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Research Article

Quality of Implementation of the School Health Programme in Ondo State, Southwest Nigeria: The National School Health Policy Perspective

Ayoola Oluwaseun Bosede[1], Taiwo Akinyode Obembe[2] and Ayodeji Mathew Adebayo[3]*

[1]*Department of Environmental Health Science, School of Health Technology, Federal University of Technology, Nigeria*

[2]*Department of Health Policy and Management, University of Ibadan, Nigeria*

[3]*Department of Community Medicine, University of Ibadan, Nigeria*

Abstract

Background: School Health Programme (SHP) is a strong tool for the achievement of education and health related Sustainable Development Goals (SDG). When properly implemented, it has the capacity to prevent disease and greatly improve learning among the school children.

Objective: This study was conducted to assess the Quality of Implementation (QoI) of the SHP in Ondo state, Southwest Nigeria owing to some previous health incidents among the school children in the state which good quality SHP would have prevented.

Methods: This was a descriptive cross-sectional study. An observational checklist was used to assess the five components of the SHP as described in the NSHPo of 2006.

Results: It was found that no school in the study area had or employed the NSHPo for their SHP. The quality of implementation of SHP in the study area was found to be good in 36% of the schools. There was no significant difference in the QoI of the SHP in private and public schools, and between schools in the rural and the urban areas ($p>0.05$).

Conclusion: Although, some components of the SHP were found to be fairly implemented, others were either not available or implemented poorly. It is therefore recommended that efforts be made by relevant stakeholders in the health and education sector of the state to increase awareness on the use of the NSHPo for better and easy implementation of the SHP.

Keywords: School health programme; School health services; Feeding services; School-age children; Quality of implementation

Introduction

It is universally recognized that the health of school children deserves special attention [1]. School Health Programme (SHP) is an important component of the overall health care delivery system of any country [2]. Next to the family, the school is the secondary institution responsible for the development of young people all over the world [3]. The school has direct contact with more than 95% of the nation's 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 [4]. Globally the number of children reaching school age is estimated to be 1.2 billion children (18% of the world's population) and rising [5]. Even though school-age children do not suffer from the high mortality of pre-school children, there exists a high burden of morbidity among them, varying in prevalence from one country to another [6]. The health problems in this group of children include infectious diseases, accidents and injuries, nutritional and mental disorders including substance abuse [7].

In recognition of the needs of the school age children, the School Health Programme (SHP) has evolved all over the world [8]. The concept of SHP stems from the realization of the fact that without proper health it will be very difficult for quality education to be achieved [9]. The SHP is directed to meet the health needs of students at the present time and laying a good foundation for their future with the support of the home, community, and government [10]. The SHP can also play a role in identifying children with emotional, behavioral and mental health problems and ensuring they get proper assessment and appropriate intervention [9]. Healthy emotional and social development, including a sense of self-worth, is critical to the success of the children within and outside the classroom [11]. A historical review shows that the awareness of the need for a health service for school aged children started quite early and has spread all over the world [12]. Thus, most countries have initiated some form of SHP. The state of such programmes, however, varies from country to country, depending on certain characteristics of each country such as level of economic development, educational resources, and disease prevalence [12]. In Nigeria; many authors have observed that generally, the SHP is a neglected aspect of the Health and Education sectors of the country [7,13,14]. From the review of the programme in Nigeria, it appears that the programme was functional at the onset but then started to decline in the late seventies [12]. This may be due

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***Corresponding author:** Ayoola Oluwaseun Bosede, Department of Environmental Health Science, School of Health Technology, Federal University of Technology, Owerri, Imo State, Nigeria, Tel: +234-8032560307; E-mail: ayoola.bosede@futo.edu.ng

to the economic downturn and political instability in the country in the last three decades.

The National School Health Policy (NSHPo) was then, introduced in 2006 to improve the state of SHP in the Nigeria, it also serves as a framework for the implementation of the programme in the country [15]. Before the introduction of the NSHPo, the Federal Ministry of Health (FMoH) with the support of the WHO conducted an assessment of the environment and health situation of schools (Daycare centers, primary schools, secondary schools and other non-formal education centers where children are gathered for learning purpose) in the country [15]. It was revealed that over 70% of the schools lacked appropriate toilet facilities, more than half of the schools lacked pipe-borne water; over 30% of the schools were reported to be environmentally unfriendly. Regarding the school health services aspect of the programme, less than 15% of the head teachers confirmed that pre-employment medical examination is compulsory in their schools, less than 20% of the schools engage the service of a nurse, while a good number of the schools possess first aid box [15]. It was also reported that medical examination of food vendors and handlers are not conducted in majority of the schools. The report revealed the terrible state of the school health programme in the country prior to the formulation and adoption of the 2006 NSHPo. Sadly, despite the obvious importance of the SHP, the embrace of proper and effective health programmes in schools are yet to be fully imbibed [16]. Various studies have been conducted to evaluate the state of The SHP in schools in Nigeria, these studies have all presented different reports, while some reported poor QoI [13,17], the others reported fair quality of implementation [3], while some others reported good QoI [18]. It is, however, noteworthy that each state in the country has autonomy on issues relating to primary and secondary educational in Nigeria. This may be the reasons for the non-uniform implementation status of the NSHPo by the different states.

In 2011, a primary school pupil shot dead his colleague with a pistol that was found in the bush within the school premises, apparently, the bush has been providing cover for criminal gangs who use the school premises as their hideout [19]. A properly implemented SHP will ensure that no overgrown weeds are found within the school premises talk less of bushes. In another fatal incident, in 2019, a secondary school student fell to his death from a mango tree within a school premises in Akure, the Ondo State capital when his class teacher requested that the deceased should help him to pluck down mangoes from the mango tree [20]. A well instituted SHP and adequately knowledgeable schoolteachers in the working of the SHP would have prevented this incident from occurring. This study therefore, assessed the QoI of the SHP implementation in Ondo state, South-west geopolitical zone of Nigerian; a zone where the school enrolment is the highest [21]. This assessment was conducted based on the provision of the NSHPo, 2006.

Materials and Methods

The cross-sectional study was conducted in Akure the capital city of Ondo State, Nigeria. Akure is situated 204 km east of Ibadan the Oyo State capital, 168 km west of Benin, Edo State capital, and 312 km north east of Lagos, the commercial heart of Nigeria. Akure, comprises of two local headquarters, Akure South (urban district) and Akure North (rural district) Local Government Areas with population of about 575,000 [22]. Akure spreads over an area of 25 square kilometers and lies on the Latitude 7017" and 7020" and Longitude 5014" and 5033".

The study sites were purposively chosen; Akure South being the state capital and thus, a true representation of the situation in the state, Akure North for its close proximity to Akure South. The majority of the inhabitants of Akure South are civil servants; some others are engaged in white collar jobs with other private organizations including schools and banks. Literacy level is quite high in Akure as observed in other South-western States of the nation [23]. Akure North is predominantly an agrarian community, with few white-collar jobbers. This research is a part of a larger study that appraises the SHP in the state, thus 42 schools were selected, 33 from the urban district and nine from the rural district they, these numbers were arrived at based on proportion to size allocation.

The study population consists of all public and privately owned primary schools that were registered with the Ondo state ministry of Education; and are within the selected districts for the conduct of the study. The schools where the study was conducted were selected using simple random selection technique.

An observational checklist which was developed from the Implementation Guidelines on National School Health Programme 2006 was used to assess the status of implementation of the five components of the School Health Programme in the selected schools [24]. The five components are Healthful School Environment (HSE), School Health Services (SHS), Skill-Based Health Education (SBHE), School Feeding Services (SFS), and School, Home and Community Relationship (SHCR).

Items were given graded scores if such question was meant to ascertain both presence (1 point) and level of appropriateness (2 points) of the options. From the observational checklist, item ticked under (A) indicates availability and appropriateness, items marked under (B) indicates availability but not appropriate, items marked (C) indicates unavailability or grossly inappropriate.

The maximum obtainable score for all the items on the observational checklist on the components of the School Health Programme is 130 (Table 1). For each of the different items, the observational checklist with scores less than or equal to 39% of the Maximum Obtainable Score (MOS) were categorized "Poor"; schools with scores that fell within 40% to 59% of the maximum obtainable score were categorized as "Fair" and schools with scores above or equal to 60% of the maximum obtainable score were categorized as "Good" [3]. The data collected were analyzed using IBM Statistical Package for Social Sciences 20.0 [25]. Results were presented in descriptive forms using tables and charts.

Bias was minimized by not informing the schools prior to the visit. Ethical approval was obtained from the Ondo State Health Research Ethics Committee. Approval was also obtained from the Ondo State Ministry of Education, the Ondo State Universal Basic Education Board. Advocacy visit was paid to the Zonal Education Office (ZEO) in Akure South and to the Akure North Area Education Office (AEO) during which the intention and aims of the research was communicated and support assured.

Results

Table 2 shows information on the availability and use of the National School Health Policy document by the schools in the implementation of School Health Programme in the state, it was discovered that all the assessed 42 schools did not have the NSHPo

Table 1: Summary of the scoring and rating for the QoI of SHP.

Components of School Health Programme	Maximum obtainable score	Good (≥ 60%)	Fair (40-59%)	Poor (<40%)
Healthful School Environment	60	36-60	24-36	<24
School Feeding Services	12	45267	45082	<5
School Health Services	38	22-38	15-21	<15
Skill-based Health Education	8	45143	45019	<3
School, Home and Community Relationship	12	45267	45082	<5
Overall SHP	130	78-130	52-77	<52

Table 2: Availability and use of the NSHPo in the school.

Availability of the NSHPo in the school	Freq. (N)	Percent (%)
Yes	0	0
No	42	100
Total	42	100

document. It can therefore, be inferred that none of the schools employed the NSHPo document for use in the implementation of SHP in the school.

Figure 1 shows information on how the schools perform on each of the five components of the SHP. On healthful school environment, 73.8% of the schools were rated "good", 19.1% were rated "fair", while the remaining 7.1% were found to have poorly implemented the HSE element of the SHP. Concerning the School Feeding Services, 95.2% of the schools were found to have performed very well, thus rated "Good", the remaining 4.8% performed fairly well. When the schools were checked for the Skill-based health education element of the SHP, 90.5% of the schools were found to perform well, thus, rated "Good" while the remaining schools performed fairly well. On the School health services element of the SHP, more than half of the schools were found to perform poorly; just one school was rated "Fair", while the remaining were rated as "Good". On the school, home and community relationship element of the SHP, it was discovered that all the schools performed very well in that regard and are thus, rated "Good".

Table 3 shows the availability of facilities in the implementation of SHP in the study areas. As shown on the table, on adequacy of school ground, majority of the schools (71.4%) were sited on appropriately sized ground, majority of the schools (73.8%) were located away from sources of noise pollution. Concerning light and ventilation, 88.1% of the schools have their classes adequately lighted and ventilated. Regarding availability of gender sensitive toilets, only 35.1% of the schools have separate toilets for male and female pupils. Only 47.6% of the schools have potable source of water for the school community out of which only 2.7% presented evidence of yearly water sampling analysis. "School feeding services" was accessed based on certification of the food handlers, routine visit of a nutritionist/dietician from the health ministry to the school and availability and neatness of eating apartment/dining hall. It was revealed that all the schools made use of certified food handlers, none of the schools have ever received health ministry appointed nutritionist/dietician. Only very few schools have an appropriate dining hall.

Skill-based health education was assessed based on availability of health education curriculum in the school, availability of health education teaching aids, availability of facility for practical and availability of health education teacher with minimum NCE qualification. Almost all the schools possessed the requirements for skill-based health education.

School health services was assessed based on availability of clinic within the school premises or with 15 minutes walking distance, availability of means of transportation in case of referral of a seriously ill or injured child, availability of adequately equipped first aid box. It was discovered that only 40.5% of the schools had school clinics or clinics within 15 minutes of walking distance, very few schools (7.1%) showed evidence of means of transportation in case of emergency. Almost have the schools have well equipped first aid box.

The school, home and community relationship component were assessed based on, evidence of Parents Teachers Association (PTA) minutes of meetings, community project in the school, PTA project in the school, Teachers messaging home on matters relating to the learners, Parents routine visits to school and Teachers visiting learner's homes. It was shown that half of the visited schools had PTA projects within the school, almost all the schools had Teachers regularly messaging learners' homes and only very few schools had community projects within the school premises.

Figure 2 presents information on the overall performances of the school as regards the School Health Programme Implementation. Twenty-two schools which is the equivalent of 52.4% of the total performed fairly, 15 schools performed well and are thus rated "good", the remaining five schools performed poorly.

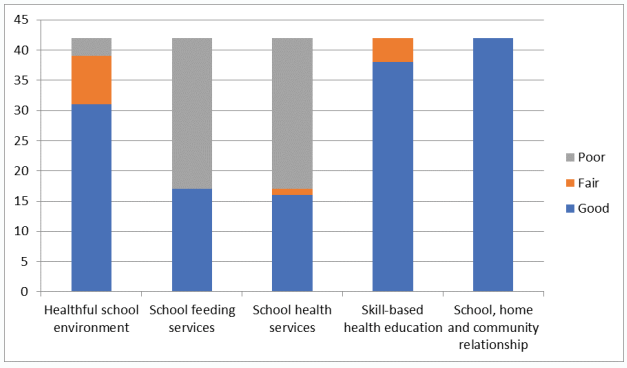

Figure 1: Performances of the schools on each element of the School Health Programme.

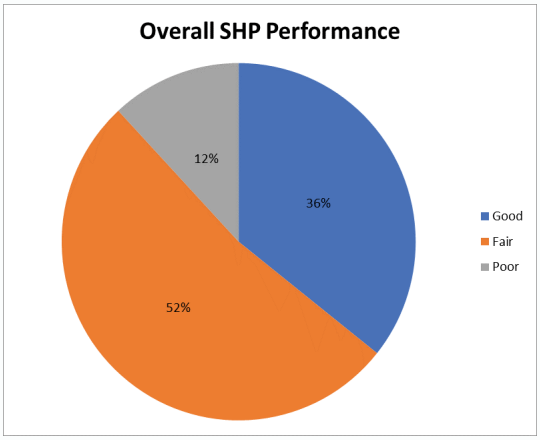

Figure 2: Overall School Health Programme performance of the schools.

Table 3: Availability of facilities for the implementation of School Health Programme.

Components of SHP	Items observed	Number and proportion of Schools n (%) N=42
Healthful School Environment	Appropriate size of the ground	30 (71.4%)
	Appropriate play ground	27 (64.3%)
	Appropriate indoor game room	3 (7.1%)
	Located away from sources of noise pollution	31 (73.8%)
	Perimeter fencing	34 (80.9%)
	Well drained terrain	36 (85.7%)
	Maximum of 40 learners per classroom	38 (90.5%)
	Well-lit and ventilated classrooms	37 (88.1%)
	Adequate spacing between Teacher and learners	29 (69.1%)
	Potable water source	20 (47.6%)
	Yearly water bacteriological analysis	1 (2.4%)
	Appropriate solid waste disposal facility	20 (47.6)
	Gender sensitive toilet facility	15 (35.7%)
	Appropriate toilet facility	38 (90.5%)
School feeding service	Certified food handler	42 (100%)
	Nutritionist routine visit to the school	0 (0%)
	Presence of dining hall	8 (19.1%)
Skill-based health education	Health education curriculum	41 (97.6%)
	Teaching aids	41 (97.6%)
	Facilities for practical	39 (92.9%)
	Health education teacher with at least NCE qualification	30 (71.4%)
School health services	Clinic within school/within 15 minutes walking distance	17 (40.5%)
	Ambulatory/transport facility	3 (7.1%)
	First aid/emergency preparedness	38 (90.5%)
School, home and community relationship	PTA project in school	21 (50%)
	Community project in school	2 (4.8%)
	Evidence of PTA meeting/minutes of meeting	15 (35.7%)
	Teachers messaging home through learner	41 (98.0%)
	Teachers home visit	30 (71.4%)
	Parents school visit	100 (100.0%)

Table 4 below is a bivariate analysis of the association between the school type and school location, and the school SHP implementation status. There were no significant association between school type and location, and SHP implementation rating/status. However, more public schools (38.5%) had good implementation status than 31.2% of the public schools (p=0.893). A higher proportion (39.4%) of the urban schools had good implementation status compared to 22.2% of the rural schools (p=0.596).

Discussion

Studies from the last 25 years or more have documented poor quality of implementation of the SHP in Nigeria [24]. This study was conducted to assess the quality of implementation of the SHP in the light of the NSHPo that was developed and adopted for Nigerian schools by the Federal Ministry of Education in 2006. Overall, we found out that more than half of the assessed schools performed fairly and about one-sixth of the school performed below average and were thus rated as poor (Figure 2). In the light of the importance of the SHP as described earlier in this report, schools should not be applauded for performing fairly in their SHP implementation, neither should poor performance be observed if the school children are to achieve maximum education and health benefits from schooling. It is our believe that the schools that obtained "good" and "fair" ratings in the QoI got the ratings by chance as we observed that none of the schools possess the NSHPo or any other SHP framework on which to base their SHP implementation.

Our finding on the QoI of SHP is similar to the findings of Ademokun et al. [3], in the report of their study among public secondary schools in Ibadan metropolis where it was found that out of all the schools that were assessed, 28.6% had poorly implemented the components of the SHP, 42.9% had fairly implemented the components of the SHP, and 28.6% had good implementation of the components of the SHP [3]. The similarity in findings between the current study and the Ademokun et al. [3] may be as a result of the similarity of the instrument that both studies employed for their data collection. This study finding also corroborates the report of Toma et al. [7] which found out that quite a number of the assessed school had some form of health services in place. The study of Toma et al. [7] was however limited to school health services; a single component of the overall SHP. Although, the finding of Toma et al. about school health services mirrors the finding of the current study, the study cannot be juxtaposed with this study as it only considered a single aspect of the SHP, whereas the current study considered all the five components of the SHP [15].

Our finding about the poor implementation of the school health services component of the SHP (Figure 1), is in tandem with the study of Kuponiyi et al. [5] which reported that there were no health personnel or a trained first aider in majority of the schools, a nurse/midwife was present in some of the schools, but overall, the practice of school health services was poor even though Kuponiyi et al. [5], study was conducted among private primary schools only, it is obvious that both the government public school owners and the private school owners have failed in the area of provision of effective school health services (a very important component of the SHP) for the school children. This poor School Health Services implementation was also found in the report of Osuorah et al. [26] in a study that was conducted in an urban district of Anambra state where it was found out that more that three-quarter of the assessed schools had poor implementation of the SHS component of the SHP.

Table 4: Bivariate analysis of the relationship between type and location of schools and the quality of SHP implementation.

Type of ownership	Overall SHP Implementation status			Total	X^2	p-value
	Good	Fair	Poor			
Public ownership	5 (31.2%)	9 (56.2%)	2 (12.5%)	16	0.226	0.893
Private ownership	10 (38.5%)	13 (50%)	3 (11.5%)	26		
Location of school						
Urban district	13 (39.4%)	16 (48.5%)	4 (12.1%)	33	1.036	0.596
Rural district	2 (22.2%)	6 (66.7%)	1 (11.1%)	9		

In a study of the QoI of SHP in a rural district of Oyo State; a public- private comparative study by Adebayo et al. [13], a slightly different finding was observed. They reported concerning the overall QoI of SHP that around 50% of the schools (63.3% public and 25% private) had poor quality of implementation of the SHP. This slight dissimilarity may be since the Adebayo et al. [13] study was carried out in a rural setting only whereas; this study covered both rural and urban settings.

In a rural-urban comparative study of the QoI of SHP by Adebayo and Owoaje [17], it was reported that more than half of the visited schools had poorly implemented SHP. Even though the study was conducted among public primary schools, it reinforces our argument that those schools that we observed to have had average and above-average QoI of SHP in our study area must have had those performances by chance as the majority of those schools had no policy framework on which to base their SHP implementation. We may also argue that the reported majority poor quality SHP as observed by Adebayo and Owoaje [17] as against our majority fair quality SHP as observed by our study may be associated with the fact that Adebayo and Owoaje [17] study only assessed the public schools in the study area. It is a known fact that most of the Nigerian public primary schools suffer from poor funding with its attending infrastructural decay unlike many private schools that are recently established by business men who pump enough fund into their development with the aim of getting return on their investment [27]. Our combined SHP QoI studies, however, suggested that the schools in Southwestern Nigerian needed to improve seriously on their SHP implementation for the benefits of the school children and the entire school community.

Mbarie et al. [18] in their study where the SHP performance in schools in Edo state Nigeria was evaluated, it was found that the state of the SHP in the study area was generally poor. This study has a remarkable semblance with our study in that it assessed both private and public schools in both rural and urban settings. These studies further lay emphasis on the generally poor implementation of the SHP in the Nigerian schools.

Bisi-Onyemaechi et al. [28] in another research in the South Eastern Nigeria reported a majority of the schools had poor Healthful School Environment (HSE) component of the SHP implementation. This finding is dissimilar to our finding where we reported almost 70% "good" HSE implementation (Figure 1). The study found that, the environment of primary schools in Enugu east, Nigeria is unhealthy and unfriendly. Bisi-Onyemaechi et al. [28] study used a SHP Evaluation scale that was developed by Anderson and Cresswell in the 1980 [29] to collect data for their study, this may the responsible for the observed differences in the current study and their study. The usage of this exotic scale by Bisi-Onyemaechi et al. [28] puts the authenticity of their finding in doubt as the contextual factors in which the Nigerian schools operate was not catered for by the Anderson and Cresswell, (1980) instrument.

Conclusion

We observed that majority of the schools had fair quality of implementation of the SHP. Some of the schools, however, had poor QoI of SHP. This situation is not good at all if the school children must benefit from schooling and if the school community must remain healthy for productivity.

It is therefore recommended that the training of the school stakeholders on the working of the NSHPo in the SHP implementation be conducted by the health and education authorities of every State of country. It is also recommended that each of the States of the federation should make it mandatory for all their schools to have copies of the NSHPo for use for an effective and efficient SHP delivery, and for the benefits of the school children who are the most vulnerable and most important school stakeholder.

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References

1. Adetokunbo OL, Gilles MH. Short Textbook of Public Health Medicine for the tropics. 4th ed. London: Book Power; 2003. p. 332.
2. Bosede AO, Obembe TA, Adebayo AM. Knowledge of school teachers and the associating factors in the effective delivery of the school health programme in Nigeria. Pan Afr Med J. 2022;43:4.
3. Ademokun OM, Osungbade KO, Obembe TA. A Qualitative Study on Status of Implementation of School Health Programme in South Western Nigeria: Implications for Healthy Living of School Age Children in Developing Countries. Am J Educ Res. 2014;2(11):1076-87.
4. CDC. CDC Healthy Schools: About CDC Health Schools. 2019.
5. Kuponiyi OT, Amoran OE, Kuponiyi OT. School health services and its practice among public and private primary schools in Western Nigeria. Biomed Cent Res Notes. 2016;9(1):203.
6. Adeyinka DA, Muhajarine N, Petrucka P, Isaac EW. Inequities in child survival in Nigerian communities during the Sustainable Development Goal era: insights from analysis of 2016/2017 Multiple Indicator Cluster Survey. BMC Public Health. 2020;20(1):1613.
7. Toma BO, Tinuade O, Gabriel IO, Agaba E. School Health Services in Primary Schools in Jos, Nigeria. Open Sci J Clin Med. 2014;2(3):83-8.
8. Kolbe LJ. School Health as a Strategy to Improve Both Public Health and Education. Annu Rev Public Health. 2019;40:443-63.
9. WHO. Creating an environment for emotional and social well-being; an important responsibility of a health promoting and child friendly school. The World Health Organization Information Series on School Health Document 10. Geneva; 2003.
10. Osaiyuwu-Osagiede IF, Agbonlahor LN. National School Health Programme and the Plight of Exceptional School Age Children in Nigeria. East Afr Scholors J Edu

Humanit Lit. 2020;2(6):266-71.

11. Morse LL, Allensworth DD. Placing students at the center: The whole school, whole community, whole child model. J Sch Health. 2015;85(11):785-94.

12. Akani NA, Nkanginieme KEO, Orumabo RS. The school health programme: a situational revisit. Niger J Paediatr. 2001;28(1):1-6.

13. Adebayo AM, Sekoni OO, Uchendu OC, Ojifinni OO, Akindele AO, Adediran OS. Quality of implementation of the school health program in a rural district of Oyo State, Nigeria; a public-private comparison. J Public Health (Bangkok). 2019;27:163-9.

14. Bosede AO, Akindulureni KC, Obembe TA. Healthful School Environment Component of the School Health Programme: Roles of the Street-Level Bureaucrats in its Implementation. Int J Innov Sci Res Technol. 2021;6(3):733-41.

15. Federal Ministry of Education. National Policy on the School Health Programme. Abuja: Federal Ministry of Education; 2006. p. 1-32.

16. Ofovwe GE, Ofili AN. Knowledge, attitude and practice of school health programme among head teachers of primary schools in Egor Local Government Area of Edo state, Nigeria. Ann Afr Med. 2007;6(3):99-103.

17. Adebayo AM, Owoaje ET. Quality of Implementation of School Health Program in Oyo state, south-west Nigeria: a rural-urban comparative survey. Am J Educ Res. 2016;4(4):307-13.

18. Mbarie IA, Ofovwe GE, Ibadin MO. Evaluation of the performance of primary schools in Oredo Local Government Area of Edo state in the school health programme. J Community Med Prim Heal Care. 2010;22(1-2).

19. Ajibulu F. Schoolboy killed by colleague spurs caring heart. Vangauard New [Internet]. Sep 25, 2011.

20. Gbadamosi H. School Tragedy: 'Head Boy' Dies After Falling from Mango Tree in Ondo. Nigerian Tribune. 2019.

21. Ihugba OA, Ukwunna JC, Obiukwu S. Government education expenditure and primary school enrolment in Nigeria: An impact analysis. J Econ Int Financ. 2019;11(3):24-37.

22. Amy M. Akure: Nigeria. Encyclopaedia Britannica, inc; 2019.

23. UNESCO. High level International Round Table on Literacy "Reaching the 2015 Literacy Target: Delivering on the promise" UNESCO, Paris, 6-7 September 2012. Paris: France; 2012.

24. Federal Ministry of Education. Implementation Guidelines on National School Health Programme. Abuja; 2006.

25. IBM Corporation. Statistical Package for Social Science (SPSS). Chicago, IL; 2021.

26. Osuorah D, Ulasi OT, Ebenebe J, Onah KS, Ndu KI, Ekwuochi U, et al. The Status of School Health Services: A Comparative Study of Primary Schools in a Developing Country. Am J Public Health Res. 2016;4(2):42-6.

27. Asaaju OA. Reconstruction of infrastructure for quality assurance in Nigeria public secondary schools. Procedia-Social Behav Sci. 2012;69:924-32.

28. Bisi-Onyemaechi AI, Akani NA, Ikefuna AN, Tagbo BN, Chinawa JN. Evaluation of the School Environment of Public and Private Schools in Enugu to Ensure Child Health Promotion. Niger J Clin Pract. 2018;21(2):195-200.

29. Anderson C, Cresswell E. School Health Practice. St. Louis: The C.V. Mosby Company; 1980. p. 1-185.