

Knowledge, Attitude and Practice of School Health Programme among Primary School Teachers in Gwagwalada Area Council, Abuja Nigeria

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ABSTRACT

Introduction: A comprehensive school health programme is an integrated set of planned, sequential, school-affiliated strategies, activities and services designed to promote the optimal physical, emotional, social, and educational development of students. Teachers play a major role in the promotion and successful implementation of the programme. This study aimed to assess the knowledge, attitude and practice of school health programme (SHP) among primary school teachers in Gwagwalada Area Council Abuja, Nigeria.

Methodology: A descriptive cross-sectional study was carried out. A sample size of 257 was studied. A cluster sampling technique was used to select the schools. Data was collected by means of self-administered, semi-structured questionnaire. Demographic variables and associations were tested using Chi-squared tests with the level of statistical significance set at $p < 0.05$.

Results: About 246 respondents completed the survey where overall, 99.2% had good knowledge on SHP. A high proportion of teachers in public schools had good knowledge (100%) compared to (98.6%) of respondents in private schools ($p = 0.228$). The knowledge on SHP increases significantly with teaching experience and respondents having above 5 years of teaching experience all having 100% knowledge compared to 98% of good knowledge observed in respondents with below 5 years teaching experience ($p < 0.0001$). About 83.33% of teachers in both public and private schools had positive attitudes to SHP. However, teachers in the private schools had a better attitude of 87.4% compared to 77.7% in public schools ($p = 0.043$). The practice of the components of SHP was generally poor. For example, our study revealed that about 37.9% practice open defecation in the public schools and there was absence of hand washing facilities in 66% of public schools and 42.3% of private school ($\chi^2 = 93.434$, $p = 0.0001$). Pre-school medical

examination was reported in only 43.9% of all the schools studied and majority were the private primary schools (58.7%). Also most of the schools studied (67.1%) do not conduct periodic medical examinations for pupils.

Conclusion: There was good knowledge of SHP and positive attitude of teachers towards SHP. However, the practice of most components of SHP was generally poor, especially in public schools that reported poor toilet and hand washing facilities. Therefore, concerted efforts by all stakeholders are required to ensure that the minimum standards for setting up schools as contained in the national school health policy are fulfilled and this should include source of portable water and provision of toilet and hand washing facilities as well as the required medical examinations.

Key words: *School health programme, teachers, primary school, knowledge, attitude, practice.*

1. Introduction

Education has been described as the most important instrument of change. Fundamental changes in the intellectual and social outlook of any society have to be preceded by educational initiative. It thus becomes imperative that in order to achieve maximum output, an enabling learning environment needs to be made available. [1] The World Health Organization (WHO) defines a health promoting school as one that is constantly strengthening its capacity as a healthy setting for living, learning and working. Such schools foster healthy learning environment. A comprehensive school health programme is an integrated set of planned, sequential, school-affiliated strategies, activities and services designed to promote the optimal physical, emotional, social and educational development of students. The program is supportive of families and is determined by the local community, based on community needs, resources, standards and requirements. It is coordinated by multidisciplinary team and is accountable to the community for programme quality and effectiveness. [1]

Historically, schools have been the focus of numerous and varied efforts to promote and secure the health of children and young people. [2] School health programme have evolved over the years and was influenced by political, societal as well as health issues. In the USA, Benjamin Franklin advocated a "healthful situation" and promoted physical exercise as one of the primary subjects in the schools that were developing during his time. Samuel Moody, headmaster of the Dummer Grammar School, which opened in 1763 as the first private boarding school taught the value of exercise and he participated in it himself. Prior to the mid-1800s however, public education was still in a formative stage and efforts to introduce health into the schools were isolated and sparse. Lemuel Shattuck, produced a report that had a significant impact on school health and has become

a classic in the field of public health. [3] When New York City was faced with an outbreak of smallpox in the 1860s, no mechanism was in place to provide free vaccinations to those who needed them, so the Board of Health turned to the schools. Education officials agreed to permit inspection of school children to determine whether or not they had been vaccinated and in 1870 smallpox vaccination became a prerequisite for school attendance. [4]

Although the schools of this period had the potential to confront and control communicable diseases, no doubt they also contributed to the spread of diseases. In the late 1860s and early 1870s, the New York City Board of Health instituted a programme of sanitary inspections of all public schools twice a year. These inspections revealed a filthy environment and excessive crowding. Modern plumbing was nonexistent, and schools were sometimes overrun by rats. Frequently, more than 100 students occupied a single small classroom with two or three children sitting at the same desk. Classrooms lacked ventilation and fresh air, a problem exacerbated by using stoves for heating and gaslights for illumination. These problems continued in New York City even into the early twentieth century and the situation was not unique to New York [4].

Provision of health services like immunization, school feeding, counselling, sick-bay and school dispensaries are not new to Nigeria. In Nigeria, the first School health service (SHS) was instituted in 1929 with the efforts of Dr. Isaac Oluwole, who was appointed the first medical officer of health, in Lagos. [5] In 1952, Government of western Nigeria introduced a policy with 4-year plan to introduce a school medical service that will be available and free while in 1971 school health services were established at Federal Government level with centers in Jos, Kaduna, Ibadan, Enugu, Zaria and Benin. [5]

In 1991 Graves, a WHO representative in Nigeria called on the Federal Government to start school health programme in primary schools with appropriate information and education [5]. These support services contributed to the quality of education Nigeria. In 2001, the Federal Ministry of Health and the Federal Ministry of Education in collaboration with WHO took the initial step by conducting a Rapid Assessment of School Health System in Nigeria to ascertain the status of school health. The assessment noted several health problems among pupils, the lack of health and sanitation facilities in schools and the need to resuscitate the School Health Programme in Nigeria and provide a legal framework for its implementation. [5]

The National School Health Policy and the Implementation Guideline on the National School Health Programme, endorsed by the then minister of education, Dr. Obiageli Ezekwesili in 2006 was aimed at promoting the health of pupils to achieve the goals of Education for all and outline roles of relevant line ministries like Education, Health, Environment, Water Resources, Information and other stakeholders for the realization of the ideal school environment for the benefit of school children in Nigeria. [6] While there were some studies that assessed the state of school programme in the southern part of Nigeria, there was paucity of literature on the state of implementation of the school health policy in the northern part of the country, where Abuja, the Federal Capital Territory (FCT) is located. Information from this study should be used to guide policies and improve the health of school children, lead to better academic performance and national development. The objective of this study therefore was to assess the knowledge, attitude and practice of school health programme among primary school teachers in Gwagwalada Area Council in Abuja, Nigeria.

2. Materials and methods

2.1 Study area

This study was carried out in Gwagwalada, which is one of the six area councils in the Federal Capital Territory of Nigeria. Gwagwalada has an area of 1,043km² and a population of 157,770 at the 2006 census. Abuja, the national capital of Nigeria is located north of the confluence of the Niger and Benue rivers with the longitude and latitude of 9^o12^o North and 7^o11^o East. Abuja is almost in the center of the country and has most of the ethnic groups in Nigeria working and living there. [7]

2.2 Study population

This study focused on teachers in public and private primary schools in Gwagwalada area council who had teaching experiences of at least one year and above.

2.3 Inclusion and exclusion criteria

All primary school teachers in the study area with less than one year of teaching experience were excluded as they lacked adequate information of the state of school health programme in their schools. Student teachers on teaching practice were also not included in the study.

2.4 Study design

The study was a cross-sectional descriptive design.

2.5 Sample size

Sample size was determined using Leslie-Kish formula: [8]

$$N = Z\alpha^2 \times p \times q/d^2$$

2.6 Sampling technique

A cluster sampling technique was used. A sampling frame of the public and private primary schools within Gwagwalada area council was made using available information from the zonal education office. There were 86 public schools and 356 private primary schools registered within Gwagwalada area council. One school was classified as one cluster; therefore, two public primary schools and 8 private primary schools were selected proportionately by simple random sampling. All consenting teachers in each cluster selected were included in the study.

2.7 Data collection

The data was collected by using a questionnaire including a combination of structured and semi-structured questions. The questionnaire was self-administered to all consenting teachers in the selected schools, after permission was granted by the head teachers in each school. Prior to commencement of the study, the questionnaire was pre-tested in a selected primary school in Kwali area council which is outside the study population. This was to minimize contamination bias that may affect the quality of data to be derived from the actual study. Low compliance was identified as a result of the initial large number of questions. This was

corrected in the final questionnaire which was administered to the study population without further difficulties. The results of the pretest were not included in the analysis of the results.

2.8 Data analysis

Data from the questionnaires was entered and analyzed using the statistical package for social sciences (SPSS version 23.0). Data presentation was in the form of tables, graphs and charts. In the analysis of the level of knowledge, the correct options for each item constituted good knowledge and scored one point while the wrong options constituted poor knowledge and awarded zero score. The maximum obtainable score for knowledge was 21 points, with a score of ≥ 10.5 (50%) taken as adequate knowledge and scores below 50% categorized as poor knowledge. The attitude of respondents was assessed using Likert scale: strongly agree and agree were categorized as positive attitude and scored two points while indifferent, disagree and strongly disagree were classified as negative attitude and a score of zero was awarded for them. Thus, the total obtainable score was 10 and a score of greater than or equal to 5 (50%) was classified as positive attitude and scores below 5 were categorized as negative attitudes. Frequency counts and percentages for the practice of some selected components of the school health programme were estimated. Chi-square test and p-value set at <0.05 were used to ascertain association between the socio-demographic variables and knowledge, attitude and practice of school health programme among the teachers.

2.9 Ethical consideration

Ethical approval to conduct the study was obtained from the University of Abuja Teaching Hospital Health Research Ethics Committee. In addition, a written informed consent was obtained from all participating school teachers. Participation was voluntary and questionnaires were administered in a setting that ensured privacy and confidentiality of information. The research process was thoroughly explained to participants and absolute honesty in answering the research questions was encouraged.

3. Results

3.1 Socio-demographic characteristics of respondents

A total of 256 questionnaires were administered out of which 246 were properly completed and returned, giving a response rate of 96.1%. Among the 246 who completed the survey, 103(41.9%) respondents were in public schools and 143(58.1%) respondents were in private schools. The mean age was 32.82(\pm 6.788) years, with the majority of 91 (37.0%) falling within 26-31years age group. There were more female teachers than males: 163 (54.3%) vs. 103 (41.7%). Most of the respondents were married 163(66.3%), while 83(33.7%) respondents were single. The average number of years of teaching experience was 7.8 (\pm 5.1) years. Majority of the respondents 122(49.6%) were degree holders, followed by 45.1% (111) who were National Certificate of Education (NCE) holders. Only 9(3.7%) of the respondents taught Physical and Health Education, with majority teaching science subjects: 79 (32.1%). The dominant ethnic groups sampled were the Igbo tribe (22.1%) followed by the Yoruba tribe (16.1%) and Hausa (6.8%).

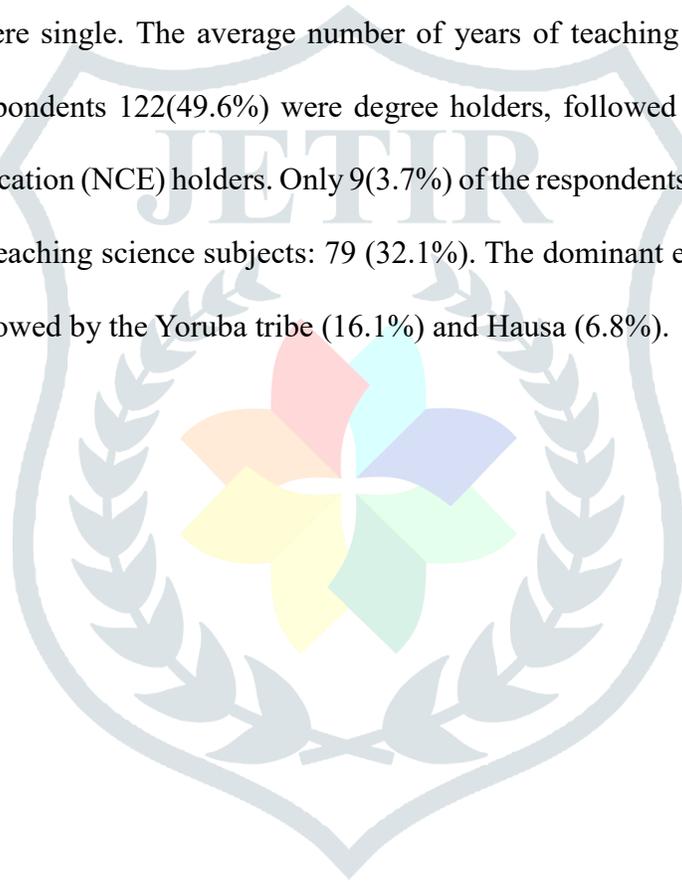


Table 1: Socio-demographic characteristics of respondents

Variables	Private school (n=143) n(%)	Public school (n103) n(%)	Total (N=246) N(%)	Statistic χ^2	p-value		
Age groups							
20-25	22(15.4)	12(11.7)	34 (13.8)	8.399	0.136		
26-31	57(39.9)	34(33.0)	91 (37.0)				
32-37	37 (25.9)	26 (25.2)	63 (25.6)				
38-43	16 (11.2)	22 (21.4)	38 (15.4)				
44-49	8 (5.6)	9 (8.7)	17 (6.9)				
50-55	3 (2.1)	0 (0.0)	3 (2.1)				
Mean age (\pm SD)	32.38 (7.034)	33.44 (7.034)	32.82(6.788)	1.209	0.228		
Gender							
Male	49 (34.3)	34 (33.0)	83 (33.7)	0.42	0.837		
Female	94 (65.7)	69 (67.0)	163 (54.3)				
Religion							
Islam	9 (6.3)	27 (26.2)	36 (14.6)	20.699	0.0001*		
Christianity	134 (93.7)	75 (72.8)	209 (56.8)				
Marital status							
Single	49 (34.3)	34 (33.0)	83 (33.7)	5.306	0.151		
Married	94 (65.7)	69 (67.0)	163 (66.3)				
Divorced	2 (1.4)	0 (0.0)	2 (0.8)				
Others(widowed)	2 (1.4)	0 (0.0)	2 (0.8)				
Qualification							
Diploma in Education	4 (2.8)	0 (0.0)	4 (1.6)	17.741	0.0001*		
NCE	50 (35.0)	61 (59.2)	111 (45.1)				
HND	6 (4.2)	1 (1.0)	7 (2.8)				
Degree	81 (56.6)	41 (39.8)	122 (49.6)				
Others	2 (1.4)	0 (0.0)	2 (0.8)				
Teaching experience							
1-5	51 (35.7)	49 (47.6)	100 (40.7)	16.514	0.02*		
6-11	69 (48.3)	30 (29.1)	99 (40.2)				
12-17	21 (14.7)	14 (13.6)	35 (14.2)				
18-23	2 (1.4)	7 (6.8)	9 (3.7)				
24-29	0 (0.0)	3 (2.9)	3 (1.2)				
Mean (\pmSD)	7.8042 (3.988)	7.8932 (6.3938)	7.8415(5.1225)	0.134	0.893		
Subject(s) taught							
All subjects	65 (45.5)	8 (8.7)	74 (30.1)	42.658	0.0001*		
Sciences	34 (45.5)	45 (23.8)	79 (32.1)				
Social sciences	16 (11.2)	13 (12.6)	29 (11.8)				
Languages	17 (11.2)	15 (14.6)	32 (13.0)				
Religion	7 (4.9)	11 (10.7)	18 (7.3)				
P.H.E	1 (0.7)	4 (3.9)	5 (2.0)				
Arts	3 (2.1)	6 (5.8)	9 (3.7)				
Ethnicity							
Igbo	52 (36.4)	36 (35)	88 (22.1)	449.243	0.0001*		
Esan	4 (2.8)	0 (0.0)	4 (1.0)				
Fulani	2 (1.4)	0 (0.0)	2 (0.5)				
Urhobo	4 (2.8)	2 (1.9)	6 (1.5)				
Ebira	7 (4.7)	2 (1.9)	9 (2.3)				
Gbagyi	1 (1.0)	9 (6.3)	10 (2.5)				
Yoruba	34 (23.8)	30 (29.1)	64 (16.1)				
Hausa	9 (6.3)	18 (17.5)	27 (6.8)				
Igala	3 (2.1)	8 (7.8)	11 (2.8)				
Bassa	0 (0.0)	2 (1.9)	2 (0.5)				
Efik	2 (1.4)	0 (0.0)	2 (0.5)				
Nupe	7 (4.9)	2 (1.9)	9 (2.3)				
Idoma	5 (3.5)	2 (1.9)	7 (1.8)				
Tiv	7 (4.9)	2 (1.9)	9 (2.3)				
Total	143 (58.1)	103 (41.9)	246 (100.0)				

*p-values < 0.05 are statistically significant

3.2 Knowledge on school health programme (SHP)

Among 246 respondents, 99.2% had good knowledge on SHP. A Higher proportion of teachers in public schools had good knowledge (100%) compared to 98.6% of respondents in the private schools ($\chi^2 = 1.452$, $p = 0.228$) as shown in figure 1 below.

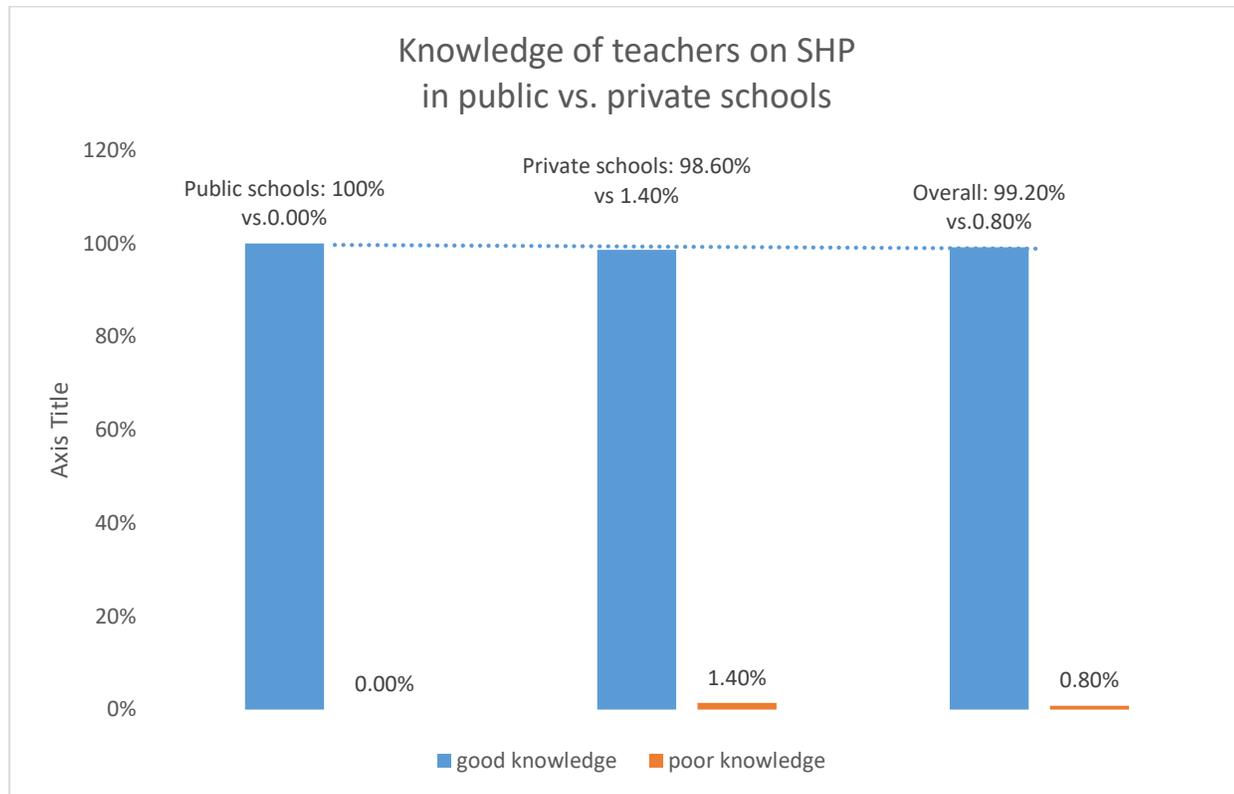


Figure 1: Knowledge of teachers in public and private schools on SHP

3.3 Teaching experience and level of knowledge on SHP

Table 2 below revealed that the level of knowledge on SHP increases with increasing years of teaching experience. Respondents having above 5 years teaching experience all had 100% knowledge compared to 98% good knowledge observed among respondents with 5 years teaching experience and below ($\chi^2 = 402.763$, $p = 0.00$)

Table 2: Association between teaching experience and knowledge on SHP

Years of teaching	Adequate knowledge (n=244) n(%)	Inadequate knowledge (n=2) n(%)	Total (N=246) N(%)	Statistic χ^2	p-value
1-5					
6-11	98 (98.0)	2 (2.0)	100 (100.0)	402.763	0.0001*
12-17	99 (100.0)	0 (0.0)	99 (100.0)		
18-23	35 (100.0)	0 (0.0)	35 (100.0)		
24-29	9 (100.0)	0 (0.0)	9 (100.0)		
	3 (100.0)	0 (0.0)	3 (100.0)		

*p-values < 0.05 are statistically significant

3.4 Attitude of teachers on school health programme

Majority of teachers in both types of school had a positive attitude to school health programme (83.33%). However, teachers in the private schools had a better attitude of 87.4% compared to 77.7% in public school teachers ($\chi^2 = 4.092$, $p = 0.043$). In both schools, teachers felt that school health programme was desirable and necessary, 82.5% in private and 69.9% in public schools ($\chi^2 = 5.419$, $p = 0.02$). 60.1% respondents in private schools and 69.9% of the respondents in public schools, agreed that school feeding will improve school attendance and academic performance of school children ($\chi^2 = 2.484$, $p = 0.115$). Out of the 246 respondents, 162 (65.9%) agreed that SHP is achievable, with no significant difference in attitude between both types of schools.

Table 3: Attitude of respondents on SHP

Attitudes on SHP	Private school (n=143) n(%)	Public school (n103) n(%)	Total (N=246) N(%)	Statistic χ^2	p-value
SHP, desirable and necessary					
Positive attitude	18 (82.5)	2 (69.9)	190 (77.2)	5.419	0.02*
Negative attitude	5 (17.5)	1 (30.1)	56 (22.8)		
SHP, achievable					
Positive attitude	7 (67.8)	5 (63.1)	162 (65.9)	0.595	0.441
Negative	5 (32.2)	8 (36.9)	84 (34.1)		
School feeding improves school attendance and performance					
Positive	5 (60.1)	72 (69.9)	158 (64.2)	2.484	0.115
Negative	7 (39.9)	31 (30.1)	88 (35.8)		

Healthful school environment is essential for teachers

Positive	22 (85.3)	72 (69.9)	158 (64.2)	0.965	0.326
Negative	1 (14.7)	20 (19.4)	41 (16.7)		

**p-values < 0.05 are significant.*

3.5 Teaching experience and Attitude on SHP

Table 4 below gives a summary of the relationship between years of teaching experience and attitude of teachers towards SHP. It is clearly depicted from the p value that the teachers with the longest years of teaching experience (24 to 29 years) had the best attitude (100%), however, the observed high number of persons with poor attitude (22.10%) among respondents with 18 to 23 years of teaching experience as compared to respondents with lesser years of teaching experience ($\chi^2 = 399.842$, $p < 0.05$). This shows that these observed variations might have occurred by chance.

Table 4: teaching experience and attitude on SHP

Years of teaching	Good attitude (n=205) n(%)	Poor attitude (n=41) n(%)	Total (N=246) N(%)	Statistic χ^2	p-value
1-5					
6-11	84 (41.0)	16 (39.0)	100 (25.1)	399.842	0.0001*
12-17	81 (39.5)	18 (43.9)	99 (24.9)		
18-23	30 (14.6)	5 (12.2)	35 (8.8)		
24-29	7 (3.4)	2 (4.9)	9 (2.3)		
	3 (1.5)	0 (0.0)	3 (0.8)		

**p-values < 0.05 are statistically significant*

3.6 Practice of school health programme

Table 5 below summarizes the practice of the components of SHP amongst the sampled schools. There was an observation of open defecation in 37.9% of public schools compared to non in private schools sampled ($\chi^2 = 82.422$, $p < 0.05$). The dominant type of toileting facility was however water closet system (74.7%), and used in 95.1% of private schools and 45.6% of public schools sampled. Another significant finding is the observation of pipe-borne water as the source of portable water in only 36.9% of public school as compared to 86% of private schools sampled ($\chi^2 = 66.462$, $p = 0.00$). The school environment is cleaned by

the pupils in most public schools (93.2%) and by cleaners in most private schools (93.7), hand washing facility was also observed to be absent in 66% of public school but present in 58.7% of private school sampled ($\chi^2 = 93.434$, $p = 0.00$). Pre-entry medical screening was reported in only 43.9% of schools sampled, with majority been the private schools (58.7%) and most of both schools do not conduct periodic medical inspection (67.1%). Among schools that perform this inspection, very few (20.3%) have doctors in charge while 8.9% of schools have nurses as their health inspectors. ($\chi^2 = 427.222$, $p = 0.00$), also more than half schools (60.2%) were linked to hospitals for referrals, the bulk of which were private schools. Availability of sick-bays for first aid treatment of minor ailments was soon 85% of schools, most of which were private school (60.8%), ($\chi^2 = 404.416$, $p = 0.00$). Meals were not offered in any of the school sampled, as school meal were provided mostly by food vendors. Pre-approval screening for food vendors/handlers were reported in only 24.4% of schools sampled with no significant difference noted in both private and public schools (23.8% and 25.2% respectively), ($\chi^2 = 0.070$, $p = 0.792$).

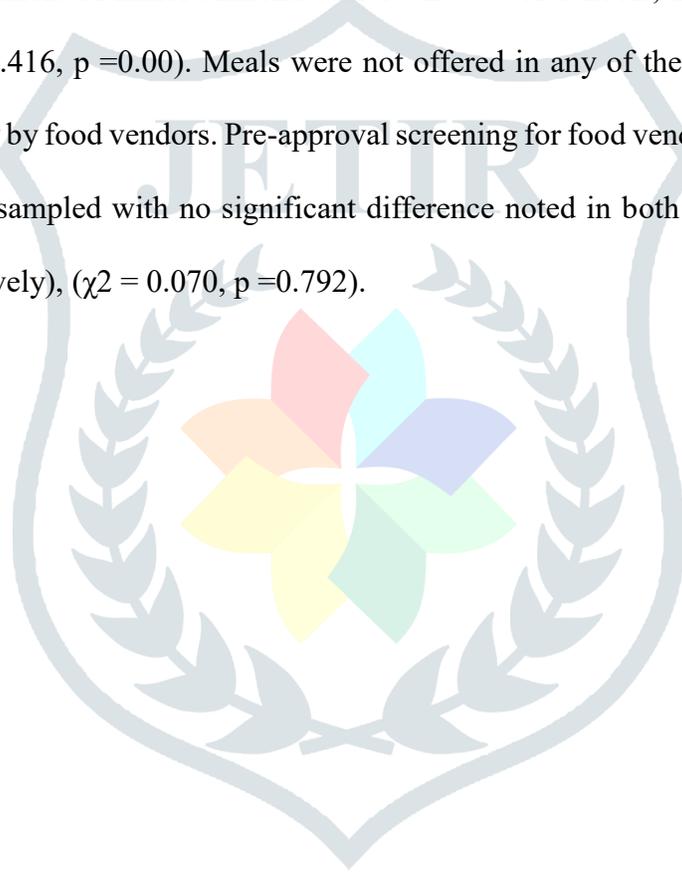


Table 5: Practice of School health programme

Variables	Private school (n=143) n(%)	Public school (n103) n(%)	Total (N=246) N(%)	Statistic χ^2	p-value
PRACTICE OF SHP.					
Availability of portable water					
Yes	140 (97.9)	95 (92.2)	235 (95.5)	4.505	0.34
No	3 (2.1)	8 (7.8)	11 (4.5)		

Source of portable water					
Pipe-borne water	123 (86)	38 (36.9)	161 (65.4)	66.462	0.0001*
Bore-hole water	20 (14.0)	55 (53.4)	75 (30.5)		
Well water	0 (0.0)	2 (1.9)	2 (0.8)		
Others (commercial supply)	0 (0.0)	3 (2.9)	3 (1.2)		
No portable water	0 (0.0)	5 (4.9)	5 (2.0)		
Types of toileting facility					
Pit toilet	5 (3.5)	14 (13.6)	19 (7.7)	82.422	0.0001*
Water closet	136 (95.1)	47 (45.6)	183 (74.7)		
Squatting pan	2 (1.4)	3 (2.9)	5 (2.0)		
Open defecation	0 (0.0)	39 (37.9)	39 (15.9)		
Availability of hand washing facility					
Yes	84 (58.7)	35 (34.0)	119 (48.4)	93.434	0.0001*
No	59 (41.3)	68 (66.0)	127 (51.6)		
Performs pre-entry medical screening					
Yes	84 (58.7)	24 (23.3)	108 (43.9)	30.535	0.0001*
No	59 (41.3)	79 (76.7)	138 (56.1)		
Pre-approval screening for food vendors/handlers					
Yes	34 (23.8)	26 (25.2)	60 (24.4)	0.007	0.0001*
No	109 (76.2)	77 (74.8)	186 (75.6)		
Linkage to referral hospital					
Yes					
No	109 (76.2)	39 (37.9)	148 (60.2)	457.473	0.0001*
	34 (23.8)	64 (62.1)	98 (39.8)		

**p-values* < 0.05 are statistically significant

4. Discussion

From this study most respondents were in public schools and the mean age was 32.82 (± 6.78) years, with the majority, 91 (37.0%) falling within age group 26-31 years. These figures were in contrast with findings by Ofovwe G E and Kuponiyi OT who reported mean age above 44years. [10, 15] There were more female respondents than males in our study and this is in keeping with the study by Ofovwe G E and Ofili AN in Egor local government area of Edo state, Nigeria where there were 71% were females as well the findings of Mandala Gowri et al. [10,11] Also most of our respondents were married and the average number of years of

teaching experience was 7.8(\pm 5.1). This finding is in contrast to the study by Obembe TA et al., who reported 12.2 (\pm 8.7) years of teaching experience. [12] In addition, most of our respondents were degree holders and this finding was similar to that of Mandala Gowri et al. [11]

The general level of knowledge among respondents was good while the practice was poor. A higher proportion of teachers in public schools had good knowledge compared to respondents in private schools. In addition, our study revealed that the better the level of knowledge of SHP, the better the practice among respondents. These findings differ from those of Ofovwe G E, and Ofili AN that revealed that the proportion of teachers with poor knowledge of SHP was higher (93.1 %) in the private schools than in the public schools (48.3%). [10] Odeyemi KA and Adebayo MA also found that more than half of all their respondents (57.0%) had poor knowledge of school health programme. [9,16].

In this study we observed 37.9% of open defecation in public schools sampled compared while majority of private schools used water closet system or squatting pans. The most of private schools had portable water in the forms of pipe-borne water and bore-hole. Our findings were better than those of Ofovwe GE, and Ofili AN where only 17.3% of all the schools had adequate portable water supply. [10] Note that Ofovwe G E, and Ofili AN studied a rural community in Edo state, Nigeria while ours was an urban setting in Abuja, Nigeria. Furthermore, our study revealed better handwashing facilities, sanitation and the availability of first aid treatments and sick bays in private schools (85%) than public schools and these were consistent with the findings of Kuponiyi OT and colleagues where sick bays were present in more private schools than public schools: 37.2% vs. 14.4%. [15] Our study reported only a small proportion of schools who practiced pre-school entry and periodic medical examination as well as the availability of medical doctors and referral services especially in the private schools. This was similar to the findings of Ofovwe G E, and Ofili A N. They reported that only a small number of schools performed pre-school and periodic medical examination for pupils. [10] We also found that screening for food vendors and handlers were very poor particularly in the private schools and our findings were in agreement with the reports of Oluwakemi M. Ademokun et al and Bose O. Toma¹, et al where none of the schools studied served school meals and food vendors were screened in only very few public schools. [13,14]

Health education was reported to be an integral part of the curriculum of all schools (100%) in our survey and most schools did not have counselling services. This is in contrast with the finding in Ogun state, Nigeria by Odeyemi KA and Chukwu EE where only 68.9% to 89.5% of schools in the local government areas studied had health education in their curriculum. [9] These inadequacies are attributable to poor policy implementation and insufficient staffing and therefore less attention given to counselling of school children.

Majority of teachers in public and private schools had positive attitude to the school health programme, however, the private schools had better attitude. These findings are consistent with the observation by Ibinga E and colleagues. [10, 17] This finding may be attributable to the commitment of private schools to offer better education because it is a private business.

Majority of our respondents, agreed that school feeding will improve school attendance and academic performance of school children and this is in agreement with the findings of Odeyemi KA and Chukwu EE where about 96.5% of the respondents in Ikenne local government area in Ogun state, Nigeria agreed that school health programme will improve the academic performance of school children. [9]

Only 65.9% of our respondents agreed that SHP is achievable but these figures are low compared to the findings by Ofovwe GE, and Ofili AN where as high as 96% of respondents reported that SHP is achievable. [10] The reason for this difference could be in the settings and the fact that Ofovwe GE and Colleagues studied an older age group with higher teaching experience compared to our study participants.

5. Conclusion

Our study revealed good knowledge and positive attitude of teachers towards SHP however, the practice of most components of SHP was generally poor, especially in public schools, with major deficiencies in the availability of toilet facilities, pre-school entry and periodic medical examination, absence of school feeding services and screening of food vendors and handlers as well as absence of counselling services among others.

6. Recommendations

The medical officer of health in the area council need to set up a team of school health inspectors, charged with the responsibility of routinely visiting schools to check the cleanliness of the environment, including toilet facilities as well as the medical screening of food vendors. Government should ensure that the minimum standards for setting up schools as listed in the national school health policy document are fulfilled. Adequate sources of portable water supply and provision of toilet and hand washing facilities are strongly recommended and this is very urgent under the present public health crisis occasioned by the covid-19 pandemic. Finally, primary school authorities should ensure pre-school and periodic medical examinations by skilled health personnel.

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