ACHIEVING BETTER EDUCATIONAL OUTCOMES IN NIGERIA THROUGH THE SCHOOL HEALTH PROGRAMME

Ekenedo, Golda O., (Ph.D)
Department of Human Kinetics and Health Education, University of Port Harcourt, **NIGERIA**
&
Ekechukwu, Rosemary O., (Ph.D)
Department of Educational Psychology, Guidance & Counseling, University of Port Harcourt, **NIGERIA**

ABSTRACT

It has been proven that implementing coordinated school health interventions in schools is an opportunity to improve both academic achievement and quality of life for students. Nigeria keyed into the WHO's Health Promoting Schools initiative with the development of the National School Health Policy (NSHP) and its Implementation Guidelines. This paper did a review of the NSHP especially the School Health Programme (SHP) which provided the baseline information and framework for the paper. The paper explored various ways the components of the SHP can contribute in enhancing educational outcomes. The authors observed gaps in the implementation of the SHP which was attributed to a number of factors including lack of commitment on the part of government. The authors suggested that the capacity of local schools should be built to enable them mobilize and apply local resources in running the school health programme rather than embark on endless wait for financial assistance from the government. Also suggested is the inclusion of Physical Education as a component of the SHP during the review of the NSHP, and that school health should be included in teacher development programs of higher institutions of learning in the country.

Keywords: School health programme, Educational outcomes, National School Health policy, Nigeria.

INTRODUCTION

Education is the bedrock of economic and technological advancement. Therefore, investing heavily in education is a priority for countries like Nigeria that seek to be among the world's greatest economy. Nevertheless, there has been a persistent outcry over the continuous fall in standard of education in Nigerian. Quality education produces sound, innovative, healthy and productive workforce. In Nigeria, about 45 million young people attend primary and secondary schools (UNICEF, 2008). Apart from constituting a substantial percentage of the country's population they require special attention because the future of the country depends on them. To be able to maximally benefit from education, young people have to be in the best physical, mental and social health. Health and academic achievement are strongly correlated. Good health enables growth, development, and optimal learning in children. Studies of young people have found that health risk behaviors negatively affect: education outcomes, including graduation rates, class grades, and performance on standardized tests; education behaviors including attendance, dropout rates, behavioral problem, and degree of involvement in school activities such as homework and extracurricular pursuits; and students attitudes, including aspirations for post secondary education, feelings about safety at school, and positive personal attitudes (Education Encyclopedia, 2012).

Learning condition is a significant determinant of learning outcome. Schools can hardly achieve the fundamental goal of education if learners and staff are not in good health and are not physically, socially and mentally fit. Children who are sick, hungry, abused, use drugs,

who feel that nobody cares, or who may be distracted by family problems are unlikely to learn well (Dilley, 2009). A wide variety of research has further demonstrated positive correlation between health and learning, and that those two things are mutually reinforcing (CDC, 2009, 2012). Put simply, healthy students are better students. Hence, efforts at educational reforms would not be very effective unless health related barriers to learning are addressed squarely. According to Tyson (1999), first among those barriers are poor physical and mental health conditions that prevent students from showing up for school, paying attention in class, restraining their anger, quieting their self-destructive impulses, and refraining from dropping out.

Appropriate school health interventions have the ability to promote effective education, prevent destructive behavior, and cultivate lasting healthy practices among learners. The practice of promoting health in the school was adopted by the World Health Organization (WHO) in line with the principles of Ottawa Charter of 1986 with the pronouncement of the "Health Promoting School" concept. A health promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working (WHO, 2012). It was this global initiative which is seen as the most promising approach in achieving both better educational and health outcomes (St Leger & Young, 2009) that informed and guided the development of the Nigerian National School Health Policy in 2006. One of the aims of the policy was to promote the health of learners so as to achieve the goals of 'Education For All' (Federal Ministry of Education – FME, 2006).

PROMOTING LEARNING THROUGH THE SCHOOL HEALTH PROGRAMME (SHP)

Like many other countries, Nigeria has a comprehensive school health programme. The school health programme was defined in the National School Health Policy as a series of harmonized projects/activities in the school environment for the promotion of health and development of the school community (FME, 2006). The components of the SHP vary from country to country both in structure and in content. The variations though are slight due mainly to differences in prevailing health problems. The SHP as constituted in NSHP has five components as follows: healthful school environment, school feeding services, skill-based health education, school health services and school, home and community relationships. Each of the components plays various roles in ensuring the best healthy environment for effective learning.

Healthful school environment

The aim of healthful school environment is the provision of safe and inclusive learning, working and living conditions that optimize the organization of day to day experiences which influence the emotional, physical and social health of learners as well as other members of the school community so that maximum benefit from education can be achieved (FME, 2006). A healthy school environment provides safe and healthy physical and aesthetic surroundings and a sound psychosocial climate and culture that are conducive for learning.

Physical environment

The condition of the school physical environment has effects on the health and wellbeing of the child and his or her ability to learn and retain knowledge. The physical school environment encompasses the school building and all its contents including physical

structures, infrastructure, furniture, and the use and presence of chemicals and biological agents; the site on which a school is located; and the surrounding environment including the air, water, and materials with which children may come into contact, as well as nearby land uses, roadways and other hazards (WHO, 2012). There is need for learners to have access to clean water for drinking and sufficient water for hygiene and sanitation purposes. It is also important to have adequate sanitation facilities, clean and safe environment as well as safe and nutritious food. An unclean environment can facilitate the spread of infectious diseases, and cause other health problems that can impede learning ability and reduce school attendance. A hazardous physical environment can cause injury and lifetime disabilities and even death. In fact, healthy learning community that is physically, emotionally and intellectually safe is the foundation for a comprehensive high-quality education (Connecticut State Board of Education, 2010).

To maintain a healthy school physical environment, the NSHP identified important areas of attention. The school compound should be large enough approximately, one hectare of land for maximum of 500 learners, should be located in a safe area, away from sources of noise and other forms of pollution such as factories, markets, airports, major highways and public motor parks (FME, 2006). Schools should have perimeter fence with a gate to promote security, and should be located in a well drained terrain to avoid flooding. The school buildings should be of standard quality and design. The country has recorded unfortunate incidents of collapsed school buildings in which hundreds of lives of school children have been lost, as a result of substandard materials and contractors used in the design and construction of the buildings. A ventilated and well lit school building provides a stress-free accommodation that is not prone to spread of infectious diseases. The physically challenged learners should be considered in developing school facilities. Desks and chairs appropriate for the age and levels of the learners should be provided. Spacious playground and a large room for indoor recreational activities should be an important feature of every school; play, and organized physical activity programmes promote physical, mental and social wellbeing.

Water supply should be adequate and the source properly maintained by the school authority. Items required to practice hand hygiene and general sanitation should be provided. There should be at least a toilet compartment for every 30 learners which should be gender sensitive for both learners and staff, and in addition adequate and functional drainage system should be in place to manage waste water from bath, kitchen and surface run-offs (FME, 2006).

In order to promote safety and prevent accident, schools are required to put adequate road signs and markings on the roads leading to the schools which should include informative, regulatory/warning signs and Zebra crossings. Speed breakers and overhead bridges should be provided by the government at the appropriate places. School recreational facilities should be located far away from the roads as possible in order to guard against children running into the roads without warning. Side rails or cross bars shall be fixed on school locations with high road traffic densities so as to promote organized crossing of the roads by the students/staff (FME, 2006).

Psychosocial environment

Psychosocial environment in school encompasses the attitude, feelings, and values of students and staff. Positive interpersonal relationships, recognition of the needs and success of the individual, and support for learning are all part of the psychosocial environment. School can promote social and emotional wellbeing by providing warm and friendly

atmosphere and rewards learning; facilitating supportive and open communications; providing opportunities for enhancing creativity; discouraging physical punishment, bullying, harassment and violence through the development of appropriate policies and procedures.

Factors that influence psychosocial environment in the school include school organization, interpersonal relationships, internal and external pressure. School organization refers to the way the school is set up and administered. A lot of flexibility is required in school organization. Important elements to be considered in school organization include length of school days, school schedule, length of classes, class size, double sessions (after school lessons) and summer school. Length of school day should vary at different levels of education to suit the age and level of development of the learners. This can have an impact on quality of education. School schedule needs to be flexible with periods of concentrated mental activity interspersed with less strenuous mental tasks and broken by periods of physical activity. Length of classes need to be fashioned to suit the age of learners as children generally tend to have low attention span which can reduce learning capacity. It has been established that optimal class size should be between 30 – 40 pupils. When class is large, individual attention to pupils decreases and regimen increases. Loss of identity and depersonalization are some of the problems experienced by pupils in large classes. The impact of afternoon school sessions commonly called school lessons on health also needs to be seriously considered.

Interpersonal relationships refer to the interaction between and among key actors in the school environment which ultimately dictates the emotional climate in the school. These relationships exist in the following manner: teacher-administrator, teacher-teacher, teacher-student, student-student, student-administrator and student-other workers. A breakdown in these interactions may lead to maladjustment, anti-social behavior and violence in the school. The emotional atmosphere of a classroom is created by the composite behavior and attitudes of the students and teachers who work together in those classrooms. When there is mutual understanding in the classroom, between the students and the teacher and among the students the outcome is that students will feel encouraged to explore and understand his environment, to clarify and resolve conflict and adapt to the classroom environment.

Other psychosocial issues that hinder learning include drug abuse and violence. Drug and substance abuse have damaging consequences on the health and development of young people. The adventurous and rebellious nature of young people puts them at risk of abusing drugs. A drug user is likely to fail at school, in relationships and at work, and are more likely to get involved in violence. Violence can be physical, psychosocial, sexual, gender based and health related. Violence can be perpetrated in the school by teachers by way of corporal punishment, sexual violence and bullying, and by students in the form of bullying, mobbing (gang violence), school yard fighting, sexual and gender based violence and assault with weapons (such as in rioting). The effect of violence in school is enormous and includes physical injury, psychological distress, permanent disability and long term physical and mental illness.

School feeding services

A correlation exists between nutrition and learning. Healthy and adequate dietary patterns are important for students to achieve their optimum academic potential, physical and mental growth, and general wellbeing. Mental growth is a very critical aspect of child development; therefore, good nutrition that provides nourishment to the brain is essential. Unfortunately,

young people may not have adequate nutrition as a result of poverty or due to specific food habits, which usually have to do with preference for snacking and food fad. There is noticeable increase in the incidence of obesity among young people in Nigeria, resulting from excessive consumption of high fat and high sugar foods and lack of physical activity. Schools have a responsibility to help students and school staff to establish and maintain lifelong, healthy eating patterns. Poor nutrition has been shown to be an underlying cause of poor attendance, retention and achievement in education among children of school age. The school feeding service is, therefore, seen as a strong means of improving enrolment, attendance, retention, completion and learning achievement among pupils, and subsequent realization of Universal Basic Education (UBE) (FME, 2006). This is especially so in parts of the country where poverty and ignorance prevent a good number of children from attending school.

The aim of the school feeding service is to provide learners with a daily supplementary adequate meal that will improve their health and nutritional status for effective and sound learning achievement (FME, 2006), thereby reducing hunger and malnutrition among learners, enhancing participatory learning, contributing to increased school enrolment, attendance, retention and completion as well as serve as avenue for teaching basic hygiene and nutritional facts to learners. Under the school feeding service, schools are expected to provide one nutritionally balanced meal each school day for the learners. Food vendors/handlers should be supervised to ensure that food and snacks are prepared and served or sold under hygienic conditions. And, finally, food vendors/handlers should be immunized against diseases such as Hepatitis B, and care taken to ensure that they have up-to-date certification.

Skill-based health education

Health education has been part of Nigerian school curriculum for decades, presented in various forms such as hygiene education, health science, and health education or sometimes combined with physical education. However, the effectiveness of the health education taught in schools in influencing knowledge, attitude and behaviour about health has remained a source of concern to stakeholders in the health and education sectors. This identified gap has been attributed to factors such as dearth of health education teachers, lack of appropriate and adequate teaching aids, less attention paid to application of skill development as opposed to instructional method of impacting knowledge and absence of adequate facilities for teaching and learning health education (FME, 2006). These informed the new concept “Skill-Based Health Education”.

The aim of skill-based health education is to provide a sequence of planned and incidental learning experiences capable of equipping learners with adequate skills to take appropriate decisions and actions that will promote their health (FME, 2006). Specifically, skill-based health education aims at providing basic information about health issues to learners as well as helps them develop life skills which influence the development of desirable health habits and discourage unhealthy practices. Skills-based health education increases awareness of environmental threats to health, generates a feeling of responsibility for health and the environment, and improves the health of students (WHO, 2012). It informs students about how to avoid health risks and how to create an environment that is conducive to healthy living as well as develop life skills which include value-based communication skills such as assertive skills; self-esteem; value clarification; and negotiation skills in the learners. Life skills provide the children with abilities for adaptive and positive behaviours that enable them to deal effectively with demands and challenges of everyday life. They enable them resist

peer pressures in various aspects of their lives, especially as it pertains to substance abuse, sex and other life choices.

School health service

School children need to have good health to be able to learn effectively. "Good health supports successful learning and successful learning supports good health" (FME, 2006). Children at school are exposed to a variety of hazards – physical injury, infections and emotional problems. The school through the school health service provides treatment through first aid and emergency services as well as counseling. The school health services are preventive and curative services provided for the learners and staff within the school setting (FME, 2006). The purpose of the school health services is promote optimal health among learners and staff and to keep school children in the best possible health condition that will enable them to maximize educational benefit. Personnel responsible for providing school health services include physicians, dentists, school health nurses, teachers and other appropriate personnel to appraise, protect and promote the health of members of the school community (FME, 2006).

The objectives of school health services include promotion of healthy growth and development among school children; early detection of defects and diagnosis of diseases among learners and staff; prevention of diseases among school children and staff; provision of prompt treatment for diseases and injuries occurring among all persons in school, provision of referral and follow-up services in schools; and ensuring effective counselling services for all learners, staff and parents/guardian when necessary; conducting pre-employment screening for all other members of the school community including food handlers (FME, 2006).

The school health services also include teacher's observation which facilitates early detection of children who require special attention and also measure some simple parameters that can be used as indices for evaluating the health status of the learners. Periodica observation by the teacher is carried out starting from the beginning of every term and includes inspection of the learners to assess their general cleanliness and to detect discharging ears/eyes, squints, unusual colour of eyes, inability to hear or read properly as appropriate for age and skin rashes and early detection of tooth decay and bad breath (FME, 2006). It also stipulates that heights and weights of children should be measured at the beginning of every school term; provision of standard equipped first aid boxes and teachers and learners trained in first aid; and fulltime counselling services to the school community and parents in all areas of living.
With the provision of the afore mentioned services learners learn in an environment that is devoid of pain, discomfort and any form of physiological upset. Attention in class is achieved when learners are in a state of physiological equilibrium, and learning and assimilation are made more effective. Absence from school due to ill-health and learning difficulties due to disabilities are also reduced.

School, home and community relationship

The compounding health problems of children and adolescents cannot be solved by the school alone. Schools need all the help they can get to deal with the negative consequences of such problems as early initiation to drugs, sex, violence, lateness and absenteeism, dropout from school and other forms of negative behaviors. The school needs to solicit community involvement by engaging community resources (both human and material) and services to

respond more effectively to health-related needs. Family and community involvement promotes an integrated school, family, and community approach that establishes a dynamic partnership to enhance the health and well-being of students (Education Encyclopeadia, 2012). Involving family members and the community helps to strengthen health knowledge and behaviours acquired in the school. Numerous studies link parent/family involvement to their children's achievement, academic standing, and decreased school failure and grade repetition, and a number of studies have shown that involving families enhances the effects of school health-promotion efforts (Education Encyclopeadia, 2012). School health programmes should, therefore, ensure that the family is assisted and supported to effectively reinforce health habits and behaviors acquired by the children in school. For a balanced development of the child, life at home should complement a healthy life-style provided in the school; therefore, regular contacts between schools and homes are essential (FME, 2006).

Where healthy relationship exists between the school and the community, the school can utilize health and social facilities in the community for healthcare and learning purposes. For example, the school can make use of a nearby health centre in the community if it cannot afford a sick bay; they can invite community health workers to provide the school with health services such as immunization, health talks and seminars; influential and wealthy members of the community can be used to attract health and educational facilities and equipment and programmes to the school. On the other hand, the school can play an important role in improving the health and development of the community as a whole through making available the school’s resources, both human and material to the service of the community. Ultimately, the success of the school health programme depends on the extent to which community members are sensitized and are willing to support the efforts of the school.

The objectives of school, home and community relationship is achieved through home visits by teachers, school nurses and social workers; regular visit of parents to school; regular communication of the health status of the learner to the home by the school health personnel and the teachers; active participation of the school in community outreach activities and campaigns; active participation of the school in community health planning, implementation, monitoring and evaluation; advocacy and community mobilization for the SHP through traditional and modern media; and involvement of the community in the promotion of health-related school policies (FME, 2006).

Physical education and recreation

Being physically active is a basic requirement for maintaining good health and preventing diseases. Besides, physical activity improves mental health and promotes learning. At school, physical activity includes participating in physical education, recreation and dance programmes, school athletics and active play during the recess; walking or cycling to and from school; and extracurricular opportunities that offer physical activities during leisure time. Participation in physical activity can lead to physical fitness. Key components of physical fitness are cardio-respiratory endurance, muscular strength and endurance, flexibility, body composition, and hand-eye and hand-foot coordination (Caspersen & Powell, 1985).

WHO (2007) considers improving physical activity in schools to be an important element of a health promoting school. It is, therefore, not appropriate and an oversight on the part of the policy makers not to have included a physical activity component in the NSHP. There is some evidence that physical activity helps children stay alert in class which improves their academic achievements (Sibley & Etnier, 2003). Physical activity also helps to relieve

tension, restlessness and lack of concentration from continuous sitting (Annesi, 2004), and reduces obesity and dullness among learners. Recreation and sport have also been established as promoting leadership qualities and psychological well-being; hence, physically active students are more likely to have good conduct and high academic achievement (Caspersen & Powell, 1985).

The Problem of Programme Implementation

Statistics from the national study of the school health system in Nigeria by Federal Ministry of Health and Federal Ministry of Education in collaboration with World health Organization in 2003 (FME, 2006) showed that most of the schools (71%) are located at a distance of less than 5km to main markets, also, most of the schools (68%) were located less than 1 km to busy main roads. Most schools had good ventilation (94%), and more than two-thirds had satisfactory doors, window and adequate light. About three quarters of schools assessed had recreation facility, one-quarter had ventilated pit latrine, 46% had pipe-borne water or bore hole and 67% were reported to be clean.

With regards to school health services, 14% of head teachers indicated that pre-medical examination was mandatory in their school, food handlers were screened only in 17 % of schools and four-fifth of schools had first aid box. Of the schools studied, 17% had school nurses, 6% have linkages with government-designated school clinics, and 29% had social welfare services provided mainly by community- based organization.

The above study was carried out prior to the development of the NSHP, hence, it is expected that with the implementation of the policy, the situation would have significantly improved. Unfortunately, there are indications that only few schools operate comprehensive, coordinated programmes designed to address the school children's health needs. One year after the launch of the NSHP, Ofovwe and Ofili (2007) assessed the knowledge, attitude and practice of school health programme among head teachers of primary schools in Egor local government area of Edo state, Nigeria. They found that none of the head teachers had adequate knowledge of SHP. 93.1% from private compared to 48.3% from public schools had poor knowledge of SHP ($\chi^2 = 56.86$, $p < 0.05$). A favorable attitude was demonstrated by all the teachers. Up to 40.4% of private compared to 31.0% of public schools had SHP. Overall 27.7% of the schools had no toilet facility, 33.3% had pit latrine while 40.0% had water closet. Only 25.6% had hand washing facilities. Regarding health services, 51.0% of private schools compared to 27.6% of public schools perform medical inspection of the pupils. Similarly 39.4% private compared to 3.4% public schools had sick bay ($\chi^2 = 11.11$; $p < 0.05$). A total of 16.5% of the schools undertake medical screening of food handlers/vendors, while 20.2% private compared to 3.4% public schools screen food handlers/vendors ($\chi^2 = 4.47$; $p < 0.05$). They concluded that the poor status of SHP in Nigeria may be attributed to failure of policy enunciation, poor primary health care base and lack of supervision.

A similar study carried out by Ademokun, Osungbade and Obembe (2012) six years after the policy came into being did not show much improvement in the situation. They discovered that implementation of SHP was poor, most especially in the areas of school health services and healthful school environment. They found that many of the school head teachers had never heard of the 2006 NSHP; the skeletal health programs in their schools were not run according to the minimum requirements stated in the 2006 National School Health Policy document; no funding came from the government for the implementation of the SHP; A higher proportion (85.7%) of schools had good implementation of school feeding services,

though school-feeding services implemented in schools does not involve the Federal Government providing at least, one adequate meal a day to students as specified in the NSHP, rather, what basically obtains is screening and supervision of food vendors by the schools. school health services was implemented by 33.3% of the schools and 23.8% of schools had good implementation of healthful school environment. All the schools had good implementation of skill based health education at the junior classes.

Regarding source of water supply in schools, most of the schools 13 (62%) had wells as their source of water supply, only 7 (33%) had borehole and few 1 (5%) had pipe borne water. Concerning means of refuse disposal, majority of the schools 18 (86%) disposed of their refuse by burning; few 2 (10%) had incinerators while 1 (5%) had no means of refuse disposal. As for sewage disposal, 9 (43%) used the water system, 9 (43%) also used pit latrine system while 3 (14%) had no toilet facilities. Only few 2 (10%) had sick bay while majority 19 (90%) had first aid boxes. With regards to health personnel, only 1 (5%) of the schools had a school nurse, environmental health officer and community health officers. Few 6 (29%) of the schools have trained first aider while 1 (5%) had school health committee. In summary, out of the 21 schools assessed, 6 (28.6%) schools had poorly implemented the components of the school health programme, 9 (42.9%) schools had fairly implemented the components of the school health program, and 6 (28.6%) schools had good implementation of the components of the school health programme.

A more recent study by Oyinlade, Ogunkunle and Olanrewaju (2014) that evaluated school health services in Sagamu, Nigeria revealed that only one (1.1%) school benefited from the services of a school doctor. Essential drugs and materials for first aid services were available in 85 (93.4%) of the schools, while only 26 (28.6%) had a sick bay. Screening tests for disabilities were performed in only 10 (11%) of the schools visited. Although school midday meals were available in all the schools, they were not free. Private secondary schools had the highest percentage of good school health evaluation scores (63.6%), while 96.2% of the private primary schools had poor health service evaluation scores. They, therefore, concluded that school health services are unsatisfactory in Sagamu.

FACTORS MILITATING AGAINST THE IMPLEMENTATION OF THE SHP

Like many other developing countries the problem for Nigeria has never been that of policy development but that of implementation. Factors identified as militating against implementation of policies especially in Sub-Saharan Africa include: lack of coordination between the national and provincial departments; management problems in states ministries; and lack of capacity on the ground (Stack & Hlela, 2002); weaknesses in forecasting capacity, dependency on volatile and unpredictable aid flows, slow project execution, less stable political systems (Lledo & Poplawski-Ribeiro, 2011), bad governance and lack of political will (Federal Ministry of Health, 2011).

It is sad to observe that education is one sector that governments at all levels in Nigeria have continuously neglected. Even when international non-profit agencies like UNICEF have continued to show interest in developing education in Nigeria, the governments often times are unwilling to join resources in partnership with them. UNICEF, after helping Nigeria to develop the National School Health Policy, embarked on the training of desk officers and other relevant personnel in the Ministry of education and other line Ministries; develop sports in schools and; distribute copies of the NSHP. In all these, governments at different levels have continued to default in making available their counterpart fund, thereby limiting the

impact and coverage of UNICEF initiated school health programmes. One other factor that affects the sustenance of government programmes is lack of continuity by subsequent governments. In their bid to impress, political office holders usually desire to start new projects rather than continue or complete those started by their predecessors. This is a clear indication of insincerity and lack of will to invest in projects that will actually impact the lives of the citizens.

Lack of knowledge and skills among policy implementers in implementing the content of the policy is a major stumbling block in the effective implementation of the NSHP. Findings from researches as shown in previous discussions reveal that few teachers and head teachers were aware of the existence of the NSHP; most of them do not possess knowledge about the SHP and its components. Meanwhile, they are supposed to be the grass-root implementers of the programme. Various personnel in the relevant ministries who should play important roles in the implementation of the SHP also lack the needed knowledge and skills in implementing the program. Knowledge has always been a relevant prerequisite for taking required action about a given situation.

CONCLUSIONS AND SUGGESTIONS

Because the health of students is strongly related to educational achievement, it is of great importance that schools promote health of students. Schools can also provide the environment and support needed to facilitate the development and sustenance of health promoting behaviors among learners. Nigeria has developed a comprehensive school health programme which has the potentials of helping the country achieve better health and educational outcomes. However, gaps exist in the implementation of the programme. Identified gaps need to be addressed for the program to achieve its health and educational objectives. Based on the conclusions made, it is suggested that

1. All Colleges of Education and Faculties of Education in Nigerian universities should add School Health to their teacher education curriculum to prepare intending teachers to adequately play their roles in the implementation of the SHP.
2. The Federal Ministries of Education and NGO's should build the capacity of head teachers in community mobilization so that they can effectively use local resources at their disposal to run the SHP.
3. The Federal Ministries of Health and Education should organize training programmes for school staff so as to build their capacity in implementing the SHP.
4. The Ministry of Education should ensure that Physical education and sports is included as a component of the NSHP whenever the policy is reviewed.
5. The Ministry of Health should revisit the practice of posting school health nurses and in addition, doctors to all primary and secondary schools in the country.
6. On the part of the government, a trust fund can be set up with people of integrity put in its charge. This is to ensure that such fund is disbursed to schools specifically for the running of the SHP, and the use of the funds adequately and promptly monitored.

REFERENCES

Ademokun, O, M., Osungbade, K. O. & Obembe, T, A. (2012). A Qualitative Study on Status of Implementation of School Health Programme in South Western Nigeria. *Science and Education Publishing,* 2I, (11). http://pubs.sciepub.com/education

Annesi, J.J. (2004) Relationship between self-efficacy and changes in rated tension and depression for 9- to 12-yr.-old children enrolled in a 12-wk. after-school physical activity program. *Percept Mot Skills*, 99(1):191-194.

Caspersen, C. J. & Powell, K. E. (1985). Physical activity, exercise, and physical fitness: definitions and distinctions for health-related research. *Public Health Rep,* 100(2):126-131.

Dilley, J. (2009). *Research review: school-based health interventions and academic achievement*. Washington D.C.: Washington State Department of Health.

Education Encylopeadia (2012). *School Health Education-Characteristics of Effective Programs, Conclusion.* http://education.stateuniversity.com/pages/2035/HealthEducationSchool.html.

Federal Ministry o f Education (2006). *The National School Health Policy.* Abuja: Federal Ministry of Education.

Federal Ministry of Health (2007). *National strategic framework on the health and development of adolescents and young people in Nigeria.* Abuja: FMOH.

Federal Ministry of Health (2007). *National guidelines for implementing health promotion and education programmes.* Abuja: Federal Ministry of Health.

Lledo, V. & Poplawski-Ribeiro, M. (2011). Fiscal policy implementation in Sub-Saharan Africa. *IMF working paper*, African Dept..

Ofovwe, G. E & Ofili, A. N. (2007). Knowledge, attitude and practice of school health programme among head teachers of primary schools in Egor local government area of Edo state, Nigeria. *Annals of African Medicine*, 6, (3); 99-103. http://www.annalsafrmed.org/article.asp?.

Oyinlade, O. A., Ogunkunle, O. O. & Olanrewaju, D.M. (2014). An evaluation of school health services in Sagamu, Nigeria. *Nigerian journal of clinical practice, 17, (3);* 336-342. http://www.njcponline.com/article.asp?

Sibley, B.A & Etnier, J.L. (2003). The relationship between physical activity and cognition in children: A meta-analysis. *Pediatric Exercise Science*, 15:243-256.

Stack, L & Hlela, K. (2002). *Enhancing policy implementation: Lessons from the health sector.* Johannesburg: Center for Policy Studies.

Tyson, H. (1999). "A Load off the Teachers' Backs: Coordinated School Health Programs." Kappan Special Report. *Phi Delta Kappan* 1999.

UNICEF (2009). *Schools and health*. www.unicef.org.

World Health Organization (2007). Promoting physical activity in schools: an important element of health promoting schools. *WHO information series on school health.* Geneva: WHO.

World Health Organization (2012). *What is a health promoting school?* http://www.who.int/school_youth_health/gshi/hps/en/index.html.