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Perception of Head Teachers on School Health Policy and Community Interaction in Primary Schools in Ogun State, Nigeria

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Authors' contributions

This work was carried out in collaboration between all authors. Author OTK did the study design and wrote the protocol. Authors OEA and OTK2 did the statistical analysis and literature searches while analyses of study and manuscript writing was done by author OEA. All authors read and approved the final manuscript.

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ABSTRACT

Introduction: The success of the School Health Programme depends on the extent to which community members are aware of, and are willing to support health promotion efforts. This study was therefore designed to assess the perception and practices about school health policy and community interaction among school head teachers in primary schools in Ogun state Nigeria.
Methods: The study was a cross-sectional survey conducted between February and May, 2014 in Ogun State, Nigeria using a multi-stage sampling technique. Participants in the study were interviewed using a structured questionnaire, which was administered by a trained interviewer. Data collected was analyzed using the SPSS version 20.0.
Results: A total of 360 head teachers were recruited into the study with 95% response rate. One

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hundred and forty eight (82.2%) of the Public and 149 (82.8%) of the Private School Head Teachers were of the opinion that advocacy to community and the parents was necessary to have an effective School Health Programme. A functional Parents-Teachers Association was found in 162 (94.4%) of the Public Schools and in 160 (94.7%) of the Private Schools. It was observed that 99 (55%) Public and 79 (43.9%) Private School Head Teachers were aware of the existence of the National Policy on School Health in Nigeria (p=0.035). Only 9 (9.1%) of Public and 17 [21.5%] of Private Head teachers had ever seen a copy of it. (p=0.020). Nine (9) Teachers claimed to have a copy of the Policy but none (0%) could produce it on demand.

Conclusion: The study concludes that the level of provision of an adequate emotional climate in the school is low and that Head Teachers are not aware of the existence of the National School health Policy in Nigeria. This implies that most of the schools in Nigeria may practice the School Health Programme based on personal understanding of the Head Teacher.

Keywords: Perception; practice; school health policy; relationships; primary schools; Nigeria.

1. INTRODUCTION

The success of the School Health Programme depends on the extent to which community members are aware of, and are willing to support health promotion efforts [1]. Schools are to therefore encourage parents and community members to make inputs regarding the design, delivery, content and assessment of the School Health Programme so as to respond to their concerns and obtain their commitment. At the same time, schools can play an important role in improving the health and development of the community as a whole [2]. The objectives of promoting school, home and community relationship with regard to School Health Programme are to build and strengthen capacity for effective community involvement and participation in school management and improve advocacy and community mobilization to bring about necessary support from stakeholders.

Parents and educators pull together expertise and skills in support of a common focus: the improved education of all children. The parents bring to the table all the available community assets, skills, capacity and expertise [3]. The benefits of such collaborative efforts include improvement in students' attitude towards schools [4], and better grades by students [5]. An improved relationship between the school, home and the community, from previous studies resulted in more engagement in classroom learning by students [6], improved test scores [7], improved attendance rates/ lower suspension rates [8], and an overall success [9]. The dynamics of this relationship is; 'to ensure a productive parent- school staff relationship. Parents and school staff need to accept the child holistically in the context of the home and school. When both parties are uncooperative in investing in the relationship, the child is segmented into the school child and the home child ignoring the whole child [3].

School health education programmes especially those that are integrated with other community health promotion efforts can provide information to families of participating students by employing the students as a 'common messenger' to precipitate healthier family behaviours [10]. More importantly, school health education can be expected to increase specific competencies and skills that students can use to predispose, enable and reinforce healthy lifestyles of the families they would be responsible for as adults [11]. We should therefore enable and then expect our schools to be able to increase the desires and abilities of individuals to participate effectively in civic decisions and activities that will ultimately influence their personal health, the health of their families and the health of the communities in which they reside [10]. The potential of health education is only limited by its inadequate integration with others sources of influence on health such as social structures, legal framework, economic and environmental factors. The proper understanding and use of health education is in the context of the several determinants of behaviour and health and not in isolating it in the class room without regard for the family, economics, genetics and environment etc that it will influence. The end result would be temporary or partial achievements of intended outcomes [10].

It is essential that Head teachers are knowledgeable about the school health policy, health records and its implementation. With regards to Health records, the school health programme should assesses if health records are available within the school. If available, are

the records cumulative and if cumulative are they transferrable? Peculiar health records and histories of each child within the school system should be readily available for school health personnel and teachers. Deviations from normal should be noted and appropriate preventive measures instituted. This should also include health records of the teachers and all other school staff. School guidelines and protocols should be developed especially for the diagnosis and treatment of common communicable diseases within the community where the school is located. This should be made available to members of the immediate community and parents/ guardian of the school children. The school therefore serves as functional boost to the primary health care activities within its immediate environment.

This study was therefore designed to assess the perception and practices about school health policy and community interaction among school head teachers in primary schools in Ogun state Nigeria. This has implications in the development of policies that will reduce the incidence of preventable disease early in life and encourage access to essential facilities which subsequently improve the health of school children and their families in low income countries such as Nigeria.

2. MATERIALS AND METHODS

2.1 Study Area

Ogun state is situated on latitude 7.00°N and longitude 3.35°E in the Greenwich Meridian. It covers a total land area of 16,409.26 square kilometers within the South West region of the country. It is bounded in the north by Oyo and Osun States, in the east by Ondo State, in the west by the Republic of Benin which makes it an access route to the expansive market of the Economic Community of West African States (ECOWAS) and in the south by Lagos State and the Atlantic Ocean. The State Capital Abeokuta, lies about 100km north of Lagos State, Nigeria's business Capital [12]. The projected population of the State as at 2012 is 5.1 million. The people of the State belong to the Yoruba ethnic group of South-West Nigeria. The main ethnic groups of the State are Egbas, Ijebus, Remos, Yewas, Eguns and Aworis. A greater proportion of the State lies in the tropical rain forest zone [12]. The State has Twenty (20) Local Government Areas (LGA). Each LGA is headed by an Executive Chairman. It has three (3) Senatorial Districts and is divided into four (4) geo-political zones.

2.2 Study Population

The study population consisted of all the Head Teachers in Public and Private Primary Schools in Ogun State and their Schools. The Ogun State Universal Basic Education Board (SUBEB) is in charge of Primary School Education and activities within the State under the Ministry of Education. There are One thousand, four hundred and forty nine (1,449) registered Public Primary Schools and One thousand, six hundred and ninety four (1694) registered Private Primary Schools within the State making a total of 3,143 Primary Schools.

The Schools have a Chairman of Administrative known as the Head Teacher and he/she supervises all school activities and the activities of the Teaching and Non- Teaching Staff. The Head Teacher and other Staff within the Public Schools are employed by the State's Ministry of Education while the Private School Heads and Staff are employed by a Proprietor/ Proprietress who may also function as the Head Teacher. All the Public Schools run the Six (6) year programme but some Private Schools run a Five (5) year programme. The Private Schools usually have an attached Crèche and Nursery Units.

The Zonal Education Office (ZEO) is responsible for compliance and adherence to the Educational standards as specified by the Ministry of Education for all Public and Private Schools within each Zone. In each Local Government, the Local Government Education Authority (LGEA) is directly responsible for the supervision and human resource management of Public Primary Schools. The three (3) Local Government Areas where the study was carried out are Sagamu, Abeokuta South and Ado-Odo/Ota.

2.3 Study Design

The study design was a cross sectional study that assessed the School Health Programme in Public and Private Primary schools in Ogun State.

2.4 Inclusion Criteria

All fully registered Public and Private primary schools in the selected LGAs.

2.5 Exclusion Criteria

All schools that are not fully registered in the selected LGAs.

All schools operating a boarding system in the selected LGAs.

2.6 Sample Size

A prevalence of 31.0% of Public Schools [13] [75] was used to estimate the sample size using the formula

$$n=Zpq/d^2 = \frac{1.96*0.31*0.69}{0.05*0.05}$$

Hence, minimum sample size calculated was 329

2.7 Sampling Technique

A Multi-stage Sampling technique was employed.

A simple random sampling was used to select three local government areas from the 20 local government areas in Ogun state namely Abeokuta South LGA, Ado-Odo/Ota LGA and Sagamu LGA.

In each Local Government Area selected, 60 Public Primary Schools and 60 Private Primary Schools were recruited into the study by listing all the Public Schools and all the Private Schools and then randomly selecting 60 each into the study.

2.8 Data Collection Instruments and Technique

A self-administered semi-structured Questionnaire with open and closed ended questions for the Head Teachers was designed for the study. It was adapted from that used by Ofovwe and Ofilli in a similar study in 2004 [13]. The Pre-tested Questionnaire was administered to the 360 Head Teachers. Schools were used as the sampling frame and the teachers as respondents.

The questionnaire addressed the following:

Section A: Socio-economic and Demographic characteristics such as age, sex, marital status, highest educational qualification and length of time as a Head Teacher. This section gave insight into the Respondents' socio-economic and demographic background.

Section B: This section contained questions that assessed the Head Teachers' Perception of School Health Policy and Relationships.

Questionnaire for the Head Teachers were pre-tested in ten (10) Public and ten (10) Private Primary Schools in Ibadan North East Local Government and modified as appropriate. Twenty (20) Research assistants were recruited and trained in the correct use of the Questionnaire and the Checklist for the Project. Identification tags with pictures were issued to the Research Assistants to facilitate School Entry.

Schools were then randomly selected into the study from the obtained list of Schools. Data was collected over a three (3) month period.

2.9 Analysis of Results

Quantitative Data collected was checked for errors, cleaned, entered and analyzed using the SPSS version 15.0. Variables about knowledge were coded into correct and incorrect based on National Operation guidelines. Data was summarized with proportions and means and presented using frequency tables. Inferential statistics to test for associations between variables was done using the chi-square test.

2.10 Ethical Consideration

Approval was also obtained from the Permanent Secretary of the Ogun State Ministry of Health and the Local Government Authorities of Sagamu, Abeokuta-South and Ado-Odo/Ota Local Governments respectively. Consent to conduct the study was obtained from the ethical committee of the Olabisi Onabanjo University Teaching Hospital, Sagamu.

Written informed consent was obtained from all the participants after study objectives were explained to them. They were assured that participation was voluntary and they would incur no loss if they decided not to participate. Study participants were assured of strict confidentiality and this was indicated on the questionnaire. Data collected was only used for research purposes.

3. RESULTS

3.1 Socio-dermographic Characteristics

A total of 360 head teachers were recruited into the study with. Majority of the Public School Head Teachers, 147 (81.7%) fell into the 51-60 age group, while the highest number of the Private School Head Teachers, 110(61.1%) were

in the 31-40 age group. The Private Head Teachers also had 30 (16.7%) members in the 21-30 age group while the Public Head Teachers had 0 (0%) members within that age group. The overall mean age of all the Head Teachers was 45.7±9.9 years. Female Head Teachers out-numbered their male counterparts in both the Public and Private Schools. A total of 270 female teachers [75%] and 90 [25%] male teachers were recruited into the study. A high percentage of the total respondents numbering 302 (83.9%) were married. Over 80% of the respondents were Christians.

Table 1. Characteristics of respondents' socio-demographic variables

Characteristics	Total N = 360 (%)
Age at last birthday	
21-30	30 (8.3)
31-40	112 (31.1)
41-50	61 (16.9)
>50	157 (43.6)
Sex	
Male	90 (25.0)
Female	270 (75.0)
Marital Status	
Single	36 (10.0)
Married	302 (83.9)
Separated/divorced	4 (1.1)
Widowed	18 (5.0)
Religion	
Christianity	313 (86.9)
Islam	44 (12.2)
Others	3 (0.8)
Ethnicity	
Ibo	50 (13.8)
Yoruba	299 (83.1)
Others	11 (3.1)
Highest educational qualification	
Masters degree	25 (6.9)
University degree	191 (53.1)
Certificate from college of education	128 (35.6)
Teacher's training school certificate	16 (4.4)
How long have you been a head teacher	
1-5 years	191 (53.1)
6-10 years	82 (22.8)
11-15 years	39 (10.8)
>15 years	48 (13.3)

Most 299 [83.1%] of the respondents were of the Yoruba tribe. About half 191 [53.1%] of the Teachers in both groups had a University degree as their highest educational qualification, 25 (6.9%) of the respondents had a Masters Degree. One hundred and Ninety one (53.1%) of the respondents had between 1-5 years working experience as a Head Teacher. Whereas, 48 (13.3%) of the respondents had been working as a Head Teacher for over 15 years.

3.2 School, Home and Community Interaction

One hundred and forty eight (82.2%) of the Public School Head Teachers and 149 (82.8%) of the Private School Head Teachers were of the opinion that advocacy to community and the parents was necessary to have an effective School Health Programme (X^2= 0.019, p= 0.890). A high percentage 176 (97.8%) and 175 (97.2%) of the Public and Private Schools' Head Teachers felt that Health records of school children must be consistently updated periodically and this did not show a statistically significant difference (X^2= 0.336, p= 0.845). A functional Parents-Teachers Association was found in 162 (94.4%) of the Public Schools and in 160 (94.7%) of the Private Schools. This was not statistically significant. (X^2=0.039, P= 0.694).

3.3 Emotional Climate and Community Interaction

A high number of respondents, 151 (83.9%) of Public School Head Teachers and 156 (86.7%) of the Private School Head Teachers said that schools were not properly sited in the community to provide easy access to children (X^2= 0.553, p= 0.457). This difference was not statistically significant. Sports field were found in 129 (71.7%) Public Schools as against 92 (51.1%) Private Schools (X^2= 16.043, P= 0.001). Sixty four (35.6%) of the Private Schools and 17 (9.4%) of the Public Schools had other sports facilities apart from a football field (X^2=35.189, P=0.001).

Majority 130 (72.2%) of the Head Teachers in Public Schools felt that government must provide all the funding needed for School Health Programme activities while 50 (28.7%) of them felt funding should come from other sources such as the community. On the other hand, 126 (70.0%) of the Private School Head Teachers felt government should provide all the funding while 54 (30.0%) were of the opinion that there should be other sources of funding (X^2= 0.216, p= 0.624). One hundred and forty seven (81.7%) and 152 (84.4%) of the Public and Private School

Teachers respectively were of the opinion that the School Health Programme plays a vital role in the attainment of Millennium Development Goals (X^2= 0.493, p= 0.482). only 39% of the schools in the study population have a functional School Health Committee.

The fact that the School Health Programme is part of the World Health Organization's strategy to produce health promoting schools worldwide was affirmed by 168 (93.3%) of the Public School Head Teachers and 156 (86.7%) of the Private School Head Teachers.

3.4 Perception about School Health Policy

It was observed that 99 (55%) Public School Head Teachers and 79 (43.9%) Private School Head Teachers were aware of the existence of the National Policy on School Health in Nigeria (X^2=4.445, P=0.035). This was statistically significant. However, out of the 99 Public School Head Teachers who were aware of the existence of the National School Health Policy, only 9 (9.1%) of them had ever seen a copy of it. Similarly, out of the 79 Private School Head Teachers who were aware of the existence of the National School Health Policy, only 17 (21.5%) of them had seen a copy of it (X^2=5.441, P=0.020). This was also statistically significant.

Out of the 9 Public School Head Teachers who had seen a copy of the School Health Policy, only 4 (44.4%) of them reported that they had a copy in their Schools. On the other hand, out of the 17 Private School Head Teachers who had seen a copy of the Policy, 9 (52.9%) reported that they had a copy of it in their Schools (X^2=0.170, P=0.680). This finding was not statistically significant. Overall, 4 (2.2%) Public School Head Teachers out of 180 and 9 (5%) Private Head Teachers out of 180 reported that they had a copy of the National Policy in their schools. However, when asked to produce the copy, it was observed that none of the Head Teachers in both the Public and Private Schools were able to do so.

Table 2. Knowledge of respondents about school health program

Knowledge	Public schools N=180 (%)	Private schools N=180 (%)	Total N = 360 (%)	Test statistic value (x^2)	P-value
Knowledge of the role of advocacy and community participation for an effective School Health Programme					
Correct	148 (82.2)	149 (82.8)	279 (82.5)	0. 019	0.890
Incorrect	32 (17.8)	31 (17.2)	63 (17.5)		
Knowledge of environmental factors and its influence on School Health Programme					
Correct	151 (83.9)	156 (86.7)	307 (85.3)	0.553	0.457
Incorrect	29 (16.1)	24 (13.3)	53 (14.7)		
Knowledge of the sources of funding for School Health Programme activities					
Correct	50 (27.8)	54 (30.0)	104 (28.9)	0.216	0.642
Incorrect	130 (72.2)	126 (70.0)	256 (71.1)		
Knowledge of the relationship between School Health Program and Millennium Development Goals					
Correct	147 (81.7)	152 (84.4)	299 (83.1)	0.493	0.482
Incorrect	33 (18.3)	28 (15.6)	61 (16.9)		
Knowledge of School Health Program as part of World Health Organization's strategy to produce health promoting schools worldwide					
Correct	168 (93.3)	156 (86.7)	324 (90.0)	4.444	0.073
Incorrect	12 (6.7)	24 (13.3)	36 (10.0)		
Knowledge of the most important staff needed in the implementation of School Health Program activities					
Correct	18 (10.0)	77 (42.8)	95 (26.4)	49.778	0.001
Incorrect	162 (90.0)	103 (57.2)	265 (73.6)		

Table 3. Influence of policy on implementation of school health program in public and private schools

Characteristics	Public schools N=180 (%)	Private schools N=180 (%)	Total (%)	Test statistic value (x^2)	P-value
Are you aware of the National School Health policy (NSHP) in Nigeria? [N=360]					
Yes	99 (55.0)	79 (43.9)	178 (49.4)	4.445	0.035
No	81 (45.0)	101 (56.1)	182 (50.6)		
Have you a seen a copy of NSHP? [N=178]					
Yes	9 (9.1)	17 (21.5)	26 (14.6)	5.441	0.020
No	90 (90.9)	62 (78.5)	152 (85.4)		
Do you have a copy of NSHP in your School? [N=26]					
Yes	4 (44.4)	9 (52.9)	13 (50.0)	0.170	0.680
No	5 (55.6)	8 (47.1)	13 (50.0)		
Awareness about the "Implementation guidelines on National School Health Programme" (IGNSHP)? [N=360]					
Yes	59 (32.8)	55 (30.6)	114 (31.7)	0.205	0.650
No	121 (67.2)	125 (69.4)	246 (68.3)		
Copy of IGNSHP seen? [N=32]					
Yes	13 (22.0)	19 (34.5)	32 (28.1)	2.207	0.137
No	46 (78.0)	36 (65.5)	82 (71.9)		
Presence of IGNSHP copy in School? [N=32]					
Yes	6 (46.2)	12 (63.2)	18 (56.2)	0.907	0.341
No	7 (53.8)	7 (36.8)	14 (43.8)		

It was observed that 59 (32.8%) Public School Head Teachers and 55 (30.6%) Private School Head Teachers were aware of the existence of the Implementation Guidelines on National School Health Programme in Nigeria (X^2=0.205, P=0.650). This was not statistically significant. However, out of the 59 Public School Head Teachers who were aware of the existence of the Implementation Guidelines on National School Health Programme, only 13 (22.0%) of them had ever seen a copy of it. Similarly, out of the 55 Private School Head Teachers who were aware of the existence of the Implementation Guidelines on National School Health Programme, only 19 (34.5%) of them had seen a copy of it (X^2=2.207, P=0.137). This also was not statistically significant.

Out of the 13 Public School Head Teachers who had seen a copy of the Implementation Guidelines on School Health Programme, only 6 (46.2%) of them reported that they had a copy in their Schools. On the other hand, out of the 19 Private School Head Teachers who had seen a copy of the Guidelines, 12 (63.2%) reported that they had a copy of it in their Schools (X^2=0.170, P=0.680). This finding was not statistically significant. Overall, 6 (3.3%) Public School Head Teachers out of 180 and 12 (6.7%) Private Head Teachers out of 180 reported that they had a copy of the Implementation Guidelines in their schools. However, when asked to produce the copy, it was observed that none of the Head Teachers in both the Public and Private Schools could produce it.

4. DISCUSSION

This study set out to assess the perception of head teachers on school relationships and policy in Primary Schools in Ogun State, Nigeria. The importance of a good and functional School Health Programme as a component of Primary Health Care in the overall development of children and the citizenry of a nation cannot be over emphasized. Various studies in the last 20 years or more in Nigeria have indicated poor status of the School Health Programme [14-18].

The success of the School Health Programme is dependent on the extent to which community members are aware of and are willing to support health promotion efforts. Parents Teachers Association (PTA) is a voluntary association of parents and teachers in a particular school established for its development [2]. Where functional and effective, it facilitates good school and community relationship [2]. Eighty-nine

percent of the schools have a functional Parents Teachers Association (that is, one that meets regularly at least once every 3-4 months). This figure was higher than that obtained in another study where 65% of the schools studied had a functional PTA [19].

However, the fact that the PTA met did not mean that Health issues were discussed or ways of improving the School Health Programme within the School and its immediate community was discussed. Most PTA meetings were usually centred on issues related to finance and funding [2]. This will account for the high number of schools with Parents Teachers Association but poor practice of School Health Programme. The low impact of the Parents Teachers Association is also reflected on the fact that in this study only 39% of the schools in the study population have a functional School Health Committee with the figures slightly higher on the side of the Private Schools. This was similar to the 36% of schools reported in a similar study in Nigeria [20]. It should be noted however that on probing about the functions and activities of the School Health Committee, none of the schools provided a satisfactory answer.

Provision of an adequate emotional climate in the school is a necessity for effective learning [19]. A positive or adequate emotional climate is dependent on the adequate provision for the physical and psychological needs of the pupils and the school personnel [19]. In this study, 68% of the schools affirmed the presence of an adequate emotional climate within the schools. Out of this, 60% were Private schools. A cordial relationship between the School Administrators, Head Teachers, Classroom Teachers, School Community and the Host Community helps to create an excellent environment for living, teaching and learning [19].

Sports field for sporting and recreation activities were available in 64% of schools studied and the Public Schools constituted 59% of this population. This is in contrast to the study in Imo [21] that reported the presence of a sports field in 100% of the schools studied. The fields were however for football activities only. Physical education (PE) provides children with the knowledge, skill and understanding necessary to perform a variety of physical activities, maintain physical fitness and to value as well as enjoy physical activity as an ongoing part of a healthy lifestyle [22]. In an era of increasing childhood and adult obesity, alongside healthy eating lifestyle they have the combined potential to make a positive lifestyle change. It provides additional benefits for pupils- co-operation in group situations, acceptance of failure and success, concepts of working hard and fair play and an appreciation of the skills and attributes of others. In our environment, sport men and women have made a name for themselves through excelling in sporting activities and should be encouraged in children.

Out of the 178 (49.4%) Head Teachers who were aware of the National School Health Policy, only 26 (14.6%) of them had seen a copy of it. Nine (9) Teachers claimed to have a copy of the Policy but none (0%) could produce it on demand. The same trend was seen with the Implementation Guidelines since none of the ten (10) Head Teachers who claimed to have a copy could produce it on demand. This simply means that Head Teachers are not aware of the existence of the Policy. They do not have a copy and have never seen it. The downside is that it will be practically impossible to implement an efficient School Health Programme. Most activities would be mere trial and error as different schools would practice the School Health Programme based on personal understanding of the Head Teacher [14-15,23].

A copy of the National Policy on the School Health Programme and the Implementation Guidelines should be given to the Proprietor/ Proprietress of every new Private School that comes for registration so that they can become aware of the requirement of the Policy and practice School Health Programme based on the documents. For all Private Schools that are registered, a copy should be given to the Head Teacher/ Proprietor at the point of renewal of their licenses. They should be mandated to implement the Policy and the Implementation Guidelines. All the Head Teachers in the Public Schools should be sent copies of the Policy or given copies of the Policy during their usual meetings with the Zonal Education Officers (ZEO). Furthermore a team of inspectors from the local government should be constituted to ensure the implementation of school health policy and guidelines.

5. CONCLUSION

The study concludes that the level of provision of an adequate emotional climate and community interaction in the school is low and that Head Teachers are not aware of the existence of the

National Policy in Nigeria. This implies that most of the schools in Nigeria and other developing countries may practice the School Health Programme based on personal understanding of the Head Teacher [23]. This non challant attitude to health of school children needs to be addressed if health targets such as SDG goals need to be achieved in Nigeria and other developing countries.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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