Republic of Kenya

National School Health Strategy Implementation Plan 2011-2015

Ministry of Public Health and Sanitation

Ministry of Education

NATIONAL SCHOOL HEALTH STRATEGY

IMPLEMENTATION PLAN 2010-2015

MINISTRY OF PUBLIC HEALTH AND SANITATION

AND

MINISTRY OF EDUCATION

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ACKNOWLEDGMENTS

This School Health Strategy and Implementation Plan is the product of a broad consultation and collaboration. The Ministry of Education and the Ministry of Public Health and Sanitation would like to acknowledge the contributions and commitment of the various committees and individuals and the support from a number of development agencies, who contributed to the preparation and production of this School Health Strategy and Implementation Plan document.

Our utmost thanks go to Japan International Cooperation Agency (JICA),World Health Organization (WHO), German Development Cooperation (GTZ) for their financial and technical input.

Ministry of Education; School Health and Nutrition and Planning, Kenya Institute of Special Education (KISE), Kenya Institute of Education (KIE);Ministries of Social Services; Local Government; Planning; Housing; Water and Irrigation; Gender and Children Affairs (Department of Children Services);Agriculture, Public Works and Office of the President (Police Department),
ESACIPAC

The Ministry of Public Health and Sanitation and Ministry of Education is especially indebted to the core team that worked tirelessly to draft and review this Strategy and Implementation Plan, comprising the Director Dr.S.k. Sharif(MOPHS),Prof. George Godia (MoE),Dr. Annah Wamae (MOPHS), Dr. Santau Migiro(MOPHS), Dr. Assumpta Muriithi(WHO), Dr. Stewart Kabaka, (MOPHS), Leah Rotich (MoE), Jane Kabiro(MGC&SD),Jimmy Kihara (ESACIPAC/KEMRI), Jedidah Obure(MOPHS), Margaret Ndanyi(MoE),Barnett Walema(MoE),Dr. MargaretMeme (MOPHS), Elizabeth Washika(MOPHS),Joseph Onwong'a(MOPHS),Alex Mutua(MOPHS), Grace Otieno (NACADA), Alice Mwangi(NACADA),Raphael Owako (MOPHS),Erastus Karani (MOPHS),Takashi Senda(JICA) Dr.Geoffrey Wango(MoE),Joyce Kariuki (MGC&SD), George Mwitiki(KISE),Mary Kangethe(MoE),Irene Gitahi(KIE),Agnes Mutua(MOMS),Tobias Omufwoko (MOPHS),John Kimani(MOPHS), Laban Benaya(MoE), Prisca Oira(MOPHS),

ABBREVIATIONS AND ACRONYMS

AIDs Acquired Immunodeficiency Syndrome
ANC Antenatal Clinic
BCC Behaviour Change Communication
CBOs Community Based Organizations
CRC Convention on the Right of the Child
CSHP Comprehensive School Health Programme
CWDs Children with Disabilities
CWSNS Children with Special Needs
DCAH Division of Child and Adolescent Health
DEH Division of Environmental Health
DEO District Education Officer
DMOH District Medical Officer of Health
DRH Division of Reproductive Health
DSHCC District School Health Coordinating Committee
ECDC Early Childhood Development Centre
EFA Education for All
ESACIPAC Eastern and Southern Africa Centre for International Parasite Control
FANC Focused Antenatal Care
FBOs Faith Based Organizations
FGM Female Genital Mutilation
GBV Gender Based Violence
GTZ German Technical Cooperation
HIV Human Immunodeficiency Virus
HT Head Teacher
IEC Information Education Communication
IRS Indoor Residue Spray
ITNs Insecticide Treated Nets
JICA Japan International Cooperation Agency
KESSP Kenya Education Sector Support Programme
KIE Kenya Institute of Education
KIBHS Kenya Integrated Budget and Household Survey
KISE Kenya Institute of Special Education
KNBS Kenya National Bureau of Statistic
KNSPWDs Kenya National Survey for Persons with Disabilities
LLITNs Long Lasting Insecticide Treated Nets
MoE Ministry of Education
MGC&SD Ministry of Gender Children and Social Development
MOMS Ministry of Medical Services
MOPHS Ministry of Public Health and Sanitation
NACADA National Campaign Against Drug Abuse
NGOs Non-Governmental Organization
NSHTC National School Health Technical Committee
OVC Orphans and Vulnerable Children

PE Physical Education
PHO Public Health Officer
PWD People with Disability
SHC School Health Committee
SHO School Health Office
SHT School Health Teacher
SNs Special Needs
STIs Sexually Transmitted Infections
STH Soil Transmitted Helminthes
TB Tuberculosis
UN United Nations
UNESCO United Nations Educational, Scientific and Cultural Organization
UNICEF United Nation Children's Fund
WASH Water and Sanitation Hygiene
WFP World Food Programme
WHO World Health Organization

Foreword

The Government of Kenya is committed to achieving education for all (EFA) and improved health status. These are two key targets in the millennium development goals. The new constitution of Kenya stipulates that every child has the right to basic nutrition, health care and basic education. Improved health for children implies safer and healthier lives for a better world. These National school health strategy implementation aims at improving the health of all children in school.

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

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

The school environment must create an enabling atmosphere for social, cultural and emotional well being that promotes a healthy child friendly school. This strategy will ensure that positive changes in school environment are supported, reinforced and sustained through a school health policy; skills based health education and school health services. It envisaged that effective and efficient healthy school environment shall ensure access, retention, quality and equity in education.

Vision: A healthy, enlightened and developed nation.

Mission: To plan, design and implement sustainable quality health interventions across the education sector.

Mandate

This strategy intends to provide a framework for implementation of a comprehensive school health programme in Kenya.

Values

Schools shall enhance appropriate values and attitude towards growing up, gender roles, risk taking, sexual expression and friendship.

(Define the following)

a) **Integrity**

b) **Teamwork**

c) **Discipline**

d) **Honesty**

e) **Humility**

f) **Respect for human rights**

g) **Assertiveness**

Goal: To enhance the quality of health in the school community by creating a healthy and child friendly environment for teaching and learning.

1. Values and Life Skills

Introduction

World Education Forum in Senegal-Dakar in April 2000 resulted in a Dakar framework for action 2000 which refers to life skills in goal 3. Life Skills Education are abilities which enable an individual develop adaptive and positive behaviour so as to effectively deal with challenges and demands of everyday life. The main goals of the Life Skills approach is to enhance young people's ability to take responsibility for making choices, resisting negative pressure and avoiding risky behaviour. Where life skills education is well developed and practiced, it enhances the well being of a society and promote positive outlook and healthy behaviour. Life skills are classified into three broad categories namely:

a) Skills of knowing and living with oneself

b) Skills of knowing and living with others

c) Skills of effective decision making

Values

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

Background

Ages 0-19 years are critical formative years for the development of behaviour and skills in an individual. Learners in pre-school, primary and secondary school, face varied challenges, which are compounded by various factors. These include intra & interpersonal conflicts, lack of positive role models, negative mass media influence and inadequate and unreliable sources of information especially on human sexuality. Traditional education addressed the holistic view of human personality through the informal education system. However, due to historical reasons, traditional family and educational ties have largely broken down thereby leaving young people vulnerable. Therefore, there is need for the youth to be enabled to develop positive values, attitudes, skills and healthy behavior in order to help them effectively deal with the challenges of everyday life (WHO, 2003 – Skills for Health; UNICEF, 2005- The voices & identities of Botswanas school children). **Skill based health education supports the basic human rights included in the Convention on the Rights of the Child (CRC) especially those related to the highest attainable standards of health(article 24) www.unicef.org/programme/life skills/)- Magnitude of the life skills, www.lifeskills.or.ke)**

.Life Skills Education enables learners to acquire and develop skills such as critical thinking, problem solving, decision-making, interpersonal relationships, stress and anxiety management, effective communication, self-esteem and assertiveness. KIE has developed Life skills Education Curriculum for Primary and Secondary schools and being implemented since January 2009.

There is need to develop Life skills Education Curriculum for Pre service teachers for quality implementation.

Issues

1. Inadequate knowledge on values and life skills for pre-service teachers
2. Indulgence in risky behaviour and negative peer pressure
3. Inadequate communication skills
4. Lack of capacity, information and role models

1. values and life skills

Out put: Values, attitudes and skills of learners enhanced

Target Learners Teachers, support staff, parents and community

Strategy	Objective	Activity	Time Frame					Indicator	By Who	Target
			2010	2011	2012	2013	2014			Baseline
a. Values, attitude and life skills education in schools	1.To promote positive values, attitudes and life skills in schools	Hold 12 consultative meetings to develop 22,000 curriculum and training manuals/materials on values, attitudes and life skill education	Nov 2010 – June 2011					Life skills, values and attitude curriculum No. of manuals materials developed and distributed	KIE, MoMs MoPHs MOYAS MGCS FBOs CBOs NGOs Consultant	
		Ii .Hold 6, 5-day training sessions for a a team of 5 per constituency on values, attitudes and life skills						Numbers trained No. of constituencies covered Training reports	MoE	
	2.T o train Peer Educators on values, attitudes and lifeskills	iv.Consuct 1,100 3-day trainings for 2 peer educators per school						Number of students trained as Peer Educators No. of trainings	MoE	
Sensitization onlife skills, values and	To sensitize support staff and parents on	Hold 870 sensitization fora for parents on						Number of life skills fora held	MOE MOPHS MoMs	

attitudes	life skills, values and attitudes	life skills, attitudes and values						Nos. trained	MGCSS PTAs
		Develop and air Radio Programmes for life skills, values and attitudes						No. of radio programmes developed and aired	KIE

Gender Issues

Background

Gender refers to the socially constructed roles, behavior, activities and attributes that a particular society considers appropriate for men and women. The distinct roles and behavior may give rise to gender inequalities i.e. differences between men and women that systematically favors one group. In turn, such inequalities can lead to inequities between men and women in both health status and access to health care. The state of the world's children 2004. New York; (UNICEF, 2003:
There are several gender related issues that affects learning for both girls and boys. In the MDG's, MDG 2 Achievement of universal primary education by the year 2015 and Target 3(a)of MDG 3 emphasizes elimination of gender disparity in primary and secondary school education preferably by 2005, and at all levels 2015.

Globally 150 million children currently enrolled in school may drop out before completing primary school- at least a 100 million of these are girls. Kenya secondary and primary schools have at least 1 million menstruating girls at least 3/5 or 872,000 of who miss 4-5 days of school per month, due to lack of sanitary pads and underwear, combined with inadequate sanitary facilities in their schools(GCN and MOE, 2006).

The daily routine of a school is structured by formal and informal rules and ways of behaviour. A 'gender regime' is manifest as part of this routine. Ways of relating and the type of interaction between boys and students, are part of this gender regime and serve to normalize certain types of behaviour. This regime under which boys and girls interact is so 'naturalized' in schools that people don't see a need to intervene when this interaction may have negative effects. Some examples include; physical space that boys and girls have e.g. who gets to speak, roles that girls and boys play, how theycontribute to the school, who cleans the classroom,.

These gender roles produce a gender hierarchy, which more often than not is one where the male hierarchy dominates. Boys tend to have more physical space such as in sport than girls. Peer pressure to tease, hassle, intimidate, exclude, and in some cases perpetrate physical violence, can become a part of the school environment.

These gender roles within the school are reinforced by boys and girls themselves both of whom are protecting their space, but in a very gender stereotyped way. There are few if any alternatives put forward that suggest that gender roles could be otherwise.

Teachers themselves perpetuate gender inequalities. They are not trained on gender hence they do not see it as an issue. Instead they have internalized local norms and rarely question them. As a result, they do not intervene on gender, harassment nor abuse issues in the classroom.

In addition discipline issues have been seen to be mainly male led, and boys are most often the subject of corporal punishment resulting in more school truancy and violence by boys.
It has also been reported media and some reports here in Kenya that transactional sex for good exam results is rampant. This sometimes lead to pregnancies and in most cases the girls are blamed for becoming pregnant, leading to expulsion without option for re-entrance. This results in high drop out for girl, while the perpetrators are not punished.
Sexual exploitation of both sexes is also rampant while there exists no mechanisms of addressing it.

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

In view of above the issues and gaps to be addressed are the following:

National Environment

- Slow implementation of policies and legislation
- Inadequate resources
- Lack of sex disaggregated information and data.

School environment

- Lack of redress systems in school
- Lack of gender sensitive infrastructure
- Lack of networking (e.g state institutions, communities, households).

Teachers

- Not trained on gender issues
- Lack of a gender sensitive and gender responsive teachers and other staff.

Community.

- Unfavorable social norms, values, beliefs and culture which perpetuate gender inequalities.
- Communities not sensitized on gender issues
- Lack of community involvement in school activities

1. **Gender Issues**

Output: Behavior, attitudes and age appropriate values of school aged boys and girls are enhanced

Target: learners, teachers, parents and communities

Strategy	**Objective**	**Activity**	**Timeframe**	**Indicator**	**By who**	**Target**		**C**
						Baseline	**2015**	Cost
Advocacy and BCCs	1) To mainstream gender issues into national, sub national and school level development plans 2) To fully advocate for elimination for legal a social-cultural barriers that perpetuates/reinforces gender inequalities in schools. 3) To advocate for full implementation of gender policies. 4) To advocate for reduction of	i. Mainstream gender issues into national, sub national and school level development plans ii. Advocate for elimination for legal an dsocio-cultural barriers that perpetuates/reinforces gender inequalities in schools. iii. Advocate for full implementation of gender policies. iv. Advocate for reduction of GBV in schools.						7.5m

	GBV in schools											
Capacity Building	1) To sensitize communities on Gender issues 2) To train	i. Develop IEC materials (brochures, pamphlets, messages, posters) ii. Conduct sensitization forums for County teams on gender issues iii. Organize communities into gender focus groups i. Review existing training manuals on gender issues ii. Train teachers						No. of IEC materials No. of sensitizations forums held N0. of gender focus groups formed	MOPHS MoMs MOE Line Ministries and Community leaders other key stakeholders			17.5m

	teachers on gender issues	on gender mainstreaming in the school environment										
	3) To train teachers on GBV (sexual violence) in school.	i. Train teachers on GBV (sexual violence) in school.										
	3) To empower existing governance structures on gender issues	i. Sensitize the existing governance committees on gender issues. ii. Dissemination of I.E.C material on gender										
			Training reports						MoE MoPHS MoMS MGCS			
	4) To build the capacity of education officers,	i. Hire consultant develop and produce 240 training										

	health care providers and other key stakeholders on gender needs, priorities and concerns in schools	materials annually on Gender Issues in schools i. Hold 6 of 5-day TOT trainings for 235 pax at County level on Gender Issues in schools										
Coordination and Partnership	1) To develop organizational structure 2) To establish inter-agency committees, guidance on strategy implementations 3) To strengthen the national steering committee 4) To establish stakeholders fora for school health at national level and develop TOr	develop organizational structure I. Mobilize resources for implementation of school health strategy. Establish stakeholders fora for school health at national level										5.0m

Procurement	To increase the provision of sanitary pads for 2.5m school going girls aged 9-18	I. Map out other stakeholders providing pads II. Procure and distribute a minimum of 2 pkts per girl sanitary pads						Number of sanitary pads purchased and distributed in schools % increase in no. of pads procured and distributed	MoE MOPHS MoMs Other stakeholders			19.5b
Monitoring and Evaluation	To conduct regular monitoring of activities and to assess the impact of interventions on gender issues	Carry out support supervision Conduct a mid-term evaluation Conduct an end-term evaluation						Supervision reports Mid-term and end-term evaluation reports	MoE/ MOPHS MoMs Community MOE MGCS Other stakeholders			

2. Child Rights, Child Protection And Responsibilities

Introduction

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

Background

Kenya Government has ratified several international and national conventions / treaties on the rights of the child. These include, the United Nations Convention on Rights of the Child (UNCRC) on July 30th 1990, and the African charter on the rights children (2000??), the disability act 2003 and welfare of the child (Year??), enactment of the Children's Act 2001, and the sexual offences Act 2006. These laws have since enhanced effective child protection in Kenya.

Several other Acts with positive implication for protection of children were later passed. These include the Industrial Properties Act (year??), Persons with Disabilities Act 2003 and Criminal law Amendment Act (year??).

The new constitution 2010 addresses issues of affecting children and guarantees for the Right of Children in various sections that include vulnerable children and those with disabilities.

In line with the Child Rights and Millennium Development Goals (MDGs) the Ministry of Public Health and Sanitation and the Ministry of Education in collaboration with partners developed a National School Health Policy and Guidelines 2009. The two Ministries essentially have come up with a comprehensive School Health Programme addressing child rights, child protection, responsibilities, special needs, disabilities and rehabilitation among others.

Children in Kenya (0—18) years) constitute more than half of the 38million (Kenya national Census 2009) total population while 20% of the population is under 5 years of age. Since the introduction of free primary education in 2003, Primary school enrolment has increased from 77% in 2002 to 92% in 2007 with near parity nationally between boys and girls (National plan of action for children 2008-2012).

ISSUES

1. Inadequate / inaccesible medical services to school children(Provide medical services in schools)

   Objectives:

   - Referral procedures
   - Basic medical skills
   - Distribution of First Aid

2. Poor coordination of feeding of vulnerable children and those coming from marginalized areas(Coordination)
3. Inadequate play and leisure for the child's holistic growth in school(Coordination)
4. Slow realization of the children's rights (Capacity building)

   Objectives

5.

6.

7.

Child rights, protection and responsibilities
Output: child rights, protection and responsibilities enhanced
Target: School age children, teachers, parents, communities

Strategy	**Objectives**	**Activities**	**Time Frame**						**Indicator**	**By Who**	**target**	**Cost**
			2010	**2011**	**2012**	**2013**	**2014**	**2015**				
1. Provide Medical services to all schools and children's homes	-To provide basic medical skills to school teachers & improve referral system	-Train school health teachers on basic medical skills and referral process and procedures in 5,000 schools -Conduct medical camps in schools in 3,000 schools - Set up Sanatoriums	X	X	X	X	X	X	-No. Teachers trained -Reports -No. Medical camps	MOH & MOE MOH	5,000 primar y school s -3,000 primar	

	-To distribute first Aid kits to schools	/Health rooms in 5000 schools - Distribute the First Aid Kits to ------schools 5,000 schools	X X X	X X X	X X X	X X	X X	X X	conducted -No. of schools with health rooms -No. of schools with first Aid kits	& MOE MOH & MOE MOH & MOE	y school s - 5,000 primar y school s - 5000 Primar y sch.	
Co-ordination	-To Feed orphans and vulnerable children in schools	- To sensitize teachers & communities on the importance of feeding programmes for vulnerable children. -	X	X	X	X	X	X	_No. of teachers sensitized -No. of orphans & vulnerable children feed -Reports No. of	MOH & MOE	5,000 primar y sch.	

									schools with play & leisure activities			
Strategy	**Objectives**	**Activities**	**Time Frame**						**Indicator**	**By Who**	**target**	**Cost**
			2010	**2011**	**2012**	**2013**	**2014**	**2015**				
	To enhance play and leisure activities in schools	- To develop & distribute IEC materials on play and leisure activities for schools - To sensitize teachers on the importance of play & leisure activities for pupils	X	X X	X X	X	X	X	-No of teachers sensitized -Materials developed & in use	MOH & MOE	20,000 primar y sch.	
Capacity Building	To enforce child rights at all levels (by all sectors)	Sensitize stakeholders at all levels on child rights	X	X	X	X	X	X	No. of teachers and health workers, stakeholders sensitized in	MOH & MOE	50% in the region	

									child rights No. of schools where children have been sensitized on their rights No. of community sensitization meetings held on child rights			

Special Needs, Disability and Rehabilitation

Introduction

Children with disabilities and those with special needs find themselves in difficult circumstances in accessing quality health and education equitably (KNSPDS 2007). Although the needs of vulnerable children are largely similar to those of other children in various aspects, they differ in that these children require additional support in maintaining and enjoying their rights as children (Child survival and development strategy Kenya 2008).

The ministry of education has developed a national Special needs education policy framework which is intended to improve the quality and access to education provided to children with special needs. It also addresses issues of equity and improvement of learning environment in all schools (The national special needs education policy framework 2009).

It is in this regard that the ministry of Public health and sanitation and ministry of education intends to improve access to health care and education for children with disabilities and special needs through the development of this strategy.

Background

The Kenya National disability survey 2007 reported that the disability prevelance in Kenya is 5.7%. PWDs are often marginalized and face difficulty as a result of their disability. Most have no access to education, health employment or rehabilitation. The majority experience hardships as a result of widespread social cultural and economic prejudices which results to stigmatization. Amongst children 0-14 years of age and 15 to 25 years of age only 55% of this target group is able to access health services when in need (KNSPWDs2007). Averagely 41% of children with disabilities of school going age drop out due to various illnesses. On the other hand 39% of children with disabilities drop out due their disabilities (KNSPWDs).

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

It is evident that there is a growing number of children with disabilities and special needs whose requirements are not being met. The lack of awareness amongst community and school age going children is also a major barrier to the education and integration of children with disabilities and special needs. The interventions will include but not limited to the following;

a) Screening and identification for disabilities and special needs
b) Medical care
c) Rehabilitation and therapy
d) Provision of appropriate assistive and supportive devices / appliances

e) Educational referrals and interventions
f) Vocational and skills training
g) Social interventions and integration

Isssues

1) Lack of data on CWDs in school and children in primary schools
2) Lack of Early identification and intervention of CWDS and special needs
3) Integration of CWDs and special needs in schools
4) Enhancement of health care and rehabilitation services for special needs and disabilities

Special needs disability and rehabilitation

Output: Rehabilitation of learners with Special Needs and Disabilities is enhanced

Target: School age children, teachers, parents and communities

Strategy	Objectives	Activities	Time Frame						Indicator	By Who	target	Cost
			2010	2011	2012	2013	2014	2015				
Provide data on children with disabilities & special needs in primary schools	To establish the No. of children with disabilities & special needs in primary schools	1. Conduct a baseline survey on children with special needs and disability in all primary schools and rehabilitation centers 2. Disseminate the findings of the survey to stakeholders 3. Conduct assessment, identification and placement of	X X	X X	X X				Situational analysis report. -No of schools/Rehab centers data collected. -No of children identified. Dissemination report -No. of children assessed	MOH & MOE	CWDS & special needs countrywide	

		children with special needs and disabilities. 4. Train community leaders, parents on early identification of children with special needs and disabilities	X	X	X	X	X	X	No. of community leaders & parents trained			
Rehabilitation services for children with special needs and disabilities	To improve rehabilitation services for children with disabilities and special needs	i. Train teachers and health workers on the CBR concept, principles and practices ii. Conduct outreach rehabilitation	X	X	X	X	X	X	No. of teachers & health worker trained on CBR No. of Outreach rehab services	MOH & MOE	50% in the region	

		services levels 2 & 3, community settings and all schools having CWDs iii. Procure and Supply educational aids / adaptive devices to schools for children with Special Needs / disabilities, assistive & supportive devices							conducted Assistive / supportive devices/ appliances / aids procured & supplied			
Strategy	**Objectives**	**Activities**	**Time Frame**						**Indicator**	**By Who**	**target**	**Cost**
			2010	**2011**	**2012**	**2013**	**2014**	**2015**				

WATER, SANITATION AND HYGIENE

Introduction

Water, sanitation and hygiene are critical towards creating an improved learning environment. The government's commitment towards Education for All (EFA) has resulted in the over stretching of already inadequate water and sanitation facilities due to the dramatically increased enrolment and lack of adequate resources.

Improving water, sanitation and hygiene in our learning institutions generates considerable benefits in terms of improved child-health, attendance, retention, performance, and transition of all learners including girls, boys and children with special needs. The aim for improving school Water, Sanitation and Hygiene (WASH) is reducing water-born and sanitation-related diseases e.g. cholera and other diarrheal diseases, worm infestation, skin infections, etc.

Learners are positive change agents within their communities, and instilling habits early is the most effective way to change current practice. Therefore, the multiplier effect of appropriate and positive messages on hygiene promotion will influence the larger communities. This influence will translate in reduced ill health and ignorance and will ultimately result in a well-informed society.

The MOE, within the Kenya Education Sector Support Programme (KESSP), is currently taking measures to better equip school managers, teachers and learners in Water, Sanitation and Hygiene promotion, knowledge and practices. Funding for infrastructure, recurrent costs and improved practice in water, sanitation and hygiene has been increased, and the government and development partners intend to adequately support the sector. Given the need to coordinate and harmonize support from the various providers within the sector, this strategy will provide the MOE with the framework to do so.

Background

The introduction of Universal Primary Education resulted in a rapid increase in the number of children in the primary schools from 5.9 Million pupils in 2002 to 7.2 Million pupils in 2003 and currently at more than 8 Million pupils. This trend has resulted in straining hygiene and sanitation facilities in schools.

Water, sanitation and hygiene are critical towards creating a child friendly environment in learning institutions.

Improved water, sanitation and hygiene in learning institutions generate considerable benefits in terms of improved child health, attendance, performance, retention and transition.

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

Issues

1. Inadequate safe water in schools
2. Lack of adequate toilets for boys and girls
3. Lack appropriate of disposal mechanism for sanitary towels in school
4. Lack of effective control of vectors, vermin and rodents
5.

Water, Sanitation and Hygiene

Output: Water, Sanitation and Hygiene & Infrastructure and Environmental safety enhanced

Target: School children, Teachers, Parents, Communities and partners

Safe Water 1.Provision of adequate and safe water	To improve access to adequate and safe water to schools in Kenya from the current 50% to 70%	1.Facilitate 2000 schools to connect to existing piped schemes						No of schools connected to existing piped schemes	MOWI, MOE, MOPHS DPs Community/A ,CDF	50%	70%	120m
		2.Site and construct shallow wells at safe distances from toilets for 2000 schools						No. of shallow wells constructed	MOWI, MOE, MOPHS DPs Community ,L/A ,CDF	50%	70%	100m
		3.Construct boreholes in cases where no other viable options exist for 200 schools						No. of bore holes constructed	MOWI, MOE, MOPHS DPs Community/A ,CDF			360m
	To provide water storage facilities in at least 70% of all schools in Kenya by	Construct rainwater harvesting facilities for 5000 schools						No. of schools with rainwater harvesting facilities.	MOWI, MOE, MOPHS DPs Community/A,CDF			150m

	2014.											
		Construct masonry storage tanks for 1000 schools						No. of schools with masonry storage tanks constructed	MOWI, MOE, MOPHS DPs Commun ity/A,CD F			300m
		Provide plastic storage tanks(appropriate size)for 4000 schools						No of schools with tanks (appropriate sizes for 4000 provided.	MOWI, MOE, MOPHS DPs Commun ity/A,CD F			400m
	Ensure safe water quality and facilitate point of use treatment	Conduct water quality surveillance monitoring in 30 selected district						No of water samples analyzed	MOWI, MOPHS, MOE, L/A, CDF			25m
		Provide point of use disinfection /chlorination in 10, 000 schools						No of schools conducting point of use disinfection	MOWI, MOPHS, MOE,CD F,L/A			20m

Capacity building in operation and maintenance of water facilities	Develop capacity for opera ration and maintenan ce of water facilities within the schools	Train school management, support staff and learners on operation and maintenance in 5000 schools.						No schools trained on Operation & Maintenance	MOWI, MOPHS, MOE Communi ty. Local Authority, CDF			120m
Sanitation Provision of adequate sanitary facilities to schools	To construct and rehabilitat e school sanitation facilities in 70% of schools.	Develop appropriate technical toilet design for schools including children with disabilities						Designs developed	MOPW, MOE,MO PHS,L/A, CDF.			8.5m
		Construct new school toilets in 10, 000 schools in all constituencies						No. of schools with new toilets constructed	MOE, SMC, MOPW, MOPHS,L/ A ,CDF.			
		Rehabilitate existing toilets in 10, 000 schools						No of schools with rehabilitated toilets.	MOE, SMC, MOPW, MOPHS,L/ A, CDF			800m

		Construct new toilets for children with special needs (disabilities) in 216 special schools						Number of schools with toilets for special needs (disabilities)constructed	MOE, SMC, MOPW, MOPHS			64.8M
Capacities building on Operations and Maintenance of sanitary facilities	To build/ strengthen operation and maintenance capacities	Sensitizing 1,000 School Management Committees/ District Education Board members on operation and maintenance of school toilets						No of SMC/DEB members sensitized.	MOE, SMC, MOPW, MOPHS			12m
		Train 5,000 school support staff on operation and maintenance of school toilets						No of support staff trained	MOE, SMC, MOPW, MOPHS			22m
		Train 50 000 learners(peer trainers) on monitoring school sanitation facilities Develop and produce training manual for water, Sanitation and hygiene						No of learners trained Manuals produced	MOE, SMC, MOPW, MOPHS MOE, MOPHS			20m
Provision of Solid Waste	To develop appropriat	Construct incinerators in						No of schools with incinerators	MOE, MOPHS,			10m

management systems.	e school waste management systems	10,000 schools						constructed	MOPW, SMC			
		1. 10, 000 dust/rubbish bins provided						No of dust/rubbish bins provided	MOE, MOPHS, MOPW, SMC			5m
		2. Train school communities on waste management						No of school communities trained.				
		1000 sanitary pads bins installed in girls toilets						No of sanitary pad bins installed in girls toilets.	MOE, MOPHS, MOPW, SMC			8m
Sanitary inspections in schools.	To support operation and maintenance of sanitation infrastructure in schools through regular sanitary inspection.	Quarterly sanitary inspection of school sanitation facilities in all districts						No of quarterly reports	MOE, MOPHS, SMC			2m
		Procure cleaning and maintenance tools for 10, 000						No of schools with cleaning/mainte	MOE, SMC			20m

		schools in all districts						nance tools				
		Provide schools with Operation & Maintenance grants quarterly /bi-annually in 10, 000 schools						No of schools with O&M grants	MOE,			100m
School Hygiene Advocacy, social mobilization and communication	To strengthen /develop advocacy, social mobilizatio n and communic ation	Hold stakeholder meetings for advocacy at all levels						No of meetings held	MOE, MOPHS			20m
		Sensitize learners, parents and partners in 5000 schools on hygiene						No of schools with learners, parents and partners mobilized	MOE,MO PHS,SMC			30m
		Development/har monize and production of IE C material on hygiene promotion						No of IEC materials developed	MOE, KIE, MOPHS			120m

		Dissemination of hygiene promotion materials in 500 schools						Reports on dissemination	MOE, KIE, MOPHS			30m
		Support hygiene promotion through health days, education days, competition(murals)						Reports	MOE, KIE, MOPHS			20m
Capacity development for hygiene and sanitation	Capacity development in Hygiene and sanitation	Train school staff and stakeholders in Hygiene promotion						No of school staff and stakeholders trained	MOE, MOPHS			60m
		Form/strengthen, support Learners on health clubs and peer support clubs in Hygiene promotion.						No of learners health clubs formed & trained	MOE, MOPHS			120m
	Implementation of skills based hygiene promotion activities	Conduct School based hand washing campaigns in 5000 schools						No of hand washing campaigns conducted	MOE, MOPHS			30m
		Establish School performance						School performance	MOE, MOPHS			

		evaluation and award scheme at (national, district and zonal)best performing Province, school and most improved school						evaluation award scheme established				
		Regular inspection of schools and treatment of hygiene related ailments, especially for jiggers.						Inspection and treatment reports	MOE, MOPHS			42m
	Integrated M& E to update , implementation process at (National, district, school)	Conduct operational research and support piloting of emerging innovations						Research reports	MOE, MOPHS			38
Food Safety Provision of safe food in schools	To ensure all food for use should be transported, stored, prepared and served	Construct /provide 10, 000 food storage facilities using approved designs by Ministries of works and public health and						No of food storage facilities constructed	MOPW,MOPHS,MOE			35

	in a hygienic manner	sanitation.									
		Renovate kitchens in 5,000 schools						No of schools with renovated kitchens	MOPW,MOE,MOPHS			28
		To construct standard kitchens in 10,000schools						No of schools with standard kitchens constructed	MOPW,MOE,MOPHS			37
	To sensitize school management committee on the importance of medical examination, hygienic food handling and use of protective gear in schools.	1.Sensitize school management committees on the importance of medical examination in 10,000 schools 2.Purchase protective gear						Reports on sensitization sessions and enforcement undertaken.	MOE,MOPHS			30
		Sensitize SMCs on need for food handlers with protective gears,						No of food handlers with protective gear.	MOE			35

		headgears and uniforms										
		Schools to be sensitized on need to use disinfectants and detergents for cleaning in 10, 000 schools						No of schools provided with disinfection ad detergents	MOPW,MOE,MOPHS			40
Vectors, Vermin and Rodents	Capacity building of school communities in vector rodent control.	Train teachers, learners, support staff and school managers on vector, vermin and rodents control in 10,000 schools.						O of learners, Learners, support staff and school managers trained	MOE, MOPHS			25

Disease Prevention and Control

Background

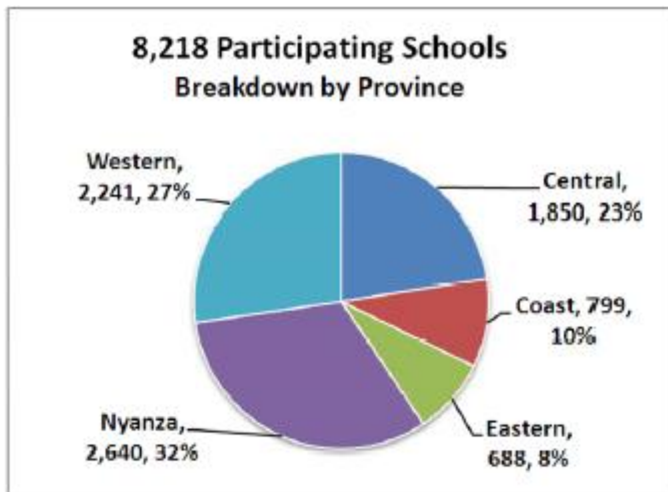
WHO estimates that between 25% and 33% of the global burden of disease can be attributed to by environmental risk factor (WHO Information series on school health; Document 2). Globally causes of mortality, morbidity and disability for the age group 5-18 years conforms with this as it is shown that they are mainly due to cardiovascular disease, cancer, chronic lung diseases, depression, violence, substance abuse, injuries, nutritional deficiencies, HIV/AIDS/STI and helminthes infections and can be significantly reduced by preventing six interrelated categories of behaviour, that are initiated during youth and fostered by social and political policies and conditions:

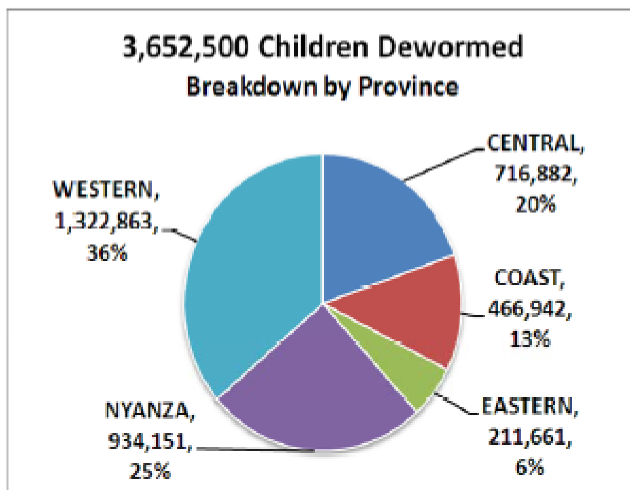
- tobacco use
- behaviour that results in injury and violence
- alcohol and substance use
- dietary and hygienic practices that cause disease
- sedentary lifestyle
- sexual behaviour that causes unintended pregnancy and disease

Worm infections are likely to affect children's cognitive development differently according to their levels of poverty, psychosocial stimulation, and general health status. (Donald A. P. Bundy et all 2009)

Two billion people are infected with intestinal worms [1]. In many areas, the majority of schoolchildren are infected and the World Health Organization (WHO) has called for school-based mass deworming. Existing evidence indicates that mass school-based deworming is extraordinarily cost-effective once health, educational and economic outcomes are all taken into account, and it is thus unsurprising that a series of studies from the 1993 World Development Report [18] to the recent Copenhagen Consensus [19] argue that treatment of the most prevalent worm infections is a very high return investment.

In Kenya the documented causes of outpatient morbidity (health facility service statistics-HMIS report 2009) although different from above are also largely due to environmental factors. These are malaria, respiration system infections, skin diseases, diarrhea, accidents, pneumonia, rheumatism, urinary tract infections, eye infections, intestinal worms and dental disorders.





- However WHO has also shown that worm infestation is the greatest cause of morbidity in the age group 5-14 years (ref WHO school and youth health). The resulting diseases give rise to much suffering and death. In addition, they contribute to perpetuation of poverty by impairing the cognitive performance and growth of children, and reducing the work capacity and productivity of adults and hence negatively impacting on national development.

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

the Nation’s disease burden (Kenya vision 2030 first medium- term review). This is being implemented under the existing health policies and legislations.

- Issues/gaps to be address
    - Lack of knowledge on the linkage/interaction of environment and health
    - Unhealthy lifestyles
    - Poor health seeking behavior
    - Poor compliant to treatment
    - Lack of regular check ups
    - Lack of an enabling environment for health.

6. Disease Prevention and Control

Output: Enhanced disease prevention and control in schools

Target: Communicable and Non-communicable diseases

Strategy	**Objective**	**Activity**	**Time Frame**					**Indicators**	**Respon sible**	**Target**		**Estimated Cost**
			2010	2011	2012	2013	2014			Baseline	2014	
Support for malaria free schools initiative.	To have at least 80% of learners in boarding schools in Malaria endemic and epidemic-prone areas using appropriate Malaria prevention measures by 2014.	1. a. Distribution of LLINs in boarding schools every three years in malaria endemic and epidemic-prone areas.						Number of learners receiving LLINs	MoE MOPHS and partners			=546,000,000
		1. b. Mandatory inclusion of bed nets in requirements for all new boarding schools admissions.							MoE MOPHS			
		1. c. Supervision by school administrators on bed net use among boarders.							MoE			

		ii. Train spray operators						Number of spray operators trained.	MoPHS & Stakeholders				
		iii. Carry out IRS in schools in targeted areas.						No. of schools where IRS has been undertaken.	MoE MOPHS and partners				
Capacity building	Create awareness on preventable diseases in 80% of the schools by 2014.	i. Sensitize school communities on transmission, prevention and control of targeted preventable diseases.						Number of school communities sensitized	MoE MoPHS and stakeholders				
		ii. Harmonize and update existing IEC materials on preventable diseases.						No. of IEC materials harmonized and updated	MoE MoPHS And stakeholders				
		3. Printing, dissemination and distribution of I.E.C materials. of IEC materials,						Number of IEC materials printed, disseminated and received I.E.C materials	MoPHS MoE and stakeholders				

	Enhance knowledge on non-communicable diseases	i. Sensitize school communities on prevention and control of non-communicable diseases.										
		ii. Harmonize and update existing IEC materials on non-communicable diseases							MoE MoPHS and stakeholders			
Screening	To promote early detection and prompt management of diseases.	1.Carry out annual checkups on school communities						No. of annual checkups done.				
Treatment and referral.	To enhance treatment and referral of 50% of schools by 2014.	1.Train School Health Teachers on early detection, management of minor ailments & Referral.						Number of School members treated and referred.	MOPHS, MOMS ,MOE and stakeholders			
		2. Conduct outreach services						Number of schools receiving outreach services.	MOPHS, MOMS and Stakeholders			

		3.Training of school health teachers on transmission, prevention and control of preventable diseases						Number of school health teachers trained	MOE MOPHS and partners	0%	50%	Ksh. 900,000,000
		4. Train school health teachers on diseases training skills										
	To de-worm at least 75% of school age children by 2014	i. Deworming of school age children.						Number of children dewormed.	MoE MOPHS and partners		75%	Ksh350,000,000
	To promote good oral health hygiene among school age children by 50% by 2014.	i. Training of school communities on good oral hygiene practices.						i. No. of school communities sensitized.	MoE MOPHS ,MOMS and partner			Ksh. 80,000,000

		ii. Conduct bi-annual check ups						Number of schools having oral check ups				350,000,000
Advocacy	To sensitize the stakeholders at all levels on the importance of good oral health	1. Sensitization meetings with major stakeholders (MPS, Civic leaders.						No. of sensitization meetings	MOE MOPHS MOMS and Stakehol ders.		60%	100,000,000
		2. Conduct stakeholders forum on school oral health						No. of Stakeholders forum held			**50%**	**50,000,000**
		3. Sensitization of SMCs/PTA on the importance of establishing school oral health clubs.						2.No. of Stakeholders forum held No. Of school oral health				20,000,000

								clubs established.				
M & E	Conduct M & E for preventable diseases.	1. Carry out disease mapping in selected schools						Report of disease mapping in schools	MOPHS MOMS AND Stakeholders			50,000,000
		2. Carry out supportive supervision						Reports				50,000,000
		3. Carry out mid-term and end –term reviews.						No of reviews done				20,000,000

NUTRITION IN SCHOOLS

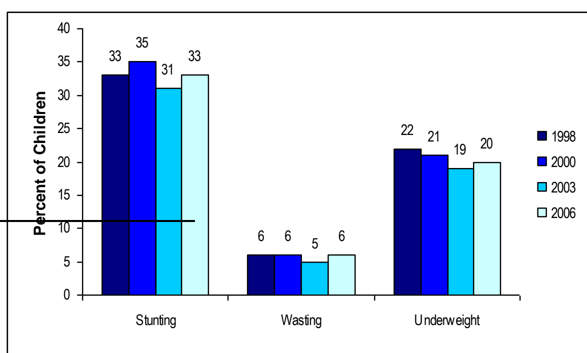
INTRODUCTION

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

BACKGROUND

Poor diet and sedentary behaviours are among the major risk factors of chronic diseases which account for 59% of 56.5 million deaths annually and 46% of the global disease burden. There is clear evidence that high consumption of energy-sugar, starch and fat-in relation to physical inactivity is a fundamental determining factor of nutrition-related chronic diseases. Health diet and physical activity are key to good nutrition and necessary for a long and healthy life. Eating nutrients dense foods and balancing energy intake with the necessary physical activity to maintain health is essential at all stages of life. Consuming too much food high in energy and low in essential nutrients contributes to energy excess, overweight and obesity. (WHO: http://www.who.int/gb/ebwha/pdf_files/WHA/A57_R17-en.pdf).

In Kenya, malnutrition continues to affect a significant proportion of children and women. The most recent countrywide study done in 2005/06 (KIHBS[1], 2007) shows persistently poor nutrition outcomes with marginal increases in stunting (33%), wasting (6.1%) and underweight (20.2%) compared to 2003 data as shown below. (Kenya Integrated Household Budget Survey 2005/06 (2007)



Micronutrients

The last national micronutrient survey of 1999, found high levels of Vitamin A deficiency (VAD) among pre-schoolers, with 14.7% having acute and 61.2% moderate VAD. Factors that were associated with this high prevalence include malaria infection, hookworm infestation and acute malnutrition.

From the national micronutrient survey Iron deficiency was also high with 43% of preschool children

Data on Iodine deficiency (ID) data from KEMRI (2004) indicate an improvement from 16% deficiency in 1994 to 6% in 2004, attributed to the consumption of iodized salt by a large proportion of Kenyan households (91 percent CBS/UNICEF Multi Indicator Cluster Survey or MICS 2000).

Issues to be addressed;

- **Lack of information on dietary intake.**
- **Lack of knowledge on the link between diet and disease.**
- **Lack of coordination ; national to the school level**
- **Lack of regular nutritional assessments/check ups in schools**
- **Insufficient food varieties/non- nutritious food.**
- **Poor Monitoring and Evaluation.**

5. School Nutrition: Implementation Plan

Output: Improved nutritional status of school children.

Target: School children, teachers, school administration, communities, Ministries of Health, line Ministries and other stakeholders.

Strategy	Objective	Activity	Time frame	Indicator	By Who	Target		Cost
						Baseline	2014	
1. Advocacy	To sensitize the stakeholders at all levels on the importance of school nutrition services.	1, Sensitization …… meetings with members of parliament (Health & Education), civic leaders.	April - June 2011	-Number of sensitization meetings held.	MoE, MoPHS		80%	50 M
		2 Conduct …… stakeholders' forum on school nutrition services and resource mobilization at all levels.	April - June 2011	-Number of stakeholder's forum held.	MoE, MoPHS		80%	50 M
		3, Develop/harmonize and disseminate IEC materials on Nutrition education and counseling.	Jan-March 2011	-Number of IEC materials produced. -Number of dissemination meetings held.	MoE, MoPHS		100%	10 M
		4,Sensitization of SMCs/PTA on importance of establishing Home grown school meal programmes.	April-Dec 2011	-Number of meetings held.	MoE		100%	200M

2.Instituting sustainable home-grown meals programmes	1.To ensure all schools have instituted sustainable home-grown meals programmes by 2014	1, Partner with stakeholders to initiate and enhance sustainable home-grown meals programmes	April 2011-Dec 2011	Number of school having functional SFP	All stakehol ders			50 M
		2a. Provide mid morning snacks to pre-primary and primary school children in ASALs and targeted slum schools. 2b. Sensitizes the stakeholders on the scaling up of the mid-morning snacks.	April 2011-Dec 2014 April 2011-Dec 2014	-Number of pre-primary school providing mid morning snack. Number of stake holder s meeting held	MoE		a.75% b,70%	200 M 1 M
	2.To standardize home –grown school meals programmes	1.Develop standards and guidelines on home-grown meals programmes	July- Sept 2011	Standards and guidelines developed and in place			100%	500,000
3. Enhancing nutrition	1. To promote	1. Review and update the curricula to enhance nutrition information	Jan 2011,Jan 2012,Jan 2013,Jan 2014	Curriculum reviewed and updated	MOE, MOPHS			2 M

education in schools	acquisition of appropriate knowledge, skills and attitudes on nutrition.	2a. Develop/harmonize/print training manuals on nutrition, education and counseling. 2b. Train TTC lecturers and in-service teachers on nutrition education & assessment.	July 2011-Sept 2011 Oct -2011-June 2012	-Number of manuals developed and printed -Number of TTC lectures and in-service teachers trained.	MoE, KIE, MoPHS Other partners		80%	4 M 20 M
		3. Sensitize school community, and parents on nutrition education.	April 2011-March 2012	-Number of sensitization carried out.	MoE, MoPHS		70%	5 M
		4. Initiate and strengthen health clubs (4K clubs) in schools.	July 2011-June 2012	-Number of schools with functional 4K clubs.	MoE/MoA		60%	330 M
		5.Intiate school gardens including container gardens in urban schools for demonstration	July 2011- June 2012	Number of schools with Demonstration gardens	MoE/MoA		60 %	330 M
4. Micronutrient Supplementation	1. To address micronutrient deficiencies	1. Conduct bi-annual micronutrient supplementation (Vitamin A)	May 2011- Dec 2014	-No. of children supplemented	MOE/ MOPHS		70%	50 M
5. Enhance sustainability of school nutrition services	1. To strengthen mechanisms for sustainability of school nutrition services	1. Initiate/strengthen school gardens/tree nurseries and income generating activities.	April 2011-Dec2014	-Number of schools with functional kitchen gardens/trees nurseries and income generating activities.	MoE/MoA		50%	100 M
		2. Supporting community based growing of food, diversification, milling, fortifying and preservation initiatives	June 2011-Dec 2014	Number of community based nutritional IGAs	MoA, MOE, MOPHS		70%	120 M
		3.Involve communities in planning, mobilization of resources and management of home-grown meals programmes	April 2011-Dec 2014	Number of community members involved in home grown school meal programmes	MOE, MOPHS		70%	1 M

		4. Encourage schools to use locally available foods	April- Dec 2014	Number of schools utilizing local foods	MOE, MoA,M OPHS		70%	1M
6.Monitoring and evaluation	1.To institute comprehensiv e, effective, efficient and sustainable monitoring and evaluation system for school nutrition services	1, Carry out needs assessments in schools (nutritional status, coverage of HGSM Programmes, current practices, curriculum, food composition etc)	Jan- March2011	-Survey Report	MoE, MoPHS		80%	150 M
		2, Disseminate the findings of the survey at national, provincial, district and school levels.	April-June 2011	-Number of dissemination meetings held.	MoE, MoPHS		100%	20 M
		3.Purchase and distribute nutritional assessments equipments to schools	Jan-March 2011	Number of equipments purchased and distributed	MOPHS, DPs		100%	50 M
		4. Regular monitoring of nutritional status and referral of malnourished children to health facilities.	2011-2014	-Report. -Number of times monitoring carried out. -Number of children referred.	MoE, MoPHS		100%	50 M
		5. Regular monitoring of school meals to ensure that meals are adequate (both quality and quantity).	2011-2014	-Report on Monitoring carried out.	MoE, MoPHS		80%	50 M
		6.Regular monitoring of home-grown school meal programmes to ensure implementation of the standards and guidelines	2011-2014	-Number of schools conforming standards and guidelines the			80%	50 M

School Infrastructure and Environmental Safety

Introduction

A healthy school environment should include the structures that protects pupils and staff but poorly designed school buildings and play areas may present serious health risks. Special construction techniques may be required to ensure safety particularly in areas prone to natural disasters. Schools should be designed to prevent temperature extremes inside classrooms. Cold damp and poorly ventilated classrooms provide an unhealthy environment for school children particularly poorly nourished and inadequately clothed pupils who are especially vulnerable to respiratory and other infections. Extremely warm conditions may reduce concentration and attention span and can lead to heart related illnesses, thermal stress, fatigue and heat stroke (WHO – Physical school environment document II - 2003)

Appropriate measures should be put in place in schools to ensure an equal basis for children disabilities with to live independently and participate fully in all aspects of life. These measures shall include the identification and elimination of obstacles and barriers to accessibility to buildings, roads, transportation and other indoor and outdoor facilities including schools, housing, medical facilities workplaces (UN Convention on the righst of persons with disability 2007 – article 9).

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

Background

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

Primary education still continues to experience many challenges relating to access and equity, including overstretched facilities, overcrowding, and poor learning environments and lack of appropriate sanitation. Education opportunities for learners with special needs and disabilities are a major challenge to the education sector. There is need to link inclusive education with wider community based programmes for persons with special needs and disabilities. Successful implementation of the strategic plan is expected to improve efficiency in resource allocation, improve the quality of education provided to Kenyans while also addressing equity and gender

imbalance, improve the learning environment for both boys and girls including those with disabilities and special (Ministry of education strategic plan 2006 –2011) .

Issues

1. The lack of adequate and inaccessible infrastructure and shortage of permanent classrooms to all learners
2. Poor construction standards and inadequate maintenance of school infrastructure.
3. Lack of fully functional fire and safety facilities
4. Enforcement of transport safety regulation for school children

School Infrastructure and Environmental Safety

Output: Safe, healthy environment and school infrastructure

Target: School age children, teachers, parents and communities School infra structure and environmental safety

Strategy	Objectives	Activities	Time Frame						Indicator	By Who	target	Cost
			2010	2011	2012	2013	2014	2015				
Safe health environment and adequate accessible school infrastructure	To enforce existing school buildings code and Education Act	-Regular inspection of all school facilities, equipment and the suroundings - Sensitize school managers, teachers, support staff and learners on occupational health and safety - Sensitize on transport safety for 10, 000 schools - Sensitize school	X	X	X	X	X	X	-Inspection reports -No of schools with sensitized staff in occupationa l health - No of schools tried/ sensitized in transport safety - No of	MOH & MOE	75% of primar y school s	

		community on hazards - Build ramps in 10,000 schools for children with special needs and disabilities							community schools sensitized - Number of ramps built			

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