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REVIEW ARTICLE

School health and well-being in Nigeria: gaps in policy and design

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Abstract

Aims This paper describes the history of school health in Nigeria leading to the formulation of the existing policy and the current status of policy implementation, as well as gaps and recommendations for review.

Methods A review of school health documents in Nigeria was carried out, as well as analysis of findings from a stakeholder's workshop.

Results School health is a vital tool for the holistic well-being of the school population. It has dual roles, both promoting health and adapting schools as settings for health-promoting activities. School health also provides an opportunity to maximize the investments and profits in the education and health sectors through an organized set of policies, procedures and activities intended to be well coordinated under the school health programme (SHP). The SHP in Nigeria can be categorized into three: pre-policy, policy and post-policy. However, the Nigerian SHP has been poorly implemented over the years with multiple policy gaps.

Conclusion There is an urgent need for SHP review in Nigeria. This will aid community awareness and facilitate implementation.

Keywords School health · Policy · Nigeria · Policy gap

Introduction

School health can be defined as the promotion and maintenance of the highest degree of physical, mental and social well-being of the school population. According to the American School Health Association, school health includes a healthy environment, nursing, and other health services that students need to stay in school, nutritious and appealing school meals, opportunities for physical activities that include physical education, health education that covers a range of developmentally appropriate topics taught by knowledgeable teachers, programmes that promote the health of students, school faculty and staff, and counseling, psychological, and social services that promote healthy social and emotional development and remove barriers to students' learning (ASHA 2023). It involves promoting health through schools and adaptation of schools to health-promoting settings. According to the World Health Organization (1996), the health-promoting school promotes the health and well-being of both students and staff, enhances learning, upholds social justice, provides a safe environment, encourages students participation, links health and education, addresses the health and well-being of all staff including teachers, collaborates with parents and the local community, integrates health into the school's activities, sets realistic goals based on sound scientific evidence, and seeks continuous improvement through ongoing monitoring.

Why school health and well-being? Schools have been described as one of the most productive and least stigmatizing platforms for providing health care services for children and staff (Mason-Jones et al. 2012). This is because schools are tailored to learning and development, making them a natural context for prevention and intervention. Also, the four levels of prevention, comprising health promotion, disease prevention, early diagnosis, and prompt treatment and rehabilitation can be facilitated in schools. Schools have the

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potential to make a substantial contribution to the health of students because they spend a significant proportion of their lives there, often eight hours per day for five days a week, for six to 12 years in school. Paying attention to the health and well-being of school children is also a way to increase school enrolment and retention rates and reduce dropout rates. School health and well-being enhances learning and contributes to developing the human capital index of any country because children's health and well-being is the nation's future wealth.

Education today is viewed as not only teaching and instruction, but also the preservation of health and well-being as an integral part of school activities and programmes. The School Health Programme (SHP) is the composite of procedures and activities designed to protect and promote the well-being of students and school personnel (Akani et al. 2001). The main objectives of the SHP are to obtain a rapid and sustained improvement in the health of school children and to ensure that children from pre-school age to adolescence are in optimum health at all times, so that they can attain their physical and intellectual potential, as well as receive maximal moral and emotional benefits from health providers, teachers and the school environment in general (Okeahialam 2003). Ademuwagun and Oduntan (1986) recommended that the SHP should be able to ensure promotion of healthy growth and development in all school children by promoting optimal conditions in the school, detecting any physical and mental problems among children, controlling the spread of communicable diseases, and providing emergency care to school children, among others. Ademuwagun and Oduntan's recommendation is in support of the World Health Organization (WHO) definition of health which describes the three domains of well-being, namely physical, mental, and social well-being of the school population. The WHO defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.

School health services deal with health appraisals, control of communicable and non-communicable diseases, record keeping, and supervision of the health of school children and personnel. School health education provides a formal classroom opportunity for passing on information concerning knowledge, habits, attitudes, practices and conducts that pertain to individual or group health, while a healthful school environment deals with conditions within the school that are most conducive to the optimal physical, mental, and social health and safety of pupils, satisfactory relations among pupils, teachers and administrators, as well as rest, relaxation and recreation (Akani et al. 2001).

School health is not just about what is taught in the classroom. It is about creating policies and programmes that promote a healthy school environment, thereby reinforcing healthful living. It is about reinforcing healthy habits every day and every year that children are in school. The SHP is usually integrated with activities within the homes and community. Its success requires the cooperation and collaboration of the vital functional sectors of the community and if well implemented, 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.

The SHP is a series of harmonized activities, meaning that it is not just a single action. This shows that the school is a setting where children can maximize their full capacities in education and health. The potential gains in health cuts across physical, mental and social well-being. According to the words of a former Director General of WHO, Gro Bruntland, 'without proper education, health suffers. And without proper health, good education is not possible. An effective SHP can be one of the most cost-effective investments a nation can make to simultaneously improve education and health' and can contribute to achieving the sustainable development goals (SDGs) through its multipronged intervention strategies.

Because of the importance of school health in the life of children, families, communities and the nation, this article aims to review the historical perspectives of school health and well-being in a developing country, the current status of school health and well-being, and the future prospects of school health and well-being in Nigeria. The findings from a stakeholder workshop on school health held in Ibadan, Nigeria, in June 2019, are also discussed.

Historical perspectives of school health and well-being in Nigeria

School health services were established in Nigeria in 1929 by Dr. Isaac Ladipo Oluwole, who introduced a medical service that could cater to school children (Oduntan 1972). A scheme was proposed that entrusted school inspection to medical officers with special training in that field. This included examination of school children three times a year, throughout the duration of their schooling. In 1944, the Christian Council of Nigeria called attention to the high incidence of malnutrition among school children and urged the government to 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 school medical services which would be available and free for all school children. The objectives of this policy were to ensure that all school children received regular medical examinations, to bring health education into children's homes, and to liaise 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, South-western Nigeria. 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 an operational base at Diobu Health Centre. It was manned by public health nurses with occasional input from physicians. The health activities centered on sporadic school inspection and health talks. Despite this effort, there was no appreciable improvement in the health status of school-age children. The situation became so bad that it took a save-our-souls letter from a student to the then Commissioner for Health of Rivers State in 1989, calling on the latter to act. The Ministry of Health thus formulated a proposal for improving school health services in the State in 1990 (Rivers State Ministry of Health 1990). As of 1995, the project had still not been implemented to any satisfactory degree. In fact, a SHP status assessment exercise carried out in 1996 in Obio-Akpor Local Government Area (LGA) in Rivers State, reported low levels of school health knowledge among primary school teachers and an absolute lack of input into the SHP from physicians and other health care professionals. In addition, the review showed that the primary school environment was hygienically unsafe and hazardous to health and that there was no practical example of the health instruction supposedly being taught as a subject to the pupils (Akani et al. 2000). A short training course improved the health knowledge of the teachers and stimulated some of them to take responsibility and initiative towards implementing aspects of the SHP that were not capital intensive, such as periodic examination of pupils, keeping of school health records and introduction of first aid boxes (Akani et al. 2000).

Using the state of the authors as a case example, Oyo State SHP was formally launched on 28 March 2001, with the vision of establishing a preventive health system for all school children that would ensure their maximum physical and mental health development with a particular focus on communicable and non-communicable diseases, and nutrition. An SHP committee was also inaugurated to sustain the programme. The committee was expected to conduct regular health visits to schools for the inspection and routine training of teachers and the 33 local government SHP officers to take charge and sustain SHP in schools and Local Government Areas (LGAs). The committee was also expected to recommend and introduce standardized first aid boxes in all schools, design a referral form for sick pupils and encourage provision of adequate, nutritious and hygienic meals for the pupils. In addition, the committee was expected to conduct regular monitoring and supervision of the above-listed activities to ensure that the set goals of the government were achieved. These functions were meant to be carried out in collaboration with governmental and non-governmental organizations on issues relating to health matters. However, since the inauguration of the programme in Oyo State, there has not been any form of assessment of the programme to ascertain any improvements or lack thereof.

The Nigerian school health policy

The National School Health Policy (NSHPo) in Nigeria was introduced in 2006 to improve the state of school health services in the country (Federal Ministry of Education 2006). Before formulation of the NSHPo, SHP was neglected. Studies prior to the policy adoption revealed that most health care services in schools were absent, and those present were sub-optimal (Federal Ministry of Education 2006). Many head teachers were not aware of pre-admission medical examinations which are meant to be compulsory. Even if teachers were aware of this and other requirements, many families could not afford to pay for these services. This shows that the challenge goes beyond having a policy in place, but also requires allocation of necessary resources. According to health economics, it is cheaper to invest in healthy childhoods to foster healthy and productive adulthoods than not invest in childhoods and have to engage in damage control later in life. Therefore, a wise government should invest in school health and well-being programmes.

According to Anderson, the policies within a nation's SHP as listed by the American National Education Association should include assurance of healthful school living through standards for safety and sanitation, adequate food services, maintenance of teachers, health, and promotion of the mental and emotional health of both teachers and pupils. Recommendations also include health instruction in the curriculum, provision of services for health protection and improvement through first aid for emergencies, prevention and control of communicable diseases, health appraisals, guidance and assistance, as well as emphasizing the hygiene aspects of physical education and seeking to adapt the school health programme to individual needs. In addition, the policies involve designing the education and care of handicapped students. These practices have been pursued effectively in a number of countries, particularly the developed nations, where the need for the harmonious development of children is recognized (Anderson and Creswell 1980; Fajewonyomi and Afolabi 1993).

Current status of school health and well-being policy in Nigeria

While the policy on SHP in Nigeria is like those in some developed countries, the execution in Nigerian educational institutions has been very poor (Fajewonyomi and Afolabi 1993). Moronkola believes that the country is yet to

define a definitive SHP administrative policy (Moronkola 2003). This has far-reaching negative consequences for implementation.

The NSHPo framework in Nigeria describes five operational components for the SHP, namely: School Health Services (SHS), Healthful School Environment (HSE), School Feeding Services (SFS), Skills-Based Health Education and School (SBHE), and School, Home and Community Relationships (SHCR) (Federal Ministry of Education 2006). One major problem is that the policy document has not been well positioned to influence the activities detailed for implementation of the programme. Since the NSHPo was adopted in 2006 (Federal Ministry of Education 2006), there has been no monitoring of the implementation process, nor evaluation of the objectives. Of all the components, SFS is the only component that has been accorded some attention in a few states where it is implemented for primary school children, as interventions are relatively lacking for the other components even though they are all meant to run as a series of harmonized activities (Dania and Adebayo 2019). The Ibadan Adolescent study found a 15.7% prevalence of stunting among school-going adolescents and 18.9% were undernourished (Omigbodun et al. 2010). Adolescents from urban slums and rural areas were more likely to be undernourished. On the other hand, children from private urban schools were more likely to be overweight. This shows that the double burden of malnutrition occurs in our context, whereby children and adolescents with inadequate nutrition cannot learn effectively (Popkin et al. 2020). In addition, one of the objectives of the SFS is to improve the nutritional status of school children. However, there is no baseline data for children which can be used to compare their current nutritional status, and thus ascertain whether there has been an improvement or not. Establishment of school admission or resumption anthropometric measurements may help fill this gap.

A recent survey which assessed awareness and availability of the NSHPo in both rural and urban schools in Oyo State, Nigeria, found that about one-half of teachers reported they were aware of the document (ref of the survey). However, on further probing, fewer (24.1%) said they had ever seen a copy and very few (16.3%) claimed to own a copy. Further checklists in selected schools found that there was not a single copy available in any of the schools, either rural or urban (Ademokun et al. 2014; Dania and Adebayo 2019). This observation raises an important question: If the SHPo is not even available in schools, how can schools then formulate, coordinate, implement, monitor and evaluate the SHP? A recent review of all published studies on school health in Nigeria retrieved 26 papers, with 17 from the Southwest, four from the Southeast, two from the South South, three from North Central, none from the Northeast and none from the Northwest zones. This analysis shows that SHP is a sleeping giant in Nigeria, having minimal implementation (Dania and Adebayo 2019).

Stakeholder perspectives of the Nigerian school health policy

A recent Stakeholders Workshop was held in Ibadan, Nigeria, organized by the Centre for Child and Adolescent Mental Health (CCAMH), a Centre of Excellence for training and research at the University of Ibadan, Nigeria. Participants at this event included policy makers, school owners, teachers, students, parents and academia from departments involved with school health, such as Community Health, Mental Health, Child Health and Nutrition. In the discussion that ensued, panelists discussed the poor state of school environments in their communities. In the words of one of the panelists:

> *There is no water supply in the school, so the school get its water from a well located outside the school premises. The school is fortunate to have a water closet for the teachers and a pit latrine for its pupils. About 90 pupils have to compete for one pit latrine, there is open dumping and burning of general refuse (Student).*

Another panelist spoke of the unfavourable psychosocial climate found in government (public) schools:

> *Teachers bring their anger…., they are aggressive to students by bringing canes to the class. When the teacher brings cane to the class, the students won't be able to express him or herself in the class, he will be afraid to ask or answer questions in the class (Student).*

However, there were glimmers of hope, as one panelist spoke of efforts to provide a health-promoting environment in her school:

> *At the X school we believe that a child must be healthy: healthy body, soul, and spirit. So, we don't just concentrate on the academic part, we make sure that they eat nutritious meals that are well balanced, [….]. In the school, we observe mental health day, mental health awareness, we get people to come and talk about mental health, we ask children to write questions that they want to be addressed. We have a very open communication policy in the school, [….]. Every child must be able to have one adult that cares, and we like to make sure there's interaction…. We have a policy of one teacher mentoring four students, so there is no way…. If we notice your child is depressed, the grades are falling, he is isolating himself, we are able to detect it (Private school owner).*

And another panelist shared:

> *[…] over the course of the year we've been able to train teachers in different schools about child mental health issues, we've also done students training, had sessions*

with students […]. We also have a counselling service called a drop-in clinic and basically, it's just students who have issues who want to talk. They just come in… so we fix a day, and they know we are coming, and they just drop-in and talk to us. Some of the things they've talked about are academic pressures, test anxiety, relationship issues, dating, self-esteem, depression, self-harm, and loneliness…. Having nobody else to talk to, nobody to reach out to (Academic).

Policy gaps in Nigerian SHPo

Mental health

An identified gap in the Nigerian SHPo is the mental health or psychosocial component. Despite the WHO definition of health as complete physical, mental and social well-being, and not merely the absence of disease, the mental and social components of health and well-being appear to have been marginalized in the Nigerian SHPo. References to mental health in the policy are sparse and vaguely described. Although, the policy mentions healthy relationships between students and teachers, provision of mental and social health education, and counselling services but there is no reference to supporting them, such as teacher and staff psychosocial support and education, anti-bullying policies and use of positive disciplinary measures.

Mental disorders are among the top causes of disability in childhood and adolescence. Studies have shown that 50% of mental disorders have their onset before the age of 14 years, a period where critical growth and development occurs (Kessler et al. 2005). Unfortunately, most children and adolescents in Nigeria and other countries in sub-Saharan Africa who suffer from mental health conditions go undetected and untreated, even though a lot of these disorders are preventable and treatable. In 2004, a large-scale survey carried out within 22 rural and urban schools in Ibadan among in-school adolescents found that one in five of these adolescents had thoughts of suicide and one in ten said they had attempted suicide in the past year (Omigbodun et al. 2008). From Omigbodun et al.'s study, Nigeria appears to have one of the highest rates of suicidal thoughts and attempts among in-school adolescents worldwide. In addition, one in every three adolescents had suffered a tragic life event, such as a road traffic accident, armed robbery attack, sexual abuse and/or physical abuse. School-going adolescents who had these experiences were more likely to have symptoms of depression (Omigbodun et al. 2008).

In primary schools, it is estimated that up to 8% of children have attention deficit hyperactivity disorder (ADHD), a mental health condition characterized by the inability to sustain attention, regulate one's activity level and engage in activities. Many teachers do not understand the condition nor possess the skills to work with or help children with ADHD, and they described children with ADHD as wicked, evil, stubborn, and even sometimes as witches and wizards (Ibeziako et al. 2009). Given the high rates of psychosocial issues among our adolescents and the effects on their ability to learn and maximize their potential, it is imperative that there should be a robust mental health component in the NSHPo or even a stand-alone school mental health policy.

Children with disabilities

Another gap identified was the absence of provision for children with disabilities. As stated by one of the panelists at the Ibadan Stakeholders Workshop:

Some children can have hearing or visual impairment…, they can't hear properly, or they have difficulty seeing, so they can't copy notes and they get beaten all the time for being lazy according to the teachers and parents. Meanwhile nobody has taken time to check whether their hearing or vision is perfect. They are at risk of being bullied because of the way they perform, so their friends call them names, bully them…. They are discriminated against, and nobody wants to associate with them and that will in turn worsen the poor performance (Academic).

It is estimated that 1–3% of children are living with disabilities in Nigeria, and there is an urgent need to ensure that the SHPo addresses their right to be educated.

Children living in areas of conflict and war

In the past couple of years, Nigeria has witnessed increasing conflict and violence, particularly in the northern part of the country. This has affected the ability of many children to attend school. Those who have managed to remain in or return to school have urgent health needs which need to be addressed by the SHPo.

Current practice targeted at in-school children only instead of the entire school population

According to the NSHPo, implementation of the SHP is targeted to benefit both school pupils and staff. However, the current practice does not incorporate any plan for the school staff. Emphasis is placed on the school children as the beneficiaries. Being silent on the health of the school staff is another huge gap in the implementation of the Nigerian SHP.

Lack of effective coordination among stakeholders

A catalogue of stakeholders was listed in the NSHPo document for implementation of the SHP. However, it is not clear which ministry or sector should take responsibility

for coordination of the stakeholders. The question is 'Which ministry should be held responsible for failure in implementation? Is it the Ministry of Health or Ministry of Education?' Even though the roles of each sector were itemized in the policy framework, there is a need to define an organizational or administrative structure for the programme.

Future prospects of school health and well-being for Nigerian children

The SHPo remains an indispensable tool in realizing the SDGs, especially goals 2 (reducing hunger), 3 (improving health), 4 (improving education), 5 (gender equality) and 6 (clean water and sanitation), and the advancement of society (Strickland 2018). No expenditure in the SHP can be too high as it represents a huge investment for the future.

Link to COVID and post-COVID era

In the past two years, the whole world has faced one of the most difficult periods in history with the onset of the COVID-19 pandemic. Adults and young people have all been affected. As countries all over the world endeavour to 'build back better', the time is ripe to re-focus attention on the health and well-being of all, especially our children. As new health priorities emerge, they should all be addressed in the revised NSHPo.

Conclusions

There is no doubt the current Nigerian SHPo is replete with obvious gaps. There is, therefore, a dire need to review the policy document and strategies for its implementation. The components of the programme should be revised to include other dimensions of health, especially the mental and social aspects. In addition, each of the 36 states should review the implementation of the SHP based on the NSHPo, provide relevant feedback which may support policy agenda, and adapt the revised agenda to strengthen the SHP in the respective state.

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