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EVALUATION OF THE LEVEL OF IMPLEMENTATION OF THE SCHOOL HEALTH PROGRAMME IN PRIMARY SCHOOLS IN JOS SOUTH LOCAL GOVERNMENT AREA OF PLATEAUS STATE

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ABSTRACT

The purpose of this study is to evaluate the level of implementation of the school health programme in five selected primary schools in five wards in Jos South Local Government Area of Plateaus State. Two research questions and specific objectives were raised to solve the research problem. A cross sectional research design was used for this study. Target population for the study are head teachers of the schools. The five Schools were purposively selected from five wards of the Local Government Area. The instrument for data collection is an observational check list and questionnaire which was developed based on the characteristics of the five School Health Programmes and structured questions to assess impediments to implementation of the SHP. Finding on Healthful school environment revealed that the four schools met the criteria of a healthful school environment base on their locations and recreational facilities, these can be attributed to the fact that these schools were built long ago by the missionaries and they were able to acquire large land for future development.

Keywords: School Health Programme, Healthful School Environment, Primary Schools.

Introduction

School health programme is a series of harmonized projects/activities in the school environment for the promotion of health and development of the school community. Research shows that when schools and community have effective polices and practices that support the health of their students and staff; the following will be achieved:

i. Students and staff absenteeism will decrease.
ii. Students concentration will improve.
iii. Students behavior problems are reduced.
Iv. Children and adolescent establish life-long health promoting behaviours.

According to AdemokunOM, Osungbade KO, Obembe TA (2014) that "the school has direct contact with more than 95% of the nations young people aged 5-17 years for about 6 hours a day and for up to 13 critical years of their social,

psychological, physical and intellectual development". In line with the above, education must address the needs of the whole child in order to make the child fit and ready to learn as healthy children make better students, and better students make healthy communities.

1. EVOLUTION OF SCHOOL HEALTH PROGRAMME

Numerous public health initiatives and professional societies have promoted the development of school health since the colonial American era. Benjamin Franklin advocated a "healthful situation" and promoted physical exercise as one of the primary subject in the schools that were developing during his time. However, prior to the mid-1800s, effort to introduce health into the schools were isolated and sparse. It was not until 1840 that Rhode Island passed the first legislation to make health education mandatory and other American states soon adopted the concept. Shattuch served as a teacher in Detroit and member of the school committee in concord, Massachusetts, where he helped reorganized the public school system of the town. This background led to school health programs receiving major attention as a means to promote public health and prevent disease. the report states that good health is the basis for wealth, happiness and long life and that all children should be taught that preserving their health and that of others is one of their most important duties. The report further states that knowledge leads to good health while ignorance leads to poor health and disease.

In the 1890, schools in Boston and Philadelphia were early pioneers in establishing cooperative programms with philanthropic organization to provide school lunches to fight malnutrition.

The era of medical inspection in schools started at the end of the nineteenth century in response to problem of urbanization and immigration. In 1894 50 "medical visitors were appointed in Boston to visit schools and examine children. In 1899, Connecticut made examination of school children for visual defects compulsory. In 1906 Massachusetts made medical inspection compulsory in all public schools and this ushered in broad – base programs of medical inspections in which school nurses and physicians participated. By 1911, there were 102 cities employing school nurses. In 1913, New York city alone had 176 school nurses, A great deal of the nurses' time was spent in home visits to families with children who had been excluded from school because of illness or infection; encouraging these families to have their children treated and returned to school.

One of the most influential group in the development of school health was the joint Committee on health problems and education, which was jointly sponsored by the American Medical Association and the National Education Association prior to 1920, the committee published the report *Minimum health Requirements for rural schools.* Their 1927 paper *Health Supervision and Medical inspection of schools* strongly promoted the emerging concept of coordination among the medical services, the physical education and the health education programs in schools.

During the twentieth century several White House conferences have been convened that relate directly to school health issues, one of the most important was the White House conference on children and youth, which had a session in December 1970 on children under age 13 and a session in February 1971 on young people over age 13. Each of this conference resulted in specific recommendations and suggested programs related to school health services, health instruction and a healthy school environment.

However, it is clear from this brief overview that for many decades, health and education professional have joined together to established, implement and evaluate school health programs in response to societal needs.

1.1 The comprehensive school health programme

Today school health has evolved into what is termed a comprehensive school health programme, its general goal is to establish a system of home, school and community support to assure that students are provided with a planned sequential programme of study, appropriate services and a nurturing environment that promotes the development of healthy, well-educated productive citizens.

1.2 History of school health programme in Nigeria

Before the 19th century, there were no school facilities. Christian missionaries started to implement the western education in Nigeria only in 1842 with primary education and secondary education in 1859 with the first Grammar school in Lagos. However, the sanitary standard for pupils was low. Though, efforts were made by teachers, heads of schools to improve sanitary conditions of the pupils through health inspection, providing first aid to pupils and taking sick pupils/student to nearest government clinic. This mean that every school was left on their own to decide how to go about school health programme.

Not until April 2000 in Dakar, Senegal, where the recommendations for the school health programms were defined at the world Education forum by: The World bank , World Health Organization (WHO), United Nations

Education and Scientific Organization (UNESCO), United Nations International Children's Emergency Fund (UNICEF) Tamatea Laurence (2005), which Nigeria was represented and a signatory to the outcome of the meeting. The World Educational Forum in Dakar launched a new strategy for achieving the effectiveness of School health in all countries of the world.

This strategy was named FRESH (The Focusing Resources on Effective School Health).

The strategy promotes four main components of any National School Health programme which are;

i. Health related school policy services
ii. Safe water and sanitation and healthy environment.
iii. Skilled based health education
iv. Health and nutrition

in addition, the school health programme must follow the criteria of world health organization (WHO) for a health promoting school, these criteria are;

i. Active promotion of self esteem of all pupils by demonstrating that everyone can make a contribution to the life of the school.
ii. Development of good relationship between staff and student/pupils and among pupils in the daily life of the school.
iii. Clarification for staff and pupils of social aims of the school.
iv. Provision of stimulating challenges for all pupils through a wide range of activities.
v. Use of every opportunity to improve the physical environment of the school.
vi. Development of good links between school, home and community.
vii. Development of good links among associated primary and secondary schools to plan a coherent health education curriculum.
viii. Active promotion of the health and well-being of the school and staff.
ix. Consideration of the role of staff as examplers in health related issues.
x. Consideration of the complementary role of school meals (If provided) to health education curriculum.
xi. Realization of the potentials of specialist services in the community for advice and support in health education.
xii. Development of the education potentials of school health services beyond routine screening and towards active support for the curriculum.

After the World Education Forum in April 2000 in Dakar, Senegal, Nigeria took a giant step to coordinate and develop a policy frame work to guide the implementation of school health programms in the country, its main goal is to improve the health of learners and staff as responsible and productive citizens,

With the following objectives to help achieve the goal;

1. Promote growth and development of every child taking into consideration his/her health needs.
2. Create awareness of the collaborative efforts of school, home and the community in health promotion.
3. Develop health consciousness among the learners.
4. Create awareness on the availability and utilization of various health related resources in the community.
5. Promote collaboration in a world of interdependence, social interaction and technological exposure in addressing emergent health issues.
6. Build the skills of learners and staff for health promotion in the school community.

1.3 Components of School Health Programme

1. Healthful school environment.
2. School feeding services
3. Skilled base health education
4. School health services
5. School, home and community relationship.
6. Health promotion for staff
7. Physical education
8. Counselling and psychological services

But Nigeria adopt the first five components and domesticate it.

The Nigerian National School health policy was finally introduced in December 2006 to improve the state of school health services in the country.

From all the steps that has been put in place by the government regarding school health programme, actual implementation is still very low in government schools.

1.4 Statement of the Problem

School is seen as an important context for health promotion, principally because it reaches a large proportion of the population for many years. The emphasis on schools is also a recognition that learning of health related habit and behaviour begin at an early age.

Despite the importance of the school health programme, almost all the components are poorly implemented or not implemented at all in government primary and secondary schools in many states of the country as reported by many researchers.

This study therefore, intends to evaluate the level of implementation of the school health programme in five selected primary schools in five wards in Jos South Local Government Area of Plateaus State.

1.5 Aim and Objectives

1. To evaluate the level of implementation of the five components of school health programme.
2. To find out impediments to its implementation

1.6 Research Questions

The following questions will guide the study.

1. What is the level of implementation of the five components of school health programmes?
2. What are the impediments or hindrances to its implementation?

1.7 Theoretical Framework

Health promotion model/theory by Dr. Nola J. Pender was used to support this research.

A theory presents a systematic way of understanding events. It is a set of concepts, definitions and proposition that explain such events by demonstrating the relationship between variables.

Health promotion can be defined as the process of empowering people through education to make healthy life style choices and motivating them to become better self-managers.

The goal of the health promotion model is not about helping patients prevent illness through their behaviour but to look at ways in which a person can pursue better health or ideal health.

1.8 Significance of the Study

The importance of a good and functional school health programme in the overall development of children and adolescents of a nation cannot be over emphasised as it facilitates early detection and diagnosis of illness with prompt intervention in order to prevent mortality and reduce morbidity. From the above, it indicates that the entire citizen of the country will benefit from this research as every family have a schooling child.

1.9 Scope and Delimitation of the Study

The study will be limited to head teachers of LEA Primary school Gyel A, EKAN primary school Vwang, Islamiya Primary school Zawan, LEA Primary school Sabon pegi Kuru "A" and Islamiya primary school Bukuru all in South L.G.A.

1.10 Operational Definition of Terms

- **School**: it is an institution for educating learners, in the context of this research, it include Nursery, Primary, Secondary and Tertiary Institutions.
- **Health**: according to the world health organization "is a state of complete physical mental and social well-being and not merely the absence of disease or infirmity."
- **School Health Programme**: it is a series of harmonized projects/activities in the school environment for the promotion of the health and development of the school community.
- **School Community**: this refers to all the people living/working within the school premises and they are' pupils/students, teaching and non-teaching staff as well as members of their family.

2. LITERATURE REVIEW

This chapter deals with review of literature that are relevant to this study, it will be presented under two headings which are theoretical and empirical review.

2.1 Theoretical Review

In 1980, Bill Gate set up a health organization called "Health for all" in war – torn areas like Syria and Africa, but the organization came into existence on the 4th January, 2004.

Health for all means that health is to be brought within reach of everyone in a given country, this implies the removal of the obstacle to health, that is to say the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing.

In April 2000, at the World Education forum in Senegal, Dakar, Education for All (EFA), a global movement led by United Nations Educational, Scientific and Cultural Organization) UNESCO was launched aiming to meet the learning needs of all children, youths and adults by 2015 alongside the pursuit of millennium development Goal 2 on Universal Primary Education.

However, it was noted that School health programme is one of the strategies for the achievement of Health for all, Education and health related Millennium Development Goals, (National Health Policy, 2006), because school is seen as an important context for health promotion principally because it reaches a large proportion of the population for many years. "The emphasis on Schools is also a recognition that the learning of health – related knowledge, attitudes and behavior begins at an early age," (Naido, and Wills, 2000).

According to U.S department of health and Human services (2010); that "schools have more influence on the lives of young people than any other social Institution, except the family and provide a setting in which friendship networks develop, socialization occurs and norms that govern behavior are developed and reinforced."

2.2 Empirical Review

In a study conducted by Kuponiyi, Amoran and Kuponiyi (2006) in Ogun State to determine the School health services available and its practices in government and Private primary Schools, Ogun State, Nigeria. The study revealed that more than three quarters of the head teachers in both groups could not provide a basic definition of the School health programme. The study further revealed that despite the importance of the school Health Programme, almost all the components are poorly implemented or not implemented at all in government Primary Schools. While the School health Services in private school is better in terms of implementation because they have access to funding and the school is run as a profit oriented business.

In another study by Obembe, and Ademokun (2016); in Ibadan, Southwest Nigeria to assess "Awareness and knowledge of National School Health Policy and School Health Programme among Public Secondary School Teachers in Ibadan Metropolis." The study revealed that about third of the respondents had heard of National School Health Policy, few had seen the document, many of the respondents had a good knowledge of School Health Programme which they attributed to their level of Education. The study concluded that awareness of School Health programme was low.

Similarly, a study conducted by Bisi – Onyemaechi, Becki, Tagb and Chika (2017) to assess school health services in Primary Schools in Enugu State of Nigeria, the study involved thirty three Head Teachers of Primary School and Officials of Ministry of Education (Eight Public and Twenty five Private Schools). The result revealed that only four Private Schools had health Personnel, only Six Private Schools had a health room, two public schools had a functional first aid box, no health records available in any of the Schools and School lunch was given by only one Private School.

The study conclude that School health services are at minimal level in Enugu State, but are comparatively better in the private schools than public schools as the public schools were ill equipped to handle emergencies as well as lack awareness of School Health Services.

In another study by Ofovwe, and Ofili, (2009); conducted in Egor local government area of Edo State, Nigeria to assess knowledge, attitude and practice of school health programme among head teachers of primary Schools. The study involved private and public primary schools, it revealed that none of the head teachers had adequate knowledge of School health programme, 93.1% of 104 head teachers had poor knowledge of SHP. Overall 27.7% of the schools had no toilet facility, 33.35 had handwashing facility. 51% of private schools compared to 27.6% of public schools performed medical inspection of pupils, 39.4% private schools compared to 3.4 public schools have sick bays. 20.2% private compared to 3.4% public schools screened food handlers/vendors.

The study concluded that poor status school health programme in Nigeria may be attributed to failure of policy declaration, poor primary health care based and lack of supervision.

In an evaluation study of School health programme in Sagamu, Ogun State by Ogunkunle, Oyinlade, Olanrewaju (2014); the study revealed that school health services in Sagamu is inadequate and needs to be strengthened in order to optimize the health of School children in the locality.

In another study titled status of implementation of school health programme in South Western Nigeria, in Ibadan by Ademokun O, Osungbade KO, and Obembe TA (2014); the study revealed that despite the initiative such as FRESH that has been proposed to improve the school health services, the state of the school health system has not recorded any strides with regard to much development.

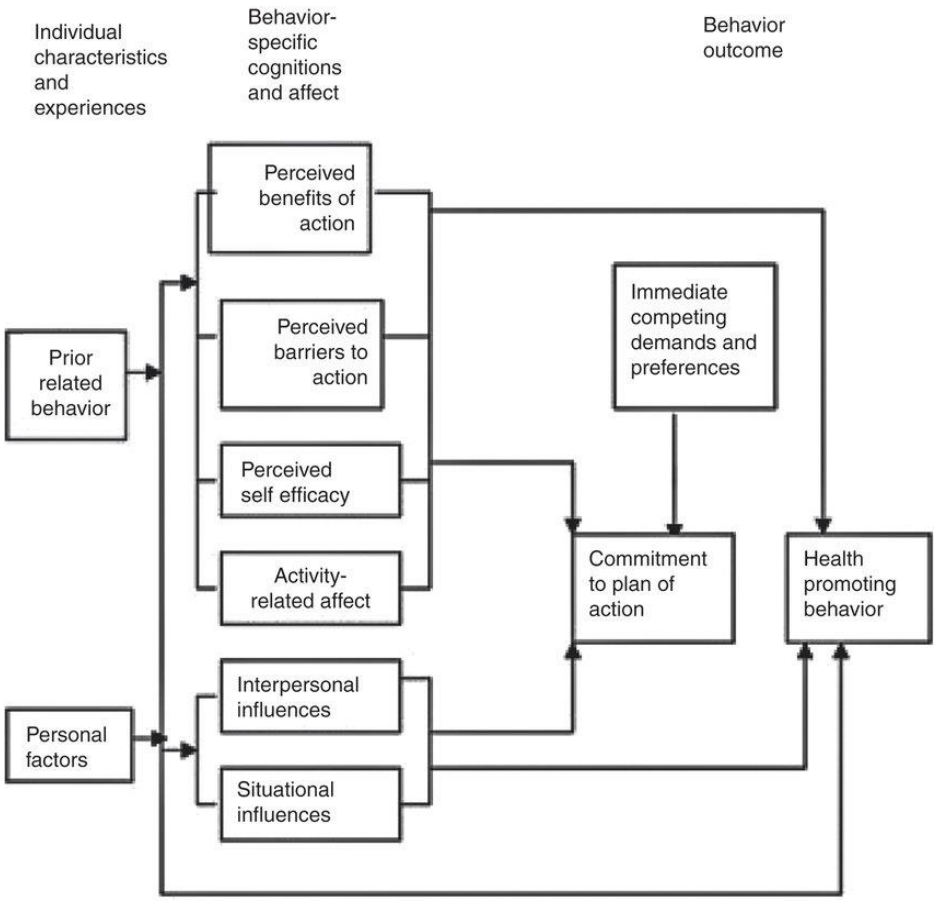

Figure 2.1: The health promotion model

The health promotion model (HPM) proposed by Dr Nola J Pender (1982; revised, 1996) was designed to be a "complementary counterpart to models of health protection." It defines health as a positive dynamic state not merely the absence of disease. Health promotion is directed at increasing a client's level of well being. The health promotion model describes the multi dimensional nature of persons as they interact within their environment to pursue health.

The model focuses on following three areas:

- · Individual characteristics and experiences
- · Behavior-specific cognitions and affect·
- Behavioral outcome

2.3 Individual Characteristics and Experiences

Personal Factors

Personal factors categorized as biological, psychological and socio-cultural. These factors are predictive of a given behavior and shaped by the nature of the target behaviour being considered.

Personal biological factors

- Include variable such as age gender body mass index pubertal status, aerobic capacity, strength, agility, or balance.

Personal psychological factors

- Include variables such as self esteem self motivation personal competence perceived health status and definition of health.

Personal socio-cultural factors

- Include variables such as race ethnicity, accuculturation, education and socioeconomic status.

2.4 Behavioural Specific Cognition and Affect

Perceived Benefits of Action

- Anticipated positive outcome that will occur from health behaviour.

Perceived Barriers to Action

- Anticipated, imagined or real blocks and personal costs of understanding a given behaviour

Perceived Self Efficacy

Judgment of personal capability to organise and execute a health-promoting behaviour. Perceived self efficacy influences perceived barriers to action so higher efficacy result in lowered perceptions of barriers to the performance of the behavior.

Activity Related Affect

Subjective positive or negative feeling that occur before, during and following behavior based on the stimulus properties of the behaviour itself. Activity-related affect influences perceived self-efficacy, which means the more positive the subjective feeling, the greater the feeling of efficacy. In turn, increased feelings of efficacy can generate further positive affect.

Interpersonal Influences

Cognition concerning behaviours, beliefs, or attitudes of the others. Interpersonal influences include: norms (expectations of significant others), social support (instrumental and emotional encouragement) and modelling (vicarious learning through observing others engaged in a particular behaviour). Primary sources of interpersonal influences are families, peers, and healthcare providers.

Situational Influences

Personal perceptions and cognitions of any given situation or context that can facilitate or impede behaviour. Include perceptions of options available, demand characteristics and aesthetic features of the environment in which given health promoting is proposed to take place. Situational influences may have direct or indirect influences on health behaviour.

2.5 Behavioural Outcome

Commitment to Plan of Action

The concept of intention and identification of a planned strategy leads to implementation of health behaviour.

Immediate Competing Demands and Preferences

Competing demands are those alternative behaviour over which individuals have low control because there are environmental contingencies such as work or family care responsibilities. Competing preferences are alternative behaviour over which individuals exert relatively high control, such as choice of ice cream or apple for a snack

Health Promoting Behaviour

Endpoint or action outcome directed toward attaining positive health outcome such as optimal well-being, personal fulfillment, and productive living.

HPM provide a basis for investigative work on health behaviors. The HPM is based on the following theoretical propositions:

1. Prior behavior and inherited and acquired characteristics influence beliefs, affect, and enactment of health-promoting behavior.
2. Persons commit to engaging in behaviors from which they anticipate deriving personally valued benefits.
3. Perceived barriers can constrain commitment to action, a mediator of behavior as well as actual behavior.
4. Perceived competence or self-efficacy to execute a given behavior increases the likelihood of commitment to action and actual performance of the behavior.
5. Greater perceived self-efficacy results in fewer perceived barriers to a specific health behavior.
6. Positive affect toward a behavior results in greater perceived self-efficacy, which can in turn, result in increased positive affect.
7. When positive emotions or affect are associated with a behavior, the probability of commitment and action is increased.
8. Persons are more likely to commit to and engage in health-promoting behaviors when significant others model the behavior, expect the behavior to occur, and provide assistance and support to enable the behavior.
9. Families, peers, and health care providers are important sources of interpersonal influence that can increase or decrease commitment to and engagement in health-promoting behavior.
10. Situational influences in the external environment can increase or decrease commitment to or participation in health-promoting behavior.
11. The greater the commitments to a specific plan of action, the more likely health-promoting behaviors are to be maintained over time.
12. Commitment to a plan of action is less likely to result in the desired behavior when competing demands over which persons have little control require immediate attention.
13. Commitment to a plan of action is less likely to result in the desired behavior when other actions are more attractive and thus preferred over the target behavior.
14. Persons can modify cognitions, affect, and the interpersonal and physical environment to create incentives for health actions

The health promotion model notes that each person has unique personal characteristics and experiences that affect subsequent actions. The set of variables for behavioral specific knowledge and affect have important motivational significance. These variables can be modified through nursing actions. Health promoting behavior is the desired behavioral outcome and is the end point in the HPM. Health promoting behaviors should result in improved health, enhanced functional ability and better quality of life at all stages of development. The final behavioral demand is also influenced by the immediate competing demand and preferences, which can derail an intended health promoting actions.

2.6 Application of the Health Promotion Model to The Study

The HPM is based on the following assumptions, which reflect both nursing and behavioral science perspectives:

1. Individuals seek to actively regulate their own behavior.
2. Individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.

3. Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their life span.
4. Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change

3. METHODS AND PROCEDURE

This chapter consist of the following sub – headings; design of the study, population and sample of the study, sampling techniques, instruments for data collection, validation of instruments, procedure for data collection and method of data analysis.

3.1 Design of the Study

A cross sectional research design was used for this study.

3.2 Study Area

The study area are:

i. Islamiya Primary Schhol in Zawan Ward of Jos – South L.G.A. The School was founded in 1970 and located at Zawan junction, under the leadership of Mrs. Fellicia Mangai. Presently, the School has 716 pupils and 22 teachers which are all government employee, the school consists of Primary 1 – 6.

ii. L.E.A Primary School in Gyel A Ward of Jos – South L.G.A, was founded in 1930, it has primary 1 – 6 with 707 pupils and under the leadership of Mr. Sunday B. Dakun.

iii. EKAN Primary School Vwang in Jos South L.G.A, was founded in 1952 and has 956 pupils presently. The school has 16 government employed teachers, 4 P.T.A teachers, 3 Volunteers and 2 em–Power teachers with Mrs. Atyose Chundung Mwankon as the head Teacher.

iv. L.E.A Primary School Sabon Pegi in Kuru A ward in Jos – South L.G.A is located in Trade centre. It was founded in 1976 and presently it has 1, 740 pupils with 28 em–Power teachers. The Head Teacher is Mr. Yakubu Mark.

v. Islamiya Primary School Bukuru in Jos South L.G.A, The School has 630 pupils, Primary 1 – 6 and Nursery 1 – 3. The school has 16 government employed teachers and 16 em– Power teachers with Mr. Mathias Chun Davou as the Head Teacher.

Jos – South Local government Area was created out of Jos Local Government Area, now Jos North with the headquarter in Bukuru. The local government area covers an area of 510 km^2 of land. It is bounded to the North by Jos – North Local government, to the East by Jos – East Local Government, to the South by Barkin – Ladi and Riyom Local Government Area and to the West by Bassa Local Government. Jos – South Local government has 12 wards out of which five wards was purposively selected for the research.

3.3 Population and Sample of the Study

Target population for the study are head teachers of the schools.

3.4 Sampling Technique

The five Schools were purposively selected from five wards of the Local Government Area.

3.5 Instruments for Data Collection

The instrument for data collection is an observational check list and questionnaire which was developed based on the characteristics of the five School Health Programmes and structured questions to assess impediments to implementation of the SHP.

3.6 Validation/Reliability of Instrument

Validation of Instruments

Validation refers to the extent to which the instrument for data collection measures what it claims to measure, this was established through face and content criteria.

Face Validity

The typing of the questionnaire was closely supervised to ensure error free in order for respondents to read it clearly. Neatness was also stressed during printing of questionnaire to avoid stain, all these were geared towards clear reader- ability by the respondents.

Content Validity

The check list has developed based on the characteristics of the school health programme as documented in the school Health policy 2006. Similar check list was used by Ademokan, Osungbade and Obembe in their research titled; "status of implementation of School Health Programme in South Western Nigeria."

Reliability of Instruments

Reliability is the extent to which a measuring instrument measures what it claims to measure consistently. This was done through test – retest coefficient. The checklist and questionnaire was administered in two of the schools, after two weeks, then it was re-administered in the same school to the head teachers. The two results were correlated and found to be the same.

3.7 Procedure for Data Collection

The Observational check list andstructured questionaire was completed by the head teacher and the researcher, in some schools, a teacher was nominated to complete the qusetionaire / observational check list with the researcher.

3.8 Method of Data Analysis

Data collected was presented in frequency table and percentages according to the characteristics of the school health programme.

4. RESULTS AND DISCUSSION

The findings of the research were presented according to the research objectives and the characteristics of the school Health programmes.

4.1 Results

Objectives 1:

To evaluate the level of implementation of the five components of school health programme earlier mentioned in the background of the study.

SECTION A: Healthful school environment:

Table 1

Variables	Frequency(N=5)	Percentage (%)
1. School located away from noise in safe area	4	80
2. School has perimeter fencing with gate	1	20
3. School located in well drain terrain	5	100
4. School build on more than one hecter of land	4	80
5. School has a play ground	4	80
6. Play ground is clean and safe from reptile	4	80
7. School has a large room for indoor game	0	0
8. The school is well lighted and ventilated	5	100
9. School have room for counselling	0	0
10. School has safe drinking water	4	80
11. Source of drinking water	Hand dug well	80
12. Presence of wash hand basin with towel	0	0
13. School has water and rodent proof container	4	80
14. Presence of toilet in school, boys/girls	5	100
15. Separate toilet for boys & girls	5	100
16. Presence of road signs, zebra crossing	1	20

Source: field survey (2019).

The above table present the characteristics of a healthful school environment in the five schools visited, four of the school were located in safe area away from noise, only one of the five schools has a perimeter fencing with gate. All the schools are build on more than one hecter of land, four of the schools has play ground which is clean and safe from reptile. Non of the schools has room for indoor games and counselling. Of the five schools, four has safe water for drinking and its source is from a hand dug well. Non of the school has a wash -hand basin for the pupils, all the schools has a well ventilated improve pit toilet separate for boys and girls. Of the five schools, only one has a zebra crossing to the school.

SECTION B: School feeding programme

Table 2

Variables	Frequency(N=5)	Percentage (%)
17. Provision of one adequate meal or snack to pupils a day	Pap turn brown 5	100
18. Medical screening of food vendors	0	0
19. Deworming of pupils	0	0

Source: Field survey (2019).

From the above table, pupils in the five schools are provided with turn brown pap and beans cake twice a week. The food handlers are not screened medically because the schools do not have contact with them neither are the pupils dewormed.

SECTION C: Skilled based health Education.

All the underlisted topics listed in the 2006 school health Programme policy are taught in the schools.

i. Personal Health
ii. Diseases including HIV/AIDS
iii. Mental and social Health
iv. First aid and safety education
v. Community Health
vi. Family life education
vii. Environmental Health
viii. Maternal and child Health
ix. Nutrition
x. Consumer Health
xi. Drug Education
xii. Ageing and death Education
xiii. Parts of the human body
xiv. Health Agencies

SECTION D: school health services

Table 3

	Frequency(N=5)	Percentage (%)
21. Pre-entry screening	0	0
i. Routine medical examination	0	0
ii. Psychological examination	0	0
22. Referral or follow up health service	0	0
23. Maintenance of health record for each pupil	0	0

Source: field survey (2019).

The five schools do not conduct pre-entry screening for the pupils, neither do they conduct routine medical examination nor psychological examination nor maintain health record or referral services for pupils.

But the five schools have first aid box which contain dressing materials and paracetamol tablets.

SECTION E: School, Home and Community relationship

Table 4

Variables	Frequency(N=5)	Percentage (%)
24. Teachers/Nurse visit home of pupil with health challenges	5	100
25. Parents visit their children in school	5	100
26. Schools have open day to discuss progress of their wards	5	100
27. School participate in community outreach	0	0

Source: field survey (2019).

Objective 2: to find out impediments to its implementation.

The five school head teachers said lack of financial support and commitment from government has hindered the implementation of the policy document of school health programme since its adoption in 2006.

4.2 Discussion

The findings from this study was discussed based on the characteristics of the school health programme.

Finding on Healthful school environment revealed that the four schools met the criteria of a healthful school environment base on their locations and recreational facilities, these can be attributed to the fact that these schools were built long ago by the missionaries and they were able to acquire large land for future development. These findings agree with that of Oluwakemi M. Ademokun Kayode O. Osungbade and Taiwo A. Obembe (2014) in their research tittled "a qualitative study on status of implementation of school health programme in South Western Nigeria"

Concerning school feeding programme, the five schools head teacher said only turn brown pap with beans cake is provided for the pupils once at times twice in a week. The pupils are not de-worm neither do the head teacher know whether the food handlers undergo medical examination because they do not have contact with them. This has implication on the health of the pupils because some communicable diseases are transmitted through food. This poor implementation of the school feeding programme agree with the findings of Ofovwe and Offili (2009), Oluwakemi, Kayode and Taiwo (2014).

According to National school health policy document, that pupils be taught subjects which are listed in the policy document which will lead to acquisition of skill based in Health education. The head teachers said all the topics listed are taught at elementary level. This finding agree with that of Oluwakemi, Kayode and Taiwo (2014).

School Health services programme is the list implemented among the components of school health programmes as revealed by this study in the table presented under school health services but the five schools have a first aid box. The poor or lack of implementation of this very important component can be associated to lack of school clinic or the service of a school health nurse. This means that early detection and prompt treatment of disease is impossible. This findings agree with those of Bisi-Onyemaechi, Becki, Ugo, Tagb and Chika (2017), O.T. Kuponiyi, O. E. Amoran and OT. Kuponiyi (2006), Ogunkule O. O., Oyinlade O. A and Olarewaju D. M. (2014).

CONCLUSION

School, Home and community relationship is the only component that the teachers are directly involved in its implementation of which they set a day aside to have open day and visit home of pupils with challenges.

On the impediments to implementation of the school health programme, finances and lack of commitment on government side was reported by the five school head teachers to be the major draw-back for the school health programme in the schools. These findings agree with all other researchers cited in this work that finance and lack of commitment on government side are responsible for the failure of the school health policy.

REFERENCES

Academy living legends, (2010). *American Academy of Nursing.*

Ademokun O.M. Osungbade K.O. Obembe Ta (2014) A qualitative study on implementation of school health program in south west Nigeria: implication for healthy living of school age children in developing countries. *International Journal of Nursing Science.* D01:10.4103/0300-1652.188341.

Bisi-Onymaechi, Becki, Tagb, Chika (2017) school health services in Enugu East Nigeria. Perspectives from a resource poor setting. *International Journal of Nursing Science.* Dol: 10.4081/his 2017.6357 .

Kuponiyi OT. Amoran OE, Kuponiyi OT (2006) school health services and its practice among public and private primary schools in western Nigeria. *International Journal of Nursing Science.*

Ofovwe GE. Ofili AN (2007) knowledge. Attitude and practice of school health program among head teachers of primary schools in Egor Local Government Area of Edo state Nigeria, *Ann Afr Med* 2007, 6:99-103

Ogunkunle OO, Oyinlade OA, Olanrewaju DM (2014) an evaluation of school health services in Sagamu, Nigeria. *Niger J Chin Practice* Dol: 10. 4103/1119-3077.130236.

National school health policy (2006)

Tamatea Laurence (2005). *The Dakar framework: Constructing and deconstructing the global Neoliberal Matrix.*

UNESCO (2013) Monitoring and Evaluation guidance for School Health Progran

US Department of Health and Human Service (2010)

World Health Organization (2003). *Overview of the world.* Health report: Shaping the future, Geneva.