

# Appraisal Of School Health Programme as A Potential Predictor of The Health Status of Children Aged 6–12 Years in Rural Public Primary Schools in Imo State Nigeria

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**Abstract-** *The School Health Programme (SHP) is crucial for promoting the health and well-being of school children, yet its implementation remained inadequate. This study appraised the SHP as a potential predictor of health status of children aged 6-12 years attending rural primary schools in Owerri-West Local Government Area (LGA) of Imo State, Nigeria. The study employed a descriptive cross-sectional design. Data were collected using observational checklist and interview guide based on the National School Health Policy. Seven rural public primary schools, from six randomly selected communities, representing approximately 30% of all communities in the LGA were studied. Data on schools' performance were analyzed using descriptive statistics such as frequencies, percentages, and mean percentage scores (MPS), for selected characteristics of the components of SHP. Results on performance based on MPS revealed that the schools performed excellently (73.8%) in only Skill-Based Health Education component. Performance on School, Home and Community Relationships component was fair with MPS of 45.2%. Performance on the rest components was rated poor, with School Health Services scoring 31.0%, and Healthful School Environment had 23.8%, while School Feeding Services had the lowest MPS of 5.4%. The implementation of SHP in rural public primary schools in Owerri-West LGA, Imo State was highly unsatisfactory. This situation predicted unfavourable health status for the target population studied, who were underserved with health care and depended largely on SHP for easy access to health promotion and disease prevention services, and even some level of emergency health care. Urgent government intervention in SHP was recommended to safeguard the*

*health and educational development of these vulnerable school children.*

**Index Terms-** *School Health Programme, health status, public primary schools, Nigeria*

## I. INTRODUCTION

Promoting the health of learners in schools is a critical step towards achieving a desirable quality learning outcomes in education which is attainable with improved opportunities and access to quality healthcare. The World Health Organization (WHO) affirms that promoting health of school children is a fundamental pathway to the prevention of several childhood infections and illnesses (WHO, 2022). Therefore, promoting school health would transmit relevant values and health information to families, friends, neighbours and the community-at-large. Operational School Health Programme (SHP) at the primary education level is strategic to ensuring constant strengthening of a healthy setting for living, learning, working and other aspects of life (WHO 2002). Children undergoing primary education require optimum health at all times in order to attain their physical and intellectual potentials, as well as to receive maximal moral and emotional benefits from their teachers, the school environment and the healthcare providers (Web et al., 2023; Nurture & Nature, 2025).

Generally, SHP represents a set of planned sequential strategies, and activities aimed to promote the optimum social, emotional, physical, mental, nutritional and educational development of the school children (WHO/UNESCO 2021). SHP should in addition to providing health benefits also promote child friendly school environment, which is an important foundational support for a child's development (Allensworth, Lawson, Nicholson & Wyche, 2009; Pulimeno et al., 2020). Melendez (2026), stated that a well-coordinated school health programme should embrace up to eight components that incorporate; health education, physical education, health and medical services, nutrition, psychological and social services, positive healthy school environment, health promotion, and family and community involvement. Nevertheless, Nigeria has a National School Health Policy that stipulates the components of School Health Programme (SHP) and the mechanism of implementation in the country.

The current Nigerian National School Health Policy was endorsed in the year 2006, with the aim of promoting the health of learners, for the realization of the goals of Education For All (EFA) (FMOE, 2006). The National School Health Policy guides the implementation of SHP in the country. School Health Programme in the context of this policy refers to the series of harmonized projects and activities in the school environment carried out to promote the health and development of the school community, comprising learners and personnel. The scope of SHP as contained in the policy covers; Healthful School Environment, School Feeding Services, Skills-Based Health Education, School Health Services, and School, Home and Community Relationships.

Some challenges in the implementation of SHP in some parts of the country had been documented, such as poor funding, inadequate infrastructure, shortage of trained personnel, lack of political will on the part of government, lack of inter-sectorial collaboration, poor community involvement, and low awareness of the National School Health Policy (NSHP) among teachers (Alafin et al., 2019; Dania & Adebayo, 2019; Sanni et al., 2022). This situation created great concern as to the health status of public primary school children, particularly age 6-12 years who are underserved by the existing government health

programmes in the country, when compared with under-fives and adolescents. SHP hence, becomes the available option for their routine health appraisal and care. Regrettably, SHP attracted negligible attention from stakeholders in Nigeria, leaving many school children vulnerable to preventable health conditions such as malaria, malnutrition, and poor vision among others, with associated high rates of school absenteeism and related poor academic performance (Ezeonu, et al., 2022; HFN, 2025; Halliday et al., 2020).

This study appraised the SHP as a potential predictor of health status of children aged 6-12 years in selected primary schools in Owerri-West Local Government area (LGA) of Imo State, Nigeria. It identified gaps in the implementation of School Health Programme (SHP), which would likely have adverse consequences on the health status of the targeted children. It is hoped that the findings of this study would create the needed awareness on the status of SHP implementation, and also serve as call for paradigm shift in the implementation if the desired target must be achieved.

#### Objectives

The aim of this study was to appraise the School Health Programme (SHP) as potential predictor of health status of school children aged 6–12 years in rural public primary schools in Owerri-West LGA, Imo State Nigeria. Specifically, the study appraised the different components of SHP as stipulated in the National School Health Policy which are; Healthful School Environment, School Feeding Services, Skills-Based Health Education, School Health Services, and School, Home and Community Relationships.

## II. METHODOLOGY

The design of study was descriptive cross-sectional design, and the location of the study was Owerri-West LGA, which is one of the 27 LGAs in Imo state Nigeria. Rural public primary schools were targeted, and seven of such schools from six communities (constituting 30% of the 21 communities in the LGA) participated in the study. Communities were selected by simple random sampling technique, and the schools were; Primary School Irette, Community

Unity School Ihiagwa, Community Unity School Orogwe, Primary School Avu, Development Primary School Umuguma, Primary School Ohii and Community School Ohii. This study was conducted between August 2025 and January 2026. Approval and permission for the study were sought and obtained from relevant government authorities and stakeholders. The study assessed the availability of required infrastructures, items and services, as well as their adequacy and functionality. Observational checklist and interview guide developed by the researchers were used for data collection. School personnel and pupils were interviewed accordingly, while observations were recorded on the checklist. The assessment was based on stipulations in the National School Health Policy, covering the stated scope of SHP.

Data analysis was performed using statistical descriptive techniques in IBM SPSS statistics version 29. Score was awarded to each characteristic, computed as frequencies and percentages and summed up as grades for each SHP component as mean performance score and mean percentage score (MPS) for the schools. Mean percentage score of 0-39 was described as poor performance, 40-59 was fair performance, and 60-69 was good performance, while 70-100 was excellent performance. Results were presented on tables.

Ethical approval was obtained from Ethics Committee of the Federal University of Technology Owerri, as well as from the State Ministry of Health. Permission was gotten from the State Ministry of Education, the Imo State Universal Basic Education Board (IMSUBEB), the Chairman of Owerri-West LGA, and Head Teacher of the different schools consented. Respondents gave informed consent for voluntary participation, while confidentiality promised to respondents was kept. The study posed no risks to the pupils and personnel in the schools.

### III. RESULTS

School Health Programme (SHP) was appraised in seven (7) schools in Owerri-West LGA. The distribution of pupils' enrollment by school and gender was presented in Table 1. School enrolment ranged from 68 to 136 pupils with overall total of

691, comprising male 360 (52.1%) and female 331(47.9%). The ratio of male pupils to female pupils was 3:1 and the mean of pupil school enrolment was 99 (male 52 and female 47).

Table 1: Distribution of pupils' enrollment by school and gender

S/N	School	Male (%)	Female (%)	Total (%)
1.	Primary School Irete	57 (57.0%)	43 (43%)	100 (14.5%)
2.	Community Unity School Ihiagwa	50 (52.1%)	46 (47.9%)	96 (13.9%)
3.	Community Unity School Orogwe	47 (52.8%)	42 (47.2%)	89 (12.9%)
4.	Primary School Avu	32 (47.1%)	36 (52.9%)	68 (9.8%)
5.	Development Primary School Umuguma	40 (54.8%)	33 (45.2%)	73 (10.6%)
6.	Primary School Ohii	62 (48.1%)	67 (51.9%)	129 (18.7%)
7.	Community School Ohii	72 (52.9%)	64 (47.1%)	136 (19.7%)
	Overall Total	360 (52.1%)	331 (47.9%)	691 (100%)
Ratio males to females =3:1				
Mean of pupil school enrolment = 99				

#### Healthful School Environment

Table 2, showed the result of appraisal on Healthful School Environment based on the characteristics studied. All schools (100%) had playground and playing materials for the pupils. Most schools (5, 71.4%) had properly spaced and well ventilated classrooms. Other characteristics of this component were neither not in any school or found in one or two schools. Only 2 schools (28.6%) had fenced premises, though none had functional gate. In the school with gate, the front gate was permanently locked while no gate was fixed in the space created for the second gate. Similarly, only 28.6% of the schools had clean school premises without being surrounded by over grown bushes. Sanitary materials such as tissue paper, wash hand basin, running water, and soap/hand sanitizer were not available in 6 schools (85.7%). There were no safe and clean water except in one school, no adequate functional sanitary

facilities except in one school, no proper waste management except in one school (14.3%) where waste baskets were positioned, no adequate drainage system and no regular power supply. Only one school (14.3%) had enough waste disposal bins. Evidence of dilapidation of buildings including broken walls, broken floors, broken roof and ceiling were observed in 4 out of the 7 schools. Mean performance score was 3.57 and mean percentage score was 23.8% indicating poor performance on this component.

Table 2: Distribution of schools by characteristics of Healthful School Environment

Characteristics	Available		Functional	
	Yes Freq. (%)	No Freq. (%)	Yes Freq. (%)	No Freq. (%)
School premises fenced with entrance and exit gates	2 (28.6)	5 (71.4)	0	7
Clean School premises without bushes	2 (28.6)	5 (71.4)	N/A	N/A
Safe and clean water	1 (14.3)	6 (85.7)	1	6
Sanitary facilities (toilet)	1 (14.3)	6 (85.7)	1	6
Sanitary materials (e.g. tissue paper, wash hand basin, running water, soap/ hand sanitizer)	1 (14.3)	6 (85.7)	1	7
Waste disposal Bin	1 (14.3)	6 (85.7)	1	6
Proper waste management	0 (0.0)	7 (100)	0	7
Properly spaced and well ventilated classrooms	5 (71.4)	2 (28.6)	5	2
Playground and playing materials	7 (100)	0 (0)	7	0
School premises fumigated against pest and vectors	2 (28.6)	5 (71.4)	N/A	N/A
Drainage system in the school premises	0 (0.0)	7 (100)	0	7
Drainage system covered	0 (0.0)	7 (100)	0	7
Fire extinguisher and/or sand buckets	1 (14.3)	6 (85.7)	1	6

Well-lit classrooms	2 (28.6)	5 (71.4)	7	0
Regular power supply	0 (0.0)	7 (100)	0	7
Mean Performance Score = 3.57				
Mean Percentage Score = 23.8%				

### Skill-Based Health Education

Table 3 showed the result on the Skill-Based Health Education component. All the schools (100%) taught relevant health education topics (hygiene, nutrition, reproductive health, drug/substance, etc.) appropriate the pupils' level. Also, all the schools encouraged pupils' participation by giving them opportunity to ask questions and proffer responses during discussions. Most of the schools (6, 85.7%) conducted regular health education classes, and 5 schools (71.4%) had trained health education teachers. Health education materials (posters & IEC materials) were available in 3 (42.9%) schools, and similarly the teachers in 3 (42.9%) schools regularly updated themselves with modern concept of health education. The Mean performance score for Skill-Based Health Education component was 4.43 and Mean percentage score was 73.8%, indicating excellent performance.

Table 3: Distribution of schools by characteristics of Skill-Based Health Education

Characteristics	Available		Functional	
	Yes Freq. (%)	No Freq. (%)	Yes Freq. (%)	No Freq. (%)
Regular health education classes	6 (85.7)	1 (14.3)	6	1
Trained Health Education Teachers	5 (71.4)	2 (28.6)	5	2
Teaching of relevant health education topics (hygiene, nutrition, reproductive health, drug/substance, etc.)	7 (100)	0 (0.0)	7	0
Health education materials (e.g. posters & other IEC materials)	3 (42.9)	4 (57.1)	3	4
Learners encouraged to ask questions and participate in discussion	7 (100)	0 (0.0)	7	0

Teachers regularly updated themselves with modern concept of health education	3 (42.9)	4 (57.1)	3	4
Mean Performance Score	4.43			
Mean Percentage Score	73.8%			

#### School Health Services

The result of schools' performance on School Health Services component was presented on Table 4. None of the schools had a health clinic or sick bay for rendering healthcare services to the pupils. Equally, none of the schools had trained healthcare personnel. Six (85.7%) schools had first aid box, but only two (28.6%) of the first aid boxes had some basic supplies. Unfortunately, none of the first aid boxes was functional. Health appraisal of pupils at enrollment into school was not carried out in any of the schools; however, 4 (51.1%) schools demand medical report gotten from public health facility, from learners at enrollment into school. None of the schools maintained health records of learners in the school. One school (14.3%) offered minimal emergency health care, but no form of referral was practiced in any of the schools. The Mean performance score for School Health Services component was 1.44 and Mean percentage score was 20.59%, indicating poor performance.

Table 4: Distribution of schools by characteristics of School Health Services

Characteristics	Available		Functional	
	Yes Freq. (%)	No Freq. (%)	Yes Freq. (%)	No Freq. (%)
Health clinic/sick bay	0 (0.0)	7 (100)	0	7
Trained healthcare personnel (doctors, nurses, pharmacists, etc.)	0 (0.0)	7 (100)	0	7
First aid box	6 (85.7)	1 (14.3)	0	7
First aid box contain basic first aid supplies	2 (28.6)	5 (71.4)	0	7
Health appraisal of learners carried out in the school at enrollment into school	0 (0.0)	7 (100)	0	7
Demand medical report of learners gotten from public health facility at enrollment into school	4 (51.1)	3 (42.9)	4	3

Health records of learners maintained in the school	0 (0.0)	7 (100)	0	7
Any form of emergency health care offered in the school	1 (14.3)	6 (85.7)	1	6
Health referral carried out in the school	0 (0.0)	7 (100)	0	7
Mean Performance Score	1.44			
Mean Percentage Score	20.57%			

#### School Feeding Services

Result of School Feeding Services was presented on Table 5. Three schools (3, 42.9%) encouraged their pupils to practice good hygiene during meals. None of the schools had any form of school meals provided for learners, hence, all the other characteristics of this component studied, such as; the adequacy of nutritional contents of meals consumed by the pupils, screening for food handlers, training on food safety and hygiene practices and provision for safe food storage facilities were not available in the schools. Schools Mean performance score for this component was 0.43, while the Mean percentage score was 5.4%, depicting this component as the most poorly performed component when compared with the rest.

Table 5: Distribution of schools by characteristics of School Feeding Services

Characteristics	Available		Functional	
	Yes Freq. (%)	No Freq. (%)	Yes Freq. (%)	No Freq. (%)
Provision of school meals for learners	0 (0.0)	7 (100)	0	7
School meals contain required nutrients	0 (0.0)	7 (100)	0	7
Food handlers screened for infectious diseases before engagement	0 (0.0)	7 (100)	0	7
Food handlers trained on food safety and hygiene practices	0 (0.0)	7 (100)	0	7
Safe food storage facilities	0 (0.0)	7 (100)	0	7
Access to clean water for washing of hands before and after eating	0 (0.0)	7 (100)	0	7

Learners encouraged to practice good hygiene during meals	3 (42.9)	4 (57.1)	3	4
Students regularly dewormed (at 3 months interval)	0 (0.0)	7 (100)	0	7
Mean Performance Score	0.43			
Mean Percentage Score	5.4%			

#### School, Home and Community Relationship

The result of the schools' performance on School Home and Community Relationship component was presented on Table 6. In all the schools, parents/guardians were regularly informed of their child's health and well-being while they were in school. Regular parents and Teachers Association meeting were held in 4 (57.1%) schools. In 3 (42.9%) schools parents/guardians pay regular visits to the school to check on their children/wards. Similarly, 3 (42.9%) schools partner with key community leaders in ensuring healthful school environment. Participation of parents and guardians in School Health Programme, and school having interest in health needs of the community were reported in one school for each characteristic. School Mean performance score for this component was 2.71, while the Mean percentage score was 45.2%, an indication of fair performance.

Table 6: Distribution of schools by characteristics of School, Home and Community Relationship

Characteristics	Available		Functional	
	Yes Freq. (%)	No Freq. (%)	Yes Freq. (%)	No Freq. (%)
Parents/ guardians regularly informed of their child's health and well-being while in school	7 (100)	0 (0.0)	7	0
Parents and guardians participate in School Health Programme	1(14.3)	6(85.7)	0	6
School partners with key community leaders in ensuring healthful school environment	3 (42.9)	4 (57.1)	3	4
Regular meetings of parents/guardians, community and school management	4(57.1)	3(42.9)	4	3

School has interest in the health needs of the community	1(14.3)	6(85.7)	1	6
Parents/ guardians pay regular visits to the school to check on their children/wards	3(42.9%)	4 (57.1%)	3	4
Mean Performance Score	2.71			
Mean Percentage Score	45.2%			

#### General Performance Rating of the Schools

The schools performed excellently in only one component (20%) out of the 5 components studied, had fair performance in one component (20%) out of the 5 components, and performed poorly in the rest 3 components (60%). General performance was therefore rated as poor.

#### IV. DISCUSSION

##### Healthful School Environment

The schools performed poorly on this component (MPS=23.8%), as most characteristics of healthful school environment were either nonexistent or performed at a low rate. Most of the schools had no perimeter fencing exposing the children to various hazards. Pupils were likely to face the risk of being abducted by criminals, particularly with the current high rate of kidnapping and similar vices in the society. Pupils could as well be knocked down by moving vehicles when they stray out of the school premises, facilitated by the porous school environment.

Inadequate or lack of the characteristics of healthful school environment were also exemplified by dilapidated buildings (broken walls, broken floors and roofs), lack of sanitary facilities, poor waste disposal system, lack of adequate safe water supply, over grown bushes surrounding the classrooms, predicted unfavourable health consequences for these children. The learners were children aged 6-12 years in basic 1 to basic 6 (primary 1- primary 6) classes. They were young and susceptible to diseases associated with poor and unhealthy school environment such as lower respiratory tract infections, malaria, diarrhea diseases and injuries (Kurt & Serdaroglu, 2024; World Health

Organization, 2022; Eighbobo et al., 2014). These findings corroborated with some earlier studies (Alafin et al., 2019; Asiabaka & Mbakwem, 2008). The children were equally exposed to bites from poisonous insects and reptiles from the surrounding over grown bushes.

On the positive side, there were playground and playing materials in all the schools, which would motivate and facilitate different forms of games and physical exercises that promoted social, mental, and physical health resulting in general wellbeing of the pupils.

#### Skill-Based Health Education

Relevant health education topics were taught in all the schools and learners were encouraged to participate in health discussion. This approach would increase health knowledge, attitudes and practice. This aligns with the assumption that knowledge leads to positive attitude that results in healthy practices. However, there was dearth of health education materials and trained health education teachers in some schools which raised concern on the quality of teaching and learning as it relates to skill-based health education in those schools. The absence of trained teachers created doubt on effective coverage of the topics and methods of content delivery that would meet the needs and interests of the learners. Skill-Based Health Education if effectively implemented should prepare the learners to deal with risky behaviours that could affect their health and well-being.

#### School Health Services

The absence of health clinic or sick bay, health personnel of any discipline, or even any form of health visits from government and private Health Department or Units in all the schools suggested that the learners never benefitted from any form of in-school health care (appraisal, screening, emergency treatment or referral). School Health Services was designed to enable school children access healthcare promptly, thereby reducing delays that would impact negatively on their health and education. Health conditions that could have been detected early from health appraisal, and promptly managed, might progress and worsen even before diagnosis would be made. The consequence would be; manageable

conditions becoming life-altering crises that could result in physical, psychological, emotional and financial stress. This finding was slightly similar to the result of a study carried out at Federal Capital Territory Nigeria by Sanni et al., (2022), that reported that only 4.7% of the schools had nurses. Another study in Ogun State South West Nigeria reported availability of trained health professionals in 32% of primary schools studied (Kuponiyi, Amoran, & Kuponiyi, 2016). The two studies mentioned above occurred in different states and regions of the country, from this study. The slight difference could come from the level of the different state government's commitment and support to School Health Programme. Likewise, lack of first aid box and its supplies was a possible indication that first aid treatment was not available for the learners leading to delays that could result in complications. This finding was partly in line with the findings by Alafin et al., (2019), where only 28.6% of first aid boxes in schools had some basic first aid supplies.

#### School Feeding Services

School Feeding Services were not being implemented in any of the schools studied. Most of these children did not eat anything from the time they arrived school at about 8am in the morning till when they dismiss from school in the afternoon between 1-2 pm. The essence of School Feeding Services is to provide at least one free adequate meal to the school children to reduce hunger, increase school enrollment, attendance and retention. Inability of the government to sustain the provision of school meal would make the children to stay for many hours without any meal, which would negatively affect their nutritional status, as well as their concentration in class, with adverse consequences on their development. This finding slightly aligns with the findings by Alafin et al., (2019), that reported provision of a free meal for only primary-1 pupils in just 20% of the schools studied. Their study was carried out in a different state and as that time the Federal Government of Nigeria was funding the school feeding programme. The provision of at least one free meal daily for school pupils as stipulated in the SHP seemed to be neglected in Imo State.

#### School, Home and Community Relationship

The schools hold regular parents and teachers meeting where issues concerning the school and pupils were deliberated upon. The school authorities also shared certain information with community leaders. However, parents' visits to the school to discuss their children's performance and progress were rare. Also community participation in the running of school was less than required. Increased community participation in the school programmes would be of benefit to the school. Effective collaboration between the school, home and community would create a whole-child support system that will lead to improved health and better academic achievement. The Mean percentage score of this component (45.2%) corroborated with a recent study in South-West Nigeria that rated School, Home and Community Relationship at 43% (Akinola & Akinnubi, 2025).

#### Strengths and Limitations

This study appraised School Health Programme (SHP) in public primary schools in Owerri-West LGA Imo State Nigeria based National School Health Policy. The study stood out as potential predictor of the health status of the children in public primary schools in Imo State Nigeria. It was the first coordinated study to appraise SHP for health status prediction among 6-12 years in this state. The findings of the study had created awareness on the possible link between SHP and the health status of the target population, and should guide related policies. The limitation of this study would have been the number of schools studied, which might be viewed as small. Nevertheless, the number of selected school did not invalidate the result as they were from randomly selected 30% of the communities in Owerri-West Local Government Area (LGA), which constituted a representative sample size for communities in the LGA.

#### V. CONCLUSION

Implementation of SHP among public primary schools in Owerri-West LGA was generally poor. These learners aged 6-12 years, without alternative health promotion programme targeted or tailored for them by the government, could not take advantage of the benefits of SHP. They were hence at risk of preventable health conditions capable of adversely

affecting their development and wellbeing. The findings of this study showed that the status of School Health Programme (SHP) implementation could be employed to foretell the likely health status of primary school children aged 6-12 years.

It was therefore recommended that data-informed decision be taken by the government and other relevant stake holders to effectively implement and sustain SHP.

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