation of School Health and Nutrition Programme. The researcher deemed it fit to collect information from both primary and secondary sources. Primary data was collected through the administration of questionnaires and interviews to parents and teachers while the bulk of secondary data was obtained from the University of Zambia Library and the internet.

3.3 Population of the Study

The population comprised all parents of pupils at the targeted schools, head teachers and teachers from the selected primary schools of Mwense District and their local environment.

3.4 Sample Size

A sample is a group of subjects or situations from a larger population. Devos(1998:191) says “A sample comprises the elements of population considered for actual inclusion in the study”. A sample therefore, can be viewed as a subject of measurement drawn from the population in which the researcher is interested in.

Five primary schools were selected randomly out of the total number of 40 schools in the District. The sample size comprised 100 respondents. These included 55 teachers, 5 Head teachers and 40 parents. This shows that 11 teachers; 1 Head teacher were selected from each school and 8 parents from the nearby communities (Refer to table 1 and 2).

Demographic characteristics of participants

Respondents' age group

Age	Parents		Head teachers		Teacher		Total
	M	F	M	F	M	F	
5 – 14	0	0	0	0	0	0	00
15 – 24	7	4	0	0	5	1	17
25 – 33	8	7	0	0	18	14	47
34 – 43	8	3	0	0	7	10	28
44 – 55	0	0	3	2	0	0	5
56+	2	1	0	0	0	0	3
	25	15	3	2	30	25	100

Source: Field Project data-2017

The study comprised of forty(40) parents who were categorized as twenty-five (25) males and fifteen (15) female respectively, while Head teachers were five (5) in total categorized as

three(3) males and two (2) females and fifty-five teachers comprising of thirty (30) males and twenty-five (25) female. In total, there were hundred (100) respondents.

Table 2 presents the geographical location of parents and teachers by gender.

Respondents’ geographical location

No. of respondents from peri-urban schools		No. of respondents from rural schools			
Male	Female	Male	Female	Total	Percentage
7	12	0	0	19	19
0	0	19	23	42	42
0	0	6	13	19	19
0	0	8	12	20	20
7	12	33	48	100	100

Source: Field project data-2017

The district is divided into two locations namely the peri urban and rural. Nineteen percent (19%) of parents and teachers were in the peri-urban schools while eighty-one percent (81%) of parents and teachers were in the rural schools and the surrounding areas. Table 2 further shows that a large number of respondents were selected from schools located in rural areas.

3.5 Sampling Techniques

In this study, both probability and non-probability sampling procedure were selected because interest was in the representativeness of the concepts. . Silvestri (2009) described sampling techniques as a technique which permit each individual teacher an opportunity of being selected for and is a convenient process of getting a more representative sample of this kind of research. Thus purposive sampling technique was used to select Head teachers of each school for the study,

because these were believed to be reliable for the study. Purposive sampling enabled the selection of information-rich individuals whose experiences illuminated the questions being studied. Under probability sampling; simple random technique was used in the selection of parents and teachers because they had an equal chance of being part of the study. White (2003) defined simple random sampling as a selection technique that provides each population element an equal chance of inclusion in the sample. This method avoids biasness in the selection of participants. Lay (1976), suggests that random sampling procedure is the method of sample selection which gives each possible sample combination of an equal and non-zero possibility of being included in the sample. Under the same probability sampling, forty (40) names of schools in the district were listed on the piece of paper and the researcher made cut outs, fold each cut out and placed them in the small box, mixed well and started picking the folded paper from the box one by one, unfold it, read the name of the school, and pile them until they were five (5) schools. These schools became targets.

The school staff lists were used in the selection of teachers. The researcher assigned numbers to all the names of teachers who appeared on the school staff list at the time of the study thereafter, each number was written on a separate piece of paper. The slips of papers were later put in a box and a raffle was conducted by the researcher. The study needed fifty-five teachers as respondents from all the five schools that were selected to participate in the study, therefore eleven slips of papers were randomly drawn from the box for each school participated in the study. The teachers whose names were matched with the numbers that appeared on the slips of papers that were randomly picked automatically participated in the study. This method was consistently conducted in five schools that were sampled. The class registers of each the five (5) schools were used in the selection of parents. The researcher assigned numbers to all names of pupils who appeared in the register at the time of the study, each number was written on a piece of paper. The slip of papers were put in the box and raffled. The study needed forty (40) pupils to represent parents from each of the five schools that were selected to take part in the study, thereon eight (8) slips of pupils to represent parents were randomly drawn from the box. When eight (8) slips of pupils were picked from the sample, each pupil was given a letter to call their parent. A period of time was given and agreed the date in which to meet their parents.

3.6 Research Instruments

In order to solicit views from head teachers, parents, and teachers, interviews and questionnaires were used. Margret (1991:58) defined interviews as “A purposive conversation usually between two people that are directed by one in order to get information.” Semi structured interview was used to collect data from parents from surrounding communities. Silvestri (2009) observed that semi-interview was used because they are flexible and allow the researcher to ask respondents a follow up questions where necessary and a researcher was free to formulate additional questions depending on the situations. Semi structured interview was as well important in piloting survey meant to aid the formulation of pre-accurate questions and answers. The questions were used because data was collected from a sample, all participants were asked similar questions, when the interviewee remained blank, the question had to be adjusted.

3.7 Data Collection Procedure

An introductory letter was obtained from the Directorate of Research and Graduate Studies of the University of Zambia and it was presented to the District Education Board Secretary in Mwense District. Request for permission to conduct the study was obtained and lastly permission was sought from head teachers who were also participants where the research took place with additional personal consent from the parents and teachers who were participating in the study. The respondents were briefed about the purpose of the study and that they had been given the right to take part in the study or to withdraw from the study. This was followed by distributing questionnaires to all the teachers who were selected to take part in the study. A researcher left questionnaires to teachers because they read and write. In this case, the researcher had to deliver questionnaires by hand to participants who were selected to take part in the study. The researcher attached the letter to the instrument giving clear instructions of how to answer the questionnaires (Brink, 1996). Sometimes, the researcher used interviews to teachers who felt they were occupied with work to fill in questionnaires. To the parents, the researcher generally conducted the interviews.

3.8. Reliability and Validity of findings

The validity of an instrument is a determination of how well the instruments reflect the abstract thought being examined (Saunders et al. 2011). Reliability on the other hand refers to how consistent a measuring device is. A measurement is said to be reliable or consistent if it is able to produce similar results if used again in similar circumstances (Neuman, 2000). In order to augment reliability of the findings, data collected were tested by using triangulation and respondent proof.

Triangulation was done by associating different kinds of data from different tools to establish whether they collaborated. Respondent validation was done by verifying the results with respondent and by connecting the findings with the confirmation from the available literature. In order to ensure that the findings were valid, the researcher cross-checked the respondents' responses with those of other respondents that were obtained by different instruments. For instance, data collected by questionnaires from administrators and teachers were validated with data collected from interviews for the parents.

3.9 Data Analysis

Makinde (1994) claims that data analysis is the examination of the given problem in the light of the information collected, after which some tentative inferences may possibly be made. Qualitative data was analyzed thematically. Major themes were drawn from interviews with parents and in some cases teachers. Description of each theme was done, analysed and interpreted critically and objectively. (Patton, 2002) in his book, said that qualitative data analysis is an inductive and interactive process that transforms data into findings. While there were several approaches to analyzing descriptive survey data, the researcher chose to use (Best and Khan)'s modification of Kulbir Singh method as explained by (Creswell, 1994).

The first step was to use the researchers' personal experiences although this could not be achieved entirely because qualitative research cannot be bias free. Janesick (1994) advises that the researcher must be completely open and receptive in order to listen to the participants describe their experiences. Listening to and repeatedly paying particular attention to each interview the researcher got the meaning of the whole interview and its context. The next step was to bring out a list of significant statements from the interviews and questionnaires. Those

were statements concerning how the informants are experiencing their teaching and addressing the challenges. Every statement was considered as having valuable information although sooner or later, the researcher decided to get rid of irrelevant or repeated statements, leaving only those statements that were valuable to the research.

Quantitative data were analyzed using Microsoft excel to obtain numerical data. Graphs such as bar charts and the pie diagrams were used to obtain clear and accurate data that effectively convey the message easy to read.

3.10 Ethical Consideration

Regarding issues of ethical consideration and confidentiality, the names of respondents were not included in the study. Therefore, all respondents in the study remained anonymous. The researcher came up with questions which did not cause psychological harm to the respondent's emotions. The completed interview schedules and questionnaires were kept under strict security conditions to avoid unauthorized access to the information contained therein. The researcher interviewed all respondents with permission and made them to sign the consent letter

3.11 Summary

This chapter presented the methodology that was used in the study. A descriptive survey research design was used to determine parents and teachers perceptions towards School Health and Nutrition Programme in selected primary schools of Mwense District of Luapula province. Instruments for data collection included, interview schedules and questionnaires. Interviews and questionnaires were used to collect primary data. The study employed both qualitative and quantitative approaches. Qualitative data was analysed thematically while quantitative data was analysed using Microsoft excel to obtain numerical data. Ethical issues were also taken into consideration.

CHAPTER FOUR

PRESENTATIONS OF RESEARCH FINDINGS

4.1 Overview

The chapter presents the findings of the study basing on the data collected from different schools and the surrounding areas of Mwense District. The chapter further presents the information collected qualitatively into themes and the quantitative approach was used for mathematical data presentation. Data was presented in line with the research objectives.

Perceptions of parents and teachers towards School Health and Nutrition Programme.

Three questions were asked to determine parents and teachers perceptions towards School Health and Nutrition Programme. The presentation of findings therefore, begins with determining the facilities and activities through table presentation followed by parents and lastly Head teacher/teachers being the custodian of the schools.

Table 4.1 presents data on facilities and activities done in schools to effectively comply with the School health and nutrition policy of School Health and Nutrition Programme.

Indicate with a tick to determine facilities and activities done to support the programme.

Table 4.1 shows facilities and activities that support School Health and Nutrition Programme

School	Evaluating the availability of facilities and activities done in the School Health and Nutrition Programme				
	Health card	Tablet pole	Immunization	Deworming	Feeding
A	✓	✓	X	✓	X
B	X	X	X	✓	X
C	X	X	X	✓	X
D	✓	X	X	✓	X
E	✓	X	X	✓	X

Field Project data-2017

Table 4.1 shows that School Health cards were found in three (3) schools (A, D and E) and these cards were designed to monitor children's growth but remained under utilized and in most schools these cards had been eaten by termites. Tablet poles used to measure the height of

children to help teachers determine the correct dosage when administering drugs were only found in one school (School A). Immunisation, and feeding were not done in all schools (School A, B, C, E and E) except for deworming exercise which was done after five (5) years.

4.1.1 Parents perceptions barriers of the effective implementation of School Health and Nutrition Programme.

4.1.1.1 Respondents were asked what they thought about deworming, feeding and immunization when children were in school.

One question was asked to determine the perceptions of parents towards immunization, deworming, and feeding done in schools to meet the objectives of the programme.

Views from a parent when asked a question. He said that those activities such as *“Administering of drugs to innocent children is evil because us parents we do not know the negative effect of these drugs have on our children, you teachers have never brought this programme to the attention of the community members. Every member in the community remains ignorant of the programme and the activities. You do them privately, .if the community members get knowledge of what you do, they may rise against you, I really feel bad.”* When he was asked that what about if teachers educate you about the programme, would you welcome all the activities of the programme? He said *“Even though, I would remain ignorant because there are so many programmes that we have heard but our children do not benefit, only teachers benefit from these programmes. You will see teachers move from one workshop to another drawing a lot of money.* Another parent was asked have you heard of the feeding exercise taking place in schools, what would you say about this? In response a parent said; *“No, in fact I am poor I cannot allow my child to risk taking food which has no source.”*

The result of the research findings showed that parents had no regard for the programme and the perceptions were negative.

4.1.2 Teacher's/Head teachers' perceptions barriers of School Health and Nutrition Programme.

Two questions were asked to determine where teachers had been making use of health cards and tablet pole or had received deworming and feeding done in schools.

4.1.1.2 Respondents were asked how they were making use of the health cards and the tablet pole to monitor children's growth.

The head teacher said, *"The school received the health cards and tablet poles but teachers did not use them, these health cards and tablet poles had gone missing."* When asked to state the reason why? The head teacher said, *teachers have little knowledge on how to use them and perhaps teachers had wrong perceptions of School Health and Nutrition Programme.*

4.1.1.2 Respondents were still asked what they thought about deworming and feeding at school.

When he was asked to give the general over of the response about deworming, immunization and feeding from teachers. The head teacher said, *"Teachers received these with mixed feelings, few teachers had positive perceptions while many teachers had negative perception of deworming, immunization and feeding"*. The Head teachers revealed that parents together with teachers did not welcome the move taken by Jesus Care Ministry of feeding children with tea and local buns when they were at school. One teacher whispered to his fellow teacher saying, *"Wetataifiyakulyabaleletafili no bwafya"* meaning *that these foods being given to our children have got problems*. The teacher himself said, *'Health cards and tablet poles cannot be found in schools because schools are not hospitals.'* In schools, teachers wrote that health cards and tablets poles were not there. This was done mainly to children at grade one. Teachers were asked the question. How do you perceive School Health and Nutrition Programme? Teachers even reacted more badly than parents. They perceived the programme with negative feelings.

Table 4.1 presents perceptions of parents and teachers towards cleanliness and hygiene. Head teachers and teachers expressed concern about the inadequacy of sanitary facilities making the learning environment very unfriendly to the learners. Table 4.1 presents items and infrastructure needed in schools for effective implementation of the programme. None of the schools mentioned had tools required and put them into good use.

Table 4.2 Water and sanitation facilities in schools

SCHOOL	Source of water			Types. of toilets			Types of toilet cleanser used		No. of times cleaned				No. of toilets				
	B.Hole	Rivers & Streams	Piped	VIP	W/B	Trad.	P/C	DIS	Once	Twice	Thrice	Every Day	Two	three	Four	Ten	Ten &above
A	✓	X	✓	✓	X	X	X	X	X	X	X	✓	X	x	X	X	✓
B	✓	X	X	✓	X	X	X	X	X	X	X	✓	X	x	✓	X	X
C	✓	X	✓	✓	X	X	X	X	X	X	X	✓	X	x	X	✓	X
D	✓	X	X	✓	X	X	X	X	X	X	X	✓	X	x	X	✓	X
E	✓	X	X	✓	X	X	X	X	X	X	X	✓	X	x	X	X	✓

W.B- waterborne PC – powder chlorine Dis- Disinfectant

Source: Field Project data-2017

Table 4.2 also, shows that School (A) and School (C) received water from both piped water and boreholes while the rest three schools which include school B, D and E depended on boreholes. Even though it showed that two schools had piped water, teachers reported that the schools had no money to pay service charges. Water supply had already been cut off making this school also to rely on bore

hole as the only source of water. Among the schools visited, only one school in the peri urban had piped water which was running. School (A, B, C, D and E) had VIPtoilets; none of the schools had water bone toilets. Few schools had ten toilets and above. Cleaning of toilets was done every day without the application of chlorine or disinfectant. Results also showed that during dry season, water reticulations became a source of worry and it became very difficult to clean the toilets which had no water. Since schools visited in the District were found in high risks of water borne diseases, it was considered that provision of adequate clean and safe water supply should be a priority.

4.2.1 Perceptions of Head teachers/teachers toward hygiene and cleanliness in selected primary schools

Two questions were asked to find out the source of water, the flow of water in schools and type of toilets found in schools.

4.2.1.1 The Head teachers and teachers were asked the sources and the flow of water in schools.

4.2.1.2 Views of Head teacher and teachers on the source of water and the flow of water in schools?

Views from the head teachers from schools selected when they were asked the question from questionnaires thus, they gave similar reports thus; *“Water flow in many schools is not adequate, for most schools draw water from boreholes. The government and the non-governmental organizations had initiative to sink one borehole for each school. But water flow from these boreholes is rusty because there had never been any repair ever since they were sunk and these boreholes serve as communal ones. Many people from surrounding areas use the same boreholes. Further, school boreholes being communal, it has become very difficult for any school in the district to set up water points because water flow is very irregular”*.

One head teacher at a certain school reported that *“The school came up with an initiative of getting a small amount of money from the community for maintenance and repair of the borehole. He further went on to say that it is common for most people in Mwense District think boreholes at schools are government property and they cannot pay, they are the government themselves”*.

4.2.1.3 Head teachers and teachers were asked about the type and condition of toilets found in schools.

4.2.1.4 This question was specifically answered by teachers.

Type of toilets found in all schools were VIP but were in a deplorable state and some schools had inadequate number of toilets to cater for the population of the school. Table 4.2 also shows how often each school was cleaning the toilets. A teacher reports on the availability of toilets was that, *“Many schools had inadequate VIP toilets which were not properly maintained. Cleaning of toilets was mainly done without applying any toilet cleanser except for one school. Many toilets were not lockable as a result many passersby use and leave them very dirty.”* A grade seven teacher from school (A) narrated that at one time, *“My school was nearly closed when the environmental technician visited the school and found that sanitation at the school was poor. Learners passed faecal matter all over the place making learning environment very dirty. Here commended that the school be closed. Had it not been for the District Education Board Secretary interventions by urgently organizing teachers to supervise children to clean the toilets the school would have been closed.”*

Teachers from schools (A, BC, D and E) did not carry out physical inspection from head to toes for fear of the community. They thought the community might rise against them with the beliefs vested in them that they might be accused of taking ifishimba (juju or charm) from their children. Schools visited had their glass panes broken in nearly all classrooms and some classrooms block had been abandoned because they were in a dilapidated state making the learning environment very hostile.

4.2.2.5 Parents perceptions towards hygiene and cleanliness in selected primary schools

4.2.3.6 Parents were asked about hygiene and cleanliness in primary schools.

4.2.3.7 Views of Parents on Head teachers and teachers towards water and sanitation in schools.

Views from the parents at schools (A, and E), when interviewed said that it was the duty of the PTA to ensure they work with teachers to improve water and sanitation in schools. One parent who was interviewed from the three Schools (B, C and D) said, *“I’m not a teacher to promote hygiene and cleanliness in schools, teachers are responsible to do so, teachers levy parents if they want to use the school boreholes and parents cannot preside over this matter because teachers do demotivate them. PTA is there to make sure they work with teachers.”*

Roles parents and teachers play towards School Health and Nutrition Programme.

Three questions were asked to establish the roles played by parents and teachers towards School Health and Nutrition Programme. The presentation of findings therefore, begins with the presentation of the figure to establish crops grown as one of the roles of parents.

Parents' roles in the production of varieties of food crops to sustain School Health and Nutrition Programme.

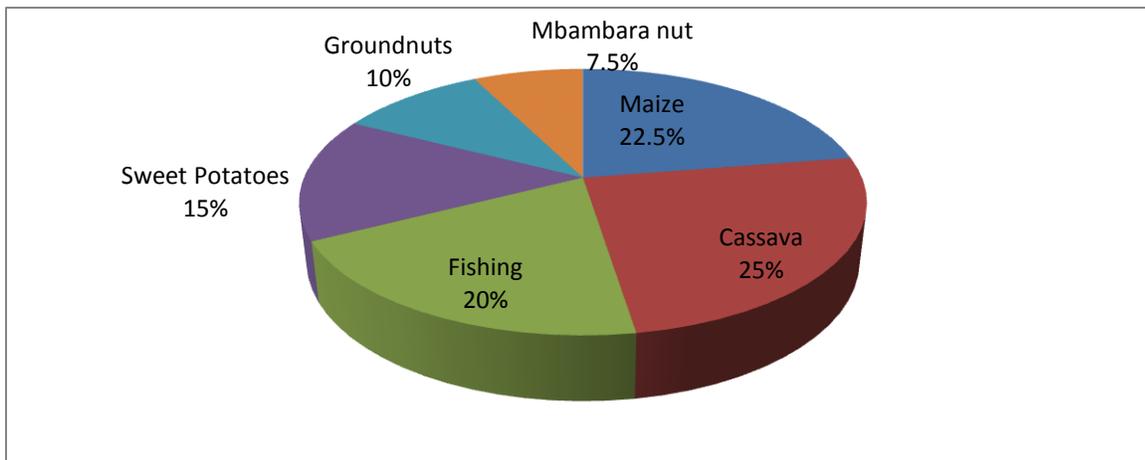


Figure 4.1: Crop distribution grown by parents

Source: Field Project data-2017

Figure 4.1 shows twenty-five percent (25%) of parents grew cassava while twenty percent (20%) engaged in fishing. Twenty-five point five (22.5%) grew maize while ten percent (10%) grew groundnuts. And fifteen percent (15%) grew sweet potatoes while seven point five (7.5%) grew Mbambara nuts. The result shows that many parents engaged themselves in crop production though done on small scale.

4.1.1 Parents roles play in the effective implementation of School Health and Nutrition Programme

4.1.2 Parents were asked about the roles they have in the production of crops to help children receive enough food to increase retention in schools.

4.1.3 Views of Parents on roles they have to support School Health and Nutrition Programme?

Parents said, *“We have engaged ourselves in different activities such as the growing of maize, cassava, sweet potatoes, groundnut and catching of fish. In an effort to boost enrollment rates and ensure that school-age children are well fed in homes where they are coming from.”* When parents were asked to tell the challenges they were facing with maize. Parents said, *“Maize is being grown by few individuals and on small scale because this type of crop is very expensive since it requires proper management. For example, the crop requires fertilizer, a lot of labour and all these need money. Next, application of fertilizer for long period of time destroys soil fertility, so people would rather go for cassava which does not require a lot of farming input, so as a parent I grow cassava.”* Parents had roles to train their children to become fishermen. One parent said in an interview when he was asked to tell the occupation and the benefit he had found, he said: *“I have been a fisherman for so long and this kind of occupation has sustained me for most of my life. I have been able to send my children to school though not as far as tertiary colleges. So I would like my children to take up my talent.”*

Mbambara nuts and ground nuts were among the crops cultivated of the region, parents liked taking them to Lusaka and Copper belt Province where there were ready markets leaving their children alone work for long hours or for many months. A single parent said: *“I have been leaving my children alone, before I leave; I prepare enough food for my children, niwalindawalyanshi meaning if you can't work, will you have anything to eat?”* As a single mother, she could not rest.

4.1.3 Teachers roles in the effective implementation of School Health and Nutrition Programme?

4.1.3.1 Views of teachers on the roles they play to support School Health and Nutrition Programme. A teacher said when he was asked to state his roles thus: *“My roles are to create a conducive learning environment for the learners, work together with parents to ensure our*

learners progress to higher grades, and we possess roles as mothers and fathers when children are in schools, imparting knowledge, inculcate moral values, skills and good attitudes.

A grade 5 teacher at a particular school said especially to parents who left their children unattended to: *“Doing so has caused a lot of problems to children who were left alone without elderly persons to look after them. He had a situation in which a 14 year old girl was Impregnated by her cousin when her parents went out leaving her with sisters and brothers. Another incidence was one of a grade four pupil who was found with HIV/AIDS. The teacher was also asked about the measure she had taken to help these parents to care for their children. He said; “I summoned parents to come to school and advised them on the importance of attending to children rather than leaving them alone.”* He went on to say; *“Children without parental control became too playful and forgot about school. But remember, school absenteeism is a predictor of repetition. Learners who were absent from school missed a lot of lessons and their academic performance was very low. They missed opportunities to learn from their peers. School determines the time spent in learning the intended outcomes. Finishing the syllabus depended on the number of times a child attended classes, so those learners who attended school regularly had a better chance of progressing to higher grades or passing the examinations.”*

In an interview conducted further to a grade one teacher at a certain primary school said: *“Children remain absent from school for a long period of time because parents leave them alone taking up roles as parents to provide themselves with all essential needs.”* It was noted that many parents grew cassava and this was eaten as a staple food of the region. The teacher noted that most children of this area were stunted in height because they always feed on cassava the crop with low nutritional value. One teacher the researcher talked about said; *“Bakalambandedabwa, In my grade 4 class I was expecting my children to be in the range of 11 years to 12 years old but as I checked and marked the class register their ages I found were not matching with their years, abaice aba balitusakumulandu wakalundwe meaning these children are stunted because of feeding on cassava.”* From the analysis, maize was the second important cash crop of the region with high nutritional value though grown on the small scale.

The head teachers were asked to fill in the table in the questionnaire and later on teachers were given questionnaire to answer some questions.

Figure 4.2 presents teachers who took part in the School Health Month July which was held once in a year as one of their roles to discuss the way forward of the programme but the attendance was in variation depicting low turnout.

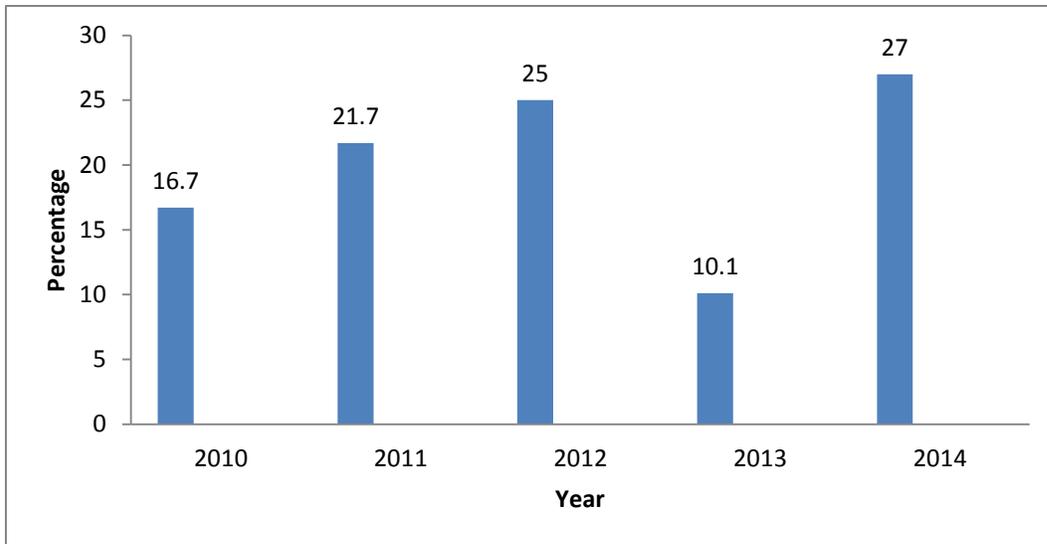


Figure 4.2 showed teachers who participated in School Health Nutrition Month.

Source: Field Project data-2017

Sixteen point seven percent (16.7%) of teachers attended the meeting in 2010 while twenty-one point seven percent (21.7%) of teachers turned up in 2011 while in 2012, twenty-five percent (25%) of teachers showed up. Furthermore, in 2013 ten percent (10%) of teachers took part in the School-health month. Finally, in 2014, twenty-seven percent (27%) of teacher had a chance of attending the meeting.

This result shows that the number of teachers attending the School Health- Month was smaller compared to the number of respondents found at each school.

4.2.1 Roles of Head teachers and teachers in promoting School Health and Nutrition Programme.

4.2.2 Views of teachers on relationship with parents to support the programme.

Teachers who received the questionnaires said that parents felt very inferior to come close to teachers as a result they shun away every meeting that they were called for. These showed that teachers were able to state their roles but they never struggled to follow these roles and apply them. Further, teachers did not want to welcome the responsibilities assigned to them without allowances. In every responsibility they were assigned for, teachers longed for allowances.

Head teachers were asked to fill in the questionnaire on the number of times parents attended the meeting. The table was given to the Head teachers to fill in, later on parents were interviewed (The data was interpreted into the graph)

Figure 4.2 presents the number of parents attending the school health month to fulfill their roles as enshrined in the school health nutrition manual. The attendance of parents had been so low.

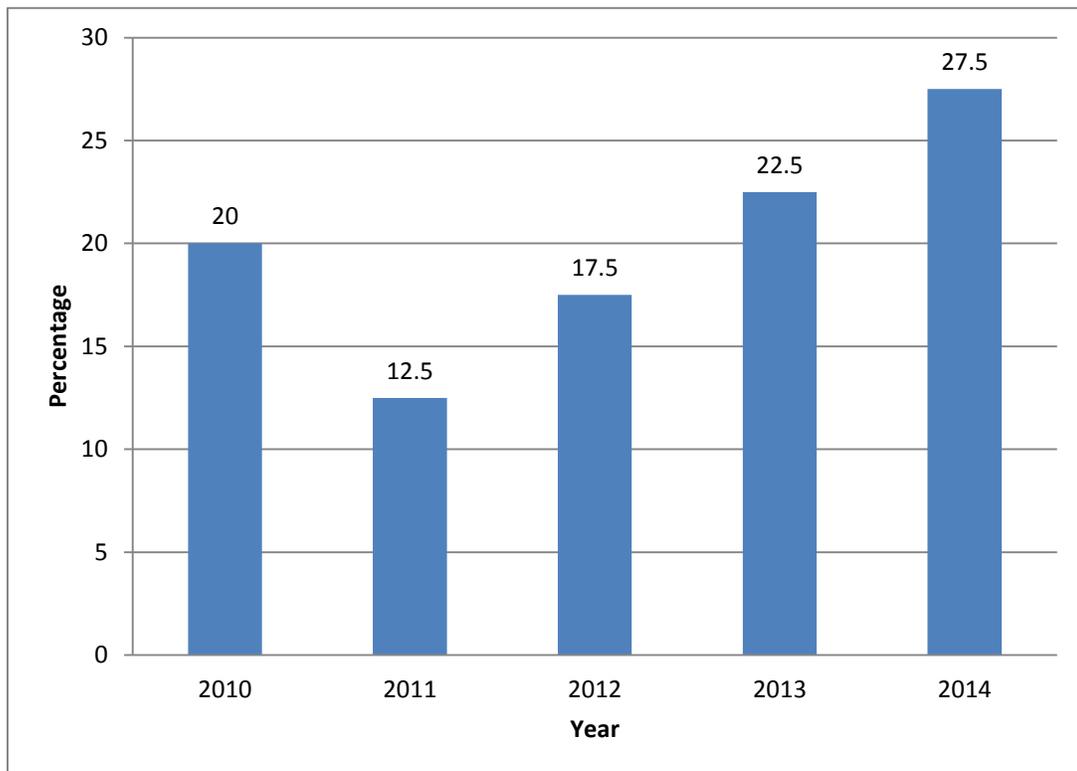


Figure 4.2: Parents turn out during school health month - July

Source: Field Project data-2017

Twenty percent (20%) of the total respondents were present in 2010 while twelve percent (12.5%) of parents attended the event in 2011. In 2012, seventeen point five percent (17.5%) of parents attended the School Health- Month while twenty two point five percent (22.5%) of parents showed up during the School Health-Month. Finally in 2014, twenty seven point five percent (27.5%) of parentstook part.

4.2.1 Roles of parents in promoting School Health and Nutrition Programme

4.2.2 Views of parents on their roles and the relationship they have with teachers

The findings indicated that parents were able to tell the researcher their responsibilities such as to provide children with essential basic needs like water, food, shelter, clothes and to protect them from diseases. It is through meetings that parents were going to enhance knowledge about these essential basic needs but they never fulfilled these roles. Figure 4.2 shows poor attendance from parents an indication that few parents knew their roles. One parent said in an interview that: *“Teachers give us all sorts of names such as ba group one or ba goalkeepers meaning that parents lifestyle was very primitive, some of them had little education while others were completely illiterate. For the said reasons she would neither interact nor associate with teachers.”* From these comments, it seems teachers in most schools where the research was conducted were very proud with the education they have received from schools. The results also showed that few parents and teachers were attending the meetings which were part of their roles.

Attitudes of parents and teachers towards School Health and Nutrition Programmes.

Table 4.3 presents general overview of the response of parents, teachers and head teachers' attitudes towards the programme and it presents a total summary of the attitudes of the respondents in the study. All responded with different views towards the activities. The number of respondents with negative attitude was higher compared to those with positive attitudes.

Table 4.3 Views of Parents and teachers towards School Health and Nutrition Programme.

Parents and Teachers	Not in support (negative)	In support (positive)	Urban/Rural	Total	Percentage (%)
Teachers A	20	13	Rural	33	33
Teachers B	07	04	Peri-urban	11	11
Parents A	25	23	Rural	48	48
Parents B	06	02	Peri-urban	08	08
	58	42		100	100

Source: Field Project data-2017

Regarding the attitudes, teachers were asked if they supported the programme, twenty (20) teachers in school (A) were not in support of School Health and Nutrition Programme (the attitude was negative) while thirteen (13) teachers from rural schools supported School Health and Nutrition Programme meaning that the attitude from teachers (A) towards the programme was positive. The total number of teachers who took part in the study from rural schools of teachers (A) were thirty three (33) and the percentage was thirty-three (33%). Teachers (B) from peri-urban were asked the same question to find out if the attitude towards the programme was negative or positive. Seven (7) teachers were not in support of School Health and Nutrition Programme while four (04) teachers were in support of the programme. The total number of teachers from teacher (B) who took part in the study were eleven (11) and the percentage turn out were eleven percent (11%). Furthermore, twenty-five (25) parents of parents (A) from the rural schools were not in support of the programme while twenty-three (23) parents supported the programme. The total number of parents who took part in the study were forty-eight (48) and the percentage turn out were forty-eight (48%) from rural schools of parents (A). Finally, the same questions to determine the attitudes of parents were asked, six (06) parents of parents (B) from peri-urban were not in support of the programme while two (02) of parents (B) were in support of the programme. The total number of parents (B) who took part in the study was eight

(8) and the percentage turnout was eight (8%). The analysis in the table indicate that there were fifty-eight (58) parents and teachers who were not in support of School Health and Nutrition Programme and forty-two (42) parents and teachers were in support of the programme.

4.3.1 Views of Parents towards the School Health and Nutrition Programme

4.3.2.1 One question was asked to determine parents' attitudes towards School Health and Nutrition Programme.

Views from parents were different when they were interviewed, those parents who were not in support of the programme received this programme with negative attitude. They did not pay much attention to the programme. A parent said, *"I do not have much information about this programme, so I cannot support it"* Another parent from parents (B) said, *" I have been hearing about this programme, this programme encourages and promotes learners to receive medical attention when they are in school, how can teachers administer drugs when in the actual sense they have no knowledge about drugs. Feeding is also done in schools, where do schools get these foods from to feed our children because schools have no production units and I cannot encourage my child to eat food which I do not know the person who is supplying, the world is becoming so sophisticated and we have to be careful with certain programmes."* The negative attitudes were further emanated as a result of the misconceptions of parents that health and nutrition was the responsibility of the Ministry of Health alone.

4.3.3 Teachers and Head teachers' attitudes towards School Health and Nutrition Programme

4.3.3.1 Views of teachers about School Health and Nutrition Programme

The teachers were asked to state their views of School Health and Nutrition Programme. They indicated that the programme was being looked down upon. One of them said, the programme was regarded as one programme which had no bright future for the children. The class teacher had this to write: *"I do not think if this programme will successfully be implemented because those who trained as focal point persons do not take active roles in co-ordinating activities, they were just given allowance and forgot of what they were required of the programme."* Teachers (A) said, *"Since, there had never been proper messages that have reached the communities, a lot*

of bad things had been said about this programme, others said children are initiated into Satanism.” Teachers as well accused administrators that they channelled grants to activities not connected to School Health and Nutrition Programme. Therefore parents and teachers received this programme with negative attitudes.

Challenges and solutions to the effective implementation of School Health and Nutrition Programme

Asked teachers and parents to establish the challenge faced in the implementation of school and Nutrition Programme

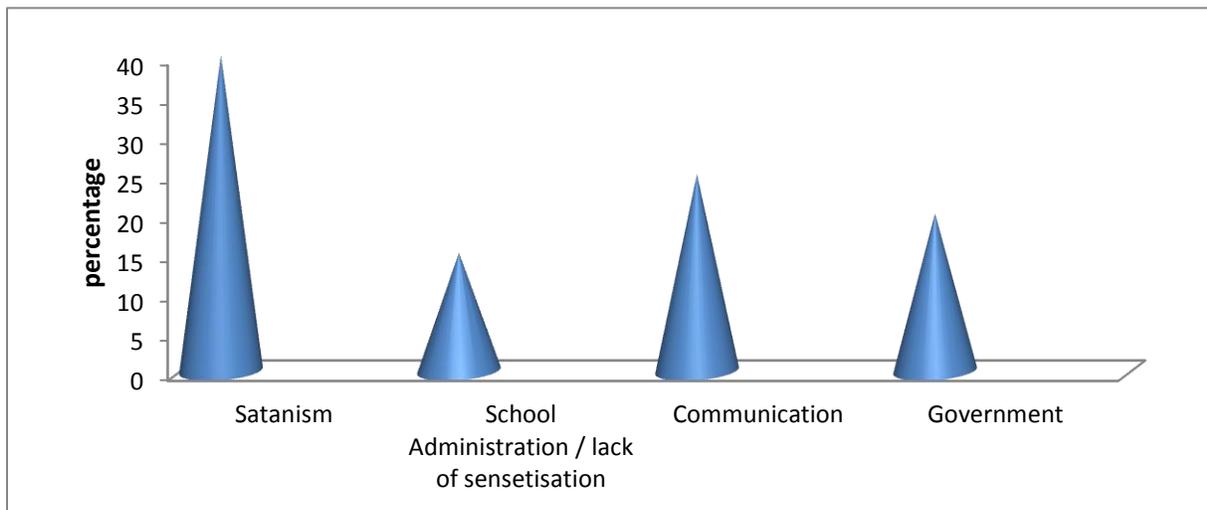


Figure 4.3 Contributing factors on poor performances of SHN

Field project-2017

Figure 4.3 shows the opinions expressed by the total number of respondents for the poor performance of the School Health and Nutrition Programme.

Forty percent (40%) of parents and teachers believed that people who brought this programme practice Satanism and their children could be initiated into such activities and they might end up losing their children to unknown places or be taken to oceans where they would be interacting with Satan. Fifteen percent(15%) of parents and teachers blamed the administration of not taking serious concern to sustain the programme through funding and engaging health workers.

Small grants which were allocated to the programme had been stopped and some head teachers channelled them to other activities not connected to the programme. Twenty percent (20%) of parents and teachers said the government was the leading cause of poor performance because they only introduced this programme and forgot about it. There was too much dependency on donor Aid and when the Donors pulled out of the race, the government also pulled out. While twenty-five percent (25%) of parents and teachers linked the failure due to poor communication. They said those teachers who went for training became very irresponsible with regard to carrying out the message to all communities about the importance of the programme.

4.3.1 Challenges faced when implementing School Health and Nutrition Programme

Under this subject, two questions were asked to establish challenges faced by Head teachers when implementing School Health and Nutrition Programme in selected primary schools of Mwense District.

4.3.2 Views of Head teachers on challenges faced when implementing School Health and Nutrition Programme.

The question sought to find out the main challenges commonly faced by the Head teachers during the implementation of the programme.

Asked on the main challenges they faced when implementing School Health and Nutrition Programme, all the five Head teachers wrote in their questionnaires distributed to them that they faced numerous challenges that included; lack of funds from government to improve water and sanitation in schools, no production units to reverse the consequences of malnutrition among children in primary schools, misunderstanding between parents and teachers, failure by focalpoint persons to effectively co-ordinate the programme and unfounded myths such as belief in Satanism among parents and teachers.

4.3.3 Views of teachers on challenges to the implementation of School Health and Nutrition Programme

Under this heading, three questions were asked to find out the challenges faced by teachers when implementing the programme.

4.3.4. Challenges faced when implementing School Health and Nutrition Programme

The study revealed that teachers faced numerous challenges that demanded immediate intervention from the policy makers and administrators. Areas of major concern included inconsistency in the supply of drugs like praziquantile and mebendazole to treat bilharzia, diarrhea and ringworms among school going children.lack of basic suppliesand clean water; insufficient linkages to local agriculture,and government failing to supply food to enhance School feeding programme in primary schools of MwenseDistrict. Teachers die of HIV/AIDS the implementers and facilitators of the programme. Teachers did not receive training to work as nurses to administer drugs to the school going children. There were no materials received in schools such as textbook in which valuable information was written on theprogramme, poor state of classroom blocks. For example, the class teacher said,

The programme is there to provide a conducive learning environment to the child but you find that children learn in dilapidatedclassrooms, these classroom blocks have no enough desk where children sit. Most schools have poor water and sanitation, for example, quite a good number of toilets are not girl friendly, water born toilets are not found in schoolsyou will find that a girl who has reached puberty stage or is observing her day is shunning away classes but the policy of the programme states that the programme is there to support the girl friendly environment.The other challenge was that the toilets were not conducive enough, there were not lockable, because passersby made them very dirty.Over enrolment in classes is also a factor of the conducive learning environment. The other problem was lack of attention given to the programme by Head teachers and teachers.

The teachers who attended the workshop when theprogramme was launched had this to write, *“The challenges that is there is that ever since the programme was launched there had never been several measures that had been put in place to ensure theprogramme is well co-ordinate as expected.”*

4.3.5Views of parents on challenges to the implementation of school Health and Nutrition Programme in primary schools

Two questions were asked in order for parents to give responses.

4.3.6 Challenges parents face when implementing the programme

A diversity of perceptions from previous research has been raised on barriers that are perceived to deter parents from taking active roles to ensure School Health and Nutrition Programme

succeeds. In response, parents gave varied responses when being interviewed and this is what was said by the parents, *“School Health and Nutrition Programme could be effectively implemented if those involved as stakeholders knew its advantages and disadvantages, for example some parents do not even know the meaning of the programme. Furthermore, the programme can take shape if the all people to whom the programme was introduced to were literate enough to welcome this move. But with this case, some communities have low literacy level as a result they could have wrong perceptions of the programme. This was the reason a lot of unfounded myths such as initiating their children into Satanism are attached to the programme. Despite having little knowledge, some parents did not allow the indoor residential spray of their houses, the government goals to eliminate malaria by the 2021.”*

The observation made during the study was that the school had challenges which were as outlined below.

Challenges faced when implementing School Health and Nutrition Programme

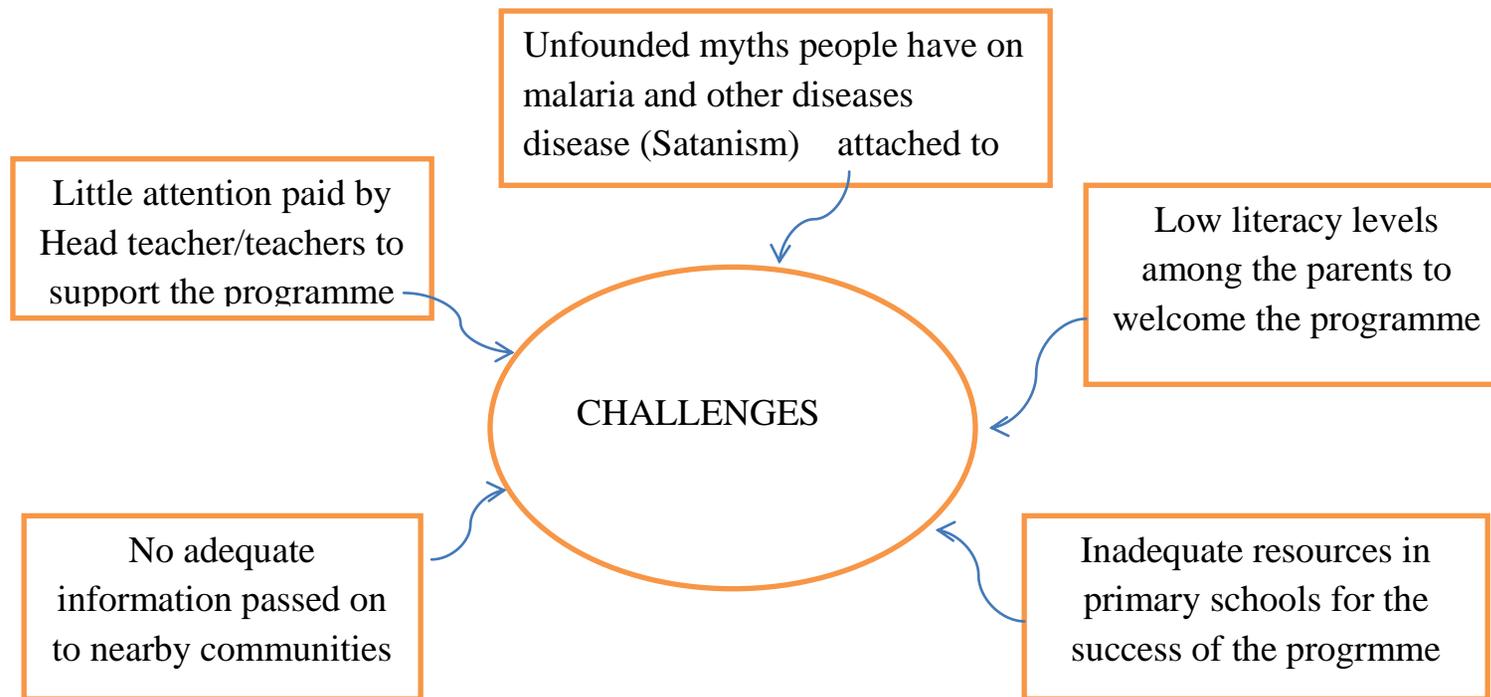


Figure 4.4: The figure tries to illustrate challenges faced when implementing School Health and Nutrition Programme

Source: Field work data, 2017

This figure illustrates some of the factors that inhibit the proper implementation of School Health and Nutrition Programme in Mwense District.

4.5. Summary

This chapter has presented the findings of the study in line with the research objectives. The study found out that School Health and Nutrition Programme plays an important role in promoting learner academic performance. However, the programme had not been fully implemented in Mwense District due to the number of factors that the programme had passed through. For example, health cards and tablet poles to monitor children's growth were not found in schools. In the case of health cards, some of these tools were just eaten by termites and some schools had just piled them in shelves without working their intended purposes. There were myths attached to immunization, feeding and deworming which were introduced to keep learners healthy in schools. There were no safe water and enough sanitary facilities to keep the learning environment conducive for learners. The roles of parents and teachers to sustain the programme through production of food crops both in schools and communities were somehow not given much attention. The attendance of teachers and parents at the meetings during the School Health Month was in most of the time very low. Due to the number of challenges listed, it was concluded that parents and teachers did not fully understand the meaning of School Health and Nutrition Programme. The literacy levels of parents were very low to understand the importance of the programme. Hence, the perceptions of parents and teachers towards School Health and Nutrition Programme were negative.

CHAPTER FIVE

DISCUSSION OF RESEARCH FINDINGS

5.0 Overview

This chapter discusses the findings of the study. This is done using objectives thus to; determine perceptions of parents and teachers towards School Health and Nutrition programme, establish the roles of parents and teachers, determine the perceptions and establish the challenges to the effective implementation of the program e.

5.1 Objective 1: Perceptions of parents and teachers towards School Health and Nutrition programme in selected primary school of Mwense district.

The first research objective was to determine the perceptions of parents and teachers towards School Health and Nutrition program .

The study found that parents and teachers held different perceptions about the programme. Few parents and teachers were more concerned about the health and nutrition status of children while the majority of the respondents had negative perceptions. Schools received the health cards and tablet poles to monitor children growth. This was to ensure that learners were healthy when they were attending classes. The study revealed that some of these schools had health cards eaten by termites and in some schools health cards and tablet poles were not found. Head teachers and teachers accepted that when teachers were sent to attend the workshop, they came with these tools. Teachers and Head teachers were responsible to take stock of these tools have proper records of them. This was in line with Kulbir (1996) who explained that the Head teacher holds a key position in the administrative network of the school. He is the hub of the school activity; all the things demand his attention and all persons look at him for guidance and inspiration. Furthermore, Longwe (1997) states that the Head teacher is responsible for providing management services and could interpret and implement the policies in the school. It was the responsibility of the head teachers under the supervision of head teachers to ensure that teachers took stock of all equipments and materials received in schools. From the study, head teachers and teachers were not responsible with tools and materials received in schools. The head teachers and teachers were the key players to account for all equipments that government send to all

schools. When negligence of this nature is shown, a chargeable offence may be given because they are responsible to interpret and implement policies in schools.

The School Health and Nutrition Programme focuses on the health and nutrition status of children. Health and nutrition is improved through feeding; drug administration and immunization. According to Young (1985), the Zambian Government prioritised health and nutrition as a cross curricular theme with a view to putting health and nutrition as key factors that promote growth and psychological well-being of children which teachers and parents needed to embrace. However, from the research findings, schools worked hand in hand with the Ministry of Health to ensure drugs were made available in schools and deworming exercise were done at greater intervals. Despite parents and teachers had little information about drug administration, myths were attached to these activities. Foods to enhance feeding when children were in class were not found but the school health policy stated that schools shall be supplied with food. Each and every school store vamps production units to supplement foods in schools. Because in rural communities, parents live in absolute poverty and they could not afford to give their children meals in a day. In other homes, parents had insufficient foods to provide their children with 3 meals or more in a day. This was the reason why School Health and Nutrition Programme was introduced in schools of Mwenze District. In relation, similar research work has therefore, been done to determine the perception of a child towards certain object. For example, Brown and Goodman (1974) showed different coins to children coming from a well to do families and asked them about the size of those coins. These children were able to retrieve the information from memory fast and recognized the size of the coin. Further results showed that children from poor background (Poverty) consistently perceived those coins as much larger than estimated group. Later on, Carter and Scholmer took up a well-designed and follow up of the study conducted by Brown and Goodman and found that children from poor families on the basis of memory alone perceived coins as being larger than did the children coming from rich families. Children from poor families are more likely to be chronically ill and die of hunger than children from well to do families. The academic performance of learners is generally poor when they are in class.

The study revealed that parents had wrong perceptions of the idea of immunization, drug administration and feeding thinking injections and deworming could pose a threat to their children. For example, barrenness, impotency might occur in their children and at the same time

children could be initiated into Satanism. MOE (2002) alluded that there were some romour mongers who perpetuated that the School Health and Nutrition Programme was there to abdict children to unknown places where parents cannot go. If teachers and parents have no enough information on certain programmes, little attention is paid and the programme cannot stand. Furthermore, communities really live in absolute poverty and even those in formal sector complain of not getting enough salaries or wages to buy essential commodity to support their families. Children leave home to schools without eating anything.

The government of Zambia has embraced the keep Zambia clean campaign, so every person in Mwense District has that obligation to ensure a place where he is living in is ever clean. Perceptions from people towards this campaign have been so poor that garbage dumping, passing of urine and faecal matters in public places are the things of the day resulting in cholera outbreak in towns and rural areas of the district. Kochhar (2011) in his book, said that in the widest sense, health education is the very foundation of a successful public health and nutrition programme. A great deal of ill-health is the result of ignorance of simple roles of hygiene or the inability to public application of such roles.

In many schools, it was found that teachers did not assist children to understand about cleanliness and hygiene. Even in homes, parents did not show concern to train their young one to cultivate that spirit of oneness towards hygiene and cleanliness. The study revealed that many teachers found it too hard to supervise their learners to keep their surroundings clean because of parents from homes do not teach children this value. But teachers and head teachers have greater task to educate parents and school going children about the importance of hygiene and cleanliness. In the school community, the head teacher has that responsibility to make sure that the school has availability of water, enough toilets and enough disinfectant to create and promote learning. Schools which have no such kind of facilities do not support effective learning. The responsibilities of the headteachers and teachers are to ensure schools promote hygiene and cleanliness. Curzon (1997) reminds teachers that they have tasks of creating a conducive learning environment for the learners and increase their curiosity to learn. Furthermore, Longwe (1997) states that the Head teacher is responsible for providing management services and interprets and implement the policies in the school. Parents, teachers and head teachers have powers to make the learning environment conducive. Conducive learning environment is created if head teachers and teachers adhere to the findings of MOE (2007) which says therefore, that a health

environment promotes positive perceptions, behaviours and change lifestyles in a child. The head teachers complained of not receiving enough funds in most primary schools to either build sanitary facilities or purchase materials for cleaning. They found too difficult to create a conducive learning environment for the learners. Stub (2000), expressed the need for positive perceptions and showed that limited resources are a barriers to learning therefore creating hostile environment. Primary schools receive inadequate funds. Fund raising ventures had been abolished in schools. Schools rely on grants from government as a result administrator finds it difficult to implement programmes.

The study as well found that there were poor water supply and schools relied on boreholes. Water flows from these boreholes were poor and rusty. The finding was in line with, Kaluba and Mwale (1992) who said that many schools had no safe drinking water and good sanitation facilities and these promote unhygienic condition resulting in heavy burden of waterborne diseases. Cholera outbreak in Mwenze District inhibits learning because schools remain closed for many months. If schools close, children remain home, they do not receive much instructions compared to their friends who are learning. In this way, children's performance become poor and the moral of learning cools off because children stay away from school for longer period of time. Furthermore, the findings were that parents and teachers had poor perceptions by viewing the School Health and Nutrition Programme with little impact on the children academic performance. On the contrary, Mwanamwenda (1997) noted that some programmes help learners to develop mental capacity, engage them in thinking, reasoning, interpretation, understanding, knowledge acquisition, remembering, organizing information, analysis and problem solving. The views on this matter indicated that parents and teachers were not doing what was expected of them. They were not moving together with what was contained in the school health policy. It seems concentration was more on academic performance of their children than on hygiene and cleanliness. What parents and teachers ought to know is that a child cannot concentrate in class when the health is poor. When the health of the child is poor, knowledge acquisition, critical thinking and decision making in a child shall also be poor.

5.2 Objective 2: Establish the roles that parents and teachers play to the effective implementation of School Health and Nutrition programme.

The second objective was to establish roles that parents and teachers could play towards effective implementation of School Health and Nutrition Programme.

From the research findings, most of the parents engaged themselves in peasant farming; they grew cassava, groundnuts, maize, sweet potatoes, Mbambara nuts and others engaged themselves in fish farming. This was done on peasant farming. This indicated that, the roles of parents and teachers deferred from community to community and from place to place. Some parents were fishermen and they had roles to train their children to be fishermen and farmers did the same. Teachers also did the same, some of them wanted to take up their talents. The said findings coupled with Snelson (1974) in his book, the youngboys would accompany his father on hunting expedition with a view to become hunters and to the girls they spent much of their time with mothers, aunts and grandmothers doing domestic work. Wildaf (1981) as well added that girls still carried out their domestic chores that interfere with their schooling and these resulted in girls beginning to dropping out of school. Parents have greater influence on the well-being of the child, when a parent has no interest in education, the child shall have no interest in education as well. A similar incident happened, when a child who was trained by the father in fishing refused to be sent school. The son got married and died without receiving any formal education.

Further findings indicated that parents traded in groundnuts and Mbambaranuts; they went out for some months to sell them leaving their children living by themselves taking up their roles as parents. Leaving children who have reached puberty stage alone without any elderly person to look after them, children tended to enter into immoral conducts.

The study revealed that taking up roles as parents was not an easy task to carry, girls did not withstand the pressure mounted on them and at the tender age they got pregnancies. To the young boys they dropped out of school and they ended up contracting AIDS. From the study, it is clear that parents should be well informed that during the transition from childhood to adolescence, both girls and boys experience rapid physical and physiological changes in their bodies. Various researches have been carried out among adolescents in schools of Zambia. Among the notable studies include those which were undertaken by (MOH, 2008). The main focus of these studies was to find out the prevalence of the problem of high sexual activity

among the adolescents. Parrinder (1974) as well pointed that puberty is the great transition between childhood and physical maturity, and is therefore an occasion for considerable ritual. The essential principle throughout is to make the child into adult, a full person, and to introduce him or her to sex life. A common understanding is that adolescents are persons with the ages from twelve to eighteen. These ages are considered to be sexually active and prone to risks of getting sexually transmitting infections like HIV/AIDS. Sensitization on the danger of HIV/AIDS is only effective if people tasked to do the work, preach on abstinence and condom use but all these have little impact unless parents change their attitude of not leaving their children unattended to. It is evident that many children in Zambia are not enjoying the freedom they deserve. They are living unhappy life and some parents abandon their children. Kelly (1999) quoted in Sampa and Chitalu(1999) explaining that many children are missing out type of healthy, happy and caring upbringing that Zambia and other members of the world community have pledged to fundamental human rights of the child.

The studies given above relate to the findings on the incidence of high sexuality that has contributed to the high dropout rate in Mwense and elsewhere. The other study which was undertaken was that of Tembo(2002) whose findings were that there was a high incidence of abortions among school girls. The findings were based on the data obtained from the University Teaching Hospital in Lusaka which conform to the researches that have been done in Mwense district. Hence, high school dropout rates in Mwense can be reduced through School Health and Nutrition Programme because the programme tries to educate children on abstinence of casual sex. Parents should take up their roles with proper care. For example, working to distant places, spending number of days leaving children alone is a serious issue which parents need to think about it.

The study found that the roles of parents and teachers were to create a conducive learning environment for learners, impart knowledge of cleanliness and hygiene, parents to provide food to school going children to make them stay longer in school, protect children from diseases, work together to ensure children excel in their education and teachers to possess roles of a mother when children were in school. These roles could only be enhanced when parents and teachers meet together to discuss issues concerning the welfare of children. This finding was in line with (Kelly, 1974) who stressed that if parents and teachers relationship is poor, the child

suffers. When parents and teachers pass mutual cooperation of the roles they could play in the education of the child, opportunities for development increase.

According to the policy of School Health and Nutrition programme, parents and teachers should come up with priorities and formulate the objectives that would enable them facilitate the effective implementation of the programme. This was done through meeting as one of the vital roles in the management of the School Health and Nutrition Programme. The research findings were that attendance of parents and teachers who were participating in the activities during the school health month from the period of 2010 – 2014 had been very poor. The attendance had been very low in each school compared to the population of parents and teachers in the surrounding area. From this finding the percentage attendance varied from year to year with few parents attending the meetings. The percentage had been always below 50 percent, the respondents had always been very negative of the programme. In order to promote and facilitate effective learning in the school environment, parents, teachers and head teachers should remember the findings of Ezewu (1994) in his remarks who noted that every parent, the mother as well as the father should imitate an organ of human body, the way it functions with different purposes, but all perform as one body. When parents and teachers work together, there could be excellence in the performance of the programme. Not only in July but also in ordinary days, teachers were supposed to meet with parents to discuss the matters affecting schools programmes. Further researches correlated with Kelly (1974) who noted that a parent visit brings new knowledge about the learner and parents are better able to assist the school to the fullest. It is through sports day, prize distribution, variety show, educations, trade fair, and independence in which the teacher can pass knowledge on the new programme including the school health and nutrition programme. Teachers must invite competent and intelligent parents to come and speak to the learners on the importance of certain newly introduced programme. From the research findings, these activities did not take place, launching of the programme became very irregular.

There is need for parents and teachers to enhance their roles. Highlighting the need for the roles of parents and teachers, Campbell (1992:3) wrote, “ultimate responsibility for creating harmony between the school and the home rest with the principal. When harmony is created among parents and teachers, health and nutrition status shall be restored and children will actively and

positively participate in the learning process. Parents would have ideas of how their children were getting on and it would have helped the teachers to clear up with parents any misunderstandings that might be there. Teachers and parents work together to fulfill their roles. Parents are being urged to visit schools and talk to teachers, about their children's work. Annie and Peter (2004) pointed out that parents and grandparents are champions of the school to work towards the common mission where community resources enrich the school curriculum and provide support to the staff. An institution could be effectively managed if teachers involve parents; no school can run smoothly without the involvement of parent. Every person in a society is very important. We all depend on one another.

Parents and teachers were the key players in the effective implementation of the programme. Castle (1971) noted that teachers must be aware of this because these modern changes affect the lives of the children they teach. But the needs of young children remain the same they must be rightly feel very secure and feel they are loved by their parents and their parents exists it to protect and guide them. Peterson (1976) in contrast suggests that, to understand how aggressive behaviour develops, one must view the family as a social system in which all members influence each other reciprocally.

School Health and Nutrition programme always promote and facilitates children's health in order to receive quality education. Hence, education should focus mainly on the Child's own interests, experience and needs. Castle (1974) quoted in Russian or Naturalist philosopher when he talked about the roles of the teacher as the teacher is portrayed as the gardener in the analogy of the child and the plant. The teacher provides the resources for learning for the child to choose and explore. Therefore the teacher also more especially the Headteacher is to bring together learners, parents and teachers together. The school is the big community which should be presented by the parents. The teacher has been said to be the moderator and the councilor who assist parents to understand certain programmes which are introduced in schools. Teachers must invite competent and intelligent parents to come and speak to the learners on the importance of certain newly introduced programme. The research on the second objective conclude that there had been negative roles in the sense that there were no mutual understanding among parents, teachers and the school authority attendance, from the key stakeholders during the school health month, even in ordinary days had been poor.

5.3 Attitude of parents and teachers towards School Health and Nutrition programme in relation to learner performance.

The third objective was to determine the attitudes of parents and teachers towards school health and nutrition programme in relation to learner performances.

Research on attitudes on education seems to give different results in different countries and people with different background. Hence, the study found that there had been positive and negative attitudes among the respondents. (MOE, 2007) further added that the poor performance of School Health and Nutrition Programme was the misconception of parents and teachers that health and nutrition was the responsibility of Ministry of Health alone and these have attracted many people to respond with negative attitude towards any form of treatment that was done in schools. In connection with this observation Mangal (2006) and Kulbur (2006) found that likes and dislikes, interests and attitudes, social distance and prejudice of the people may have an impact on the success or failure of the programme in turn affects the performance of the child. Zambia Association for Research and Development (ZARD, 1995) concerning the welfare of a girl child expressed concern that the attitudes that some education institutions give, School curriculum and career guidance accorded to boys more and better prospects. In such situations girls acquire attitudes and aspirations which gave them best second place. An inferior treatment was very often to girls and put them last, hence undermining them. A single parent narrated that he was in the habit of forcing his daughter to enter into marriage not knowing that the child were being deprived of their rights to education. These reservations made by parents show that parents had negative attitudes towards the girl child. School Health and Nutrition Programme supports both girl child and a boy child to receive education but in areas where they have no regard for education, they would like their child to enter into marriage rather than sending the child to school.

The head teacher from the rural school said: "The parents in that area had attitudes of advising their children not to accept any form of treatment done at school or sharing any portion of food with their friends when they are in school. He further went on to say that he witnessed an incident in which his fellow teacher was accused of poisoning the child by giving her food when her parents were away from home.

The research findings were that the majority of respondents expressed accepting the negative attitudes with any activity located within the School Health and Nutrition Programme. Parents and teachers said that they would continue receiving the programme with negative perceptions or negative attitudes because several activities within the programme had no source and might lead to children be initiated into Satanism and be abducted and taken elsewhere. This was in line with (MOE, 2002) who expressed concern about the rumours that were perpetuated that children to undergo medical examinations might expose them to HIV/AIDS and blood samples being taken outside the country for private scientific investigations.

Attitudes play a big role in determining the success or failure of any programme, if somebody acquires the positive attitudes or perceptions that there is no Satanism, and then she or he will live with no psychological effect. According to Kerlinger (1984) attitudes are enduring and organized structures of social beliefs and predispose individuals to think, feel, perceive and behave selectively towards referent or cognitive or objects. Regarding attitudes, Kalabula (1991:21) argues that; "Attitudes are not immutable, they often change and new ones develop as individuals mature and widen their experiences in life." Because of different experiences parents and teachers have gone through, their attitudes may not be the same as they were sometime back. Furthermore, Kerlinger (1984) claimed that some people's attitudes are generally conservative (traditionally) who are too rigid to adapt to any change while other people's attitudes are liberal (progressive) meaning that they can accept any change in relation to education. Since parents and teachers did not fully understand the meaning of School Health and Nutrition Programme, they did not want to pay attention as a result they had a negative attitudes towards the programme.

Positive attitude makes anyone to succeed and the poor attitude is responsible for all the misery people pass through. In another words, the researcher could conclude that parents' and teachers' poor attitude inhibited the effective implementation of the programme. Bandura (1973) supported that children acquire certain attitudes either positive or negative by observing others and doing as they do. Attitudes can be said to be the determinant factor to the success or failure of any activity. People strive to venture into business and succeed when their attitudes are positive but when they fail; it means they had a negative attitude to say that they cannot run a business.

Poor attitude is responsible for all the misery that children might pass through. Therefore, from the general overview of the research findings, parents and teachers did not want their children to succumb to any form of treatment and feeding done when they were in school, they were

reacting with negative response towards those activities hence, making the programme very unsuccessful.

5.4 Challenges and solutions to the effective implementation of the programme.

The Fourth objective was to find out the challenges to the implementation of the programme.

A change in perceptions of people determines the success or failure of any newly introduced programme in school. Little knowledge of the programme also affects the performances in the effective implementation of the programme in turn affect learner academic performance. If people were able to acknowledge the importance of health and nutrition, then there could be no problems faced in the implementation of School Health and Nutrition Programme in schools of Mwense District. But there had been the knowledge gap in health and nutrition that affected the children healthy.

According to the research findings, there had been a big challenge in the effective implementation of the programme. Evidence from the study had clearly shown that the majority of people from Mwense District had negative perceptions towards the programme. There respondents especially parents believed that the School Health and Nutrition Programme was associated with Satanism in which many children were initiated. Parents and some teachers revealed that they did not want their children to be initiated in the unknown activities that were being introduced in schools. This showed that parents and teachers did not know the meaning of School Health and Nutrition Programme and its relevance. This was an indication that the teachers responsible to coordinate the School Health and Nutrition Programme did not pass on information to the people about the ways the programme operated. This was in line with Fantan and Weinstein (1968) who said that the numerous studies done examined by comparing between the degrees of schooling of parents and their children. Further Barton et al (1974) explains that the social economic classes differ in how much they encourage psychological independence and foster individual thinking related to academic success. Before introducing any activity or programme in an area, you need to know the area first, people's traditions and custom, their education background and assess whether people shall develop interest in your activity or not.

Further findings indicated that the wider community believes in witchcraft suspicion and it is very difficult to educate them about negative effect these have on their children. Parrinder (1974) denoted that when somebody is possessed with demons, European contracts it is malaria but African have got their own way of handling issues. No wonder why people in the area did not pay

attention to any newly introduced programme. Many people in Mwense District think on those lines because of low literacy among the community members. The effect of malaria was evident among the challenge that deterred the effective implementation of the programme. When reading from “A statistical analysis report of MOH (2008), revealed that in 2008, 3.2 million cases of malaria was reported countrywide with 3,871 deaths. The annual malaria incident was estimated at 252 cases per 1000 population in 2008, there was a fair dropping from 358 cases per 1,000 populations in 2007. Malaria case accounts for up to 40 percent of all infant mortality and 20 percent poses social and economic burden on communities living in endemic areas.” These statistics were a true reflection that malaria cases are high in Zambian districts especially Mwense District. The area is infested with Black mosquitoes which are extremely dangerous to health.” Ministry of health had put preventive measures of distributing mosquito nets. People sleeping in housing units, which have been sprayed with insecticides through the indoor residual spraying campaign but there had been adverse report that people did not their houses be sprayed due to unfounded myths attached. Mosquito nets had been turned into fishing nets by people living in the area where the main occupation is fishing. Spraying has been believed to have been increasing the spread of mosquitoes instead of eradicating them.

The founded strategies had benefits to the people of Mwense when putting them into practices. But the findings were that surprisingly, when parents were being interviewed, the responses were that some parents in homes did not allow the health workers to spray their homes. Children in homes did not sleep under mosquito nets. To children coming from homes where parents were fishermen, those nets which were distributed to every housing unit had been turned into fishing nets. At school, many parents forbade children to receive prevention tablets and only few children from schools were given prevention medicine. Many children were running away meaning that few parents and children had positive perceptions towards to the programme. But the rest of the residents of Mwense were reacting with negative perceptions towards the strategies of preventive measures.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Overview

The research was carried out principally to determine the perceptions of parents and teachers towards the School Health and Nutrition programmes. This chapter concluded the study and also presented recommendations based on the key findings of the study.

6.1 Conclusions

School Health and Nutrition Programme focus much on the home background environment of a learner as well as school related factors. However, the meaning of School Health and Nutrition Programme is not fully understood by the school staff and parents. Because School Health and Nutrition Programme is not fully understood, it is not given due attention; other pressing matters like providing for the family take centre stage. Single parent homes are a factor to understanding School Health and Nutrition Programme. Level of education of the community in Mwense District (illiteracy) is a factor to understanding and effecting School Health and Nutrition Programme. Communities in Mwense District do not understand the importance of the programme therefore cannot pass on this information to their offspring. In view of the listed factors, the Zambian government through the Ministry of General Education recognized healthy as key driver to the education of the child. While the Ministry of General Education had expressed its willingness to effectively address the issue of hunger and disease burden in Mwense District which interfered with learners' academic performance, there were still serious challenges the government of Zambia had faced in the effective implementation of the programme. Parents and teachers belief in Satanism had been identified as one among the major factors that had inhibited effective implementation of School Health and Nutrition Programme in the area. There were other factors connected to unsuccessful implementation of the programme such as parents and teachers discouraging their children from receiving any form of treatment and food supplement done in schools. The initiative taken by government to introduce School Health and Nutrition Programme was inhibited by parents and teachers negative perceptions of accusing the school authority of deviating a small amount of money disbursed to schools to activities not connected to the School Health and Nutrition activities. Insufficient funds in primary schools and government failure to fund the programme had been among factors that had hampered the

effective implementation of the School Health and Nutrition Programme. Furthermore, poor sanitation and water supply in schools were barriers as well.

Therefore, the findings of this study concluded that the perceptions of teachers and parents' towards School Health and Nutrition Programme were negative as it was seen as one programme that initiates children into Satanism which hitherto is unfounded myth. Negative perceptions emanated as a result of parents and teachers not understanding fully the meaning of School Health and Nutrition Programme.

6.2 Recommendations

In line with the study objectives and on the basis of the findings, the researcher recommended the following basing on the change in perceptions of parents and teachers.

6.2.1 Recommendations to policy makers

- Before the introduction of any new programme in schools, the perceptions or attitudes of parents from the wider communities and teachers must be assessed and determined so that the policy makers can gauge in advance to know whether the programme will succeed or fail.
- The government should allocate enough funds in primary schools to help Head teachers and teachers to practically implement programmes which are beneficial to learners and the community at large if funds are not available.

Government through the Ministry of General Education, to improve on water and sanitation facilities in primary.

- The uses of Indian Mark II hand-operated bore-hole pumps or other suitable alternative which are relatively cheap to be sunk down in schools to any reduce the problems of irregular supply of water in schools.
- School authority to formulate School Health and Nutrition policy guidelines and distribute them to stakeholders to gain administrative support for School Health and Nutrition implementation.

6.2.2 Recommendations to Head teachers

- Head teachers, should work together with teachers to sensitize the community on the importance of health and nutrition and help people remove cultural barriers and

traditional beliefs that can be detrimental to the effective implementation of the programme.

- Increase good relationship between teachers and parents. Head teachers and teachers to enhance school health month- July so that learners are de-wormed and immunized. This is to ensure children stay very healthy.
- Schools to chlorinate water fetched from boreholes, rivers and shallow wells.
- School administrators to purchase disinfectant to apply when cleaning pit latrines in school. Dust bins to be placed at accessible points. Walls of toilets to be cared for and classes to be given in turn duty of seeing that they are always clean.
- Through fundraising activities, schools to revamp production units and build tuck shops to be stocked with foods.
- The school health and nutrition should not be regarded as a cross cutting issue but it should be imbedded in the curriculum so that it comes out as a subject on its own.
- The school to have income generating activities such as school market days opens days, drama and civilian days. Civilian days work well in schools where learners wear school uniforms.
- Provide clean water, adequate toilets, and hand washing facilities in schools.

6.2.3 Recommendations to teachers

- Teachers to advise children not to buy food sold by vendors in the street because these food stuffs are often laden with dust which is harmful to their health. The school tuck shop should always be kept clean and carefully supervised.
- Teachers to inculcate in learners the spirit of sense of belonging to reduce vandalism in schools. Health rules to be tightened through the use of rhymes and stories taught should bring out moral values that cleanliness is next to Godliness.
- Teachers to teach children sexuality and health reproductive to ensure children abstain from casual sex which can harm them.
- Classroom teachers to create school health and nutrition corner, use of pictures on the walls, illustrating washing of bodies, hand washing, cleaning of the teeth and so forth.

- Teachers to visit homes of children who are reported sick have a bearing upon the emotional health of their learners and conveys to their learners attitudes of cheerfulness, enthusiasm friendliness and fairness.
- Ensure teachers carry out physical examination before children enter their classes.
- Enforce immunization as a pre-requisite for school enrolment.
- Provide consistent health education.
- Revamp school production units to support school nutrition.

6.2.4 Recommendations to parents

- Parents Teachers Association to encourage parents to prepare breakfast for learners before coming to school.
- Parents Teachers Association to work with teachers to change their mental attitudes towards the growing of different kind of crops that may help children to grow health .
- Parents pay a small fee to the school boards to have people to cook food for learners while they are at school.
- The school health and nutrition should not be regarded as a cross cutting issues but it should be imbedded in the curriculum so that it comes out as a subject on its own

Recommendation for future research

Owing to the vast nature of the topic studied, one would wonder to deal extensively and conclusively with it as simple studysuch as this one. Hence, several aspects of the effective implementation of School Health and Nutrition were not completely covered. To this effect the following should be considered for future research: Further studies are needed to develop further educational interventions for parents and teachers to improve their knowledge and attitudes towards School Health and Nutrition Programme, which will eventually improve their understanding of the programme. Parents be acquainted with more information in order to dispel assertions that the programme is linked with Satanism and this will bring about a change in perceptions.

REFERENCES

- Annie, B. and Peter, G. (2004), Family and Nutrition Guide, Rome: FAO.
- Annie, E. T. and Neal, G. (1976), Involvement of Parents in School Affair: The sex factor and the School Management, Newyork: Longman Limited.
- Annual Health Statistical Bulletin (2008), Action to improve health, Lusaka, Zambia.
- Aries, P. (1962), Centuries of Childhood, Alfred:Aknoplfy limited.
- Adelman S, Alderman H, Gilligan DO, Lehrer K.(2008). The impact of alternative food for education programs on learning achievement and cognitive development in NorthernUganda. International Food Policy Research Institute, Washington DC.
- Bandura, A. (1973), Aggression: A social learning analysis, Englewood Cliffs: NP Prentice Hall.
- Barton, K. (1974), Childrearing Practices and Achievement in School. Journal of genetic Psychology, 124:155-154,165.
- Bauch, P. (1997), Education for development: An attitude that Influences learning, Oxford: Oxford University Press.
- Becker, W.C. (1984),Parents and Teachers Campaign, London: Research press.
- Best, J.W. and Khan, J.V (2008), Research in Education 10thed, New Delhi: Prentice Hall.
- Beverly, Y. and Susan, D. (1987),Primary Health Education: Methodology for Health, St.Upheld: Adson Wesley Ltd.
- Bishop, G. (1989), Alternative Strategies for Education, London: Macmillan.
- Black J.M. (2006), Medical Surgical Nursing, 6thed.Philadelphia: Elsevier Mosby:
- Brink, H. (1996), Fundamental of Research Methodology for Health Care Professionals. Cape Town: Juta& Company Ltd.
- Brown, R. and Goodman, C. (1974), The Childs Grammar from 1 to iii, in Minnesota Symposia on Child Development, Vol2 Ed JP Hill Minneapolis University of Minnesota Press.

Bwalya, T .M and Simbeye, S. (1997),Our world 7: The world community, Lusaka, Macmillan Publisher.

Campbell, B. (1992), Whole School Curriculum Development in Primary, London: The Farmers Press.

Carter, C.D. (1979), Recent Advances Advantages in Genetic Counseling Nursing times, 75/October, 1975-1998.

Castle, E.B. (1974), Principles for Education for Teachers in Africa, Nairobi, Oxford University.

Central Statistical Office (2000), Census of Population and Housing/ online available.

Central Statistics Office (2003), Living conditions monitoring survey report, Lusaka: Zambia Changes 2 (2006), USAID / Zambia's changes programme, Lusaka: Zambia

Clergy. C.J, Mackean, P.G and Murray, J. (1994), Advanced Biology Principles and Application, London: John Murray Publisher Ltd.

Cotton, S. and Savard, E. (1992), The Adolescent Society, New York: Free Press.

Curzon, L.B. (1997, Teaching in Further Education, London: continuum.

DC: The World Bank.

Creswell, J. W. (1994), Research Design: Qualitative and Quantitative Approaches.Thousand Oaks, CA: Sage.

De Mause, L. Ed. (1974), The History of Childhood, New York: The psycho history press.

De Vos, A.S. (1998), Research at Grassroots: A Primer for Caring Professionals, Pretoria: Van Schaik.

Diane, R. W. (2000), Water Wars- Drought,Flood, Folly, and Politics of Thirst,Newyork: Harvazad University.

Dixon, S. (1992), Parents Full Partners in Decision– Making Process NSSP Bulletin 76 (543), 10-14.

- Elise, L. et al (1998), *Critical Issues in Modern Education*, Tohaslough: Heinemann.
- Ezewu, E. (1983), *Sociology of Education*, Lagos: Longman
- Examinations Council of Zambia (2000-2007), *Learning Achievement at the middle basic level: Report on Zambia National Assessment project-2001*, Lusaka: Ministry of Education
- Fantan, I. and Weinstein, T. (1968), *Factors affecting Food Selection, intake and Nutrition Status of the Elderly in Mathare Slums in Nairobi*, Nairobi : Kenya.
- Farrant, J.S. (1980), *Principle and Practice of Education*, Edinburg: Longman.
- Fishben, F. and Ajzen, T. (1975), *Nutrition and Health of School Children*, Oxford: Universitypress.
- FNDP (1980-1993), *EducationReforms*, Lusaka, Zambia.
- Janesick, V.J. (1994), *The dance of qualitative research design*. In N.K. Denzin and Y.S, Lincoln.(Ed), *Handbook of qualitative research* (pp. 209- 219).Thousand Oaks, CA: Sage.
- Kaluba, H. and Mwale, J.F. (1992), *A study of Primary Schools in Cholera Affected Communities*, Lusaka: UNZA Press.
- Kasonde – Ng’andu S. and Moberg, S. (2001), *Moving Towards Inclusive Schooling. A Baseline study of western province*, Lusaka: BESSP
- Kelly, J.M. (1991), *Education in Declining economy, the case of Zambia (1975 – 1985)*, Washington: DC WR.Lusaka: Zambia
- Kelly, M .J. (1999), *The Origin and Development of Education in Zambia: From Pre-colonial times to 1996*. Lusaka: Image Publisher Limited
- Kelly, T.B and Stern, J.S (1976),*The Effectsof Parental Divorce. Experiences of the Child in EarlyLatecyMerican Journal of Orthopsychiatry*, 146(20-32)
- Kennedy, F. and Jenifer, A (1991), *Introduction to survey sampling*, Sara Miller McCune: Sage Publication.

Jukes MCH, Drake LJ, Bundy DAP. 2008. School health, nutrition, and education for all:

Leveling the playing field. Cambridge, MA: CABI Publishing

Kerlinger, F.N. (1984), *The Liberalization and Conservation: Nature and the Structure of Social attitudes*, Hillsdale, NJ: Lawrence Ellbaum associates.

Kestenberg, J. S. (1970), *The Effect on Parents of the Child's Transition into and out of latency*: Parenthood.ed EJ Anthony, Burton: Little Brown Ltd.

Kochhar, S.K. (2011), *School Administration and Management*, New Delhi: Sterling Publisher.

Kombo, K .D and Tramp, D .L .A. (2006), *Proposal and Thesis Writing. An Introduction*, Nairobi: Pauline Publication Africa.

Kubbir, S. (1996), *School organization and Child Administration*, New Delhi: Sterling Publication Limited.

Kulbir, S. (2006), *Research Methodology in Education*, New Delhi: Sterling Publication Limited.

Lambers, W. *Fighting Hunger in Kenya with School Meals*. Global Hunger Examiner, July 15, 2009. Accessed online: <http://www.examiner.com/x-16819-Global-Hunger-Examiner~y2009m7d15-Fighting-hunger-in-Kenya-with-school-meals>

Levinger, B. (1992), *Nutrition Health and Learning: Current Issues and Trends*: New York: Newton Publication Limited.

Longwe, W. (1997), *School Management*, Lusaka: Zambia.

Makinde, O. (1994), *Fundamental of Guidance and Counselling*, London: Macmillan.

Mangal, S.K (1998), *General Psychology*, New Delhi: Sterling Publisher Ltd

Margret, E. Anzul, M. and McCormack, A.S. (1991), *Dog Qualitative Research Circles within Circles*, London: The Falmer Press.

Mark, T. (1992), *Ending Malnutrition. Why Increased Income is not Enough*. Washington,

World Bank.

Meckel, R. (2013), Classrooms and Clinics Urban School and the protection and promotion of Child Health,1870-1930. New Brunswick; NJ.Rutgers University.

Ministry Of Health (2002), Malaria an Endemic Disease in Sub-Saharan Regions, Nairobi: Image Publisher.

Muzumara, P.M. (2008), Becoming an effective science teacher, 2nd Edition, Lusaka, ImagePublishers

MOE (2005) Guideline for Implementation of School Health and Nutrition Programme. Lusaka: Zambia.

MOE (2002), School Health and Nutrition News: a Health Child in a Healthy School, Lusaka:Zambia

MOE (2000), Zambia Education Curriculum Frame Work. Lusaka: CDC.

MOE (1996), Educating our Future, Lusaka: Zambia.

MOE (1992), Focus on Learning, Lusaka: Zambia

MOE (1977), Education Reform Document, Lusaka:Government Printer

MOE (1976), Draft Statement on Education Reforms, Lusaka:Government Printer.

MOGE (2015), School Health Management Framework, Lusaka: USAID.

Ministry of Health (2008), Action Plan. Lusaka: Zambia.

Ministry of Health (2005), National Health Strategic Plan, 2006-2011, Lusaka; Zambia.

Mwanza, P.G. (2002), Teachers' Perceptions of barriers to promotion for Female Teachers in Schools in Petauke District in the Eastern Province of Zambia, Lusaka:

University of Zambia.(Unpublished Thesis)

Mwanza, P. (2004), Teacher Perception of School Management Practice and their influence on teaching performance, Lusaka: University of Zambia. (unPublicitythesis).

Mwanamwenda, T. (1997), Education psychology, Nairobi: Kenya.

Mwense, (2010-2014), District Health Management Information System, Report,

Neuman, I. (2000), *Social Research Methods: Qualitative and Quantitative Approaches*. London: Pearson Education.

Newman, H. (1981), *A Study of Heredity and Environment*, Chicago: University of Chicago Press.

Nordheimer, J. (1977), *The Family in Transition: A challenge from within*, New York, University Press.

Oroldho, A.J. (2003), *Essentials of Educational and Social Science Research Method*, Nairobi: Masola Publisher.

Parrinder, E.C. (1974), *African Traditional Religion*, London: Sheldon Press.

Patton, Q. M. (2002). *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage Publisher.

Polit, D.F. and Beck, C.T. (2007), *The Nursing Research Principles and Methods*. 7th Ed. Philadelphia: Lippincott Williams & Wilkins

SACMEQ II & III (1995), Southern African Consortium for Measuring Educational Quality, Lusaka, Zambia

Saunders, I. (2011), *Advances in Social Methodology*, London, Jai Limited.

Save the Children, (2017), Save the children, 501 Kings Highway East, Suite 400, Fairfield CT.

Snelson, .P (1974), *Educational Development in Northern Rhodesia 1883 – 1945* 2nd Ed. Lusaka: Kenneth Kaunda Foundation.

Stub, T. (2008), *Inclusive Education where there are Few Resource* Oslo: Atlas; Allence

Tembo, V.M. (2002), *The Higher Morality*, Ms. Lusaka, Zambia.

Tiberbu, E. (1995), *Malnutrition and Infection in the Classroom*. Paris: UNESCO

Ware, A. (1996), *Creating a Responsive Environment for People with Profound and Multiple Difficult*, London: David Fulton Publisher

Whiteside, A: (1995), *Productivity: Health and Education* Africans, VI 25, No 1 pages 15 – 26 Griffin, GA & *Design and the problem of change*. Paris: UNESCO

Winick, M. (1970), Nutrition and Nerve cell growth. Federation proceeding 29 1510 – 1515

Chibuye, C. (1984), Beyond Political independence: Zambian Development,

World Bank.

World Bank, (2000), World Development Report (WDR) Attacking Poverty 20-00

2001, Washington: International Bank.

World Bank, (1997), Taking Action to Reduce Poverty in Sub Sahara Africa. USA.

World Health Organization (2001), The State of Food Insecurity in the World, Washington:

USA.

Young, J. (1985), The Cultural Significant of Children's Play Ground Activities. Alberta:

Journal of education research, 31(2) 125-138, AFTHR, Washington, DC. The

World Bank

ZARD, M. (1995), Nutrition and Health of School Children in Zambia. Draft report.

APPENDICES

Append

ix I: Informed Consent

Location/School

Gender

Age:

15- 24	25- 33	34-43	44+
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Introduction

I am a postgraduate student from the University of Zambia seeking permission to interview teachers and Head teachers from your District (DEBS), Head teacher and eleven other teachers from your school on the perceptions shown by teachers and parents towards the implementation of School Health and Nutrition Programme in Mwensedistrict(Or seeking to interview parents from your Village being the Headman).

Your name will not be mentioned in the report, but findings will be shared with policy makers who are the facilitators of the programme. You are free to withdraw from the study at any time. Before I give you this questionnaire, read this consent of agreement. Thank you very much for the cooperation you have rendered.

CONSENT OF AGREEMENT SIGNED BY PARTICIPANTS IN THE STUDY

I have understood the instructions and conditions concerning the study and I agree to participate as you have asked. I also understand that I am free to withdraw from the study at any time and that records of our conversation will be destroyed at the end of the study.

Sign..... Date.....

Appendix 1I: Questionnaires for Head teachers

This questionnaire is to be completed by the Head teacher from both lower and upper primary schools

Name of school

Number of teachers by Gender. Male Female

Status of the school

School enrolment of the school

School enrolment by genderboysgirls

Name of RHC.....

Objective: 1 to determine the perception of parents and teachers toward the implementation of the programme

Section one

Circle your answer of your choice

1. Where is your school located?
 - a. Rural urban
 - b. Per urban
 - c. Urban
2. How old are you in years?
 - a. Less than 21
 - b. 21 – 29
 - c. 30 – 39
 - d. 40 – 49
 - e. 50 and above
3. How long have you been in the position of Head teachers?
 - a. 0 – 4
 - b. 5- 9
 - c. 10 – 14
 - d. 15 – 19

- e. 20 and above
4. How do parents and teachers perceive school health and nutrition programme?
.....
 5. What is the source of water do you use in School?
5.
 6. How is the flow of water in your School?
 7. How well do you keep the toilets and surrounding of the school?
.....
 8. Do you think the ideal of immunization and feeding is good when children are in schools?
 9. How can you describe learner performance from the time of SHN inception to date
.....
 10. Do you make use of health cards and tablet pole to monitor children growth ?
.....
 11. Do you have any school health policy which talks about environmental conservation and preventive maintenance?
.....

Objective 2. To establish the roles that parents and teachers could play toward the effective implementation of School Health and Nutrition programme

12. How many times in a term do you meet parents and teachers to discuss problems affecting the running of SHN program?
.....
13. Do you ensure teachers check under five clinic cards for immunization revived during grade 1 enrolment?
.....
14. An observation was made that many schools of Mwense district have no tuck-shop and production units to ensure effective implementation would you please give reasons why is it so? .
15. What types of crop do you grow as a parent?
16. Is the government through MOE, MOH continued supplying food to schools?

	Sex	2010	2011	2012	2013	2014
Attendance	Male					
	Female					

.....

17 Could you kindly provide data in the table below

- a. Number of teachers who participated in school health month – July each year at your school
 Number of parents who participated in school health month – July each year at your school

Attendance	Sex	2010	2011	2012	2013	2014
	Male					
	Female					

17. Could you please say something on the attendance for both tables and give the reasons for that attendance

.....

18. Do your teacher monitor children growth

Objective 3: To determine the attitudes of parents and teachers towards the implementation of school health nutrition programme

The statement below has been prepared so that you can indicate how you feel about each of them. Please circle your choice representing how you feel about each of them.

1. Do you like the kind of activities found in the School Health and Nutrition Programme?

Very much	Not much	I do not	Undecided
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2. Do you support that feed and immunization is good to the health of you children?

Strongly agree	Agree	Disagree	Strongly disagree	Un decided
----------------	-------	----------	-------------------	------------

3. Do you support that the School Health and Nutrition initiates children into Satanism?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

4. What do you think is caused the programme not to be effective?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

5. Do you think, School Health and Nutrition Programme is the solution to the health the child?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

6. Do you arrange for immunization for the children transferred to your school who did not receive before coming to this school?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

7. Can SHN programme be considered as important as any programme introduced in school?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

8. Does your school have a tuck shop with well-stocked health foods?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

If the answer is strongly disagree, give reasons for this answer.

.....

.....

.....

.....

.....

Objective 4: To find out the challenges and solution to the effective implementation of school health and nutrition programme?

19. What are the common diseases affecting children at your school and the surrounding area

.....

.....

.....

20. Are parents and teachers respond to the meeting when you invite them

.....

21. What could be the reasons for not having table poles and school production unit at your school.....

22. What could be the factors affecting the effective implementation of School Health and Nutrition Programme?

.....

AppendixIII: Questionnaires for teachers

INSTRUCTION

1. This questionnaire is to be completed by teachers teaching both in the lower and upper primary schools.
2. The questionnaire has three sections A and B Indicate your response by crossing where necessary.
3. In section C, write a brief explanation in space provided.
4. Where the question demands you to choose one answer, just cross the letter of your choice only.

SECTION A: Objective 1 Perception of parents and teachers toward School Health and Nutrition programme.

9. Location of your School
Rural / Peri-urban/Urban

10. Gender: Male Female

11. Age:

12. Years in service
13. Grade taught
14. Size of your present class
15. Number of toilets
16. Professional qualifications
17. Types of toilets
18. Types of cleaning materials used
19. Number of water points
20. Source of water

SECTION B- Objective II: Roles of parents and teachers towards School Health and Nutrition programme.

21. What are you doing as a school to ensure that parents provide children with food when reporting to school?

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

22. School reports reveal that parents and some teachers shun away from school feeding programme, in your opinion, what could be the reasons?

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

23. Some parents express ignorance about school Health and Nutrition programme, what could be the reasons?

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

24. Production unit could enhance School Health and Nutrition programme, but in some school production unit does not exist, give reasons why it is so.

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

25. How are you involving parents in activities during the health month-July?

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

Objective III: Parents and Teachers attitude towards School Health and Nutrition programme

The statement below has been prepared so that you can indicate how you feel about each of them. Please circle your choice representing how you feel about each of them.

26. Do you support feeding and immunization taking place when children are in school?

Very much	Not much	I do not	Undecided
-----------	----------	----------	-----------

27. Does your school have adequate and clean sanitary facilities that are gender friendly?

Strongly agree	Agree	Disagree	Strongly disagree	Un decided
----------------	-------	----------	-------------------	------------

28. Are the number of toilets mentioned in Section A question 8 enough for the status of your school

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

29. Do you support that School Health and Nutrition Programme initiates children into Satanism?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

30. As SHN school, children entering grade 1 receive TT(with or without scar) and measles)

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

31. Do you arrange for immunization for the children transferred to your school who did not receive before coming to this school?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

32. Should SHN programme be considered as important as any programme introduced in school?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

33. Does your school have a tuck shop with well-stocked health foods?

Strongly agree	Agree	Disagree	Strongly disagree	Undecided
----------------	-------	----------	-------------------	-----------

If the answer is strongly disagree, give reasons for this answer.

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

SECTIONC Objective IV. Challenges and solutions to the implementation of School Health and Nutrition programme.

1. Write in the spaces provided or circle the letter of your choice.

What is the relationship between teachers and parents in ensure that the SHN programme is effectively implemented?

- a) Very effective
- b) Effective
- c) Not effective

2. What are the factors leading to an ineffective implementation of School health and nutrition programme at your school?

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

3. What are the common prevalent diseases found at your school?

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

4. What measures have the school taken to prevent the mentioned diseases in question 3?

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

5 How often are children dewormed and fed when they are in schools?

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

Appendix IV:Semi- interview for parents

These non-scheduled questions should be only answered by parents

Fill in the details orally

Sex Male [] Female []

Name of village / town

Number of children

Name of school where children go

Occupation

Objective 1: To determine the perceptions of parents and teachers towards school health and nutrition programme

1. Are you aware of the programme of school health and nutrition programme
 - i. Yes
 - ii. No
2. If you know the programme, how did you know it?
 - a. Teacher
 - b. Learners
 - c. Fellow parents
3. How do you perceive school health and nutrition programme?
.....
4. How are have you received this programme when you head about it?
5. Do you ensure you children are clean when sending them to school?
,.....

Objective 2: To establish roles that parents and teacher cold play toward the implementation of school health and nutrition programme

6. What types of crops you grow and animals
7. you rear?
.....
.....
8. Are you able to provide children with full meal in a day
.....

9. When you are called for the meeting, do you usually attend.....
10. Where do you take your children when they fall sick?
.....
11. Have you ever been sensitized about the work of school health nutrition programme in school
.....
- ..
12. What do you do if your child is absent from school?
.....
13. What do you do if your children are absent from school
.....
14. What is the relationship between you as a parent and teachers toward the implementation of school health and nutrition programme
 - a. Very good
 - b. Good
 - c. Not good

Objective 3: To determine parents and teachers attitudes towards school health and nutrition programme

15. How do you feel if you hear that your child has been immunized and being given food from school.
16. If you feel good as a parent would you like the programme to continue to refer to question 15
17. If you feel bad as a parent, would you explain the reason why

Objective 4: to find the challenges and solution to the implementation of School Health and Nutrition Programme

18. What are the common diseases affecting your children
.....
- ...
19. How are you coping with daily lives of children?
20. Do you sit down together with teachers to make plans of SHN of how it is going to be run?
21. What are some of the challenges you are facing as a parent when it comes to children in primary