



Utilization of School Health Programme (SHP) Facilities and Factors Affecting Implementation in Secondary Schools in Calabar Municipality, Cross River State, Nigeria

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ABSTRACT

Purpose: This paper was aimed at determining the level of utilization of School Health Programme (SHP) facilities and to explore the factors that affect the implementation in secondary schools in Calabar, Cross River State, Nigeria.

Methodology: Two research questions were formulated to guide the study. The study employed the descriptive survey design. The multi-stage sampling technique was adopted to select a total of 314 SS2 students, 100 teachers and 20 principals from 20 schools (10 public and 10 private) and 2 policy makers to make up the sample size of 436. A 20-item validated questionnaire, key informant interview guides and observation checklist were used to collect both qualitative and quantitative data from respondents.

Results: It was observed that all the facilities assessed were being utilized by both students and teachers (an example is the utilization of toilet facilities by 100% of teachers from private and 90% from public schools and 98.7% of students from private and 89.5% from public schools and the utilization of plastic waste bins by 100% of teachers from private and 94% from public schools and 98.7% of students from private and 92.3% from public schools). Regarding factors affecting implementation of SHP, 50% of respondents (teachers) reported the presence of programme-related and management-related factors, as much as 90% indicated government-related factors and 49% reported community-related factors.

Recommendations: The government at different levels should review, articulate properly and enforce their roles aimed at effective implementation of SHP as indicated in the National implementation guidelines and that the Ministry of health and Education should, through collaborative effort organize awareness programmes for all school administrators, teachers and students on the why, what, how and way forward of school health programme.

INTRODUCTION

A country's level of development is measured by the health status of its children. A country with a high mortality and morbidity rates in children faces a greater challenge to improve its health care system to meet the demand (Mohlabi, Aswegen and Mokoena, 2010). Although Nigeria has since been challenged to make improvement in her health system and has launched the policy document related to the integration of health into the educational system (the National school health policy) the implementation of this policy has remained a mirage. Where they made any attempt at implementation, Akani, Nkanginieme and Oruamabo (2001) observed that the emphasis has been outside rather than within the schools. According to Moronkola (2012), in Nigeria, several factors militate against the effective implementation of school health programme which include: low level of health knowledge among trainees and practicing teachers, high level of health misconceptions among students and teachers, high level of indifference and negative attitude towards school health programme (SHP) among teaching and non-teaching staff, inadequate resources, presence of incompetent teachers, minimal support from non-governmental agencies and other community members as well as lack of legislation to protect school children from health risk in schools.

The road towards implementation of school health programme is not an easy one. According to Obembe, Osungbade and Adenokun (2016) and Mohlabi et al (2010), there must be clear policy guidelines for the process. Mohlabi et al explained that in South Africa, before 1994, the absence of a clear policy guideline hampered the implementation of SHP country-wide. There was lack of collaboration between the health and education sector in the delivery of services, resources were inequitably distributed with the black communities highly deprived. Closely linked to this is the result of their study in Mpumalanga and Guateng provinces where they identified four major factors that militated against the implementation of SHP. Some of the factors they identified were the unavailability of a Policy guideline for school health programme implementation and lack of commitment by the Ministries of health and education. These factors disorganized the process of programme implementation at different levels. This situation is confirmed by WHO (2006), who stated that the presence of policy and resources in support of SHP will facilitate and guide the implementation process.

Mohlabi et al (2010) also identified other problems they grouped as programme related issues. These problems include: shortage of man-power for delivery of health services to the tune that one of the respondents who is a registered nurse attested thus:

I am in charge of 90 schools, with a distance of more than 120 kilometers apart. The area is rural; the roads are bad, so during rainy seasons I cannot reach the schools. When I am sick, the work stops... (Mohlabi et al, 2010:9).

This situation does not agree with the recommendation by the United States government, which according to Winnard, Denny and Fleming (2005) should be in the ratio of one school nurse per 750 students. This ratio has been observed to improve service provision in US and New Zealand. Other factors identified by Moronkola (2012) included absence of intersectoral collaboration, lack of community involvement, inequitable distribution of resources and bad roads. These findings strongly justified the opinion of Winnard et al (2005) who opined that, though the collaboration of the health and education sectors can be challenging because of the difference in discipline, it is the hallmark of school based health care. Further, they observed that the absence of a team approach to provision of health service most often affects the programme negatively. They explained that adolescents are often engaged in multiple health risk behaviours and often come from complex psychosocial background and thus need a comprehensive multidisciplinary team approach to their health care to yield positive result.

Olsen and Allensworth (2012) identified Management related issues which ranged from lack of knowledge about the programme, demonstration of negative attitude towards the programme such as nonchalance and failure to play supervisory roles. These barriers according to the authors frustrated the health care providers at the implementation level. Finally, Kadinge and John (2014) identified community related issues which also stood as barriers to the implementation of SHP. They observed that the weak link that existed between the schools and community affected the programme negatively. In line with this finding, Howley and Maynard (2006) stated that healthy relationship between the schools, families and community members is a useful factor that enhances effective SHP. They explained that the involvement of the community is paramount especially when issues relating to sex and sexuality are being addressed. Winnard et al (2005) explained that perceived lack of confidentiality and lack of privacy have been identified as significant barriers to adolescents seeking health care because of the strong concern they have for their privacy and would not want friends, teachers and parents to find out things about their personal health. They observed in USA that adolescents only seek health care from physicians who assure them of confidentiality.

The FMOE (2006) in the Policy on SHP reported that scarcity of health education teachers, inadequate resources for teaching and absence of skill development, stood against the effective delivery of health education in the country. Corroborating this, Idehen and Oshodin (2008) found out that weak school policy, inadequate instructional materials (text books, posters and other models), insufficient time allocation to the teaching of health and lack of skilled teachers hindered the implementation of the curriculum. They pointed out that the recommendation by the Nigerian Association of Health Education Teachers (NAHET) for time allotment to the teaching of health is on daily basis.

In 1998, the situation of health education in Nigeria was such that Eke (1998) described school health education as a neglected component of primary health care. After his study, he observed that most schools had no designated facilities with appropriate equipments for diagnosis and treatment. The WHO Experts Committee on Health Promoting Schools identified other factors that affect the improvement of school health programme which include lack of vision and planning, lack of accountability, inadequate coordination and collaboration and lack of programme infrastructure (Kupony and Amoran, 2016).

Supposing that the above findings (by Eke, 1998) are belated and in anticipation of developments and improvement in the system, one expects that current research results should reveal an obvious deviation. But Akpabio (2010) whose study was in Cross River and Akwa Ibom States observed that the majority of her respondents (86.7%) identified lack of equipment and facilities as problems that stood against the implementation of SHP. These were followed by lack of drugs (81.7%), poor staffing (76.7%), poor accommodation (71.7%), lack of transportation for referral (70%), lack of cooperation from school heads (26.7%) and poor teaching of students (10%). Ofovwe and Ofili (2007) in Edo State observed a lack of knowledge of SHP among 76.7% of the teachers sampled. These unpleasant revelations from recent studies seem to prove that the implementation of school health programme in Nigeria is still a hard nut to crack.

The situation in USA is different because SHP has been fully implemented as a tool to fight against negative health problems among children and adolescents and this attracted high rate of utilization with consequent positive results. CDC (2011) research report after the implementation of SHP in several schools has many success stories. A school based nutrition programme was reported to have reduced the rates of obesity and overweight among students from 13% to 2% for girls and from 9% to 1% for boys. A 2 year nutrition intervention programme in Philadelphia reduced the incidence of overweight among students by 50%. Also, in North Carolina, an antismoking campaign conducted by the youths influenced schools in many districts in the state to adopt the school policies (the number of schools rose to 100% by 2008 from 5% in 2000) that are meant to control tobacco use. These improved results, according to CDC are tied to the fact that the students appreciated the school meal programme and were always given to the meals prepared for them.

Ofovwe and Ofili (2007) who sampled students from both private and public schools in Edo State observed that students from schools with recreational facilities exercised maximum usage of the facilities during their break periods. In the same vein, Nwachukwu (2003) whose study was done in Imo State observed that students were scrambling for and crowding around recreational facilities because the facilities were inadequate.

Winnard et al (2005) in their report on successful school health services for adolescents stated that students have more confidence in the

health team within the school, as such; they regularly utilized the school's health service facilities. Corroborating the report by Winnard et al, Kupony and Amoran, (2016) stated that, , availability of school health services improves the general health of the students, improves the teachers' concentration in teaching and that of students in learning and culminates to producing higher grades.

To buttress their stand, Winnard et al (2005) presented the findings of a survey done in year 2000 among secondary school adolescents. The study revealed that most of the 10,000 youths surveyed engaged in health risk behaviour such as sexual promiscuity, suicidal attempts, violence and substance abuse as a proof of the unhealthful nature of the school environment. Most of those who demonstrated these behaviour were said to be from schools who have not implemented school-based health services; a few of them from schools with school-based health services do not access the services due to barriers such as cost (they were meant to pay for their treatment), uncomfortable with health staff and worries about privacy. The report has it that, the health service providers in the schools where there were no major barriers experience high patronage by the students.

In the same vein, the 'National Assembly on School Based Health Care (NASBHC)' (2006) in their annual report presented the research reports carried out at different intervals. The reports have it that, a study by John Hopkins University in 1996 and 2002 revealed that the inappropriate use of emergency rooms by students reduced because they now utilize the school based health centres. In Dallas School based health centre, it was observed that the medical services rendered helped to reduce absenteeism by 50% among students who had three or more absences in a six-week period due to health reasons. Students who received mental health services had a decline of 85% in school discipline referrals. It was also observed in Dallas that absenteeism and tardiness significantly reduced among truant students who received counseling services in school based health centres between 2000 and 2001.

Juszczak, Melinkovich and Kaplan (2003) during a survey of students in 2001 observed that over 70% of the students sampled reported that they now obtain health care because of the presence of health facilities in their schools; 90% of the students who confessed obtaining health care at school improved their rates of attentiveness at school, 78% reported an improvement in their health as a result of using the SBHC in their school and 87% said they now know how to take better care of their health as a result of contact with staff of the SBHC. These findings are in line with the assertion of Costin, Soderberg and English (2009) that school-based health centres (SBHCs) helps to improve the lives of school children because they bring essential services to students where they are. Further, Kupony and Amoran, (2016) explained that SBHCs give the students opportunity to have direct access to health care providers, thus they do not have to miss class time to go for health care, and their risk behaviours are easily identified and addressed. Consequent on implementing SBHC,

students were observed to be staying healthy, the emergency department in the community hospitals experienced decongestion and hospitalization rates for students especially, with Asthma dropped drastically.

It is more than a decade since the adoption of the school health programme and the subsequent production to the policy and implementation guidelines in Nigeria. This study did what has become a necessity; that is, to evaluate the level of implementation of school health programme in relation to the implementation guidelines and to identify factors (programme-related, governance-related, management-related and community-related factors) that affect the implementation/utilization.

METHODOLOGY

Study setting

The study was carried out in 'Calabar Municipality', one of the 18 Local Government Areas (LGA) in Cross River State, and in fact, the capital city of the state. Records from the secondary school education board and the inspectorate department of Ministry of Education Calabar, revealed that as at June 2015, there were 15 public and 36 private secondary schools in Calabar Municipality, bringing it to a total of 51 secondary schools.

This study was aimed at determining the status of school feeding programme in secondary schools in Calabar Municipality in relation to the implementation guidelines. The study was delimited to Senior Secondary 2 students, teachers of health-related subjects (health and physical education/nutrition/ agriculture/biology/integrated science), principals of the secondary schools and policy makers in the State Ministry of Health.

Study design/population

A descriptive survey design was adopted for the study. The study population consisted of all students, teachers and principals in private and public secondary schools in Calabar Municipality (14,502 students, 998 teachers and 15 principals – records only available for public schools) and policy makers in the state ministry of health.

Sample size determination

The sample size was determined using the formula for Dichotomous descriptive study as cited in Ejemot-Nwadiaro (2009). The sample size for students was 314 while that of teachers was 101. The principals of all the 20 selected secondary schools were interviewed as well as two policy makers from the State Ministry of Health. That made up the sample size to 437.

Sampling procedure

The multi-stage sampling and the purposive sampling techniques were used for this study. The

multi-stage sampling technique was applied for the selection of Local government area (LGA), selection of schools, selection of students and selection of teachers while purposive sampling technique was used to select principals and policy makers.

Instruments for data collection

The instruments for data collection were a well validated questionnaire called the School Health Programme Questionnaire (SHPQ), key-informant interview guide and a guide for observation.

Data collection

The quantitative data were collected from 300 students (out of the 314 students enumerated – 96% response rate) and 100 teachers (out of the 101 enumerated - 99% response rate) with the use of copies of the questionnaire. Qualitative data were collected from 20 principals and 2 policy makers using the key informant interview guides and from the school directly during a physical observation exercise in the 20 selected schools. For accuracy, data for the second research question, related to factors affecting implementation were only collected from the teachers. The researchers did not consider the judgment of students mature enough for such issues.

Data analysis

The data collected from the field were collated and verified to ensure completeness and accuracy in documentation. The questionnaire responses for the utilization of the different facilities of school health programme and the different factors that affect the implementation were scored and organized in figures. Qualitative data obtained from observation and key informant interviews conducted were critically examined and relevant information sifted and used. The information were organized and presented in percentages, tables and figures.

Ethical consideration:

Ethical approval was obtained from the 'ethical board' in the Ministry of Health, Calabar. The respondents/key informants were presented with the study objectives and were informed of their freedom to participate in the study or to opt out. Their permission was sought and verbally obtained. All respondents were assured of confidentiality and anonymity.

RESULTS:

Respondents' characteristics

The 300 students were made up of 131 males (43.7%);(86 from private schools and 45 from public schools), and 169 females (56.3%); (71 from private schools and 98 from public schools). The 100 teachers were made up of 35 males (35%); (25 from private schools and 10 from public schools), and 65 females

(65%); (25 from private schools and 40 from public schools). The 20 principals comprised of 11 males (55%); (8 from private schools and 3 from public schools) and 9 females (45%); (2 from private schools and 7 from public schools). The 2 policy makers were made of a male and a female (Table 1).

Students within 12-14 years constituted 33.7%; those within 15-17 years were 62% while those who were 18 years and above made up only 4.3%. All the 100 teachers, 20 principals and 2 policy makers were all adults above 30 years of age.

TABLE 1: Respondents' characteristics

Characteristics	Private schools n	Public schools (%)	n	Total (%)	n	(%)
Students:						
Gender:						
Males	86	(28.7)	45	(15.0)	131	(43.7)
Females	71	(23.6)	98	(32.7)	169	(56.3)
Total	157	(52.3)	143	(47.7)	300	(100)
Age:						
12 - 14 years	76	(25.4)	25	(8.3)	101	(33.7)
15 - 17 years	77	(25.7)	109	(36.3)	186	(62.0)
18 years and above	4	(1.3)	9	(3.0)	13	(4.3)
Total	157	(52.3)	143	(47.7)	300	(100)
Teachers:						
Gender:						
Males	25	(25)	10	(10)	35	(35)
Females	25	(925)	40	(40)	65	(65)
Total	50	(50)	50	(50)	100	(100)
Principals:						
Gender:						
Males	8	(40)	3	(15)	11	(55)
Females	2	(10)	7	(35)	9	(45)
Total	10	(50)	10	(50)	20	(100)
Policy makers: Ministry of Health						
Gender:						
Males	1					
Females	1					

Figures in parenthesis are percentages.

The result obtained from the field, obviously revealed that programmatic-factors, management-related factors, government-related factors and community-related factors have all militated against the implementation of SHP. A total of 51% of the teachers indicated that inadequate resources were a barrier and shortage of manpower as a barrier was indicated by 66% for specialist teachers, 92% for nurses, 100% for doctors, and 50% for counselors (Figure 1). Whereas, limited knowledge by staff and students about SHP was indicated by 73% of the

respondents, 53% indicated indifference/negative attitude towards SHP by teaching/non-teaching staff (Figure 2). As much as 98% of the teachers indicated that there was unavailability of the policy document while 90% indicated that there was a lack of commitment by the Ministry of Health (Figure 3). For community-related barriers, only 2% of the teachers indicated that non-functional PTAs was a barrier, 49% indicated that they had no support from NGOs, whereas, up to 62% accepted that they had no support from community members (Figure 4).

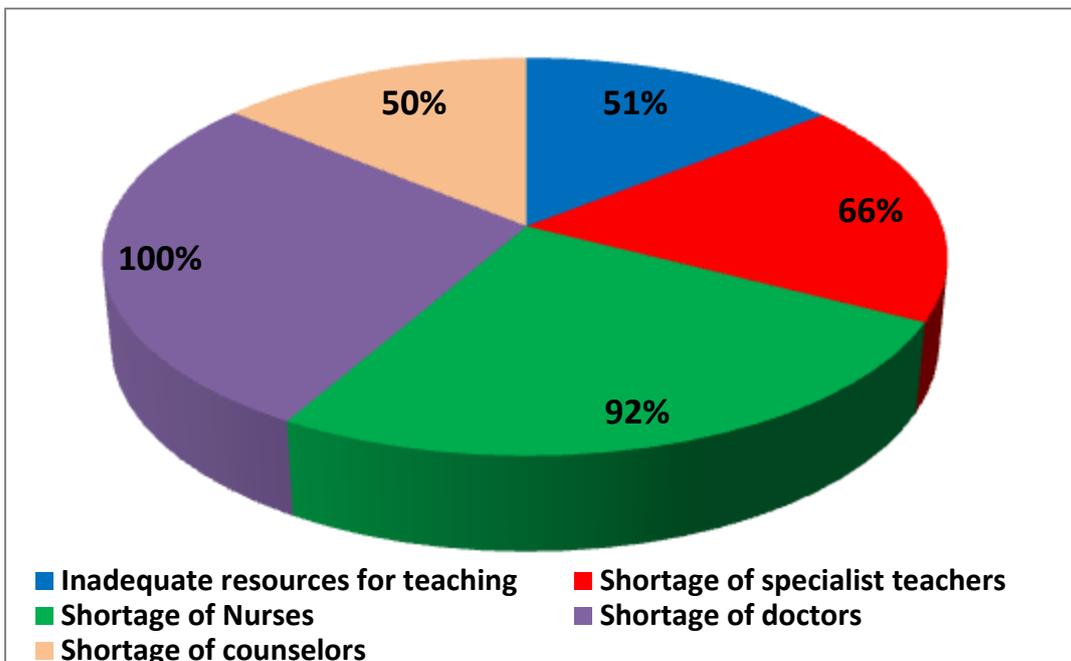


FIGURE 1: Programmatic factors affecting implementation of SHP in secondary schools as reported by respondents (n = 100).

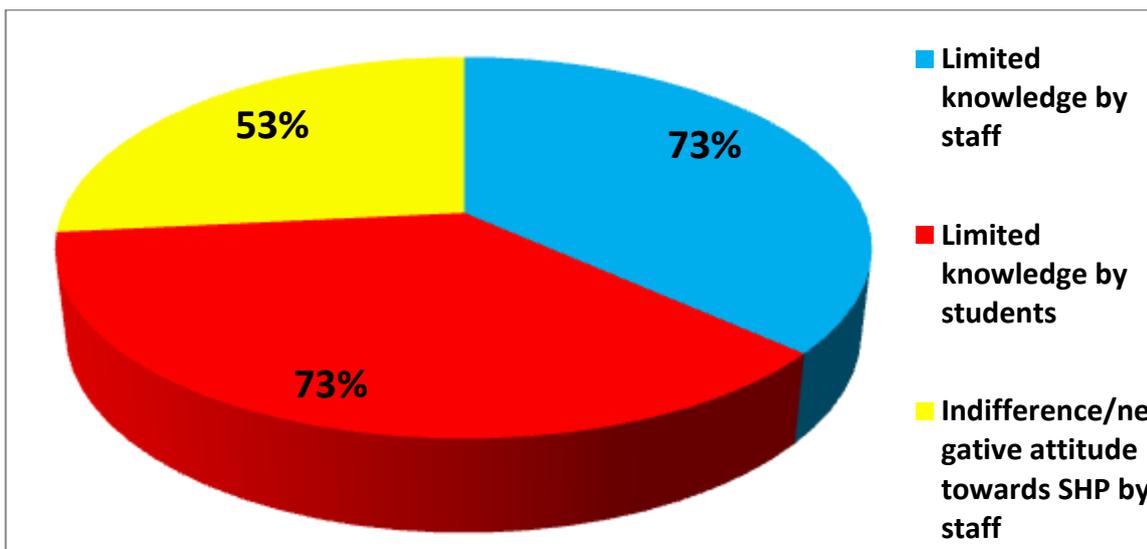


FIGURE 2: Management-related factors affecting implementation of SHP in secondary schools as reported by teachers (n = 100).

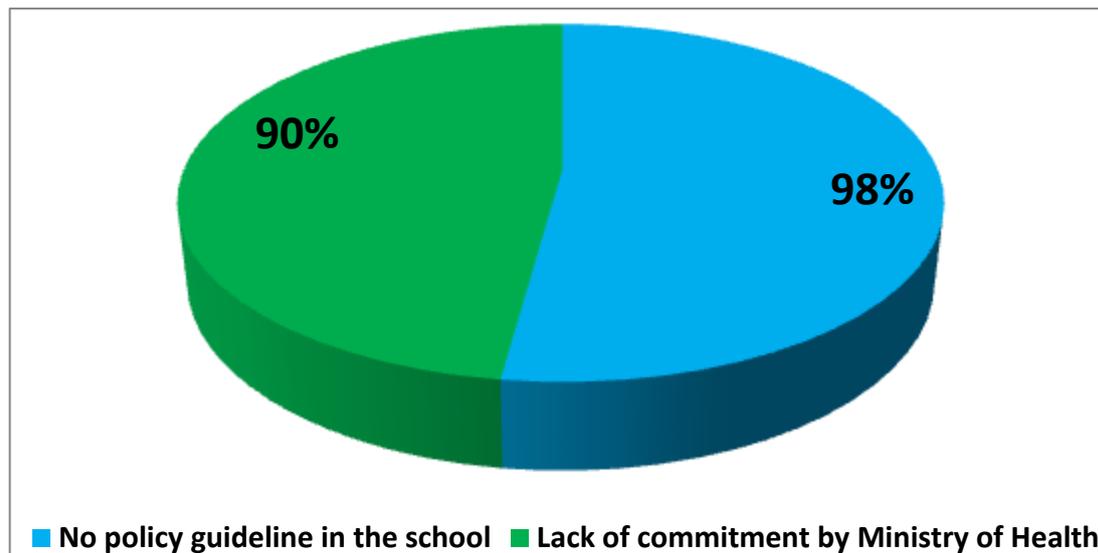


FIGURE 3: Government-related factors affecting implementation of SHP in secondary schools as reported by teachers (n = 100).

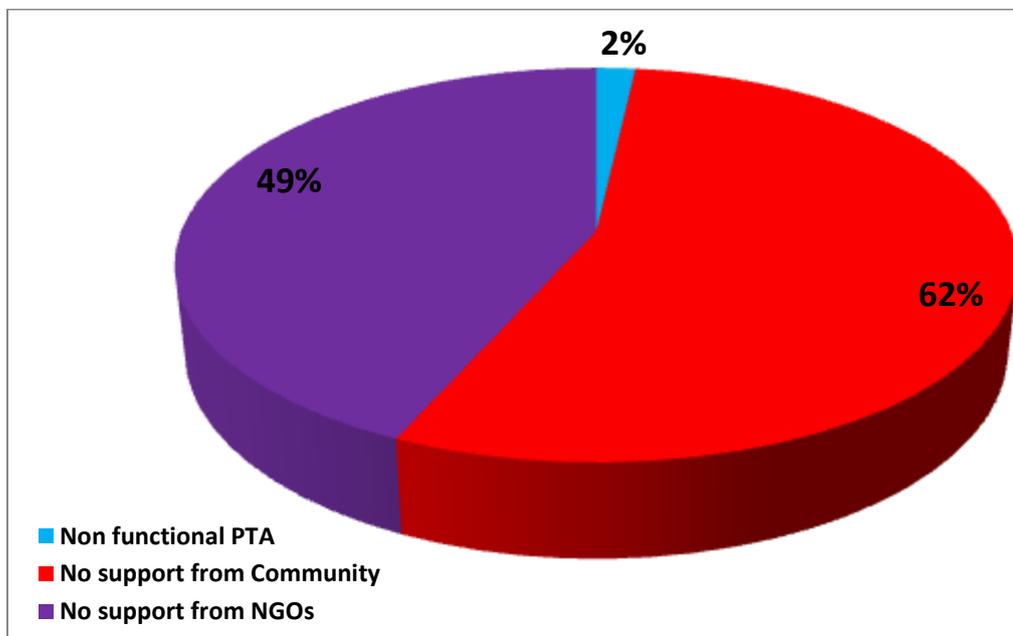


FIGURE 4: Report on Community-related factors affecting implementation of SHP in secondary schools (n = 100).

Utilization was observed to be very good for all the facilities assessed. Among the respondents that reported availability of each of the facilities assessed, only a small proportion of them that said they were not utilizing each of the facilities. For water taps and toilet facilities, all the teachers in both public and private schools (100%) affirmed the utilization whereas only 12.1% of the students from private schools and 3.5% from public schools said they do not utilize the school taps and 1.3% of the students from private schools and 0.7% from public school reported that they do not utilize the toilets. Non-utilization of recreational facilities was reported by only 4% of teachers and

7.6% of students from private schools and 12% of the teachers and 12.6% of the students from public schools. Utilization of waste bins was reported by all the teachers (100%) from private schools and 94% public school teachers; and as much as 98.7% of private school students and 92.3% public school students. It is noteworthy that school food services was being utilized by almost all the students (99.4%) Unfortunately, results revealed that school based clinic was being utilized by only 46% of teachers and 49.7% students from private schools and 12% of the teachers and 12.7% of the students from public schools. (Table 2).

TABLE 2: Utilization of school health programme facilities

Items	Number of respondents			
	<i>Private schools</i>		<i>Public schools</i>	
	Students (%)	Teachers (%)	Students (%)	Teachers (%)
Utilization of water taps				
Yes	105(69.9)	41(82)	69(48.3)	15(30)
No	19(12.1)	-	5(3.5)	-
Not available	33(21)	9(18)	69(48.3)	35(70)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of toilet facilities				
Yes	155(98.7)	50(100)	128(89.5)	45(90)
No	2(1.3)	-	1(0.7)	-
Not available	-	-	14(9.8)	5(10)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of recreational facilities				
Yes	113(72)	38(76)	85(59.4)	14(28)
No	12(7.6)	2(4)	18(12.6)	6(12)
Not available	32(20.4)	10(20)	40(28)	30(60)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of waste bins				
Yes	155(98.7)	50(100)	132(92.3)	47(94)
No	2(1.3)	-	5(3.5)	-
Not available	-	-	6(4.2)	3(6)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of disciplinary committee				
Yes	95(60.6)	40(80)	102(71.3)	43(86)
No	12(7.6)	2(4)	7(4.9)	1(2)
Not available	50(31.8)	8(16)	34(23.8)	6(12)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of school canteens				
Yes	40(25.5)	14(28)	20(14)	7(14)
No	12(7.6)	4(8)	4(2.8)	4(8)
Not available	105(66.9)	32(64)	119(83.2)	39(78)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of school food services				
Yes	10(6.4)	5(10)	-	-
No	1(0.6)	-	-	-
Not available	146(93)	45(90)	143(100)	50(100)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of school based clinic				
Yes	78(49.7)	23(46)	18(12.7)	6(12)
No	9(5.7)	3(6)	22(15.3)	2(4)
Not available	70(44.6)	24(48)	103(72)	42(84)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of counseling unit				
Yes	52(33.1)	21(42)	126(88.1)	33(66)
No	29(18.5)	4(8)	4(2.8)	3(6)
Not available	76(48.4)	25(50)	13(9.1)	14(28)
Total	157(100)	50(100)	143(100)	50(100)
Utilization of health record book				
Yes	39(24.8)	18(36)	20(14)	6(12)
No	20(12.7)	3(6)	11(7.7)	1(2)
Not available	98(62.4)	29(58)	112(78.3)	43(86)
Total	157(100)	50(100)	143(100)	50(100)

Figures in parenthesis are percentages.

DISCUSSION

The study assessed four broad factors with their sub-factors that affect the implementation/utilization of the school health programme facilities. The result revealed that all of the factors assessed were present in the schools apart from non-functional PTA. Among the programmatic factors identified, 51% of respondents (basically teachers) indicated that inadequate resources for teaching health education was a barrier while 66% indicated that there was a shortage of subject specialists, 92% said shortage of nurses, 100% said shortage of doctors and 50% said shortage of counselors. Limited knowledge by staff and students about SHP was indicated by 73% of respondents and indifference/negative attitude towards SHP by teaching and non-teaching staff was indicated by 53% of respondents as the management related factors. The presence of these factors were not a surprise since the result of the key informant interview with the director of public health revealed that nurses have long been withdrawn from schools and the programme manager in charge of school health programme confessed that, she does not visit schools to give them any form of orientation because she is not funded to carry out such duties.

Molabi et al (2001) clearly stated the necessity for a policy guideline to guide the process of implementation. They cited the instance of South Africa who suffered serious setbacks in the 90s with regards to SHP because of the absence of a policy guideline. Both the policy on SHP and implementation guidelines were not found in any school. Almost all the respondents (98%) indicated that there was no policy guideline in the school and 90% reported that there was poor commitment by the ministry of health. The school principals were observed to be very poorly informed of SHP to the tune that one of them when asked how often they conduct physical examination of the students said: "no, that one is not for us ooh; it is a day school, so parents are left to do that..." And another, when asked of the medical reports of their food vendors said: "we are not even aware that they are supposed to bring medical report..." The findings of the study can be closely linked to the result of the study by Molabi et al (2010) in Mpumalanga and Guateng provinces which revealed barriers to SHP implementation such as lack of national policy guideline, lack of commitment by the health/education department, shortage of manpower and lack of community involvement. The report of their study stated that the Management of the Schools sampled demonstrated nonchalant attitude towards SHP and had no definite plan for the supervision of the SHP activities. Among the community related factors, only 2% of respondents reported that they had no functional PTA and 62% reported there was no support from community, while 49% reported that NGOs do not support them. While it is to be commended that the PTAs are functional, there is a need to sensitize NGOs and community members on the role they need to play to enhance the health of the school population.

Talking about lack of commitment by the Ministry of health, it was quite sad to hear the response of the programme manager in charge of school health programme in the Ministry of health when she was asked about the plans the Ministry has for school health programme:

As much as I know, nothing is on ground; nothing is going on both in primary and secondary schools because nobody is sponsoring school health services. I do not receive any imprest and I have not been given any vehicle to work with. How do I visit the schools to do my work? Out of passion for the work, I used personal funds to start the work, when I saw how costly it was, I knew my salary alone cannot do the work, I had to stop...

The result from the field further revealed that teachers and students have strong perceived benefits of the available SHP facilities because utilization was observed to be very high in all of the schools where the particular facility being assessed was found available (HBM). For water taps and toilet facilities, it was observed that all the teachers in both public and private schools were utilizing them whereas only a few students 19 (12.1%) from private schools and 5 (3.5%) from public schools said they were not utilizing the water taps and 2 (1.3%) students from private schools and 1 (0.7%) from public school indicated that they do not utilize the school toilets. Only 2 (4%) teachers and 12 (7.6%) students from private schools and 6 (12%) teachers and 18 (12.6%) students reported non utilization of recreational facilities. This result is consistent with the report of WHO (2006) and Nwachukwu (2003) who observed students crowding around one or two available water taps, entrances of toilet facilities and the few recreational facilities in some Nigerian schools.

Waste bins are observed to be particularly appreciated by both staff and students because as much as 155 (98.7%) private school students and 132 (92.3%) public school students and all the teachers from private schools and 47 (94%) from public schools reported active utilization of the bins. In line with this report, Marx and Wooly (2003) in their account about schools in New York stated that a well maintained environment with safe and clean facilities was observed. It was actually a wonder to observe that some teachers, 2 (4%) from private schools and 1 (2%) from a public school were not utilizing the schools' disciplinary committee. The researchers' opinion is that such teachers may have personal issues with the members of the committee. On the contrary, almost all the students who by their nature should abhor the disciplinary committee affirmed the utilization with only 12 (7.6%) from private schools and 7 (4.9%) from public schools who indicated non-utilization. Among the students and teachers in the three schools where school canteens were found, only 8% of teachers and 7.6% students from private schools and 8% teachers and 2.8% students from public schools reported non-

utilization. Apart from 1 (0.6) private school student who reported non-utilization of the school food service, all other respondents who said their school provides food services reported that they utilized it. The findings also gives credence to the work of CDC (2011) who reported a drop in the rate of obesity and overweight among students from 13% to 2% for girls and from 9% to 1% for boys because the students appreciated and utilized a 2 year nutrition intervention programme in Philadelphia.

Whereas up to 46% teachers and 49.7% of students from private schools indicated utilization of the school's clinic, only 12% teachers and 12.7% students from public schools said they were utilizing it. This wide difference was not surprising because the researchers observed better equipped clinics with readily available facilities in private schools which were not there in the public schools. The lack of facilities and health personnel to manage the school's sick bay was an obvious factor that militated against its utilization in the public schools. Utilization of counseling units attracted positive responses from 21 (42%) teachers and 52 (33.1%) students from private schools and 33 (66%) teachers and 126 (88.1%) students from public schools. The observation is a reverse of that of the school clinic. This can be explained from the observation of the researchers that the government of Cross River State has made a lot of inputs to ensure that counseling units are established in at least 70% of the secondary schools used for this study. In consonance with the result of this study, NASBHC (2006) reported maximum utilization of the school-based health centers by students of John Hopkins University. They also reported high rate of utilization of school-based health centres in Dallas, with resultant decrease in absenteeism by 50% among students who had three or more absences in a six week period due to health reasons. They were patronizing the school health services where treatment was given to them within the school. The findings by Winnard et al (2005) in the US are consistent with that of this study though with a contrasting aspect. They reported that 10,000 students surveyed who had health-risk behavior were patronizing the health services within the school. The authors further observed that some of the respondents in the schools where they were expected to pay money for the services were not utilizing the services.

This study leaves a lot for the nation and Cross River State in particular to contend with if SHP is to be fully implemented. This is because its findings on account of the factors affecting the implementation/utilization of SHP are consistent with the findings of Akani et al whose study was done since 2001, that of Nwachukwu in 2003, FMOE² in 2006, Idehen and Oshodin in 2008 and Akpabio's findings in 2010. All these authors also observed lack of resources, poor knowledge of SHP by teachers, lack of qualified teachers, shortage of manpower and inadequate materials for teaching health education. These problems are not insurmountable yet they have existed for more than a decade. Who will bail the cart?

CONCLUSION:

The researchers conclude that there is a high level of utilization of the available SHP facilities by the school population but that several factors militated against the full implementation of SHP.

RECOMMENDATIONS

1. A copy of the national policy on SHP and the implementation guidelines should be made compulsory documents for all schools to guide programme implementation.
2. To ensure commitment on the part of the school population, the Ministry of health and Education should, through collaborative effort organize awareness programmes for all school administrators, teachers and students on the why, what, how and the way forward of school health programme.
3. The government at different levels (federal, state and local levels) should review, articulate properly and enforce their roles aimed at meeting the health needs of the school population with regards to implementing the SHP as indicated in the implementation guidelines on national school health programme (FMOH, 2006).
4. All schools should form school health committees whose duty will be to look into the modalities for the effective implementation of SHP.

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