

The School Health Programme: A Situational Revisit

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Summary

Akani NA, Nkanginieme KEO, Oruamabo RS. The School Health Programme: A Situational Revisit. Nigerian Journal of Paediatrics 2001; 28:1. School Health Programme (SHP) refers to all the aspects of the total school programme which contribute to the understanding, maintenance and improvement of the health of the school population, i.e. school children and staff. It consists of three main areas namely: school health services, school health instruction and healthful school environment. This programme should be an important component of both medical and teacher education curricula. This communication seeks to sensitize practising physicians, medical educators, medical students as well as trainee and practising teachers at all levels, to their roles in the SHP, by exploring the historical background of SHP, outlining the roles of the physician and school teacher in the SHP, reviewing the Nigerian SHP situation, identifying pointers towards positive change and suggesting some interventions towards improvement.

Introduction

SCHOOL Health Programme (SHP) refers to all aspects of the school programme which contribute to the understanding, maintenance and improvement of the health of the school population. It consists of three main areas, namely, school health services, school health instruction and healthful school environment.¹⁻³ School health services deal with health appraisals, control of communicable diseases, record keeping, supervision of the health of school children and personnel. School health instruction provides a formal classroom opportunity for passing on information concerning knowledge, habits, attitudes, practices and conducts that pertain to individual or group health. Healthful school environment deals with conditions within the school that are most conducive to optimal physical, mental and emotional health, safety

of pupils, satisfactory relations among pupils, teachers, administrators, as well as for rest, relaxation and recreation. The three areas are however, not rigidly demarcated, as each supports the others. In addition, the programme is usually integrated with activities within the homes and community. Its success requires the co-operation and collaboration of the vital functional sectors of the community. If well run, the SHP is a vital tool in the educational process which ensures that pupils imbibe a culture of healthy development towards a challenging and productive adult life.

In an article on career planning and development in engineering which featured in the *Financial Telegraph* in late 1997, Faluyi, an engineer, stated that the standard of education in Nigeria had fallen and continued to fall,⁴ such that one could truthfully speak of uneducated graduates. Institutions of higher learning may therefore be considered as preparatory schools. This view of a concerned engineer summarizes the perception of the value of our educational process and school system, by the private sector. Currently in the developed economies, the private industrial and business sectors have observed with dismay, the huge sums of money they spent on the retraining of school graduates to desirable levels of productivity. This has been attributed to the longstanding suboptimal physical, mental and emotional environments of elementary and high schools which have resulted in graduates with non-productive

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tive aptitudes. They have therefore, taken the lead in a partnership with local government administrators and specialized health and educational non-governmental organizations (NGOs) to strengthen the school health programme. The thinking is that, rather than spend large amounts retraining a few with suboptimal aptitudes, such funds were better invested in a school health programme that would benefit the entire community and, at the same time, engender a high level of communal human development.

In the light of this new awakening, one wonders to what extent the Nigerian health sector appreciates the value of the SHP. In addition to the societal decay, which has engulfed the country in the past three decades, a critical look at an outline of the roles of the physicians and school teacher in the SHP indicates that this vital link for a community health-care, education, development and productivity is lacking. It looks like only lip service has been paid to the programme at the highest and lowest levels in the education and health sectors. This review is therefore presented with a view to sensitizing physicians to their responsibilities as prime motivators with regard to the SHP and child health in the global community.

The Roles of the Physician in SHP⁵

The physician has a central and coordinating role in the SHP by ensuring the sustenance of the intersectoral cooperation and collaboration needed for the proper maintenance of the school system and preservation of the educational process. The specific roles of the physician in the SHP are to:

- (i) develop policy as well as organize and supervise health-care delivery in and out of schools,
- (ii) prescribe standards for the school health programme,
- (iii) motivate teacher-educators in complying with the set curricula and standards on SHP,
- (iv) treat sick children and arrange specialist care when necessary,
- (v) organize routine medical examinations and appropriate referrals when necessary,
- (vi) train and monitor progress of teachers in relation to school health,
- (vii) evaluate the standard of school health practice in schools, and
- (viii) serve as an advocate for the community's health by sensitizing all the stake-holders and vital functional sectors to their roles in the promotion, maintenance, improvement and conservation of the community's health.

The Roles of the School Teacher in SHP

The teacher, especially the head teacher, has been identified as a catalyst in the implementation of the SHP with the following obligatory roles:

- (i) bringing a child's condition to the attention of parents and authorities through performance of periodic health appraisals on all school children, continuous alertness over the health needs of pupils in the class, as well as initiating specific screening procedures to identify disabilities and faltering of growth and development,
- (ii) follow-up of referrals to ensure that children receive the appropriate care,
- (iii) counselling of parents on various means for obtaining professional services,
- (iv) seeking financial and other aids to obtain corrective action for the children's needs,
- (v) implementation of the orders of children's physicians, when such children are in school,
- (vi) helping of children who are not directly under the care of physicians to solve their problems through counselling, first aid and access to emergency help as the case may be,
- (vii) understanding of, and empathizing with children's problems in such a way as to make the school more enjoyable and effective,
- (viii) adaptation of the SHP to the needs of the specific child, and
- (ix) being an advocate for the health of the children and the community through provision of leadership, education of the parents, members of the governing board of the school and the local legislature and executive, towards ensuring their appreciation of the value of the SHP.

Historical Background

The relationship between the physical condition of children and their capacity to benefit from education has been appreciated for about 150 years. The earliest recorded organized efforts to improve the health of the school child were made in Europe.³ In 1790, Bavaria in Germany, provided free school lunches. In 1833, France enacted a law holding public schools responsible for the health of school children and this later included periodic inspection of schools by physicians. The First World War sensitized American educators and public to the health needs of school children. It was discovered that 34 percent of examined draftees had adverse physical, mental and emotional conditions. This raised the question of whether or not, the school could have prevented or

corrected many of the observed conditions by conserving or improving the health of children. Great emphasis was subsequently placed on the health of the school child.¹² However, this emphasis was erroneously skewed in favour of physical education, as if it was the same as health education; consequently, the desired improvements were not attained. In 1944, during the Second World War, four million out of thirteen million recruits aged between 18 and 37 years were found to be unfit for military service. The existing school health programme was therefore, adjudged a failure. The efforts that followed have culminated in the present status of school health in Europe and America.

In Nigeria, an attempt was made in 1929 to introduce a medical service that could cater for school children.⁶ A scheme was proposed that entrusted school inspection to medical officers with special training in that field, and a thrice-a-year examination of school children throughout their school years. In 1944, the Christian Council of Nigeria called attention to the high incidence of malnutrition among school children and hoped that government would inaugurate the proposed school medical service. In 1952, the government of western Nigeria published a policy white paper that contained a four-year plan to introduce a school medical service which would be available and free to all children. The objectives of this policy were to ensure that all school children received regular medical examinations, bring teaching of health into children's homes and also provide a liaison between the homes and medical authorities. In 1971, a school health service headed by a medical officer and assisted by other professional heads emerged at the Federal Government level in Lagos. Special clinics were set up to serve as treatment points for school children with minor ailments, in some state capitals and large towns such as Ibadan, Enugu, Kaduna, Benin City, Zaria and Jos.

In Rivers state, a school health service unit was established in 1975 with operational base at Diobu Health Centre; it was manned by public health sisters with occasional input from physicians. The activities centred on occasional school inspection and health talks. The situation was so bad that it took a save-our-souls letter from a student to the then commissioner for health in 1989, for the latter to call for a clear proposal on school health services. Thus, a proposal for improvement of school health services in the state by the Ministry of Health was formulated in 1990.⁷ As at 1995, that proposal had not been implemented to any degree; in fact, a school health programme status assessment exercise⁸ carried out in 1996 in Obio Akpor LGA in Rivers State, yielded

the following conclusions:

- (i) The school health knowledge of primary school head teachers was low.
- (ii) There was absolute lack of physicians or other health care giver input in the school health programme.
- (iii) The primary school environment was hygienically unsafe and hazardous to health.
- (iv) There was no practical example of the health instruction supposedly being taught as a subject to the pupils.
- (v) A short course of training improved the health knowledge of the teachers and stimulated some of them to take responsibility and initiative towards implementing aspects of school health programme that were not capital intensive.

The Nigerian SHP Problem

All efforts at addressing the issue of school health programme in Nigeria have remained largely at policy level, with minimal implementation. Where any implementation has been attempted, the emphasis has been outside, rather than within the schools. School-age children (age range, 6-14 years)^{23 8} constitute about 23 percent of the population of the average Nigerian community.¹⁰ Although largely dependent and not considered productive in terms of income generation, their health status and indices are used to determine a nation's state of development. In most populations, parents' lives virtually revolve around their children. Thus, in underdeveloped countries with high infant and under-five mortality rates, the school-age child is a survivor of the major childhood killer diseases and beneficiaries of the gains of the child survival strategies. Because many of them will continue to live in the unfavourable conditions that put them at risk of poor growth and development, their quality of life must be improved if they must attain their full potential and develop into educated and productive adults.

Despite the efforts of communities, nations and NGOs, health problems still exist among school-aged children. Oduntan⁶ recorded a high incidence of parasitic, infectious and skin diseases, and observed that 95.6 percent of children who were absent from school did so for medical reasons while 24.1 percent of rural school children lost over 15 school days (i.e. three school weeks) within six months, because of ill health. Ebong¹¹ and Okeahialam¹² noted high incidences of road traffic accidents and tuberculosis, respectively, among school-age children. In Port Harcourt, Oruamabo¹³ found that the leading causes of hospital admission of school-age children were malaria (13.5

percent), anaemia (12.4 percent) and meningitis (12.4 percent), with anaemia and respiratory diseases accounting for 10 percent and five percent of deaths, respectively. A recent 30-year autopsy study of childhood deaths in UCH, Ibadan¹⁴ revealed that 43.7 percent of deaths in the school-age children were due to infections, with other important contributors being sickle cell anaemia, renal and cardiovascular diseases. Fagbule and Joiner¹⁵ noted that sickle cell anaemia, typhoid fever and septicaemia together, accounted for about 60 percent of deaths among these children.

While these hospital-based figures are uncomfortably high, it is likely that the real situation in the communities may be worse. The figures however, do suggest that a large proportion of the morbidity and mortality in school-age children is largely preventable. That they occur, further suggests that either the environment is very unhealthy and unsafe or that parents, communities and health-care givers have not paid adequate attention to the health and well-being of these children. Schools on their own have been identified, as sites for substantial numbers of injuries in children.¹⁶ Schools should therefore be planned to provide safety, sanitation and comfort. However, since accidents cannot be completely eliminated, provision should also be made for facilities to handle emergencies and minor ailments at school, to minimize loss of valuable school hours by children. With frequent episodes of illnesses and limited access to health facilities, schools are likely to record frequent episodes of absenteeism, which will in turn, affect the child's educational progress.^{13 6} Several studies^{3 6 17} have shown that where medical facilities are in close proximity for children to receive prompt attention and report back to class, high school attendance rates are recorded.

Primary health care has been defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and the country can afford.¹⁸ Nigeria joined other countries of the world in 1986 in adopting the primary health care approach to health delivery.^{19 20} Five years later, in 1991, a WHO review team pointed out inequalities in the distribution of health facilities and resources as a priority issue,²¹ with particular need to pay attention to the vulnerable groups such as mothers and young children and those presently under-served with essential health care. The school-age children, who are still growing rapidly and whose mental capacity and initiative depend on their health and nutrition, constitute such a vulnerable and under-served group.

Pointers to the Potentials for Positive Change

In 1991, Graves, a paediatrician and WHO representative in Nigeria, called on the Federal Government to start a school health programme in primary schools with appropriate information and education, while Oduntan,⁶ quoting Bronckington, in 1972 was of the opinion that education is fundamental to health and health to education. Unhealthy children cannot be properly educated, while uneducated children cannot be healthy. School children must be physically well, mentally alert, emotionally and socially stable. Whenever any of these factors for effective learning is weakened, they become less than fit and cannot mobilize the will for sustained attention, energy and effort needed for learning and eventual productive living. This amplifies the central role of the school-teacher in the SHP and by extension, the entire community's life.²²

Several reports have stressed the key roles schools can play as agents of change in the community, and the importance of the school health programme in the implementation of primary health care.^{17 21 23-28} School health education has been described as a neglected component of primary health care^{27 28} while environmental sanitation in schools has been described as poor and disastrous.^{6 29 30} Some of the factors militating against the effective implementation of the school health programme include low levels of health knowledge among trainee and practising teachers, high levels of health misconceptions among students and teachers, high levels of indifference and negative attitudes among non-health teachers, lack of resources, lack of confidence and incompetence on the part of teachers and head teachers, ignorance and resistance by school authorities, minimal support from non-governmental agencies as well as lack of legislation to protect school children from health risks in school.^{6 17 25 28 31 32} Fortunately, these factors, which have hindered physicians and school teachers from fulfilling their roles in the SHP, are almost all remediable with attitudinal re-orientation and re-education of the key players at policy and implementation levels.

The application of good health education in school depends on the knowledge, skills and attitudes the teachers acquire through their training.^{15 24 33 34} Reviewing the status of teacher preparation for health teaching in primary schools among teacher training institutions in Anambra State, Agusiegbu³⁵ noted that no institution complied with the National Education Research Council's recommendation of three periods per week of health teaching. Physical and health education were optional courses and trainee

teachers graduated without completing up to 50 per cent of their scheduled work on health-related matters. She therefore wondered how a nation that aspired to have "health for all by the year 2000" could deploy teachers with no organized knowledge regarding health matters, to teach in primary schools where teachers are generalists.

The paradox of Kerala is famous in public and child health as well as community development circles.¹⁷ This is a situation where an extremely poor community, Kerala, in south India, transformed its prevailing unacceptable health indices of underdeveloped poor nations to those of the more developed economies, in a very short time, using simple measures. The bedrock of that transformation was the utilization of the school health programme in the training of teachers as health workers and in mobilizing schools and students as agents of change to galvanize community participation. This was in keeping with the four key elements identified in relation to the implementation of community involvement in health.³⁶ These are:

- (i) the community: the geo-political catchment area of each primary school (feasibility of Kerala experience),
- (ii) the community health/development worker: the teachers and health workers (appropriate training in school),
- (iii) the educational process: school assessment and short training workshops, using the LGA as the focal point, and
- (iv) the external agency: including the executive and the legislative arms of government for financial and legislative support, respectively and NGOs for financial and technical support.

Suggested Interventions

In order to reactivate the wholesome practice of the SHP, the following steps need to be taken:

- (i) Reinforcing and expanding the SHP in the curricula and the training of doctors, other health care personnel, as well as all levels of teachers.
- (ii) Providing supervised in-training experiences for trainee teachers and health-care personnel.
- (iii) Making SHP a vital component of barrier assessment of trainee teachers and health-care givers to give signals to students of its importance.
- (iv) Re-orientation of all practising physicians, nurses, paramedics, and teachers on the value of, and their roles in SHP, as part of continuing education. This may involve the use of LGA level workshops for teachers, doctors, nurses, sanitation and utilities engineers and all key

personnel needed for the success of the SHP.

- (v) Provision of incentives for inter-sectoral career development in the area of SHP.
- (vi) Deliberate enlightenment of the key policy makers and implementation in the legislative, executive and judicial arms of government.
- (vii) In Nigeria, since almost every small community has a primary school, in those communities without health centres, it is possible to use the primary school as a centre for primary health care delivery, not just for pupils but also for the community.
- (viii) Reinforcement of the community health extension system and redeployment of some of the currently under-utilized health extension workers to schools where they can help with primary health care delivery.
- (ix) Appropriate funding for the SHP.
- (x) Other measures of intervention would include eradication of hunger, through an all embracing agrarian policy that involves school pupils, serving soldiers, all unemployed youths, as well as retired civil servants in productive farming activities.

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