Official Publication of the Faculty of Basic Medical Sciences University of Ibadan, Nigeria

Arch. Bas. App. Med. 6 (2018) 9 – 15
www.archivesbamui.com

ARCHIVES OF BASIC & APPLIED MEDICINE

Research Article

Teachers' Training and Involvement in School Health Programme In Oyo State, Southwest Nigeria

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Received: June, 2017; Revised version Accepted: November, 2017

Abstract

School Health Programme (SHP) currently lacks effective implementation in Nigeria. Lack of training/orientation of teachers in the programme may have contributed to this. Developing an appropriate training intervention may require prior situation analysis to know teachers' current level of training and involvement in the programme, as there is paucity of information on such study in Oyo State. Thus, this study was carried out to assess primary school teachers' training and involvement in the SHP in Oyo state, Nigeria. A descriptive cross-sectional study was conducted using a 2-stage cluster sampling method to select 2 out of the 33 Local Government Areas (LGAs) in Oyo State. A semi-structured self-administered questionnaire was used to obtain information on respondents' characteristics and previous training and involvement in the SHP. The major variable for assessing teachers' involvement in the SHP was "ever been involved in health inspection of pupils". Level of involvement was categorized into "never, "once", "occasionally", "frequently", and "very regularly". These options were further re-categorized into "never", "infrequently" (once and occasionally) and "frequently" (frequently and very regularly) for the purpose of inferential statistics. Data were analyzed using descriptive statistics and Chi-square test at p=0.05. A total of 811 respondents participated in the study. Twenty-eight percent of the respondents reported previous training in the SHP out of whom 44.7% received the training on-the-job. Forty-seven percent were regularly involved in health inspection of pupils. Teachers who taught health education (92.3%) were involved in health inspection of pupils compared with counterparts who did not (74.4%) (p<0.001). Similarly, 85.3% of teachers trained on-the-job were frequently involved in the SHP compared with 73.6% of those trained during undergraduate years (p=0.026). Training and involvement of public primary school teachers in the SHP in Oyo State were suboptimal. Efforts at building the capacity of teachers through on-the-job training in SHP may be necessary to improving the current level of implementation in the State.

Key Words: *Teachers' involvement, On-the-job training, In-school children, School health programme, Health inspection, Public primary school*

INTRODUCTION

The school health programme (SHP) is a constellation of services in the school setting that address the well-being of the school population, mostly the learners. The programme is primarily based on two pertinent premises. Firstly, the relationship of quality of learning with the health conditions of students, and secondly, responsibility of the state to facilitate smooth physical and mental growth of children for their future role as productive members of the society. A third dimension emphasized in certain situations is the potential contribution of students in the dissemination of health and hygiene education messages to peer, parents and community at large. This phenomenon is also termed child to child (peer education), and child to community transmission of information relating to health care and disease control (Ministry of Education/UNESCO, 2010). Several reports have stressed the key roles schools can play as agents of change in the community, and the importance of the SHP in the implementation of primary health care for the school-age children (Van der Vynckt, 1992; WHO, 1991).

In developing countries, the state of school health education was described as a neglected component of primary health care (Van der Vynckt, 1992; Eke, 1988) while environmental sanitation in schools was described as poor and disastrous (Jewkes & O'Connor, 1990; Fagbulu, 1988). In these countries, young children are at a greater risk of various infectious diseases (Ministry of Education/UNESCO, 2010). Also, school-age children from these countries with high infant and under five mortality rates are survivors of major childhood killer diseases and beneficiaries of child survival strategies (Akanni et al., 2001). These survivors will continue to live in the unfavourable conditions that put them at risk of poor growth and development. Thus, their quality of life must be improved if they must attain full potential and develop into educated and productive adults (Akanni et al., 2001).

Studies have shown that implementation of the SHP in Southwest Nigeria was suboptimal (Adebayo & Owoaje, 2016; Kupoluyi et al., 2016). Some of the factors militating against effective implementation of the SHP have been low levels of health knowledge among trained and practicing teachers, high levels of health misconception among students and teachers, high levels of indifference and negative attitudes

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among non-health teachers and lack of resources. Other factors include 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 schools (Anate, 1993; Ochor, 1988). Recent surveys in the study area revealed that teachers had inadequate knowledge of the SHP and poor perception of their roles in the program (Adebayo & Onadeko, 2015, Adebayo & Onadeko, 2016). These findings underpin training needs for the teachers who are prime gatekeepers and stakeholders of the SHP innovation.

Developing a training programme for teachers in SHP can only be efficient and effective if preceded by a situation analysis to know teachers' current level of training and involvement in the programme as this is currently lacking in Nigeria. Thus, this study was carried out to assess primary school teachers' training and involvement in the SHP in Oyo state, Southwest Nigeria. The information obtained will be useful in developing appropriate training interventions for these important stakeholders for the effective implementation of SHP in the state.

MATERIALS AND METHODS

Ethical considerations: The protocol for the research was approved by the Oyo State Health Ethics Review Committee, Nigeria. The cooperation of the head teacher in each of the selected schools was established through courtesy calls to their offices before questionnaire administration. During such visits, the aims and objectives of the survey were discussed. Informed consent was obtained from respondents after the purpose of study was adequately conveyed to them

Study design: A descriptive cross-sectional study was conducted using a 2-stage cluster sampling method to select 2 out of the 33 LGAs in Oyo state. The second stage involved random selection of schools from the sampling frame of all the public primary schools in the selected LGAs in Oyo State by balloting. Each school was considered as a cluster and all the teachers in the selected public primary schools who consented and were available at the time of survey were recruited.

Methodology: A semi-structured, self-administered questionnaire was used to obtain information on respondents' characteristics and if teachers had ever had formal training in the SHP, the specific areas of training previously received, their previous involvement in the SHP specifically in school health inspection (SHI), assistance in pre-entrance medical examination, screening of pupils for disabilities, brought a child's health condition to the attention of parents and counselled parents on means of seeking health services for their wards. The outcome variable was teachers' involvement in the SHP and it was assessed with "ever been involved in health inspection of pupils".

Data analysis

Data were analysed using the SPSS version 21. Descriptive statistics were reported using proportions in tables. Bivariate analysis was conducted between teachers' sociodemographic characteristics, qualifications, years of teaching experience, previous training in the SHP etc and teachers' involvement in the SHP using Chi-square test at 5% level of statistical significance. For descriptive statistics, level of involvement in health inspection of pupils was reported as "never, "once", "occasionally", "frequently", or "very regularly". These options were further re-categorized into "never", "infrequently" (once and occasionally) or "frequently" (frequently and very regularly) and "never" or "ever" for the purpose of inferential statistics..

RESULTS

The mean age of the study population was 42.8±8.1 years. Most (89.4%) of the teachers had National Certificate in Education (NCE) followed by teachers' grade 2 certificate (68.1%). Above one-half (55.6%) of the respondents had two more additional certificates. Many (58.1%) were on grade level 10 and above. Few (33.6%) had 21-30 years of teaching experience while 32.5% had practiced teaching for 10 years and below. Twenty-eight percent reported ever had training in the SHP of whom 126 (54.3%) reported to have received the training during the teacher training years and 102 (44.7%) on-the-job training. About sixty percent (60.5%) were ever trained in school health services (SHS); 75.8% in school health instruction (SHI) and 51.4% in school health environment (SHE) (Table 1).

Table 1:
Distribution of respondents by ever had previous training in SHP

Variable	Frequency	%
Ever had formal training in SHP	**(N=811)**	
Yes	228	28.1
No	583	71.9
Nature of training (N=228)		
On the job	102	44.7
During training years	126	54.3
School Health Services (N=228)		
Yes	138	60.5
No	90	39.5
School Health Inspection (N=228)		
Yes	173	75.8
No	55	24.2
School Health Education (N=228)		
Yes	117	51.4
No	111	48.6

Regarding teachers' involvement in health inspection of pupils, 47.0% of the respondents rated their involvement as being very regular and 66.7% had ever referred pupils for medical care. Majority (81.1%) counseled parents on various means of obtaining health care services and 86.4% had ever brought a child's health condition to parents or school authority. Majority (75.5%) of the teachers taught health education. Among the 199 who did not teach health education, the main reason given for this by many (54.6%) was that health education was not included in their curriculum (Table 2). More of the teachers aged 40 years and above (89.3%) than those 39 years and below (85.6%) had ever been involved in health inspection of pupils (p=0.08) (Table 3). A higher proportion of the female teachers (88.9%) had ever been involved in health inspection of pupils compared to male teachers (84.0%) (p<0.09). There was no significant association between location (rural-urban) and involvement in health inspection (Table 3).

Table 2:
Distribution of teachers by their involvement in the SHP

Variable N = 811)	Frequency	%
Ever been involved with inspection of pupils		
Never	98	12.1
Once	17	2.1
Occasionally	73	9.0
Frequently	242	29.8
Very regularly	381	47.0
Ever referred a child for medical care		
Yes	541	66.7
No	229	28.2
Not sure	41	5.1
Ever counseled parents on various means of obtaining health care services		
Yes	658	81.1
No	105	12.9
Not sure	48	5.9
Ever brought a child's health condition to attention of parents or school authority		
Yes	701	86.4
No	74	9.1
Not sure	36	4.4
Teach health education		
Yes	612	75.5
No	199	24.5
Main Reason for not teaching health education		
Not included in curriculum	106	53.3
Not my area of specialty	39	19.5
Only for health education teachers	39	19.5
Not teachers' role	6	3.1
Not important	4	2.1
No response	5	2.5
Provision of assistance during pre-entrance medical examination		
Never	433	53.4
Regularly	145	17.9
Sometimes	233	28.7

Table 4 shows the association between teachers' qualifications, training in the SHP, and involvement in health inspection of pupils. Significant relationship was observed between having a NCE certificate, salary grade level, years of teaching experience, previous formal training in SHP and teaching of health education, and health inspection of pupils. A significantly higher proportion (88.8%) of teachers who acquired NCE were involved in health inspection of pupils compared to those who did not have NCE (80.2%) (p=0.021). A significantly higher proportion (90.9%) of those with 21 years of experience in teaching service were involved in health inspection of pupils compared with 85.8% of those with less than 21 years of teaching experience (p=0.03). A significantly higher proportion (91.7%) of teachers who had ever had formal training in SHP compared with 86.4% of those who had never been trained in SHP (p=0.04) were involved in health inspection of pupils. Similarly, those who taught health education as a subject (92.3%) were involved in health inspection of pupils compared with those who did not (74.4%) (p<0.001).

Table 3:
Association between teachers' socio-demographics and involvement in health inspection of pupils

Socio-demographic characteristics	Involvement in health inspection of pupils		X^2	*p*
	Never n (%)	Ever n (%)		
Location				
Rural	40 (10.3)	347 (89.7)		
Urban	58 (13.7)	366 (86.3)	2.13	0.15
Age group				
39 and below	39 (15.0)	221 (85.0)		
40 and above	59 (10.7)	492 (89.3)	3.06	0.08
Sex				
Male	25 (16.0)	131 (84.0)		
Female	73 (11.1)	582 (88.9)	2.83	0.09
Religion				
Christianity	63 (10.9)	517 (89.1)		
Islam	35 (15.2)	196 (84.8)	2.86	0.09
Marital status				
Not currently married	10 (13.0)	67 (87.0)	0.065	0.80
Currently married	88 (12.0)	646 (88.0)		
Ethnicity				
Yoruba	94 (12.0)	689 (88.0)		
Others	4 (14.3)	24 (85.7)	0.13	0.72

Tables 5 and 6 show the association between teachers' characteristics and their level of involvement in the SHP. A higher proportion (78.6%) of teachers having NCE were frequently involved in the SHP compared with 61.6% of those without NCE (p=0.002). A greater proportion (82.2%) of those that taught health education as a subject compared with 60.3% of those who did not were frequently involved in the SHP (p<0.001). Similarly, more (85.3%) of those who reported they were trained on-the-job than those trained during their training years (73.6%) were frequently involved (p=0.026)

DISCUSSION

This study was conducted to assess teachers' training and involvement in the SHP in public primary schools in Oyo State, South-west Nigeria.

Findings from this study showed that the proportion of teachers ever trained in the SHP and its components (SHI, SHE and SHS), were generally low. This finding may partly account for the previous reports where poor role perception and inadequate knowledge of the SHP were observed among teachers in the study area (Adebayo & Onadeko, 2015, Adebayo & Onadeko, 2016).

Table 4:
Association between teachers' qualifications, salary grade, years of teaching experience, training in SHP, and involvement in health inspection of pupils

Variables	Involvement in health inspection of pupils		X^2	*p*
	Never n (%)	Ever n (%)		
Grade 2				
Yes	62 (11.2)	490 (88.8)		
No	36 (13.9)	223 (86.1)	1.18	0.28
Diploma in education	10 (12.30	71 (17.3)		
Yes	88 (10.8)	642 (87.9)	0.14	0.93
No				
National certificate in education				
Yes	81 (11.2)	644 (88.8)		
No	17 (19.8)	69 (80.2)	5.35	**).02***
B.ED/Sc (ed)/A(ed)				
Yes	22 (14.9)	126 (85.1)		
No	76 (11.5)	587 (88.5)	0.25	0.16
PGDE/Masters/PhD			Fisher's	
Yes	0 (0.0)	16 (100.0)	exact	
No	98 (12.3)	697 (87.7)	test	0.13
Number of qualification				
One	32 (13.5)	205 (86.5)		
2 and above	66 (11.5)	508 (88.5)	0.63	0.43
Salary grade				
5-9	51 (15.0)	288 (85.0)		
10-14	47 (10.0)	423 (90.0)	4.71	**0.03***
Year of experience				
20 years and below	68 (14.2)	411 (85.8)		
21 years and above	30 (9.1)	300 (90.9)	4.78	**).03***
Ever heard of SHP				
Yes	75 (11.8)	558 (88.2)		
No	23 (12.9)	155 (87.1)	0.15	0.7
Had formal training in SHP				
Yes	19 (8.3)	209 (91.7)		
No	79 (13.6)	504 (86.4)	4.2	**).04***
SHS				
Yes	9 (6.5)	129 (93.5)		
No	89 (13.2)	584 (86.8)	7.5	0.06
SHI				
Yes	13 (7.5)	160 (92.5)		
No	85 (13.2)	553 (86.7)	5.9	0.11
SHE				
Yes	8 (6.8)	109 (93.2)		
No	90 (13.0))	604 (87.0)	5.2	0.16
Nature of training				
On the job	7 (6.9)	95 (93.1)		
During training years	11 (9.1)	110 (90.9)	4.8	0.089
Teach health education				
Yes	47 (7.7)	565 (92.3)		
No	51 (25.6)	148 (74.4)	45.5	**<0.001***

*Statistically significant p<0.05

The claim 'never to have been trained in SHP' was below expectation considering the fact that the curriculum of teachers' training has an aspect which consists of SHP and its components. Teachers may have access to training in the SHP either during their training years in school or on-the-job. The challenges of exposure in the different colleges of education might be due to neglect or the course not being adequately taught. In Pakistan, training of teachers on thematic areas of SHP was reported to be limited in scope and coverage but it was due to financial constraints and its non-institutionalization (Ministry of Education/UNESCO, 2010). Making the subject elective or limited to those in the sciences alone could also explain the reason for lack of or inadequate exposure. Sub-optimal exposure in the SHP will cause ineffective implementation.

The effective implementation of SHP is vital for the achievement of Health for All (HFA) declaration; education and health related sustainable development goals. An effective SHP can be one of the most cost-effective investments a nation can make to simultaneously improve education and health as the health of young people is strongly linked to their academic success and vice versa. Apart from the opportunity for on-the-job training in the SHP which only few teachers will have access, the programme should be made compulsory for teachers' education at the tertiary level just as use of English is compulsory in most colleges.

The findings of the study also revealed that a high proportion of respondents referred pupils to medical officers or school administrators for health challenges. Medical referrals help in fast-tracking medical intervention for pupils with critical conditions, reduce pupils' absenteeism from school due to childhood illnesses and prevent other pupils from contracting infectious diseases. The fact that most teachers were not trained in first aid procedures as reported in a study on status of implementation of SHP in secondary schools in South Western Nigeria (Ademokun et al, 2014) could also contribute to high referral as teachers would not know what to do.

Majority of the teachers were found to have counseled parents on means of accessing health care services. This could have been as a result of higher educational status of teachers which has positioned them to have higher knowledge of the need for seeking medical care and the means for accessing them. Several health issues occur in pupils during out of school sessions where teachers may not be present to offer any medical directive to the parents hence, instructions received from teachers will assist parents to make informed decision on where to seek appropriate health services for their wards whenever the need arises.

A few non-health education teachers were observed in this study. This was due to affirmed responses of many of the teachers that health education was not included in their teaching curriculum. Some of the teachers reported teaching health education was not their specialty and had the belief that teaching health related issues is the exclusive responsibility of health education teachers. There is no basis for any primary school teachers not to teach health education as it is clearly outlined in the primary school syllabus. This may be a disadvantage to the pupils as they may not be privileged to acquire knowledge and imbibe principles of health education if teachers fail to teach health education. In France, health education is not the exclusive prerogative of a particular category of teachers; it involves all those involved in education (Jourdan, 2011). Teaching health related subjects like the SHP should be demanded from every primary school teacher irrespective of his/her activities or subject areas. There was a significant association between teachers who had formal

training in the SHP and involvement in health inspection of pupils. This may be due to the fact that teachers who had formal SHP training were designated by school administrators as health inspectors of pupils. Training of all teachers in the SHP might increase their involvement in school health related activities. A study among primary school teachers showed that previous training has a significant impact on the implementation of a school health education project (Jourdan, 2009).

A significant association was observed between teaching of health education and ever been involved in health inspection of pupils. Teaching health education opens up greater opportunities for teachers to access more educative information about school health and hygiene practices. The teaching of health education will help teachers to have evidence-based contribution to activities of the SHP which in turn will add health benefits to the schools. This is expected because in most schools, health inspection is usually done by the health education teachers. Studies have shown positive association between type/level of education and preventive actions in the school settings and the close link between education and health (St. Leger & Nutbeam, 2000; INSERM, 2003).

This study also revealed an association between teaching of health education as a subject and levels of involvement in health inspection of pupils. Teaching health education provides an avenue for teachers to taking initiative for implementing SHP in schools. To have all teachers teach health education is to create a situation in the school whereby there will be availability of personnel who can be engaged for school health activities or act in almost similar roles performed by teachers who have had formal training in SHP. Classroom teachers, with their specific knowledge of students, can deliver health knowledge and skills through student centered teaching, respond to specific needs and create the caring relationships that underpin school connectedness and indigenous students' well-being (St Leger, 2006; Dobia & O' Rouke, 2011).

Table 5:
Association between socio-demographic characteristics and level of teachers' involvement in health inspection of pupils

Socio-demographic characteristics	Level of Involvement in health inspection of pupils			X^2	p-value
	Never n (%)	Not frequently n (%)	Frequently n		
Location					
Rural	40 (10.3)	41 (10.6)	306 (79.1)		
Urban	58 (13.7)	49 (11.6)	317 (74.8)	2.53	0.28
Age group					
39 and below	39 (15.0)	30 (11.5)	191 (73.5)		
40 and above	59 (10.7)	60 (10.9)	432 (78.4)	3.32	0.19
Sex					
Male	25 (16.0)	18 (11.5)	113 (72.4)		
Female	73 (11.1)	72 (11.0)	510 (77.9)	3.00	0.22
Religion					
Christianity	63 (10.9)	63 (10.9)	454 (78.3)		
Islam	35 (15.2)	27 (11.7)	169 (73.2)	5.74	0.06
Marital status					
Not currently married	10 (13.0)	11 (14.3)	56 (72.7)		
Married	88 (12.0)	79 (10.8)	567 (77.2)	1.02	0.60
Ethnicity					
Yoruba	94 (12.0)	83 (10.6)	606 (77.4)	Fisher's	
Others	4 (14.3)	7 (25.0)	17 (60.7)	exact test	**0.046***
Grade 2					
Yes	62 (11.2)	60 (10.9)	430 (77.9)		
No	36 (13.9)	30 (11.6)	193 (74.5)	1.38	0.50
Diploma education					
Yes	10 (12.30	14 (17.3)	57 (70.4)		
No	88 (12.1)	76 (10.4)	566 (77.5)	3.88	0.42
National certificate in education					
Yes	81 (11.2)	74 (10.2)	570 (78.6)		
No	17 (19.8)	16 (18.6)	53 (61.6)	12.5	**0.002***
B.ED/Sc (ed)/A(ed)					
Yes	22 (14.9)	18 (12.2)	108 (73.0)		
No	76 (11.5)	72 (10.9)	515 (77.7)	1.69	0.43
PGDE/Masters/PHD					
Yes	0 (0.0)	0 (0.0)	16 (100.0)	Fisher's	
No	98 (12.3)	90 (11.3)	623 (76.4)	exact test	0.085

*Statistically significant $p<0.05$

Table 6:
Association between teachers' qualifications, years of teaching experience and training in SHP, and level of involvement in health inspection of pupils

Socio-demographic characteristics	Level of involvement in health inspection of pupils			X^2	p-value
	Never n (%)	Not frequent n (%)	Frequent n (%)		
Number of qualification					
At least one	32 (13.5)	28 (11.8)	177 (74.7)		
2 and above	66 (11.5)	62 (10.8	446 (77.7)	0.91	0.63
Years of experience					
20 and below	68 (14.2)	49 (10.2)	362 (75.6)		
21 and above	30 (9.1)	41 (12.4)	259 (78.5)	5.27	0.07
Ever heard of SHP					
Yes	75 (11.8)	72 (11.4)	486 (76.8)		
No	23 (12.9)	18 (10.1)	137 (77.0)	0.33	0.85
Had formal training in SHP					
Yes	19 (8.3)	30 (13.2)	179 (78.5)		
No	79 (13.6)	60 (10.3	444 (76.2)	5.02	0.08
SHS					
Yes	9 (6.5)	22 (15.9)	107 (77.5)		
No	89 (13.2)	68 (10.1)	516 (76.7)	10.8	0.09
SHI					
Yes	13 (7.5)	24 (13.9)	136 (78.6)		
No	85 (13.3)	66 (10.3)	487 (76.3)	8.9	0.18
SHE					
Yes	8 (6.8)	14 (12.0)	95 (81.2)		
No	90 (13.0)	76 (11.0)	528 (76.1)	6.5	0.37
Taught health education					
Yes	47 (7.7)	62 (10.1)	503 (82.2)		
No	51 (25.6)	28 (14.1)	120 (60.3)	51.5	**<0.001***
Nature of training					
On the job	7 (6.9)	8 (7.8)	87 (85.3)	Fisher's	
During training years	11 (9.1)	21 (17.4)	89 (73.6)	exact test	**0.026***

*Statistically significant, p<0.05

In conclusion, most teachers in the study setting lacked training in the SHP and involvement in the programme was below average. Efforts at building the capacity of teachers through on-the-job training in SHP may be found necessary to improving the current level of implementation in the State. There is also a need to evaluate the curriculum of teachers for the contents of SHP. Training in the SHP should be made compulsory for teachers' education at the tertiary level.

Teachers who are at the core of SHP implementation have not been adequately trained in the SHP. This may have implications on the effective implementation of this health promoting and cost-effective programme. The findings have reflected that the National School Health Policy has not been adequately implemented especially in the area of capacity building for teachers who are key stakeholders in the SHP. A review of the current National School Health Policy guidelines on teachers' training and involvement in the SHP may be necessary

Acknowledgement:
Data analysis and writing of this paper was supported by the University of Ibadan Medical Education Partnership Initiative Junior Faculty Training Programme (UI-MEPI-J) project funded by Fogarty International Center, National Institute of Health under Award Number D43TW010140. The content is solely the responsibility of the authors and does not necessarily represent the official views of the funding organizations.

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