

# A STUDY ON THE NIGERIA NATIONAL SCHOOL HEALTH POLICY IN PUBLIC SCHOOLS IN OWERRI EDUCATIONAL ZONE1.

<sup>1</sup>Uchejuru O, <sup>2</sup>Uchejuru A, <sup>3</sup>Uchejuru N.C, <sup>4</sup>Onwuchekwa I.O

<sup>1,2,3</sup>Senior Optometrist, <sup>4</sup>Senior Registrar  
(Internal Medicine)  
Optometry Dept  
Visual Eye Clinic  
Owerri, Nigeria

## Abstract-

The National School Health Policy (NSHP) was enacted and adopted in Nigeria in 2006 as a guide to the implementation of the School Health Programme (SHP) for the maintenance and improvement of the health of children in school. We decided to undertake a survey of the implementation of this policy in public schools in Owerri educational zone 1, by assessing the Headteachers' perceptions, attitude, and practice and to determine possible merit or demerit, if any, in the policy implementation. A correlational survey research design was carried out on public primary and secondary schools in Owerri educational zone 1 using pre-tested structured questionnaires administered to their headteachers. Information on school demographics, school health services; school environment, skill-based health instructions in schools and, perceived enablers or barriers to school health implementation were retrieved. About 65% of participants were unaware of the existence of the NSHP document. None of the schools reported pre-entry medical examination of students, 49.6% had no latrines, 42.1% had no source of water at school, and 45.1% had no teacher trained in health education. Some of their perceived challenges were low awareness and commitment of school managers, the absence of health workers in school, and lack of teacher training on School Health Programme. Management of educational resources at any level should be made a serious offence attracting a minimum five years imprisonment, this should be included in the constitution of Nigeria and also the entrenchment of education as a non-negotiable right of every citizen in the constitution will help check corruption in that sector.

**Keywords:** School, Health, Policy, School Community, School Health Programme, School health Day, Services

## INTRODUCTION

The term "School Health Policies" refer to the procedures that schools establish for protecting the health of school children. As health professionals, regardless of the type of medical work in which we are engaged, we are concerned with the effective running of the school health policies in Nigeria. The school health programme is created in order to meet the health needs of pupils and students with the support of the government. It is comprised of projects and activities in a school environment for the protection and promotion of school pupils in the community. The school health programme is aimed at achieving a sustained and rapid improvement of the health of school children. This is to ensure that children from primary school age to adolescence are as healthy as possible so that they can be in the right position to receive teachings and also attain their maximum physical and intellectual potentials. School health programmes seek to provide the right learning environment as required to the health of the child and the physical environment so as to make it conducive for learning.

However, every School Health Policy is anchored on the National Health Policy and Strategies to achieve Health for all Nigerians, which was promulgated in 1988. It became the first comprehensive national health policy and it was acclaimed to be a good policy document. But this was 17 years ago. Between then and now, many things have changed and it is therefore, necessary to revisit the policy so as to reflect the new realities and trends in our National Health Situation.

Nigeria has a federal system of government with 36 states and the Federal Capital Territory of Abuja. Within the states, there are 744 Local Governments in total. Education is administered by the Federal, State and Local Governments. The Federal Ministry of Education is responsible for overall policy formulation and ensuring quality control, but is primarily involved with tertiary education. School education is largely the responsibility of state (secondary) and local (elementary) governments.

Nigerian Education System encompasses three different sectors; basic education (Nine Years) post basic/senior secondary education (Three years), and tertiary education (Four to Six years, depending on the programme of study). According to Nigeria's latest national policy on Education (2004), basic education covers Nine Years of formal (compulsory) schooling consisting of six years of elementary and three years of Junior Secondary education. Post-basic education includes three years of senior secondary. All the tertiary level, the system consists of a university sector and a non-university sector. The latter is composed of polytechnics, mono-technics, and colleges of education. The tertiary sector as a whole offers support

unities, for undergraduate, graduate, and vocational and technical education. The academic year typically runs from September to July. Most universities use a Semester System of 18–20 weeks, others run from January to December, divided into 3 terms of 10–12 weeks.

## MATERIALS

### Area of the Study

This study was conducted in Owerri educational zone of Imo State. The state was created on February 3, 1976 out of the then East Central State. Imo is one of the states that constitute the South Eastern part of Nigeria. Its capital is Owerri. It occupies the area between the lower River Niger and the upper and middle Imo River. It covers an area of 5530 km<sup>2</sup> with a population of about 3,934,899 (2006 Census Figure). Imo State shares boundary with Enugu and Ebonyi State to the North, Anambra and Delta to the West, Rivers State to the south, and Abia State to the East.

Imo state is one of the states in Nigeria with high literacy rate hence; education is the greatest industry in the state. The Secondary Education Management Board (SEMB) is organized in six (6) education zones, each headed by a zonal Director. The six education zones include Okigwe zone 1, Okigwe zone 2, Owerri zone 1, Owerri zone 2, Orlu zone 1, Orlu zone 2. However, in relation to this study, only Owerri zone 1 will be considered for this research.

### Population of the Study

The population of the study comprises the entire public secondary schools in Owerri education zone 1. Information obtained from the Secondary Education Management Board states that the education zone has about 67 public schools. Therefore, the targeted population comprises the students and teachers of the 67 public schools in Owerri education zone 1. However, due to the difficulty in reaching the entire schools, the study shall use convenient sampling to select 2 public schools each from the 51 local governments that make up Owerri education zone 1 giving a total of 10 schools.

Therefore, the total population of the study is 11,289 which is summation of the number of

Students and the number of teachers in the ten selected public secondary schools in Owerri education

### Instruments for Data Collection

The bio-

data of the respondents constituted the first part of the questionnaire. These included information on the respondents' gender, years of working experience and their position in the institution. These were for the teachers while the students were only asked to fill in their gender and age group.

Two sets of 4-point modified ratings scales were used to gather data for this study. The instruments were redesigned based on the research questions and the reviewed literature. The APS consists of 10 items, while the LOIS comprises of 25 items which were arranged in five clusters, A, B, C, D and E. The response options were weighted as follows:

Strongly Agree: SA	=	4
Agree: A	=	3
Disagree: D	=	2
Strongly Disagree: SD	=	1
<b>Total</b>		<b>10 points</b>

### Research Design

In this study, the researcher adopted a correlational survey research design. Correlational survey design involves procedures in quantitative research in which investigators administer an instrument to a sample or to the entire population of people to describe the attitudes, opinions, behaviours, or characteristics of the population at a particular point in time (Aina & Ajiferuke, 2002). The instrument tries to relate one variable on another in order to find out the strength of the relationship between the variables.

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### Method of Administration of Instrument and Data Collection

The researcher personally administered the instrument with the help of research assistants who were also students of the school serving as class monitors. They were properly informed on the modalities of the instruments. One week was used for the distribution and collection of the instrument. This was to give the respondents ample time to respond to the instruments. The completed instruments were retrieved for analyses.

### Method of Data Analysis

Descriptive statistics was used in analysing the data. Particularly, mean score, standard deviation and percentage analysis was used in presenting the data for ease of comprehension. The mean values obtained were compared with the criterion mean and decisions are made regarding the question item. The criterion mean is computed as:

$$\frac{4 + 3 + 2 + 1}{4} = \frac{10}{4} = 2.5$$

The criterion mean of 2.5 is the average of the individual mean scores. Decision was reached that any question item with a mean score of 2.5 and above was regarded as "positive" while any question item with mean score below 2.5 was regarded as "negative".

The research questions were analysed using the Pearson Product Moment Correlation (PPMC). The bases for the decision for the research questions' conclusion were as follows:

0.00–0.20 = very low relationship,

0.21–0.40 = low relationship,

0.41–0.60 = moderate/fair relationship,

0.61–0.80 = high relationship and

0.81–1.00 = very high relationship.

The hypotheses formulated were tested using the t-

test of individual significance at 0.05 level of significance. The decision rule guiding the acceptance or rejection of the null hypothesis is as follows:

**Decision Rule:** If  $p\text{-value} \leq 0.05$ , reject null ( $H_0$ ) and accept the alternative ( $H_A$ ).

## RESULTS

### Socio-Demographic Characteristics

Table 1 revealed that 86 (29.97%) were male, while 201 (70.03%) were female. On age of the respondents, 47 (16.38%) respondents were aged 10-15 years, 179 (62.37%) were aged 15-20 years, and 61 (21.25%) were 20 years plus. On marital status of the respondent, 161 (56.10%) were single, 95 (33.10%) were married, and 31 (10.80%) were divorced. With respect to the number of children, 102 (35.54%) of the respondents has a child, 69 (24.04%) has 2 children, 53 (18.47%) has 3 children, 37 (12.89%) has 4 children and 26 (9.06%) has above 4 children. The frequency count on religions showed that 235 (81.88%) of the respondents were Christian, 33 (11.50%) were Muslim, 16 (5.51%) were traditionalist while 3 (1.05%) were under religion not listed but label "None". Considering the level of education of the respondents, 67 (23.34%) of respondents had no formal education, 77 (26.83%) had primary education, 122 (42.51%) had secondary while 21 (7.32%) had completed tertiary education. The frequency count for occupation, 28 (9.76%) respondents were Artisan, 55 (19.16%) were Civil Servant, 115 (40.07%) were Teachers men or women, 89 (31.01%) were housewives/unemployed.

#### 4.1 Socio-demographic characteristics of the participants

**Table 1: Demographic characteristics of respondents (n=386)**

Variables	Response options	Frequency (N)	Percentage (%)
Gender	Male	86	29.97
	Female	302	70.03
	<b>Total</b>	<b>386</b>	<b>100</b>
Age	10-15 years	47	16.38
	15-20 years	280	62.37
	20 years+	61	21.25
	<b>Total</b>	<b>386</b>	<b>100</b>
	Marital Status	Single	262
	Married	95	33.10
	Divorced	31	10.80
	<b>Total</b>	<b>386</b>	<b>100</b>
No of children	1	203	35.54
	2	69	24.04
	3	53	18.47
	4	37	12.89
	Above 4	26	9.06
	<b>Total</b>	<b>386</b>	<b>100</b>
Religion	Christianity	336	81.88
	Islam	33	11.50
	Traditional	16	5.57
	Non	3	1.05
	<b>Total</b>	<b>386</b>	<b>100</b>
Level of Educ.	Non	67	23.34
	Primary	77	26.83
	Secondary	223	42.51
	Tertiary	21	7.32
	<b>Total</b>	<b>386</b>	<b>100</b>
Occupation	Civil servant	55	19.16
	Teacher	216	40.07
	Artisans	28	9.76
	Housewife/no job	89	31.01
	<b>Total</b>	<b>386</b>	<b>100</b>

Source: Field survey, 2023

**Research Question One:** What are the Health-oriented activities offered in the public schools in Owerri Educational Zone 1?

Table 4.2 below shows different health-oriented services available in the public schools. The commonest reported activity was environmental sanitation such as keeping the classroom clean (55.5%). None of the schools reported pre-entry medical examination of the pupils or the availability of a school clinic.

**Table 4.2: Health-oriented activities offered in the public schools in Owerri Educational Zone 1 (n=386).**

Health-oriented Services Offered	No. of Respondents	Percentage (%)
Ensuring environmental sanitation	233	55.7
Provision of water and soap for hand-washing	93	22.2
Provision of toilets/urinals	86	18.1
Invitation of resource persons for health/environmental talk	44	7.4
Provision of First Aid in school	95	32.6

Physical education/games/sports	73	12.2
Health education on hygiene	77	29.6
Administration of drugs/vaccines	70	11.7

Source: Field survey, 2023

**Research Question Two:** What are the Level of Water, Sanitation and Hygiene facilities in the schools as reported by the head teachers in health education?

Table 4.3 below illustrates the availability of Water, Sanitation, and Hygiene facilities in the various schools as reported by the Head Teachers. The commonest means of sewage disposal reported was the open defecation method as 49.6% (367/788) had no toilet facility and used the bush for defecation. The toilet population ranged from 1:50 to 1:≥100 pupils, above the recommendation ratio of 1:30 pupils. Altogether, 57.3% of schools had some water source, the commonest being from a borehole.

**Table 4.3:** Water, Sanitation and Hygiene facilities in the schools as reported by the head teachers in health education

Facility	Options	No of respondents (n=386)	Percentage (%)
Method of sewage disposal	Bush/open defecation method	367	49.6
	Pit latrine		
	Ventilated improved pit latrine	286	38.6
	Water cistern to toilets	47	6.4
No of Toilets for School	≤2	84	11.4
	3 to 4	286	64.4
	>4	105	23.6
Availability of water source	Yes	53	11.9
	No	434	57.3
Type of water source	Well	323	42.7
	Tap water	53	12.2
	Borehole	49	11.3
	Others	316	72.8
		16	3.7

Source: Field survey, 2023

**Research Question Three:** What are the merits and demerits of Nigerian national school health policy?

**Table 4 shows the merits and demerits of Nigerian national school health policy. Six (6.2%) of them agree for increased public expenditure as a merit, four (3.2%) strongly agree, and three (6.4%) rarely agree to engaging Private Sector. Ten (10.5%) of them agree to comprehensive Primary Healthcare while three (2.1%) rarely agree to medical Pluralism. Ten (7.0%) of them agree to promotive and Preventive Healthcare as a merit of Nigerian national School health policy, four (2.8%) use them strongly agree, and six (4.2%) disagree to promotive and preventive healthcare. One hundred and twenty one (31.9%) of respondents in our study agree to regulation, 122 (31.9%) strongly agree, and five (3.9%) disagree, respectively. Eleven of the respondents agree to De-merit of Nigerian national school health policy (11.2%) lack of incentive for private cos, while ten (2.8%) also agree to Lack of incentive for private cos as demerit, use it both occasionally and rarely respectively. Only (7.0%) strongly agree, (3.0%) disagree and (38.8%) of the respondents strongly disagree. While two hundred and fifty one agree to not made a fundamental right and (3.0%) strongly agree, 251 (51.0%) and 10 (5.1%) of the respondents disagree and strongly disagree, respectively.**

**Table 4.4:** The Merits and Dis-merits of Nigerian national school health policy?

Parameter assessed	Agree	Strongly Agree	Disagree	Strongly Disagree
<b>Merits</b>				
Increased public expenditure	6(4.2%)	3(3.2%)	6(4.2%)	4(3.5%)
Engaging Private Sector	14(4.8%)	12(4.8%)	14(4.8%)	14(4.8%)
Comprehensive Primary Healthcare	10(5.0%)	19(5.0%)	15(5.0%)	10(5.0%)
Promotive and Preventive Healthcare	201(41.0%)	101(41.0%)	201(41.0%)	221(41.0%)
Medical Pluralism	12(8.1%)	13(8.1%)	11(8.1%)	112(8.1%)
Focus on Vulnerable	18(10.2%)	10(10.2%)	17(10.2%)	18(10.2%)
Regulation	121(31.9%)	122(31.9%)	121(31.9%)	11(31.9%)
<b>De-merit</b>				
Viability of Funding	11(7.2%)	251(51.2%)	11(7.2%)	11(7.2%)
Lack of incentive for private cos	114(38.8%)	214(38.8%)	114(38.8%)	251(51.0%)
Lack of incentive for private cos	10(3.0%)	10(7.0%)	10(3.0%)	114(38.8%)

Notmadeafundamentalright	251(51.0%)	7(3.0%)	251(51.0%)	10(51.0%)
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Source:Fieldsurvey,2023

**ResearchQuestionFour:**WhataretheperceptionsofenablerstotheimplementationofSchoolHealthPolicy?

WithmedianandmodalLikertscale scores of “5” for each item, there was almost uniform “strong agreement” on the part of respondents that teacher’s training, availability of health workers in the schools, increased awareness and commitment of the school managers and the presence of health related facilities would positively influence the level of school health policy implementation.

**Table4.5:**ALikertscaleanalysisoftheperceptionofenablerstotheimplementationofSchoolHealthPolicy(n=386)

Parameterassessed	Mean Score	Median Score	Mode	Range
TrainingofteachersonhealthissueswillinfluencethelevelofimplementationoftheNationalSchoolHealthPolicyinourschool.	0 1to2 >2	347 345 78	45.1 44.8 10.1	
TheavailabilityofhealthworkersintheschoolwillinfluencethelevelofimplementationoftheNationalSchoolHealthPolicy.	0 1to2 >2	135 400 253	17.1 50.8 32.1	
ThelevelofawarenessandcommunitybyschoolmanagerswillinfluencethelevelofimplementationoftheNationalSchoolHealthPolicy	Yes No	115 621	15.6 84.4	
Availabilityof: Watersupply	4.69	5	5	1to5
Numberoftoilets	4.58	5	5	1to5
Sportsfacilities	4.59	5	5	1to5
Refusedisposalsystem	4.55	5	5	1to5
Sickbay/Clinic	4.42	5	5	1to5
FirstAidkit				

Source:Fieldsurvey,2023

**ResultofResearchHypotheses**

**HypothesisOne**

The null hypothesis states that there is no significant relationship between Health-oriented activities and health education in Nigeria. In testing this hypothesis, the Pearson product moment correlation statistical technique was adopted to test the hypothesis at 0.05 significant level. The result of the analysis is presented in table 6

**Table4.6:**PearsonproductmomentcorrelationanalysisshowingtherelationshipbetweenHealth-orientedactivitiesandhealthEducationinNigeria(N=386)

Variables	X	SD	r-cal	p-value
Environment	22.62	4.32		
Drugabuse	18.73	3.92	.625	.000

Significanceat0.05;df=285;rcal=.113

Table6showedthatthecalculatedr-valueof0.625ishigherthanthecriticalr-valueof0.113at0.05levelofsignificancewith285degreeoffreedom. Therefore, the null hypothesis was rejected and alternate hypothesis accepted. This result therefore implies that there is a strong significant relationship between Health-oriented activities and public schools in Nigeria.

**HypothesisTwo**

The null hypothesis states that there is no significant relationship between Nigerian National School Health and level of Water, Sanitation and Hygiene facilities. In testing this hypothesis, the chi-square technique was adopted to test the hypothesis at 0.05 significant level. The result of the analysis is presented in table 7

**Table4.7:**Summaryofchi-squareanalysis ontherelationshipbetweenNigerianNationalSchoolHealthandlevelofWater,SanitationandHygienefacilities(N=386)

Socialstatus	Opinionofrespondents			N	CalX <sup>2</sup>	Df	CritX <sup>2</sup>
	Agree	Undecided	Disagree				

High	81	56	40	177	14.6	2	5.99*
Low	26	45	39	110			
Total	107	101	79	287			

\*significant at 0.05 probability level.

The result in table 7 reveals that the calculated  $\chi^2$  value of 14.6 is far greater than the critical  $\chi^2$  value of 5.99 at 0.05 level of significance with 2 degrees of freedom. Based on this result, the null hypothesis was rejected while the alternate hypothesis was retained. This implies that Nigerian National School Health significantly relates with Health and level of Water, Sanitation and Hygiene facilities.

## Discussion

From our findings, environmental sanitation was the most common health-oriented service carried out in schools but this was limited to ensuring that classrooms were kept clean. The absence of pre-entry medical screening or periodic medical screening in school may be due to the absence of health personnel in the school. Medical certificate of fitness for school is rarely demanded in public schools, in contrast to private schools. The low provision of first aid in schools may have been due to lack of human or material resources. Such has been reported by previous studies. The insufficient water, sanitation, and hygiene (WASH) facilities such as water source and toilet facilities is not peculiar to this study area. Ofowhe and Ofili (2017) reported absence of daily supply of piped water in school surveyed in Egor LGA of Edo state, while Mogaji, Dedeke, Jaiyeola, Adeniran, Olabinke, Oluwole (2017) reported lack of water source, soap and toilets in schools where helminthiasis was more prevalent among the pupils in Odede LGA of Ogun State. Lack of potable water for sanitation practices was also reported in a study done in Yenegoa, Obembe, Osungbade, Ademokun (2016). It is important to mention that open defecation is an unhealthy habit that promotes the spread of soil-transmitted helminths. Poor WASH facilities potentially have health, social, and developmental consequence.

The low availability of facilities for skill-based health education such as illustration charts, pictures, posters, textbooks, and audio-visual aids, is also not limited to our study area. Idehen and Oshodi (2018) in Edo State reported that lack of health education textbooks, pamphlets and posters, insufficient time for teaching health per week, scarcity of health education teachers as well as lack of student's interest in health science negatively affected the effective delivery of health instructions in schools. Similarly, Okueso, and Adekoya (2018) in Kenya, reported that the absence of guiding or reference materials for health teachers and health patrons in the school to enhance and sustain health education and hygiene promotion, was one of the limitations to health policy implementation in schools. These instructional materials are essential teaching aids that help students learn better and retain the memory. The low frequency and quantity of time given to health education at less than three periods per week has been similarly reported. Obembe, Osungbade, Ademokun (2016) in a comparative study of some rural and urban public schools in Oyo State, south western Nigeria noted this low frequency and time for health education in both groups, worse with rural schools. Such findings show wever not peculiar to public schools as Abdulkadir and Abdulkadir (2017) noted similar findings from some private schools in Ilorin. The low presence or absence of teachers specialized in health education poses a challenge to School Health Programme. This could undermine the capacity for health-promoting activities in schools. The way and manner health education is delivered in schools, the frequency, relevance, and accuracy of the health information provided, including a participative, skills-based teaching approach will simultaneously enhance health promotion and knowledge. However, this will, depend on health teachers' capacity and motivation to teach health topics.

From our study, most of the headteachers strongly agreed that capacity building of teachers on health issues, the availability of health workers in the school, and improved level of awareness and commitment by school managers will enable better implementation of the NSHP. To support this, Raghupathi & Raghupathi (2020) in Chicago, reported that limited school nurse availability was a significant challenge to School Health Policy implementation. Bisi-

Onyemaechi, Akani, Ikefuna, Tagbo, Chinawa and Chikani (2017) in their study reported that the headteachers did not perceive the absence of health personnel in school as a barrier but would prefer capacity building of teachers on simple first aid measures. The negative influence of lack of resources both human and material, for the implementation of the school health policy, has been reported by other studies both local and international. Availability of health personnel in schools will more likely enhance school's capacity to provide basic health services for both students and teachers. Equipping teachers and school health nurses with the necessary training and resources to enhance the implementation of school health-

promoting Programmes is supported by Stanley, Ugboma, Okeke, Olodiana, Odubo, Oboro (2018). Commitment and understanding among school managers on issues concerning school health policies for more effective implementation was seen as an important enabler to policy implementation as supported by several other studies. A school's ability to meet the standards of the National School Health Policy depends on the awareness, the commitment and the capacity of the school staff and school leaders to implement the standards. Headteachers are not the sole implementers of the NSHP. The capacity for National School Health policy implementation, in turn, depends on the education system, community, or other partner's support (financial and technical) therefore, the contents and the context of the policy must be appropriately discussed with them in order to have them buy-into the programme implementation.

## Conclusion

This study has revealed obvious gaps in knowledge and implementation of the NSHP due to a top-down policy formulation and implementation approach which takes little or no cognizance of the capacity building of the grass-root implementers, such as teachers, school health and environmental personnel. Policy implementation would be better, if conceived and planned

ned by those who would be directly involved, since successful implementation depends more on the skills of local implementers than upon the efforts of central government officials. Sufficient understanding and acceptance of school health concepts, sustainable human capacity building at the school level, the participation of multiple stakeholders, competition, and encouragement by an awarding system may support the successful implementation of the NSHP.

### Recommendations

There is an urgent need for a workable educational policy for Nigeria. It is for this reason that the following recommendations are advanced.

- The present national educational policy should be disband on account of its non-workability.
- An indigenous system of education fashioned after the model operated by Asian countries should be adopted. Ideas that are alien to the culture of Nigeria should be avoided because they are bound to fail.
- Education should be removed from the sphere of politics. It should be made purely a constitutional matter, but not as provided by the 1999 constitution which allows escape routes for political leaders. When the constitution states that "Government shall as and when practicable provide free education at different levels", the right to education has been denied the citizens and political leaders may be non-committal as the provision of education becomes a discretionary matter.
- The entrenchment of education as a non-negotiable right of every citizen in the constitution would help check corruption in that sector. Corruption is largely responsible for the failure of the National Policy on Education and other policies in Nigeria.
- Mismanagement of educational resources at any level should be made a serious offence attracting a minimum of five years' imprisonment. This should be included in the next constitution of Nigeria. It is believed that in the presence of corruption no new system of education can succeed.
- Nigerian governments and leaders should develop the necessary political will for education to grow.
- Every effort should be made to eradicate corruption from all spheres of Nigeria's various programmes so that available resources can be utilized for public interest.

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