

Teachers' experiences in implementing the Zimbabwe school health policy in early childhood development classes: Barriers and drivers

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Abstract

The study focused on exploring teachers' experiences in implementing the Zimbabwe School Health Policy in Early Childhood Development (ECD) classes. It sought to determine barriers and drivers for adopting good healthy habits. The Social Ecological model provided guidance for the research. Nine ECD teachers with direct experience implementing the policy were chosen using a purposive sampling technique. This study employed a qualitative case study methodology. Data was generated through observations and key informant interviews. Results revealed that a lack of self-efficacy and resources inhibits the implementation of the School Health Policy (SHP). Inaccessible infrastructure to learners with disabilities compromised the proper implementation of SHP. One of the main drivers was that educators saw the Zimbabwe SHP as helpful and an opportunity to holistically address children's health and free up more time for their children. The study found that ECD teachers thought the SHP was essential to encouraging learners to behave well and improve their overall health. In addition, the availability of supportive Health policies was also a driver in implementing SHP. The study also revealed that the synergies between the communities, schools and Ministry of Health and Child Welfare was a driver in implementing the SHP. There is a need to involve educators in the policy-making process to ensure that the final product is practical and feasible to execute. To enhance the health and safety of ECD learners in schools, universities and colleges should also train more ECD teachers and incorporate more health, safety, and nutrition-related topics.

Keywords

Barriers and drivers, early childhood development, health education, policy implementation, school health policy.

INTRODUCTION

Health is an important issue in ECD. Minnett [1] defines health as physical and emotional well-being. According to Manzunzu et al. [2], health is a state of complete physical, mental, and social well-being and not merely the absence of diseases or infirmity. Unfortunately, a third of ECD children suffer from malnutrition and stunted growth in Zimbabwe [3], [4]. Most primary schools which integrated ECDE A (3-4 years) and B (4-5 years) do not provide food and health

services to young learners [4]. With this understanding, the Zimbabwean Government found it necessary to implement the Zimbabwe SHP to promote good health in schools. Unfortunately, the emergence of Coronavirus 19 (COVID-19) caught the school health systems off guard. Motivated by the milestone in the Education sector and drawing lessons from the COVID 19 era, the study aimed to explore the experiences of the educators in implementing the



Zimbabwe SHP in ECD classrooms. Learners' health has always been regarded as the top priority in schools. The Zimbabwean government implemented the Zimbabwe SHP to preserve the well-being and security of ECD learners [5].

Nwachuku and Gerba [6] suggest that the problem of health impact on learners is linked to their underdeveloped brain and digestive systems, as well as extensive environmental exposure to microorganisms due to poor hygiene practices. Primary schools and day care facilities are considered high-risk environments for the spread of infectious diseases, even in developing nations, necessitating the implementation of health policies to safeguard the health of ECD learners. Chipepera and Mangwensthu [7] mention that various studies have highlighted the prevalence of diarrheal illnesses in ECD facilities due to contamination of hands, objects, and surfaces. Infections of the digestive and respiratory systems often lead to absenteeism among children and parents. The World Health Organization (WHO) [8] recommends regular sanitary condition assessments in ECD centres within schools. As a result, the administration ensured the implementation of the health policy.

The government of Zimbabwe launched the Zimbabwe SHP in 2018 with the objective of promoting a healthy learning environment in all schools to enhance the academic performance, overall health, and well-being of school-going children [5]. The policy provides standards for maintaining health in schools. The policy addressed various health issues affecting learners such as poor nutrition, inadequate education and health promotion, poor hygiene, sanitation, water, and medical services [9]. Teachers played a crucial role as stakeholders in implementing the Zimbabwe SHP.

Several African nations have developed policies to support the protection and empowerment of ECD learners. The Zimbabwe SHP stemmed from the acceptance of the 1999 Presidential Inquiry into Education and Training report, which highlighted the need to improve school health. Zimbabwe is a member of international organizations that support school health. The Ministry of Health and Child Care emphasized the importance of allocating resources such as personnel, funding, and time to those in need in the planning for Enquiry in Health Policy [10].

The National Sanitation and Hygiene Strategy (2011-2015) [11], the National Water

Policy [12], Food and Nutrition Policy (2012) [13], National Nutrition Strategy (2014-2018) [14], National Gender Policy (2013-2017) [15], and Statutory Instrument 106 of 2005 [16] are crucial policy frameworks that support the Zimbabwe SHP. This level of involvement demonstrates the Zimbabwean government's commitment to providing access to information, imparting life skills, and enhancing learning capacity while promoting and safeguarding health.

According to Government of Zimbabwe, Ministry of Primary and Secondary Education, and Ministry of Health and Child Care [5], all learners should receive theoretical and practical health education through the school curriculum. Learners with impairment should also participate in physical education to encourage health and fitness. To maintain their well-being, children are exposed to a variety of sporting activities in the classroom. WHO [8] asserts that a person's social environment has a significant impact on their health and quality of life. The Health Policy addresses issues related to the learners' living surroundings to enhance health. Regardless of ownership, economic condition, or religious convictions, health services are offered at all school settings by the Ministry of Health and Child Care. In most situations, mobile clinics visit all schools to immunize children against illness outbreaks as necessary [9]. To guarantee that all learners have equal access to medical care and services, every child is immunized. Health care teams occasionally conduct screenings and provide care at ECD centers, including growth monitoring for children under the age of five. Additionally, UNICEF donates boreholes to schools in areas where there is a scarcity of water to ensure that learners have access to clean and safe water, thus avoiding waterborne diseases. Water is one of the basic needs required by children according to Maslow's Hierarchy of Needs. Healthy food is another need for learners. If a child is not supplied with a balanced diet, they will not grow up in a healthy manner. UNICEF and Dejongh [17] recognizes that the nutrition of school-age children is a core component of its child-centered programs. Schools are a proven platform for the delivery of nutrition interventions like education, counseling, support, and services. Schools offer additional benefits for nutritional outcomes, as they can promote nutritious diets and impart related knowledge through skills-based education, especially when

they are supported by policies that help create enabling environments for the awareness of good nutrition principles. These issues are covered in the Zimbabwean Health Policy, which urges ECD centers to provide a balanced diet to children. As a result, a lot has been done to promote health in learners in all schools through the provision of at least one hot meal a day. Health workers move around schools and centres teaching parents and guardians to nurture their children, practice good hygiene, promote health behaviors in children, provide good nutrition, be aware of nutrition-related diseases, monitor the growth of their children, and have the know-how of common early childhood infections or diseases [18].

Zimbabwe felt that it was vital to put in place The Zimbabwe School Healthy Policy that considers the health of the learners in schools. A variety of ways were used by teachers in schools to accomplish this. First, by including health education into the core of all school curricula, providing a comprehensive school health program, enhancing inter-ministerial ties, and coordinating the efforts of all parties, fostering Public-spirited Private Partnerships, and supporting system, Management, Coordination, Monitoring, and Evaluation, encouraging Public-spirited Private Partnership [19]. Teachers promote the policy implementation by the promotion of hand washing, health education provision and monitoring the health of the learners. The teachers monitor if the learning materials are age appropriate and clean to be used by the learners. A healthy infancy lays the groundwork for an adult life that is free from illness, which was commonly accepted [9]. Childhood habits can affect the learner's health and happiness for a very long time. Therefore, it is crucial for the teachers to encourage children to engage in regular physical activity of some kind. To raise their awareness of good health statuses, learners are once more taught several health-related topics. The teachers also engage the parents and inform them about the importance of practicing hygiene and make sure that their children are always smart. Teachers also help to inform learners the importance of practicing hygiene always to avoid the spread of different diseases that may affect their studies once they are being affected by them. During feeding programs, teachers make sure all learners are being fed, and hygiene is being practiced always.

The introduction of the SHP into ECD classrooms in Zimbabwe had several positive effects like the increase in school attendance since it reduced the rate of illness in learners through practicing hygiene, the health policy gave learners a whole set of life skills for leading healthy lives as learners who are in good health enjoy their education and advance their cognitive abilities [20]. An unhealthy child grows hostile and reclusive. This suggested that unhealthy learners could meet the demands and barriers of daily learning and playing.

In an ECD class context, the barriers to learning can be lessened by promoting a secure environment for learning that is stimulating, encouraging, and hygienic for both ECD setting teachers and learners. As an illustration, the Health Policy guaranteed that all learners were included and that schools have enough safe water, age-appropriate restrooms, and hand washing stations. The aforementioned are guaranteed by the health policy in order to limit the number of frequent illnesses that interfere with ECD learners' ability to study and be taught [19]. Through the mainstreaming of health themes in the curriculum for all schools, the policies again provided knowledge on how caregivers can prevent the spread of such widespread illnesses. According to Correia et al. [21], a child's overall development depends on their overall health. If the ECD centers are successful in putting the policy into practice as written, this will improve the learners' all-around development. According to Minnett [1], health is crucial for a child's overall development since it influences how the mind, body, and social attitudes grow. Thus, the Health Policy's execution led to the complete development of learners in ECD classes.

Teachers in schools were facing barriers such as a lack of adequate resources like funding, training, and materials to use in the SHP implementation, which disturbs the teachers to do such activities that provide health education and effective monitoring of the learners [19]. In addition, the teachers lack support from their leaders or administration. The school administration in most cases ignores informing the teachers about how to implement the SHP which leads to poor health practices in schools [22]. Resistance from the community and caregivers is one of the big barriers that teachers face in School Health Implementation. Religious or cultural beliefs lead some learners not to

participate in related learning activities. Teachers' time was very limited since they had a wide range of responsibilities such as teaching, co-curricular activities and tasks given by the administration. Lack of knowledge in teachers is one of the barriers that made it difficult to deliver the SHP.

Despite of the barriers faced by the teachers on the implementation of the Zimbabwe SHP, some of the schools in Zimbabwe have been successful through mobilizing community resources, health organization partnership and parental involvement while informing them about the importance of the practicing good health that helps to reduce illness of the learners. This was supported by Nyatsanza and Mukwenha [23]. The administration should always carry out some staff development meetings to inform the teachers about the proper implementation of the policy and share ideas on how to improve their services to maintain the good health of learners. The learners should be taught the importance of the proper practice of hygiene to have good health. Teachers in schools can also seek donations from NGOs like UNICEF, CAMFED, WASH, WHO, and UNESCO so that they can be assisted by sanitation materials like soaps, toiletries and borehole drilling close to the school so that learners will not suffer. The government also provides schools with feeding program schemes to help those learners from different

backgrounds to have at least one hot meal at the school so that they will not suffer from malnutrition.

The health of learners has been at risk due to teachers' inability to implement the SHP, which caused illnesses and injuries as well as disrupted the orderly flow of the learning process. World Health Organization, United Nations Children's Fund, and World Bank Group [24] recommends that teachers, parents, and other caregivers regularly check on their learners' wellbeing. However, in certain schools, teachers do not follow these guidelines, which triggers illnesses and injuries to ECD learners. For comprehensive and optimal development, all learners must be healthy and learn in a healthy environment [2]. As a result, every schoolchild must have access to quality medical care and a safe environment. The researchers' investigation of teachers' experiences implementing the Zimbabwe SHP in Kwekwe District schools was spurred by this issue.

The study was guided by the socio-ecological model (SEM). The SEM is a multi-layered theoretical model emphasising five levels of determinants (individual, family, community, organisation and structural level). The model advances that for an initiative to be successful, it is necessary to understand it from various levels, as shown in Figure 1.

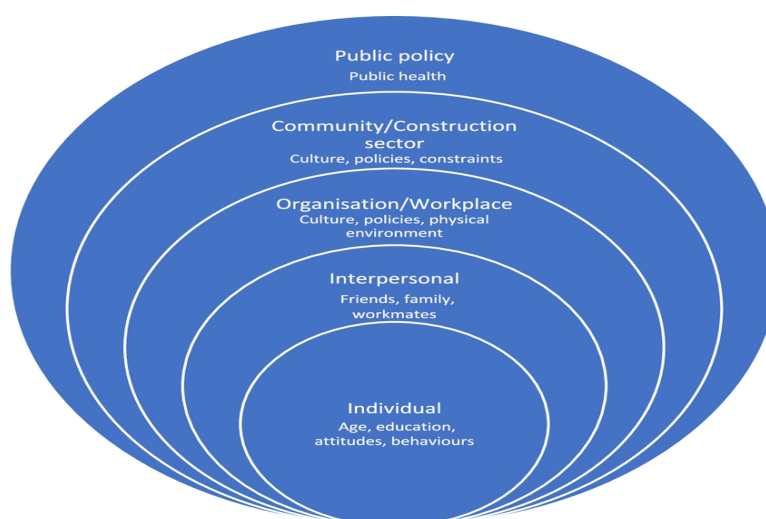


Figure 1. The socio-ecological model [25]

The social-ecological model advances that human behaviour is affected by the interaction between the individual, the group/community, and the physical, social, and political environments [25], [26]. UNICEF [27] has the

view that the social-ecological model illustrates the importance of networks of people and structures that surround a phenomenon, understanding its barriers and strategies to be adopted at various levels such as individual,

community, and structural for the successful implementation of the SHP. Barriers such as knowledge level can be individual, attitudes and beliefs can be community/ societal constructions, state of infrastructure as organisational and policy. Thus intervention/ strategies must adhere to these levels for the implementation of the SHP to be seamless.

Research questions

Main question: What are the teachers' experiences on the Zimbabwe SHP implementation in schools?

Sub questions: (1) What is the teachers' understanding of the Zimbabwe SHP?; (2) What are the drivers to the implementation of the Zimbabwe SHP in schools?; (3) Which are the barriers faced by teachers on the implementation of the Zimbabwe SHP in ECD classes?

RESEARCH METHOD

In this research, the researchers utilized the qualitative case study. A qualitative approach was used because it embraces a naturalistic paradigm to comprehend phenomena within specific real-world contexts, where the researchers refrained from manipulating the phenomenon of interest [28]. The researchers obtained a comprehensive and detailed description of what was gathered using a case study. A case study is more suitable for gaining an in-depth understanding of a specific situation and allows flexibility in data collection and use of a smaller sample. Hence, the qualitative research method is a naturalistic process that aims to achieve a comprehensive understanding of social phenomena in their respective environments.

The researchers purposively sampled six ECD teachers (name code: TR1-TR6) and three school heads (name code: HS1-HS3) on the implementation of the Zimbabwe SHP in schools. The researchers purposively sampled their participants basing on their purposes, functions and ability to elucidate a specific theme, concept, or phenomenon [29], [30].

In this study, semi structured interviews were used on six ECD teachers and three school heads. The researchers used the semi structured interviews because of their flexibility and adaptability. The researchers also observed the school health, sanitation and learning facilities to establish the state of health in schools.

Observation is a systematic process of choosing, observing, reading about, and documenting phenomena, objects, or living things [31]. The observation was used to check for any misinformation from the interviews. To ensure validity and reliability of data, triangulation of methods was done. In addition, member checking was done during and after the process of data transcription. Data were presented in narratives and tables. Thematic data analysis was also used.

RESULT AND DISCUSSION

To unpack the implementation of the SHP, data were presented and analysed in the following themes: ECD teachers' understanding of the Zimbabwe SHP, ECD teachers' views on the importance of implementing the SHP in schools, Roles played by teachers to make sure that the SHP is properly implemented in ECD classes in schools, Barriers faced by teachers on the implementation of the Zimbabwe SHP in schools and Strategies that can be used by teachers to improve the health of ECD learners in schools.

ECD teachers' understanding of the Zimbabwe SHP

Most of the teachers were much aware of the Zimbabwe SHP.

TR1: I have read and understood the SHP. The Zimbabwe SHP's implementation offers competency-based health education that includes life skills that are suitable for children's ages, relevant to their culture, and based on factual information and highlighted that a SHP as a weapon that supports raising healthy learners.

TR2: I haven't read the policy, but we are implementing health protocols at our school. Limited understanding showed the less coordination approach in the implementation of the Zimbabwe SHP in the schools.

TR3: I have a good understanding of the policy, but I think I need to be educated more on the policy. Our head made us understand the policy through staff development workshops.

HS3: It is necessary to educate the ECD teachers and the school heads about the importance of the policy and how it should be implemented in schools to protect maintain the health of the learners in schools. Almost all headmasters had copies of the policy, but

they hardly understand its requirements at their stations.

HS2: We are successfully implementing the SHP because we did staff development of teachers. At my school, the teachers are very knowledgeable about the policy.

From the teachers' responses, the researchers found out that a minority of school heads and ECD teachers were very aware of the implementation of the SHP as expected by the Government of Zimbabwe, Ministry of Primary and Secondary Education Care, and Ministry of Health and Child [5]. This finding shows that the knowledge gap between ECD teachers and school heads compromised the efficient implementation of the SHP. The knowledge gap may be caused by some school heads who do not share information when they return from meetings and workshops. These school heads take policy documents as personal, or they just put them in shelves to gather dust without using them. This corroborates the Socio-ecological view that barriers in understanding a concept in individuals may compromise the implementation of an initiative such as the SHP [27].

What are the drivers for the implementation of the Zimbabwe SHP in schools?

During the interviews, teachers provided drivers for the implementation of the SHP such as availability of the policy document, availability of health teachers in schools and some health infrastructure in place. These findings were presented in interview excerpts below.

TR2: The Ministry of Education has provided the SHP document which provides us with guidelines to ensure health in schools is supposed to be implemented.

TR3: At times we work very closely with community health workers in maintaining the learners' health needs, for example, during health education sessions.

TR6: The schools have some health infrastructure such as toilets though they may not be adequate or child-sized. Learners are also taught health education by their teachers.

HS2: We have health teachers in our schools and these help to enforce some requirements. The school health teachers were trained by

the Ministry of Health personnel on basic health issues.

HS3: The schools feeding programme has also come in hand to assist with boosting the learners' nutritional needs. However, the challenge is on the relish, and at times we just end up boiling the maize for learners to neat.

From the teachers' responses, the study revealed that, the availability of policy documents not only the Zimbabwe SHP was a key motivator to implement the policy in ECD. The finding shows that, the SHP is supported by other policies such as the National Sanitation and Hygiene Strategy (2011-2015) [11], the National Water Policy [12], Food and Nutrition Policy (2012) [13], National Nutrition Strategy (2014-2018) [14], National Gender Policy (2013-2017) [15], and Statutory Instrument 106 of 2005 [16] are crucial policy frameworks that support the Zimbabwe SHP. The broader policy framework can then be advantageous in the implementation of the SHP.

In addition, availability of the existing health structures in schools such as health teachers as well as synergies with communities and other stake holders such as Ministry of Health is a major driver to the implementation of SHP. The finding corroborates with WHO [8] which asserts that a person's social environment has a significant impact on their behavior and quality of life. In many situations, school health is supported through mobile clinics visits to schools for activities such as immunization and health education [9].

Furthermore, the teachers' responses confirm that the school feeding programme was a motivator for the implementation of the SHP as it added the nutritional dimension to learners' health, hence, taking a holistic approach to such implementation. The finding is in tandem with UNICEF and Dejongh [17] which recognizes that the nutrition of school-age children is a core component of its child-centered programmes.

Roles played by teachers to make sure that the SHP is properly implemented in ECD classes in schools

Observation was done at schools, and it showed among other issues the source of water, availability of wash basins, feeding procedures, toilet routines, and state of the toilets. The observations are presented in Table 1.

Table 1. Observations on school health issues

School Code	Water Source	Handwashing & Feeding Procedures	Toilet Practices	State of Toilets
1	Borehole (600m from classrooms)	Handwashing: Lined up, used soap & running water from a bucket (assisted by teachers). Feeding: Ate under an asbestos-roofed shade, monitored by teachers.	Facilitator assisted learners in washing hands under running water from a tapped bucket.	Clean, age-appropriate, well-ventilated. 4 toilets for boys, 4 for girls. Child-toilet ratio: 1:15.
2	Tapped water (400m from classrooms)	Handwashing: Queued at the tap, then moved to the serving point with the teacher. Feeding: Served individually on school plates, ate under a Mopani tree.	Learners washed hands independently under running tap water, not accompanied.	Clean, well-ventilated, but squat holes too big for ECD learners. 3 toilets for boys, 3 for girls. Child-toilet ratio: 1:22.
3	Tapped water (close to classes) & borehole (1km away)	Handwashing: Queued at the tap, used liquid soap. Feeding: Ate from their own plates/lunch boxes while sitting on the veranda.	Teacher accompanied learners while washing hands under running tap water.	Clean, well-ventilated, child-sized squat holes. 2 toilets for boys, 2 for girls. Child-toilet ratio: 1:20.

The observations made were corroborated through interviews. The responses from the majority of ECD teachers showed that they played a role in toilet training by accompanying the learners to the toilets as they relieve themselves or keep the toilets clean.

TR1: Our responsibility is to make sure that there is enough clean water for the learners to wash their hands before and after eating their food and after using the toilets. We also perform daily routine health checks, identify any health issues, and find appropriate solutions. In addition, our head emphasizes that one of his duties is to buy hand-washing soap, hand sanitizers, and washing buckets.

TR2: I make sure that all ECD learners are encouraged not to use old filthy toilets, not to play in the toilet area, not to bring food into the toilets, not to go to the toilets barefooted and not to drink water from questionable or unsafe water sources.

TR3: We escort learners to the toilet to avoid danger. However, we spent significant time because of the high learner-toilet ratio of approximately 1:20. Our head also encourages the teachers to check if both play equipment, toys, and furniture in the classrooms are safe, child-sized, and clean daily to prevent accidents.

During observations, in most schools, teachers play the role of making sure that the ECD learners are getting enough water to be used by learners on washing hands after visiting the resting rooms, before and after eating. Some of the teachers even accompanied the learners for the feeding programme, ensuring they observed cleanliness. This finding adhered to WHO [8] standards which state that learners should always wash their hands before and after eating and after visiting the toilet.

In another finding, every school in the cluster under the study had enough and safe sources of water as expected by the National Water Policy [12]. However, one of the schools had a borehole a bit far from the classrooms and the ECD learners walked that long distance to fetch some water to use from the borehole. Closely linked to that, the majority of the participants stated that the SHP implementation was being affected due to a lack of enough resources to maintain the proper standards that keep learners safe from harm. It was also observed that the toilet-learner ratio was too high between 1: 15-22. The wash basin-learner ratio was also too high. This finding did not resonate with the stipulations of the Statutory Instrument 106 of 2005 of 1:12 and 1:6 for toilet-learner and wash basin ratio respectively. This lack of facilities in schools, points to organizational barriers to implementing

the SHP as advocated for by the Socio-ecological model [26].

The study revealed during observations, that the schools adopted the feeding programme as recommended by the National Nutrition Strategy 2014-2018 although some of the food was not nutritious enough for the learners due to the economic barriers. The challenge was observed in relish and some resorted to boiling the maize for learners to eat. Most schools had enough plates for learners, which they cleaned daily before and after feeding, which maintained their good health as recommended by the National Sanitation and Hygiene Strategy (2011-2015) [11]. Some learners used their plates from home, and some used their lunch boxes. As a result, learners bringing plates from home was a threat to the learner's health since some of them were not clean enough.

Barriers faced by teachers on the implementation of the Zimbabwe SHP in schools

It has emerged during the interviews that ECD teachers faced an array of barriers in implementing the SHP. Some of the barriers were inadequate information about the policy, lack of resources such as accessible and child sized infrastructure and cultural beliefs. These findings are elaborated in the excerpts below.

TR1: The administrators were not giving them enough information on how the SHP is supposed to be implemented. At times we end up doing what we think without following some necessary protocols.

TR4: There is a yawning knowledge gap in terms of the SHP. There are fewer formal briefings on the implementation of the Zimbabwe SHP.

TR5: The toilets are not child-sized and not easily accessible as there are stairs without ramps prohibiting learners with physical disabilities from using them. In addition, some learners avoid using toilets because they have a negative attitude and enjoy using the bush.

HS1: Inadequate resources such as funding, training, and materials hampered the implementation of the SHP. In addition, the time is too limited since the timetable seems to be congested so we cannot compromise on learning time doing workshops.

HS2: Some learners do not want to use the toilets for cultural reasons. They believe that it is the same as defecating in the house and is against their culture.

From the teachers' responses, inadequate and unsuitable facilities compromised the implementation of the Zimbabwe SHP. Both teachers and school heads attest to the fact that the facilities such toilets were not child sized, and the resources were inadequate. This finding corroborates Mwatsamwa et al. [19] who observed that schools were facing barriers such as a lack of adequate resources like funding, training, and materials to use in the SHP implementation.

In addition, the responses from some of the teachers showed that there was a lack of communication between them and the administration about enough information on how to implement the SHP through workshops, staff development meetings, and awareness campaigns to alert the community about it as stated by Mwatsamwa et al. [19]. This lackluster approach by both teachers and school heads may be a result of a lack of self-efficacy. This finding indicates the Socio-ecological theory which advances that a successful implementation of a policy depends on stakeholders' relationships [25]. However, though some of the teachers said they were aware of the policy, this did not guarantee their understanding as they even alluded that it was not vigorously cascaded to them by the school heads.

CONCLUSION

The study concluded that the implementation of the SHP had both drivers and barriers. The major barriers included inadequate resources needed for the implementation of SHP. The execution of the school's health policy appears to be hindered by a lack of good communication between teachers and school administrators. The lack of communication between the teachers and the school head can be attributed to lack of self-efficacy. This is a problem since schools have a responsibility to create a secure and healthy environment for the learners, which includes putting health measures that support both physical and emotional welfare into practice.

It can also be concluded that the major obstacle to the successful implementation of the SHP is a lack of resources such as infrastructure

that accommodates learners with disabilities. Learners with disabilities continue to encounter restricted access to health facilities at school due to poor infrastructure, despite having rights to equal treatment and protection. The daily lives of learners with disabilities are also substantially impacted by infrastructure that is not user-friendly such as inaccessible restrooms without ramps, and a lack of adaptable toilet seats or handrails.

Another conclusion reached in the study is that The Zimbabwe SHP is strengthened in schools through the school feeding programme. For learners' physical and mental growth to be ensured, healthy and nourishing meals are crucial. Unfortunately, many ECD children are from underprivileged families and frequently lack access to nourishing meals. They are at risk of malnutrition because of this circumstance, which also hinders their ability to succeed academically.

The study also concluded that Government should prioritize funding for school feeding programmes. The school feeding programme can give learners frequent access to nourishing meals, improving their general health and well-being. Furthermore, school feeding programs can

enhance learner attendance and lower dropout rates, especially for kids from underprivileged homes.

The existence of functional structures such as availability of school health teachers enhances the implementation of the SHP. Strong synergies in the implementation matrix are of paramount importance and this is supported by the SEM, since a holistic approach provides for a successful implementation of SHP.

From the study results, the following recommendations can be made. Firstly, teachers should conduct in-service courses to upgrade themselves in terms of the proper implementation of the SHP. Secondly, schools should collaborate with parents in promoting the ECD programme to inform them about the importance of the SHP. Thirdly, the school and government should engage in staff development programmes to up-skill teachers to monitor the implementation of the SHP in schools. Fourthly, universities and colleges should train more ECD teachers and should include more health issues so that they will be able to help or teach learners about health. By so doing, the SHP will be easy to implement since everyone will be aware of its importance.

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