

An assessment of barriers to implementation of school health program in primary schools in Ido/Osi, Southwest, Nigeria: a qualitative study

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ABSTRACT

INTRODUCTION: School Health Program is an event that promotes the understanding, maintenance, and improvement of the school community's health and ensures that children are at all times in a state of optimum health. The implementation of School Health Programme in most parts of Nigeria is, however, poor or suboptimal. The objective of the study was to assess the quality of the School Health Programme being implemented in Ido/Osi Local Government Area, Southwest Nigeria.

METHODS: Focused group discussions were carried out among 4 different groups of 8 participants each, with each group comprised of different administrative heads and health instructors. The qualitative study was carried out among primary schools in the Ido/Osi local government area in Southwest Nigeria. The data were analyzed using a thematic framework approach for qualitative data analysis.

RESULTS: Administrative heads and health teachers lacked in-depth knowledge of the School Health Programme. Most private schools had good buildings but the majority of public schools had dilapidated structures. All schools had at least a source of water. Toilet facilities were present in a few public schools and in all private schools. Most of the schools practice open dumping of refuse. All the schools had a first aid box but with varying content. Only one private school had a school nurse. All the schools send a child with suspected communicable diseases home. Free mid-day meals are available in public schools but lacking in private ones.

CONCLUSION: The study revealed the poor state of SHP in Ido/Osi and identified deficiencies in the effective implementation of SHP.

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INTRODUCTION

School Health Programme (SHP) involves a series of coordinated events that promote the understanding, maintenance, and improvement of the school community's health [1,2]. It is

multidisciplinary and involves cooperation from schoolteachers, school administrators, health educators, environmental officers, physicians, nurses, and other stakeholders who appraise, promote, protect, and maintain the health of all members of the school community [2]. The

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objectives of the SHP are to obtain a rapid and sustained improvement in the health of school children and ensure that school children are in a state of optimum health at all times so that they can attain their physical and intellectual potential [3]. Primary school education is the first level of formal and structured education, forming the bedrock of any other educational attainment. Hence, there is a need to make primary schools and their environment healthy to promote school pupils' health. The SHP is a cost-effective way of meeting the health needs of children [2]. Promoting the health of the school populace is a critical step towards quality achievement in education.

Unfortunately, implementation of SHP in most parts of Nigeria has been generally poor or suboptimal, and implementation varies from place to place [4-8]. Low levels of health knowledge among teachers, scarcity of health education teachers, and inadequate resources for teaching are some of the factors noted by previous studies to militate against the effective implementation of SHP in Nigeria [5,6]. Furthermore, weak school policy, insufficient time allocation to the teaching of health, minimal support from non-governmental agencies and other community members, lack of vision, inadequate planning, lack of accountability, inadequate coordination and collaboration between the government and schools, as well as lack of program infrastructure have also been noted [4, 7, 8]. However, these factors vary from region to region and even vary within the same geographical area.

In recent times, the government of Ekiti State made efforts to improve primary school education. These efforts included the commencement of free school meals for pupils in primary one to primary three, rehabilitation of dilapidated structures, and supply of educational materials and kits to public primary schools [9, 10]. The school feeding program is meant to improve the health status and academic performance of pupils. It also aims to improve school enrolment and decrease school absenteeism [9]. These government efforts are meant to improve SHP implementation in the state. This study assessed the quality of SHP implemented in Ido/Osi Local Government Area (LGA), Southwest Nigeria, identified areas needing intervention, and offered suggestions to the relevant stakeholders and authorities.

METHODS

A qualitative study was carried out using focused group discussions (FGDs) among primary schools in Ido/Osi LGA, in Ekiti State, Southwest Nigeria. The State has six tertiary educational institutions and three teaching hospitals. According to the 2006 Census, the LGA has a total population of 159,114 people [11]. The main source of drinking water is well water, with an irregular supply of tap water and electricity.

There are 72 primary schools (52 public schools and 20 private schools) in the LGA, which serve the educational needs of the local people.

Participants were recruited purposively. They comprised administrative heads and school health instructors, as both groups are key stakeholders in the implementation of SHP [2, 5, 8]. Four focused groups comprising eight participants each were selected for the FGD. Two groups (one for private and one for public) contained only the schools' administrative heads, while the other two groups (one for private and one for public) comprised only the school health instructors.

Ethical approval was obtained from the Research and Ethics Committee of the Federal Teaching Hospital (ERC/2018/08/31/136A), the State Ministry of Education (EK/ED/SCHLS/84/VOLII/177), and the State Universal Basic Education Board (EKSUBEB/SS/57/57). Also, participants were asked to sign a consent form before the commencement of the interviews.

A round table interview was conducted with each FGD in the staff room on separate days. The staff room is quiet, and confidentiality is maintained as only participants for the FGDs were allowed in during the discussion period. Each participant in the group was asked to respond to questions asked by the researcher one after the other. An interview guide with a stem of 10 questions was used. There was audio recordings of the discussion sessions. In addition, a checklist was used to obtain relevant information on their sociodemographics, as well as SHP knowledge/awareness and implementation in their respective schools from the participants. Furthermore, field notes were taken by the researchers and their assistants. Interviews were conducted in private settings, each taking forty-five minutes to one hour. The participants' responses were noted and recorded until they reached their saturation point.

The data was transcribed and analyzed using the

thematic framework approach for qualitative data analysis [12].

RESULTS

Of the 32 participants, 5 were males, while 4 were not married. Respondents' educational qualifications are shown in Table 1. Of the respondents from public schools, 68.8% had Nigeria Certificate in Education (NCE), 25.0% had a Bachelor in Education (B. Ed), and 6.2% had a Bachelor of Science, while 37.5%, 37.5%, 18.8%, and 6.2% respondents from the private schools, had NCE, B. Ed, BSc, and Higher National Diploma (HND) respectively.

Table 1: Educational qualification of respondents for focused group discussion

Qualification	Public (%)	Private (%)
NCE	11 (68.8)	6 (37.5)
B. Ed	4 (25.0)	6 (37.5)
BSc	1 (6.2)	3 (18.8)
HND	-	1 (6.2)
Total	16 (100)	16 (100)

NCE: Nigeria Certificate in Education; B. Ed: Bachelor in Education; HND: Higher National Diploma; BSc: Bachelor of Science

Awareness and knowledge of school health program: Most of the participants have heard about SHP through various means like radio, internet, health officials, seminars, and during the course of their training as a teacher. However, all eight health teachers from the public schools claimed ignorance of SHP and its components. None of the participants could give a clear definition of SHP as they all had different ideas on the subject.

"SHP is about the health of school pupils. Teaching pupils not to injure themselves by playing with sharp objects. And giving them reasons why they should stay away from playing with sharp objects".
"A mean whereby we impact the children on how to take care of themselves and take care of minor injury".

Concerning components of the school health programme, none of the participants knew all the components.

"Nutrition, personal health, safety education, counseling, physical activities"

Healthy School Environment: Most of the respondents demonstrated knowledge of what

constitutes a healthy school environment. However, respondents varied in their responses on what is obtainable in the school environment in their respective schools. In terms of school buildings, most private schools had good structures and facilities, with few having leaky roofs. However, public schools had more dilapidated structures with broken windows, broken floors, absent ceilings, and leaky roofs.

"School buildings are of normal size with strong walls. We have few leaky roofs" in private schools.

"Our buildings are fair with broken windows and doors with, some leaky roof and ceilings" public school.

"Buildings are strong, broken floors, some leaky roof", public school.

All the interviewed private school participants claimed they had a water source located within the school, either in the form of a well or a borehole. However, some public schools had to go outside the school to access water.

"No water within the school. We get water from a borehole in a mission house not far from the school", public school.

Refuse disposal was by open dumping by all the schools except one private school that uses an incinerator. In the same vein, one in four public schools had no toilet for sewage disposal. However, all the private schools had toilet facilities. Also, of all the schools represented, only one private and one public school had a complete fence; most schools either had no fence at all or were incomplete.

"We have security to control traffic and teachers monitor pupils while playing, no playing with sharp objects" private school.

"No playing close to dilapidated structure, supervision during playing" public school.

School Health Services: Only one private school had an auxiliary nurse in its sick bay. None of the schools carried out pre-school medical screenings or routine health examinations by specialists. However, all the schools carried out routine health inspections mainly on Mondays. Also, the majority of the schools had a first aid box but with varying degrees of content. Few had no content in their first aid box. Most of the respondents had an idea of what constitutes the content of a first aid box.

"Paracetamol, cotton wool, spirit, iodine, bandage, gelusil, mixmag, vitamin C", "Stethoscope, thermometer"

On how to manage a communicable disease, all the schools send a child with a suspected communicable disease home. Few schools give health talks on communicable diseases, but none of the schools give immunization except the supplemental immunization organized by the government. During emergencies, the schools with available first aid materials render first aid and then refer the child to the nearest Primary Health Centre. No school had a trained first aider.

"In a case of an emergency, we render first aid and call the parent before referring to the health center."

About one-third of the respondents had a book for health records where they only recorded treatment given to pupils after first aid. One private school had a health record book that was commulative and transferable.

All the public schools benefitted from the federal government Home Grown School Feeding (HGSF) program. None of the private schools served food. However, some private schools had a buttry where the pupils could purchase snacks. Respondents vary in their responses to the quality and quantity of the food the HGSF program provides.

"The quantity is fair but the quality is okay."

"Nutritious, but small quantity"

"Terribly small with no quality."

The respondents had an idea of the benefits of a good school meal.

"A good school meal increases the school population, provides one quality meal a day as some pupils do not eat to school."

"It provides essential nutrients."

"Reduces school absenteeism, increases enrolment, and improves the child's mental and academic performance."

School Health Instruction: On health instruction, the schools do not practice a rotational form of teaching where a subject teacher teaches the same subject to all the arms of the primary school. Only the public pilot schools practice a rotational form of teaching. Occasionally, voluntary groups and health personnel visit the schools to teach the pupils and teachers about health. Some private schools, with pupils whose parents are health workers, leverage the opportunity to ask the parents for a health talk.

"We do not practice a rotational form of teaching. It is only pilot schools like SUBEB that have such."

"Voluntary groups like the Red Cross occasionally

visit." Health is being taught three times a week in all the schools. Most public schools lacked instructional materials like chats and audio-visual aids. The private schools fared better in terms of instructional materials.

"We have a few chats on the care of the body and teeth, use of water."

None of the teachers undergo regular in-service training on health. They are only exposed to health training when it is being organized by the government.

"We occasionally go for training only when the government invites us."

"Since I have been in school, I have not attended any health seminars. The headmasters choose who to represent the school whenever the government invites us for a health seminar."

"We have a lot of kids in our school whose parents are doctors. We use the opportunity to organize health talks, especially during a disease outbreak like Lassa or Ebola. They educate the pupils and the teachers. And we also go for government-organized health seminars."

Constraints to effective School Health Programme The participants identified the following constraints to the effective delivery of SHP in the schools: lack of political will, funding from the government and PTA, and lack of health personnel and first aid materials. Also, poor managerial skills of the HMs, lack of potable water, fences, and gates, lack of cooperation from the parents, religious bias on the part of the parents, dilapidated buildings, lack of toilets, and lack of effective PTA.

"Inadequate PTA relationship, low awareness on health, lack of cooperation from the parents, fund"

"Religiosity, some parents prevented giving pupils' medication for deworming given to us by the government."

DISCUSSION

This study revealed that the implementation of SHP in Ido/Osi LGA was inadequate. This is not surprising as the administrative heads and health teachers who are the arrowheads in the implementation of SHP in the schools lacked in-depth knowledge on the subject matter as they could not define nor say the components of the SHP correctly. A study by Ofovwe and Ofilli and Bisi-Onyemaechi et al., in Edo and Enugu States, respectively, noted that no head teacher had adequate knowledge of SHP [7,13].

Despite the teachers' educationally related qualifications, this did not impact their awareness of SHP. Incorporation of SHP into the Teacher Education Curriculum, appropriate training on school health, and regular in-service training are needed for school teachers to fill their knowledge gaps, as trained teachers are more likely to continue implementing the SHP compared to teachers who are not trained [14].

Most of the respondents demonstrated knowledge of what constitutes a healthy school environment. However, respondents varied in their responses on what is obtainable in their respective schools, thus indicating varied implementation. Most private schools had good structures and facilities, with few having leaking roofs. However, the public schools had more dilapidated structures with broken windows, broken floors, absent ceilings, and leaking roofs. These findings are similar to other studies done in Nigerian primary schools [4,15-17]. The presence of dilapidated buildings portends danger as they could collapse, killing or maiming the pupils. They could also constitute a negative factor in the psyche of school children who are in their formative years. The lack of ceilings or incomplete ceilings predisposes pupils to heat during the day, causing discomfort to maximum learning. All the private schools interviewed had a source of water located within the school, either in the form of a well or a borehole. However, some public schools had to go outside the school to access water. The location of water outside the school premises threatens water adequacy for various uses, thereby putting the schools at risk of disease outbreaks associated with water shortage/lack.

The lack of toilet facilities in some of the schools, mostly the public schools, could predispose pupils to unhygienic waste disposal, thereby putting them at risk of environmental pollution and disease epidemics. Most of the schools practice open dumping. This practice is not peculiar to the current study, as other studies reported similar findings [4,7,18-20]. Open dumping of refuse serves as a breeding site for flies, mosquitoes, and rodents. Children could also suffer injuries from sharp objects in these refuse sites.

The lack of a complete fence in some schools gives intruders easy access. Animals could freely graze within the school premises, destroying the aesthetics and also litter the environment with dung. Likewise, humans may use the school compound

for games like football and smoking centers, litter the classrooms with human excrement, and destroy some of the facilities.

Only one private school had an auxiliary nurse in its sick bay. The low availability of health personnel in schools is similar to findings by Olatunya et al., in Ilesha, southwest Nigeria, and Alex-Hart et al., in Rivers State, South Nigeria but below the recommended national average of at least 17% [3,21,22]. With the paucity of health personnel, minor ailments are unattended to early. These could progress to debilitating illnesses that could lead to school absenteeism [21].

None of the schools carry out pre-school medical screening or routine health examinations by specialists. This is similar to the findings noted in Rivers State [22]. However, the observation that all the schools carried out routine health inspections at least once a week, mainly on Mondays, is commendable, and this has been reported by previous studies, giving an indication that teachers in Nigerian primary schools routinely carry out this aspect of pupils' health appraisal [21, 23]. Also, the majority of the schools had a first aid box but with varying degrees of content. Few boxes had no content. The incompleteness of the first aid box content could imply that minor cuts and injuries sustained during school hours would be left unattended due to a lack of first aid materials. Pupils with suspected communicable diseases like measles and chicken pox are sent home by all the schools. Other authors noted this practice, which could be due to the fear of spreading such disease within the school community [24,25].

As observed in this study, the lack of adequate school records is worrisome. Poor record keeping was also documented in some previous Nigerian studies [22,25]. Lack of health personnel and knowledge of the importance of health records could contribute to poor record keeping.

The Federal Government free meal HGSF program was enjoyed by all the public schools. This is similar to the findings in Osun State and Ekiti State but at variance with the findings in Ogun State, where midday meals were available in all the schools but at a non-subsidized cost to the pupils, thus raising the need for universal applicability/implementation of free school meal program in the study area and across Nigeria irrespective of the type of school ownership [21,26,27]. The participants also reported a steady decline in the quality and quantity of food served

in the public schools, as noted by the teachers and head teachers. This may be due to the paltry value placed on a plate of meals, the increase in the cost of raw food in the market or the lack of monitoring of the food vendors by appropriate government agencies. There is a need to address the lapses observed in the free school meal program so that school children could benefit from the SHP implementation in the study area and Nigeria by extension. A well-implemented school meal provides essential nutrients, reduces school absenteeism, increases enrolment, and improves a child's mental and academic performance [26,27]. Teachers with poor knowledge of health issues were delivering health instruction in most of the schools. This shortcoming is noted by various authors across the country [8,28,29]. Same teacher teaches all the subjects in a class may lead to poor delivery of health instruction. As observed in this study, private schools took advantage of pupils whose parents are health personnel for health talk, while public school teachers depended on the occasional in-service training organized by the government. In-service training exposes teachers to updates on health and better prepares them to teach health. Teaching aids like charts were lacking in most of the schools. This is discouraging as children tend to recall better what they hear and see, thus suggesting that the use of multiple synergistic teaching methods represents the best approach to delivering health instructions in schools [29]. The lack of educational materials and good knowledge of SHP is not peculiar to this study, as similar findings have been noted in previous studies across the country [28,30]. There is a need for critical stakeholders to come to the rescue of SHP implementation in Nigeria.

There are some limitations to consider for this study.

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Some head teachers may have intentionally given inaccurate information (lie bias) or unintentionally (recall bias) on certain questions. Also, there was a lack of time and available resources to interview all stakeholders involved in SHP in the State vis a vis the Commissioner of Education in the state, representative of the LG implementation committee, representatives of the Parent-Teacher Association, community and students, etc.

CONCLUSION

The study revealed the poor state of SHP in Ido/Osi and also identified deficiencies in both human and material resources needed for the effective implementation of SHP. Also noted is the poor awareness of the teachers on the concept of SHP. Critical stakeholders saddled with the maintenance of school health and related government functionaries need to rise to stem the tide of poor SHP implementation in Nigeria.

The following recommendations are proffered: The curriculum for training teachers should be reviewed with components of SHP given the pride of place it deserves. This should be backed with regular in-service training and seminars on SHP to improve teachers' awareness and knowledge of SHP. All primary schools need to have a well-constituted and functional school health committee. Also, the stakeholders, especially the State Government to review its commitment to SHP by providing the necessary manpower, materials, and financial aid needed to make SHP more efficiently practiced, and regular/periodic on-the-spot monitoring/follow up on enforcement of minimum standards required of schools for the implementation of the SHP is advocated.

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