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Assessment and Level of Awareness of School Health Programme in Some Selected Local Government in Abuja, Nigeria.

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Abstract:*School aged children in Nigeria tend to face a lot of challenges especially in their overall development such as exposure to diseases and many other conditions that can affect their ability . This study therefore evaluates the implementation of the school health programme among schools in Bwari Area Council, FCT.*

The study employed a descriptive cross-sectional study design. The 20 schools were randomly selected using the multi-stage sampling technique. The qualitative and quantitative method was used for data collection. The Key Informant Interview was conducted among the 20 school Head teachers, while a validated questionnaire was used to collect data from the 120 teachers and students from the selected 20 schools. Data from the Key Informant Interview was analyzed using the thematic approach.

The result from the study showed 57.5% and 64.7% of respondents (teachers & students) respectively were female, 87.5% (teachers) had BSc, while 56.7% had 1-5 years teaching experience. 42.5% of students were in primary 6. The mean age of the teacher was 32.5±5.34, while students was 11.2±2.06. The awareness of the School Health Programme and National School Health Policy among teachers and head teachers was poor with a prevalence of 28.67%. Also, 50% of the schools' first aid boxes were not adequate and needed to be equipped. Reported reasons for this condition were attributed to the lack of funding, lack of basic facilities, weak monitoring and implementation by the government, lack of political will and awareness of school health programme among head teachers, Although the measures put in place are routine inspection, daily sanitation routine and monitoring of food vendors.

In conclusion, the study showed that awareness of the school health programme and national school health policy was poor. The components of the school health programme of the schools visited were poorly implemented. Reported reasons were attributed to the lack of funding, lack of basic facilities, weak monitoring and implementation by the government and lack of political will. Concerning efforts to improve the implementation of school health programme, awareness programme and training should be conducted for the head teachers and provision of funds and facilities should be made available.

Key words*: School Health, National School Health Policy, School Health Programme, Head teacher, Bwari Area Council*

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I. Introduction

The School Health Programme (SHP) refers to all aspects of the school programme which contributes to the understanding, maintenance and improvement of health of the school population (Odeyemi&Chukwu, 2015). Adebayo &Onadeko (2016) described the School Health Program (SHP) as the combination of procedures and activities designed to protect and promote the well-being of the school population. Countless research has shown that the School Health Programme can reduce the prevalence of health risk behaviours and positively affect academic performance. The programme aims at promoting and maintaining the health of children and enable them gain the maximum benefit of their education. The School Health Programme comprises of various components which include School Health Services (SHS), healthful school environment (HSE), skilled-based health education (SBHE), School Feeding Services (SFS) and school, home and community relationship (SHCR) (FME, 2006). According to Adebayo &Onadeko (2016), one of the main objectives of SHP is to obtain an improvement in the health of school children and ensure they are provided

with optimum care at all time for them to attain their physical and intellectual potentials including their maximum benefit s from health providers, teachers and school environment. Odeyemi&Chukwu)(2015 discussed further on its provision of advisory and counselling for the school community and parent by providing pre-entry medical screening, routine health screening/examination, school health records, sick bay, first aid and referral services. A school health committee is recommended for each school which bears the responsibility of effective implementation. (Adeniran *et al.,* 2016).

The implementation of the School Health Programme can ensure that efficient and standard care is provided to children to prevent important health risks among them. Promoting SHP in the school population is a critical step in improving quality education and realization of the National Policy on Education, which according to Adebayo &Onadeko (2016) is the only way SHP can be achieved. Chavan*et al.* (2018) in addition recognized children as a prime population and school as appropriate settings for health promotion, highlighting the role they play and the level of influence they have on the students' life.

The School Health Services have been described in different ways by numerous authors. Willgoose (1977) describes the School Health Services as comprising of many procedures to determine the health status of students including enlisting cooperation in health protection and maintenance and working with parents to correct defects and prevent illness. It is seen as preventive and curative services provided for the promotion of health status of staff and learners to enable them achieve the highest level of health possible for them to benefit immensely from their education. (FME 2006). In addition, according to Okafor (1982) it includes all services rendered to help an individual return to their normal state of health.

The School Health Services are an essential component of the School Health Programme that ensures that the health status of the children within the school environment is improved to enable them participate fully in academic activities. As noted by the WHO's Expert Committee on Comprehensive School Heath Education and Promotion, Good health is a requirement for effective learning. Moronkola (2003) supported this view by explaining that the purpose of School Health Services is to help school children to achieve the maximum health possible for them to obtain the full benefit from their education.

The joint committee on health problems in education of the American Medical Association (1970) states that School Health Services should be provided by physicians, dentists, health educators, nurses and other health personnel. The School Health Services helps in the prevention of diseases, early diagnosis of problems and illness, treatment and follow-up of defects. Moreover, the School Health Services include pre-entry examination, routine medical examination, keeping school health records, first aid and referral services. It also includes advisory counselling for the community and parents as stated in the National School Health Policy (FME 2006).

Del Rosso and Toma (1996) stated that Children who are hungry in class are more likely to have difficulty concentrating and performing complex tasks even if they are well nourished. Igbudu and Idehen (2007) postulated that a link exists between nutrition and learning. Healthy eating patterns are necessary to enable students achieve their full academic potential, physical and mental growth, lifelong health and wellbeing and described as a considerable means of reducing mortality risk and developing chronic diseases. There have been positive associations reported between school meal and academic performance, further research has reported increases in attendance rates in implementing the programme (Amoran*et al.* 2016) Therefore, by increasing the nutritional status of school children, their comprehension and learning abilities are also enhanced. The School Feeding Services therefore is a strategy which can alleviate hunger while supporting education, health and community development and also aid increase in school attendance, retention and completion of basic education and reduce gender inequality by attracting girls to schools and provide macronutrients and vitamins that will enable learning to take place among children allowing them to function and develop physically and intellectually (UNICEF 2005).

The school feeding can be presented as meals or snacks to be eaten during school hours or distributed to be taken home at the end of each day, month or school term. It serves a platform to support pupils and their families in a variety of contexts (Uwameiye*et al.,* 2013). Adegun*et al.* (2013) asserted that a nutrition service programme includes well prepared staffs who efficiently serve appealing choices of nutritious meals, this programme integrated within the comprehensive School Health Programme curriculum and coordinated with the food service programme and a school environment that encourages pupils to make healthy food choices.

Moreover, Poor nutrition has been identified as an underlying cause for poor living, attendance, retention and achievement in education and health among school aged children. In support of this statement, the Home-Grown School Feeding and Health Programme (HGSFHP) was launched in September 2005 by the President, Federal Republic of Nigeria to provide learners with a daily supplement of an adequate meal that will improve their overall health and enhance academic achievements (UNICEF, 2005). If food is handled poorly and not properly stored often leads to the presence of intestinal parasites in school children with serious implication for absorption and digestion of nutrients. This leads to poor growth and development. Owosafe (2008) stresses that food-borne disease prevention should be a priority of the School Feeding Services. Food-

borne diseases can be prevented through proper food preparation, handling, education and carrying out specific measures such as hand washing or ensuring the food and water comes from safe sources.The objectives of this study is toassessment and level of awareness school health programme in some selected local government in Abuja, Nigeria.

Methodology:

Research Design

A descriptive cross-sectional study design was used for this study using both a quantitative &qualitative instrument to evaluate the level of implementation of School Health Programme among public schools within the Bwari Area Council in the Federal Capital Territory (FCT).

Description of The Study Area

The Bwari Area Council (BAC) is located at the North East of the Federal Capital territory (FCT), Abuja. It has an area of about 914km^2 with a population of about 581,100 according to a population projection carried out in 2016.

Study Population

The study population of this study consists of selected primary schools with the inclusion of the head teachers, student and teachers in the Bwari Area Council.

Sample Size Determination

The sample size was determined by the number of schools within each selected polling unit identified as Local Education Agency (LEA) approved primary schools for the study.

Sample Size

A sample size of 20 schools was selected for study.

Sampling Technique

A multi-stage sampling technique was used in the selection of a sample for a study.

Each polling ward is divided into different polling unit, which is illustrated in the table below;

Table 1: Number of polling Units in the selected polling wards in Bwari Area Council

POLLING WARDS	NAME OF POLLING WARDS	NUMBER OF POLLING UNITS
1.	Bwari Central	7
2.	Byazhin	7
3.	DutseAlhaji	9
4.	Kubwa	11
5.	Usuma	15
TOTAL	5	49

Table 2: Number of selected polling unit in each selected polling ward.

POLLING WARDS	**NAME OF POLLING WARDS**	**NUMBER OF POLLING UNITS**	**SELECTED NUMBER OF POLLING UNITS**
1.	Bwari Central	7	3
2	Byazhin	7	3
3.	DutseAlhaji	9	5
4.	Kubwa	11	6
5.	Usuma	15	8
TOTAL	10	49	25

A convenience sampling technique was employed in the selection of public primary schools around the randomly selected polling units within each polling ward. As in each school, there were a certain number of school present beside each polling unit and some polling units have the same schools near them, hence the use of the convenience sampling. The head teachers of each school was used in the study. Six teachers from each primary school were selected for the study with the help of the head teacher. A number of six students were in addition selected for the study with the help of the teachers.

Instrumentation for Data Collection

The method of data collection is both qualitative and quantitative method with use of The observational checklist from the school health evaluation scale by the Federal Ministry of Education's sanitary inspection form was adapted to evaluate the practice of School Health Programme as the checklist covered all the domains of the School Health Programme.

The Key Informant Interview (KII) guide was developed and administered to the head teachersin each selected schools based on the themes listed below:
Section A: School Health Programme: This contains information concerning their awareness of School Health Programme.
Section B: Condition of School Health Programme: This contains information on the state of the School Health Programme.
Section C: Challenges faced in implementing School Health Programme: this contains information on the challenges faced by the school towards the implementation of the School Health Programme.
Section D: Role played by Government in School Health Programme: This contains information on government current involvement towards the implementation of School Health Programme in Schools.
Section E: Monitoring of School Health Programme: This contains information on the method of monitoring of the School Health Programme.
Section F: Successful Implementation of School Health Programme: This contains information on suggestion offered towards the successful implementation of School Health Programme in Schools.
A self-administered semi-structured questionnaire was given to the teachers and contained the following sections:
Section A: this contains demographic variables on the respondent
Section B: This contains information on the level of awareness of the teachers on the School Health Programme and National School Health Policy.
Section C: This contains information on the teachers' assessment of the components of the School Health Programme available at school.
Section D: This contains information on the challenges faced in the implementation of School Health Programme available at school.
A Self-administered semi-structured questionnaire was given to the students within the school based on the following sections:
Section A: This contains demographic variables on the respondent
Section B: This contains information on the students' assessment of the components of School Health Programme available at school.

Validity and Reliability
Validity: Both face and content validity of the instrument was determined by the research supervisor by going through the questions for the Key Informant Interview (KII) and questionnaire and making the necessary adjustments to the questions. A pilot study was carried out the Abuja Municipal Area Council using 2 schools which is 10% of the total sample size for the study, to examine if the questions for the questionnaire are understood and can be answered, while necessary corrections were made.
Reliability: Cronbach alpha was used to evaluate the reliability of the instrument for the teachers and students. The teachers' questionnaire with a number of 30 items had a reliability alpha (α = .717) and The students' questionnaire with a number of 21 items had a reliability alpha (α = .741)

Data Collection Procedure

A letter of Introduction was presented to the head teacher of each school. The contents of the research were explained before permission was given to carry out the research. The Key Informant interviews were first carried out before meeting with other respondents within each school to administer the questionnaire. The Key Informant Interviews were recorded with the permission of the head teachers using a voice recorder and notes were taken down from the verbal information gotten from the respondents. The recording and notes were compared and the relevant points towards the questions were taken down.

Observation of the school environment focused on the areas stated within the checklist, if they were present or absent within the school environment. The areas present on the checklist were ticked according to the level of their effectiveness under adequate, needs major correction, needs minor correction and absent.

The semi-structured questionnaires were administered to the respondents (teachers and students) after seeking their consent and the permission of the head teacher. Respondents were required not to write their names or any form of identification to ensure their anonymity. A letter of consent was presented to the respondents to sign before administering the survey instrument. The purpose and content of the questionnaire was explained to the respondents adding that their identity will not be disclosed. Completed questionnaires were collected on the spot.

Data Management and Data Analysis

The Taped interviews was transcribed punctiliously with texts analysed using the thematic approach after repeated listening to recorded responses to ensure credibility. Transcripts from the data were interpreted

with thematic approach; Main themes and sub-themes are discussed below in subheadings and illustrated by quotes. The data retrieved from this study from the questionnaire and observational checklist were analysed using the version of 20.0 statistical package for Social Sciences (SPSS). Data was analysed producing tables, frequencies and percentages, pie chart. SPSS was used to analyse all sections of the questionnaire and observational check list, while the thematic approach was used to analyse all the interviews.

II. Results:

Awareness of School Health Programme

Table 1: Awareness of School Health Programme

Variables	Respondents in this study=120	
	Frequency(n)	Percentage (%)
Have you heard of National School health?		
Yes	47	39.2
No	73	60.8
Are you aware of School Health Programme?		
Yes	53	44.2
No	67	55.8
Five components of School Health Programme		
Yes	4	3.3
No	116	96.7

Summary of Descriptive Statistic of Level of Awareness

Variable	Maximum points on a scale of Measure	Respondents in this study=120	
		x(S.E)	±SD
Level of awareness	3	0.87(0.08)	0.91

Proportion of Respondents Level of Awareness

	Respondents in this study; N=390	
	Frequency	Percentage (%)
Low level of awareness	79	65.8
High level of awareness	41	34.2

As presented in table 1, Few (39.2%) of the respondents (teachers) had heard of National School Health Policy. Less than half (44.2%) were aware of School Health Programme. Only (3.3%) of the respondents (teachers) can state the components of School Health Programme according to the National School Health Policy. Similar reports were given by the head teachers that were interviewed. most of the head teachers interviewed were not aware of School Health Programme*:*

One of the head teacher stated that "l am unaware of School Health Programme and it components, which was the response of most of the head teachers

However, about five respondents mentioned they were aware of the School Health Programme and National School Health Programme but were unaware of the components –

one of the head teacher stated that "yes I know what it is about. The school is supposed to have a committee or office responsible for the health of the children although we don't have that, we only have first aid"

Respondents (teacher's) level of awareness of School Health Programme measured on a 3-point rating scale, showed that respondents had a mean score 0.86±0.91 translated to level of awareness of School Health Programme prevalence of 28.67%.

III. Conclusion

This study shows the extent to which the School Health Programme among Schools in Bwari Area Council is being implemented. There is generally a low level of awareness among the head teachers and teachers alike and in addition, the condition of School Health Programme among the schools is generally poor. Most of the schools recorded the absence of a sick bay, health personnel, availability of playgrounds, mid-day meal programme, teaching aids.

IV. Recommendations

In view of the findings, there is a need to pay attention to the proper implantation of the School Health Programme, therefore the schools should;

1. There should be a training and re-orientation for head teachers on the National School Health policy to raise their level of awareness and knowledge.
2. There should be adequate monitoring of facilities provided within the school to ensure proper maintenance.

3. The government should attend to reports sent by the schools on the state of the school buildings and facilities.

V. Discussion:

Research Question 1: What is the level of awareness of the School Health Programme and National School Health Policy (NSHPo) among primary schools?

The level of awareness of the School Health Programme (SHP) and National School Health Programme (NSHPo) is low among respondents. This is similar to the findings in Kuponiyi (2016) were he reported that majority of the head teacherslack proper knowledge about School Health Programme and its components. This similarity could be as a result of lack of implementation of the School Health Programme.

Research Question 2: What is the condition of primary schools in Bwari area council in line with the School Health Programme?

All the schools visited maintained a clean environment in their school buildings, playground, but lacked adequate recreational facilities, toilets, roofing, ceilings, walls and appropriate materials for proper waste disposal. Most had poor hand washing facilities andportable water supply. This is similar to findingsOfovwe&Ofili (2007) reported in Edo state, where the head teachers revealed they had poor hand washing facilities, poor water supply. Also, there were enough trees provided visited. This is also similar to the findings of Boateng (2008) in the Kwabre District were majority of schools had enough trees/lawns.

Health education is enlisted as part of the school curriculum in all schools, but most schools did not have sufficient materials to aid in teaching health education. This is in contrast to the implementation guideline given in the National School Health Policy on the skill-based education which states that teachers should have adequate teaching materials such as textbooks, charts available within the school (FME 2006).

There is no mid-daymeal program in the school, however students purchase their food from registered food vendors or bring their food from home. Ofovwe and Ofili (2007) showed that students brought their meals from home while others obtain their midday meals from mobile and permanent food vendors respectively. This may be attributed to the fact that they are unaware of the component enlisted in the National School Health Policy 2006 that mandates the provision of mid-day meals for the pupils.

All the schools had a functional Parent-Teacher Association held at least once in a year or once or twice in a term. Parents contribute towards projects within the school and are encouraged to participate in activities set up by the schools. This shows an amiable relationship between the school and homes.

Most of the schools assessed on the condition of the School Health Servicesdid not have a sickbay. There were no health personnel within any of the schools. First aid boxes available were not filled with appropriate materials (cotton wool, spirit), therefore the students were sent to nearby hospitals or their parents are notified about their children state when they are sick. Contrary to our findings, Odeyemi&Chukwu (2016) observed in both Ikenne and Ifo local government area, the practice of pre admission medical examination was not compulsory and available components of the School Health Services were a functional first aid box, having some health personnel in charge of the school clinic such as a nurse.

Research Question 3: What is component of the School Health Programme that is available within the school environment?

Most components of the School Health Programme were available in the school.However, they are not implemented as stated by the National School Health Policy, but all the schools had a functional PTA and parents were concerned about the education of their children. The PTA is a source of funding to the school as tokens provided are used for repair and maintenance of the school environment, in addition, they contribute towards building new class blocks and offering advise towards the management of the school environment.

There is a health education teacher available among all the schools, as health education was an essential part of the school curriculum. Physical education was also practiced in the various schools as they all had different days for carrying out physical education, however did not have adequate materials (textbooks, charts, flyers) to carry out health education.

Among all the schools, there was no provision made for the School Feeding services as none of the schools provided mid-day meals for their students, the schools only had registered food vendors available around the school compound, which provided both the teachers and students alike with drinking water and food alike although some mostly brought their foods from home.

On the health school environment, each school regularly kept their environment clean but it lacked the necessary facilities (fencing, desk and chairs, roofing, toilets) to ensure a health environment. Majority of schools observed did not have a fence. This poses some security risks to the students as vehicles occasionally trespassed through the school grounds. Most of the classes were over populated, the students did not have enough desk and chairs to seat on and made due with the ground. Some of the schools had bad roofing and walls, collapsing toilets as a result of erosion and lack of maintenance. Good toilets available within some of the school premises were donated by non-government organisations or public institutions (churches, schools), but

the number of toilets available among the most of the school was not enough to cater to the needs of the number of students and teachers.

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