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M.Sc. HEALTH SERVICES PLANNING AND MANAGEMENT

**ASSESSING THE IMPLEMENTATION AND PRACTICE OF THE SCHOOL HEALTH
PROGRAM IN SOME BASIC SCHOOLS IN THE KWABRE DISTRICT**

BY

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NOVEMBER, 2008

ASSESSING THE IMPLEMENTATION AND PRACTICE OF THE SCHOOL HEALTH PROGRAM IN SOME BASIC SCHOOLS IN THE KWABRE DISTRICT

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES, KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN HEALTH SERVICES PLANNING AND MANGEMENT

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DECLARATION

I hereby declare that except for the reference to other people's works, which have been duly acknowledged, this work is the result of my own original research.

I hereby also declare that, this work has neither in whole nor in part been presented for degree elsewhere.

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DEDICATION

This research is dedicated to God Almighty.

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DEFINITION OF TERMS

| | |
|-----------------------|--|
| PRACTICE | To do something repeatedly in order to improve performance |
| IMPLEMENTATION | Putting something into effect or action |
| IMPLEMENTERS | Persons with the know-how to fulfill an activity (for the purpose of the study, implementers included the GES, the GHS, the Community/parents, the Local Government) |
| BASIC SCHOOLS | Most important or fundamental parts of the literacy training of an individual (Schools considered were the pre-school, primary and the Junior High School) |

ACRONYMS

| | |
|--------|--|
| SHP | School Health Program |
| HPS | Health Promoting Schools |
| GES | Ghana Education Service |
| GHS | Ghana Health Service |
| DDHS | District Director of Health Services |
| DDNS | District Director of Nursing Services |
| KNUST | Kwame Nkrumah University of Science and Technology |
| JHS | Junior High School |
| WHO | World Health Organization |
| EPI | Expanded Programme on Immunization |
| DCE | District Chief Executive |
| HIPC | Highly Indebted Poor Country |
| UNESCO | United Nations Educational, Social and Cultural Organization |
| UNICEF | United Nations Children Education Fund |
| HIV | Human Immuno-deficiency Virus |
| AIDS | Acquired Immune Deficiency Syndrome |
| MDG | Millennium Development Goals |
| CSHP | Coordinated School Health Program |
| CSH | Coordinated School Health |
| SMO | Senior Medical Officer |
| DSMO | District Senior Medical Officer |
| PTA | Parent Teacher Association |
| GoG | Government of Ghana |
| IGF | Internally Generated Funds |
| CDC | Centers for Disease Control and Prevention |
| RCH | Reproductive and Child Health |
| OPD | Out-Patient Department |
| CHPS | Community-Based Health Planning and Services |
| MoH | Ministry of Health |
| USA | United States of America |

| | |
|-------|---|
| DHS | District Health Services |
| EPSDT | Early and Periodic Screening, Diagnosis and Treatment |
| GAPS | Guidelines for Adolescent Preventive Services |
| STDs | Sexually Transmitted Diseases |
| PPS | Probability Proportionate to Size |
| WIFA | Women In Fertile Age |

LIST OF TABLES

| | | PAGE |
|------------|--|-------------|
| Table 3.1 | Study Variables | 21 |
| Table 3.2 | Demographic Data of District | 23 |
| Table 3.3 | Distribution of Health facilities in the district | 24 |
| Table 3.4 | Distribution of Health Services personnel in the district | 24 |
| Table 3.5 | Distribution of Educational facilities | 25 |
| Table 4.1 | Summary of findings of gender characteristics of respondents | 30 |
| Table 4.2 | Length of service at post of respondents (teachers and nurses) | 30 |
| Table 4.3 | Occupation of parents/community members | 31 |
| Table 4.4 | Purpose of the School Health Program | 31 |
| Table 4.5 | Levels of prevention of ill health | 32 |
| Table 4.6 | Ownership of the SHEP | 33 |
| Table 4.7 | Monitoring and Evaluation of SHEP | 33 |
| Table 4.8 | Review and frequency of review | 34 |
| Table 4.9 | Roles of School Health teachers | 36 |
| Table 4.10 | Deworming Exercises | 37 |
| Table 4.11 | Distribution of health facilities accessible to schools | 38 |
| Table 4.12 | Referral Procedure | 40 |
| Table 4.13 | Summary of sanitary facilities | 42 |
| Table 4.14 | Sources of funds and the period of release | 43 |
| Table 4.15 | Awareness and knowledge about SHEP | 45 |
| Table 4.16 | Ability of Parents to meet the health needs of their children | 46 |
| Table 4.17 | Structure of SHEP by key informants | 48 |

LIST OF FIGURES

| | PAGE |
|---|-------------|
| Figure 1.1 Conceptual Framework of the Coordinated School Health Program (CSHP) | 6 |
| Figure 4.1 Reporting on Activities by implementers | 35 |
| Figure 4.2 Cases that are normally screened | 37 |
| Figure 4.3 Frequency of visits and number of schools visited | 39 |
| Figure 4.4 Prevalence of diseases that call for referrals | 40 |

List of Appendices

| | |
|-----------------------|----|
| Sample Questionnaires | 63 |
|-----------------------|----|

TABLE OF CONTENTS

| | |
|--|------|
| DECLARATION..... | iii |
| DEDICATION..... | iv |
| ACKNOWLEDGEMENT..... | v |
| DEFINITION OF TERMS..... | vii |
| ACRONYMS..... | viii |
| LIST OF TABLES..... | x |
| LIST OF FIGURES..... | xi |
| TABLE OF CONTENTS..... | xii |
| ABSTRACT..... | 1 |
| CHAPTER ONE: INTRODUCTION..... | 3 |
| 1.1 BACKGROUND INFORMATION..... | 3 |
| 1.1.1 Window of Hope..... | 4 |
| 1.2 STATEMENT OF THE PROBLEM..... | 5 |
| 1.3 RATIONALE OF THE STUDY..... | 6 |
| 1.4 RESEARCH QUESTIONS..... | 7 |
| 1.5 OBJECTIVES..... | 7 |
| 1.5.1 General Objective..... | 7 |
| 1.5.2 Specific Objectives..... | 8 |
| 1.6 CONCEPTUAL FRAMEWORK..... | 9 |
| 1.6.1 Healthy and Safe School Environment:..... | 9 |
| 1.6.2 Parent and Community Involvement:..... | 10 |
| 1.6.3 Health Services:..... | 10 |
| CHAPTER TWO: LITERATURE REVIEW..... | 11 |
| 2.1 INTRODUCTION..... | 11 |
| 2.2 A COMPREHENSIVE SCHOOL HEALTH APPROACH..... | 11 |
| 2.3 THE KNOWLEDGE, ATTITUDE AND PRACTICES OF IMPLEMENTERS OF THE SCHOOL HEALTH PROGRAM..... | 12 |
| 2.4 HEALTHY AND SAFE ENVIRONMENT..... | 13 |
| 2.5 SOURCES AND EXTENT OF SUPPORT FOR SCHOOL HEALTH PROGRAM..... | 14 |
| 2.6 PARENT AND COMMUNITY INVOLVEMENT..... | 15 |
| CHAPTER THREE: METHODOLOGY..... | 17 |
| 3.1 INTRODUCTION..... | 17 |
| 3.2 STUDY METHODS AND DESIGN..... | 17 |
| 3.2.1 Structured questionnaire interview..... | 17 |
| 3.2.2 Key Informant Interview using a guide/checklist..... | 18 |
| 3.2.3 Personal Observation using guide/checklists..... | 18 |
| 3.3 DATA COLLECTION TECHNIQUES AND TOOLS..... | 18 |
| 3.4 STUDY POPULATION..... | 19 |
| 3.5 STUDY VARIABLES..... | 19 |
| 3.6 PROFILE OF THE STUDY AREA..... | 22 |
| 3.6.1 Geography..... | 22 |
| 3.6.2 Demographic Data..... | 22 |
| 3.6.3 The Socio-Economic Activities..... | 23 |

| | |
|--|----|
| 3.6.4 Distribution of health facilities in the districts..... | 24 |
| 3.6.5 Distribution of Health Services Personnel in the district..... | 24 |
| 3.6.6 Educational Facilities..... | 25 |
| 3.7 Sampling Techniques..... | 25 |
| 3.8 Sampling size..... | 26 |
| 3.9 PRE TESTING..... | 26 |
| 3.10 DATA COLLECTION AND ANALYSIS..... | 26 |
| 3.11 STATISTICAL PACKAGE..... | 27 |
| 3.12 ETHICAL CONSIDERATION..... | 27 |
| 3.13. LIMITATIIONS OF THE STUDY..... | 27 |
| 3.13.1 Respondent Bias..... | 27 |
| 3.13.2 Time Constraint..... | 27 |
| 3.14 ASSUMPTIONS..... | 27 |
| CHAPTER FOUR: RESULTS..... | 29 |
| 4.1 INTRODUCTION..... | 29 |
| 4.2 BACKGROUND INFORMATION..... | 29 |
| 4.3 THE STRUCTURE OF SCHOOL HEALTH PROGRAM (SHEP) IN THE DISTRICT..... | 31 |
| 4.3.1 The purpose and levels of prevention of SHEP in the district..... | 31 |
| 4.3.2 Ownership of the Program in the district..... | 32 |
| 4.3.3 Monitoring and Evaluation of the School Health Program in the district..... | 33 |
| 4.3.4 Review and frequency of review of SHEP in the district..... | 33 |
| 4.3.5 Role definition and reporting of activities among implementers in the district..... | 34 |
| 4.4 THE KNOWLEDGE, ATTITUDES AND PRACTICES OF IMPLEMENTERS (GHS AND GES) OF THE SHEP..... | 35 |
| 4.4.1 The knowledge, attitude and practices of head teachers/teachers (GES)..... | 35 |
| 4.4.2 The availability of First Aid boxes..... | 38 |
| 4.4.3 The knowledge, attitude and practices of community health nurses (GHS)..... | 39 |
| 4.4.4 Referral cases..... | 40 |
| 4.4.5 Collaboration between teachers and nurses..... | 41 |
| 4.4.6 Impact of School Health Program..... | 41 |
| 4.5 THE PHYSICAL ENVIRONMENT OF SCHOOLS THAT PRACTICE THE PROGRAM..... | 41 |
| 4.5.1 Location of schools..... | 41 |
| 4.5.2 Ventilation/lighting of schools..... | 41 |
| 4.5.3 Food Vendors..... | 42 |
| 4.5.4 Sanitary facilities..... | 42 |
| 4.6 SOURCES AND EXTENT OF SUPPORT FOR THE SHEP..... | 43 |
| 4.7 THE ROLES PLAYED BY THE COMMUNITY/PARENTS IN THE IMPLEMENTATION OF THE PROGRAM..... | 44 |
| 4.7.1 The support of parents/community towards the program..... | 45 |
| 4.7.2 The involvement of parents/community in the health affairs of their (school) children..... | 46 |
| 4.8 FEEDBACK FROM KEY INFORMANTS..... | 46 |
| 4.8.1 The purpose of SHEP..... | 46 |
| 4.8.2 Monitoring and evaluation..... | 47 |
| 4.8.3 Reporting on SHEP Activities..... | 47 |

| | |
|---|----|
| 4.8.4 Extent and support for SHEP from the perspective of key informants..... | 47 |
| 4.8.5 Activities of the Environmental Health Officer..... | 48 |
| CHAPTER FIVE: DISCUSSION..... | 49 |
| 5.1 INTRODUCTION..... | 49 |
| 5.2 THE STRUCTURE OF THE SCHOOL HEALTH PROGRAM..... | 49 |
| 5.2.1 Reasons for poor implementation..... | 50 |
| 5.3 THE KNOWLEDGE, ATTITUDES AND PRACTICES OF IMPLEMENTERS OF THE PROGRAM..... | 50 |
| 5.3.1 Health Services..... | 51 |
| 5.4 THE PHYSICAL ENVIRONMENT OF SCHOOLS THAT PRACTICE THE PROGRAM..... | 51 |
| 5.4.1 Location/compound of the school..... | 52 |
| 5.4.2 Food Vendors..... | 52 |
| 5.4.3 Sanitary Facilities..... | 53 |
| 5.5 THE SOURCES AND EXTENT OF SUPPORT FOR THE PROGRAM..... | 54 |
| 5.6 THE ROLES PLAYED BY THE COMMUNITY/PARENTS IN THE IMPLEMENTATION OF THE PROGRAM..... | 55 |
| CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS..... | 56 |
| 6.1 INTRODUCTION..... | 56 |
| 6.2 CONCLUSION..... | 56 |
| 6.2.1 Structure of the School Health Program..... | 56 |
| 6.2.2 The Knowledge, attitude and practices of implementers..... | 57 |
| 6.2.3 The Physical Environment..... | 57 |
| 6.2.4 The sources and extent of support for the School Health program..... | 57 |
| 6.2.5 The role of the Community/parents in the implementation of the program..... | 57 |
| 6.3 RECOMMENDATION..... | 58 |
| 6.3.1 The Ghana Education Service..... | 58 |
| 6.3.2 The Schools..... | 58 |
| 6.3.3 The Ghana Health Service..... | 58 |
| 6.3.4 The Local Government (District Assemblies)..... | 59 |
| 6.3.5 The Community/Parents..... | 59 |
| REFERENCES..... | 61 |
| QUESTIONNAIRES..... | 63 |

ABSTRACT

This was a cross sectional descriptive study of the School Health Program in some basic schools in the Kwabre district. The study was carried out between March and September 2008. The main objective of the study was to assess the implementation and practice of the School Health Program in some basic schools in the Kwabre district.

The district has two (2) hospitals, ten (10) Health Centers, ten (10) maternity homes and four (4) clinics serving the population in the district.

Some of the issues that bothered the implementation and practice of the program, such as the seemingly weak collaboration between the implementers, sponsorship of the program and the health support services for the program, were studied. The study, therefore, sought to describe the structure of the program as practiced in the district, the physical environment of the schools that promote health, the health services and the role of implementers of the program.

The World Health Organization Expanded Program on Immunization (WHO EPI) 30 x 7 cluster survey was used in determining the sample size of the survey. This included 30 basic schools, 30 community health nurses and a total of 210 parents (thus parents of 7 children in each school). This was selected from the eighty-nine (89) communities in the five (5) sub districts.

Structured questionnaires and checklists were used for the data collection. The data were analyzed using Epi info version 3.9.1.

The study revealed the program is poorly funded and implementers are not fully abreast with an in-depth knowledge about the structure of the School health program. The implementation of the program faces a major systemic challenge in the sense that there are no measures to monitor and evaluate the activities of implementers. Also, the study brought to light the fact that the community/parents are unaware of the role they are to play in supporting the implementation of the program.

To improve the implementation and practice of the program, there is the need for a stronger collaboration among the implementers (teachers, nurses and parents) and their roles must be clearly defined. The government must make sure the program is equitably funded among all schools in the district hence the nation at large.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND INFORMATION

Ensuring that children are healthy and able to learn is an indispensable component of an effective education system. This is particularly most relevant to efforts at achieving education for all in the most deprived areas. It is these children who are often the least healthy and malnourished, who have the most to gain from improved health, and who need health related school policies that, when effectively endorsed can lead to better educational outcomes. Health problems interfere with students' ability to come to school, stay in health, or make the most of their opportunity to learn. Schools, even those with limited resources, can do a great deal to improve students' health and thus educational outcomes. (UNESCO, 1998)

Good health increases enrolment, reduces absenteeism and brings more of the poorest and most disadvantaged children, many of which are girls to school. It is for this reason that Health policies in schools, including skilled based health education and the provision of some health services can help promote the overall health, hygiene and nutrition of children are necessary to be implemented to help promote the health of these children. (Cornwell, 2007)

The School Health Program (SHEP) activities are supportive of the Millennium Development Goals, (MDGs), especially those covering universal primary education (MDG 2), promoting gender equality (MDG 3), reducing child mortality (MDG 4) and combating HIV/AIDS, malaria and other infectious diseases (MDG 6).

The Coordinated School Health Program (CSHP) is an "organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff. This program traditionally includes three components: health education, a healthful school environment, and the provision of health services. It was expanded in 1987 to include physical education, nutrition services, counseling services, community and family involvement, and health promotion for faculty. Since students spend a major part of their lives in school, schools are a good place to influence healthful living before harmful habits are established. (Howard-Barr, E. M., 2008)

The CSHP encourages all schools to address their students' health on various levels/classes. The program's mission is to promote wellness, motivate health improvement, and offer educational opportunities for students, families, and community members. By implementing the planned, ongoing services of the CSHP, schools have the ability to improve both education and the health of students and school personnel. (Howard-Barr, E. M., 2008)

School health policies should aim to create a healthy physical and psychosocial environment for all students and staff, and to make the school a model of best practice for the whole community.

To be effective, the School Health Program needs adequate or equitable resources for its implementation. These resources must be available at the national, regional, district and local levels. It must therefore be supported by key stakeholders; for example there should be an established framework of responsibility, policies and action between the key government ministries such as the Health and Education ministries.

1.1.1 Window of Hope

Creating and sustaining a healthy and safe school environment requires the continued commitment and involvement of the school and community to address the ever-changing needs and circumstances affecting our students' health and safety. (Guidelines for the School Health Program, 2005)

Key to making this relationship effective is communication and dialogue among school personnel, parents, businesses, local health officials, and other community groups. The development of a close alliance with these groups can result in powerful coalitions that build strong support for school health programs that address the health related needs of students. (Missisipi Office of Healthy Schools, 2008)

There are a number of ways that the School Health Program can effectively be implemented to build support for quality health education positive to student development including:

- Encouraging parents, families, students, and community members to participate in the decision-making process for the selection of health and safety programs/policies, including involvement in coordinated school health planning and oversight committees (i.e. school health councils).
- Appropriate budgetary allocation to fund the School Health Program.
- Engaging qualified people to provide school children with a balanced diet. (i.e. dieticians focusing on the right food choices).
- Providing resources (in the following areas)
 - Logistics for screening programs
 - Health facilities (such as a school clinics)
 - Sanitary facilities etc.

1.2 STATEMENT OF THE PROBLEM

For the implementation of this program, there is the need for an effective partnership between the health and education sectors, teachers and health workers, schools and community groups and between the pupils and those responsible for implementing school health programs. Some countries in Africa such as Kenya have started addressing this issue by introducing school health policies.

In Pennsylvania, the School Health Program facilitates the healthy growth and development of children of school age. The program serves all children of school age attending public and non-public schools. This program prevents and detects health problems, and maintains and improves the health status of students. School health programs and services impact on the health status and well-being of more than 2.1 million school age children in the Commonwealth's public and non-public schools. Article XIV of the Pennsylvania Public School Code provides that all children attending public, private, and parochial schools receive school health services. (Martin, K.S., Scheet, N., 1992). A policy such as this is likely to go a long way to improve the health of pupils and have a positive impact on their lives in general.

The School Health Program as practiced in India, aims at providing medical examination of school children to identify ailments in them and to provide treatment and referral services. The activities undertaken under the program entail medical examination of all primary school children at least thrice during their primary school (thus from nursery to primary 6) life, treatment for minor ailments on the spot and to provide referral services to the sick children. It is done at two levels, thus, the block level and the district level. At the block level, the Senior Medical Officer (SMO) of the Block is entirely responsible for implementation of the school health program in her/his respective block. At the district level, the District Senior Medical Officer (DSMO) is directly responsible for implementation of school health program in their respective districts. Medical Officers at these levels are responsible for carrying out the medical inspections of the schools falling in their respective sectors. The monthly reports on the prescribed performance are being regularly submitted to the government of India. Monitoring is an essential component in the implementation of the program. The Senior Medical officer ensures to regularly monitor the program at his/her block and sends a detailed report to the DSMO. The DSMO monitors the program and identifies bottlenecks in the smooth implementation of the program and suggests remedial measures accordingly. (Felix, A.K., 2005)

In Ghana, however, the program seems not to receive the needed attention from the policy makers and the implementers hence a seemingly weak implementation and compromise on the comprehensive practice of the program. There seem to be lack of collaboration between the health and education ministries. The program itself is apparently not fully practiced in most schools. There also seem to be a major systemic problem due to the fact that there is no budget line for School Health activities, resulting in a seemingly poor monitoring and evaluation procedures to help ensure the sustainability of the program.

This study, therefore, sought to bring to light how the School Health Program is implemented and practiced in thirty (30) basic schools in the Kwabre District.

1.3 RATIONALE OF THE STUDY

In order to ensure an effective implementation of the School Health Program, there is the need to put in place systems that will ensure the sustenance of a proper management style. A strong intersectoral cooperation and a careful assessment of community health problems and resources

are required to plan, implement, and monitor a sustainable School Health Program.

The School Health Program, as the name implies is a program intended to improve the health of pupils in their school environment and because children spend a lot of time (about 6-9 hours a day) in their schools than at home (about 4-2 hours and the rest of hours for sleep), there is the need for a better school health package that can be sustained in order to realize the dream of having healthy school children.

This study therefore sought to evaluate the effectiveness of the implementation and practice of the School Health Program in some basic schools in the Kwabre District.

1.4 RESEARCH QUESTIONS

- What is the structure/procedure of the School Health Program as practiced in the district?
- What are the knowledge, attitude and practices of the implementers of the program?
- How does the physical environment of the school in promoting the health of the pupils?
- Is there any provision of health services to support the program?
- What roles are played by the community and parents in supporting the program?

1.5 OBJECTIVES

1.5.1 General Objective

The main objective of the study was to assess the practice of the School Health Program to strengthen its implantation and also contribute to its design and implementation.

1.5.2 Specific Objectives

- To describe the structure of the School Health Program as practiced in the district.

- To assess the knowledge, attitudes and practices of implementers of the School Health Program.

- To describe the physical environment of schools that practice the program?

- To determine the sources and the extent of support for the School Health Program.

- To evaluate the roles played by the community and parents in the implementation of the program.

1.6 CONCEPTUAL FRAMEWORK

Fig 1.1 Conceptual Framework of the Coordinated School Health Program (CSHP)



Source: UNESCO. Department of State Health Services (Coordinated School Health Program, CSHP)

The Coordinated School Health Program (CHS) consists of eight health-related areas: Health Education, Healthy and Safe School environment, Counseling and Mental health services, Parent and Community Involvement, Staff Wellness Promotion, Health Services, Physical Education and Nutrition Services, covering all aspects of the school environment that are linked together to function as a unified, effective system to the benefit of the entire school community.

For the purpose of this study, the following areas were considered.

1.6.1 Healthy and Safe School Environment:

Indoor air quality: Ventilation is a natural disinfectant hence the classrooms of the pupils must be airy in order to maintain hygienic respiration among the school children.

School facilities standards: Some basic facilities such as the urinal, the toilet, the provision of potable water, as well as play items must be available to ensure the physical health of the school children.

1.6.2 Parent and Community Involvement:

The roles of the community members/parents were assessed. This included their awareness of the program and their contribution in terms of resources (cash or kind) towards the success of the program.

1.6.3 Health Services:

The centre for health and health care in schools: the availability of health facilities as well as their accessibility to children is a very important aspect of the School Health Program.

The areas considered included: Professional health care, School based health care, Health insurance for children and Support for children with special health care need.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter seeks to review previous works and other literature of the various objectives or aspects of the study.

2.2 A COMPREHENSIVE SCHOOL HEALTH APPROACH

To encourage educational and health institutions and agencies to coordinate their efforts to promote health through schools, the World Health Organization (WHO) convened an Expert Committee on Comprehensive School Health Education and Promotion in Geneva, Switzerland, from 18 to 22 September 1995. The overall objective of the Expert Committee was to make recommendations for policy measures and actions that the WHO, other United Nations Agencies, national governments and nongovernmental organizations could apply to enable schools to use their full potential to improve the health of children and young people, school staff, families and community members. (WHO, Technical Report Series , 1997)

A school health education that is not reinforced and supported by other health-promoting actions and aspects of the school environment may increase students' knowledge of health issues, but is less likely to result in the adoption of health-promoting attitudes and the development and consistent practice of health skills which is the ultimate goal of health education. Effective school health education must, therefore, be implemented within the broader context of a comprehensive school health approach covering a combination of skills-based health education with school health policies, safe and secure learning environments and school health services. (UNESCO)

Schools have long played an important role in providing students with healthy physical activity. However, the decline in population-level physical activity suggests that schools should play an even greater role in providing and promoting physical activity. Recently, the American Heart Association issued a set of recommendations that, if implemented, would position schools as leaders in helping children and youth become more physically active. The researchers summarized the American Heart Association scientific statement on physical activity and the

schools that was recently developed by the Association's Council on Nutrition, Physical Activity, and Metabolism in collaboration with the Council on Cardiovascular Disease in the Young and the Council on Cardiovascular Nursing. (Pate R.R., & O'Neill J.R., 2007)

2.3 THE KNOWLEDGE, ATTITUDE AND PRACTICES OF IMPLEMENTERS OF THE SCHOOL HEALTH PROGRAM

An evaluation framework, called the Hong Kong Healthy Schools Award, has been developed to enable comprehensive collection and analysis of data reflecting the status of Health-Promoting Schools (HPS) in Hong Kong. The key findings revealed a high prevalence of emotional problems, unhealthy eating habits, physical inactivity and risk-taking behaviors, leading to both intentional and unintentional injuries among students, with higher prevalence among secondary school students. The results indicated a substantial lack of health policies in schools; it also indicated health services in schools not readily accessible to students and staff, and insufficient staff training in health promotion and education. However, most schools have made initiatives in environmental protection, established safety guidelines and strategies for managing students with emotional problems. The success of the HPS depends largely on teachers' understanding of its building blocks. Evidence from the comprehensive mapping of the status of the HPS in Hong Kong and from student surveys does show encouraging outcomes as well as identifying priority issues to be addressed in the next 5 years. (Lee A., etal, 2006)

The School Health Program (SHP) is an important component of the overall health care delivery system of any country. In developing countries such as Nigeria where infant and early childhood mortality is high its importance cannot be overemphasized. With this as background, and the introduction of an action plan of the Federal Government of Nigeria concerning the SHP, (Oforwe GE, Ofili AN, September, 2007) carried out a research to evaluate the knowledge, attitude and practices of the SHP among head teachers of primary schools in a Local Government Area in Nigeria. They designed a pre-tested questionnaire and administered to 133 head teachers of 104 private and 29 public primary schools in Egor Local Government Area of Edo State, Nigeria. The School premises were also inspected to check provision of pipe borne water, sick bay, toilet facilities and the adequacy of the school environments among other things. They found out 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. They therefore

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.

In his work, (Adu-Mireku, S., 2003) evaluated Ghana's school health education program, policy guidelines, curriculum topics and evaluation method at the district level. A modified version of the Health Education District Questionnaire, a self-administered instrument developed by the Centers for Disease Control and Prevention (CDC), was used to collect data from the country's 110 district school health education program coordinators. The response rate was 80 per cent. Information was also gathered through in-depth interviews with the national coordinator and her staff and by reviewing program documents. The results indicated that the program is focused on building life skills by using participatory teaching methods. In addition, less than 40percent of the coordinators reported having conducted any formal or informal evaluation of key aspects of the program at the district level. The findings of this study have implications for Ghana's school health education program.

2.4 HEALTHY AND SAFE ENVIRONMENT

‘A safe school is foundation to the success of the academic mission’. - Ronald Stephens (2005)
School safety should be addressed through a comprehensive approach that focuses on prevention, intervention and response planning. Systems and programs should be in place that creates caring school communities where all students and staff feel safe and supported. Key to the process of building and maintaining safe schools is the development of active partnerships between schools and communities.

A school's environment is the thread that connects the multitude of activities on a campus. In many respects this thread is almost invisible, yet everyone experiences its influence. Positive social relationships and attitudes about the school are as important to the environment as are safe and well-kept buildings and grounds. A safe, clean, and well-maintained school with a positive psychosocial climate and culture can foster school connectedness, which in turn boosts student and staff health as well as students' educational achievement.

In an article (Boateng, 2008) published in the 'Gender and Children' column of the Daily Graphic on the topic 'Caring for truant children', the author noted that making the school environment friendly for school children helps keep them in school and checks truancy. It was explained that parents, youth organizations, social workers and other related agencies all need to work together to develop programs and establish services that will help in the proper upbringing of children.

A school's physical environment includes the school building and the surrounding grounds, such as noise, temperature, and lighting as well as physical, biological, or chemical agents. The alarming increase in the number of students with asthma is one problem that may, in part, be affected by poor physical conditions in schools (Environmental Protection Agency.USA). The psychosocial school environment encompasses the attitudes, feelings, and values of students and staff. Physical and psychological safety, positive interpersonal relationships, recognition of the needs and success of the individual, and support for learning are all part of the psychosocial environment. Other factors that can affect a school's environment include: the economy; social, cultural, and religious influences; geography; socioeconomic status of students' families; tax bases; and legal, political, and social institutions. (Environmental Protection Agency.USA)

2.5 SOURCES AND EXTENT OF SUPPORT FOR SCHOOL HEALTH PROGRAM

Supervision and funds for the program could be managed by (Adams, L. C., 2008) the District Health Services (DHS) as done in the Illinois, where the DHS handles approximately 38 School Health Centers statewide. A School Health Center, located in, or near a school provides the following services: routine medical care, school/sports physicals, immunizations, nutrition counseling, health education, sexually transmitted disease testing and pregnancy testing. Each local community decides what other services will be provided. The health center has a Medical Director and is staffed by a Nurse Practitioner or Physician Assistant who is qualified to provide medical care to children.

She noted that it was expedient that the school children have access to medical services so as to help control the prevalence of diseases. Some medical services include:

- Well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance.
- Immunizations
- Health education
- Nutrition counseling and education.
- The preventive services specified by the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- the services specified by the Guidelines for Adolescent Preventive Services (GAPS) 1992, 515 North State Street, Chicago, IL 60610, no later amendments or editions included, prepared by the American Medical Association.
- diagnosis and treatment of acute illness and injury
- Basic laboratory tests for pregnancy, sexually transmitted diseases (STDs), primary prevention.

2.6 PARENT AND COMMUNITY INVOLVEMENT

In their article, (Maenpaa T, Astedt-Kurki P, 2008) researched on the cooperation between pupils' parents and school nurses as an important part of health promotion in primary schools. The aim of the article was to report on parents' views on cooperation with school nurses in primary schools. The study was aimed at contributing to school nurses' work so that instead of focusing only on the children, family nursing approaches could be improved. Six concepts describing parents' views on cooperation were generated on the basis of the data. They also found out that, cooperation consists of supporting the child's well-being. They also realized that parents are the initiators of cooperation within school health care and parents describe this by the concept of one-sided communication. They therefore concluded that parents do not know about school nurses' work and school health services. And that, they would like to be more involved in school nursing activities. The researchers hoped that when developing children's health services, parents' expertise in their children's well-being should be paid more attention.

A significant increase in the number of profoundly disabled children who require healthcare interventions may mean that school nursing services can no longer provide a direct service to facilitate each child's full access to the curriculum, especially support for out-of-school activities for children with complex medical needs. With the support of the Local Education Authority, education staffs in one area in England were trained by school nurses to undertake a number of healthcare interventions. This training program is underway and is proving to be effective: pupils have been able to go out of school and have had their varying healthcare needs met by education staffs that have been assessed as competent in their care. This can be seen as a good example of inter-agency collaboration in an effort to provide a needs-led, seamless service. (Brett J., Dec 2007)

In their work, (Cornwell, 2007) sought to find out whether the Coordinated School Health Programs (CSHPs) bring together educational and community resources in the school environment. The Stafford school had begun a multi-year CSHP development process, which required adaptations for implementation in a rural area. A CSHP team was formed of community and administrative stakeholders as well as school system representatives. They assessed school demographics so the program framework could target health needs. They eventually determined four priority areas for program development, as limited staff and funds precluded developing programs in all traditional CSHP areas. The program outcomes were supported by School Health Index (SHI) data. Of the 8 CSHP focus areas, the SHI found high scores in 3 of the Stafford CSHP's priority areas: Health Services; Psychological, Counseling, and Social Services; and Physical Education. The fourth Stafford CSHP priority area, Nutrition Services, scored similarly to the less prioritized areas.

They therefore concluded that the process by which the Stafford school district modified and implemented CSHP methods can serve as a model for CSHPs in other rural, high-need areas. Such a procedure could also be implemented in Ghana to enhance the areas of priority that the School Health Program could be aim at improving the health of pupils.

CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

In this chapter, the methodology of this study have been explained and reviewed. This study was focused on getting information from the implementers' point of view.

3.2 STUDY METHODS AND DESIGN

The study is descriptive in nature and the study design is cross-sectional survey which involved both qualitative and quantitative techniques to obtain information from respondents. The sampling method used for the study population was non-randomized purposive.

3.2.1 Structured questionnaire interview

A structured interview (also known as a standardized interview or a researcher-administered survey) is a quantitative research method commonly employed in survey research. The aim of this approach is to ensure that each interviewee is presented with exactly the same questions in the same order. This method ensured that answers could be reliably aggregated and comparisons could be made with confidence between sample subgroups.

To determine if the school-entry hearing screening (SEHS) program continues to make a useful contribution to the identification of childhood hearing impairment in the light of the recent implementation of universal newborn hearing screening and thereby to inform future policy development, a group of researchers (Bristow K.E., et al 2007) used a postal questionnaire survey to determine current implementation and effectiveness of SEHS setting: 244 school health services managed within primary care and acute trusts throughout the United Kingdom. The main outcome measure was 'Details of Implementation'.

In this study, therefore, a questionnaire was designed largely based on the stipulated Guidelines on the School Health Program by the Ghana Education Service (GES) in 2007. It was administered to the implementers thus the teachers, community health workers and parents/guardians of the school children.

3.2.2 Key Informant Interview using a guide/checklist

In order to obtain in-depth information on concepts, perceptions and ideas of the implementers of the School Health Program, this method was found very useful. The key informants included the Parents/Community members, School Health Coordinator of the district, the Environmental Health Officer of the district and the District Director of Nursing Services.

In an article by (Maenpaa T., Astedt-Kurki P., 2008) where they reported on parents' views on cooperation with school nurses in primary schools, this method was used. Nineteen parents from 13 families from southern Finland were interviewed for the study in 2004. The study aimed at contributing to school nurses' work so that instead of focusing only on the children, family nursing approaches could be improved.

3.2.3 Personal Observation using guide/checklists

Mostly, in the social sciences, observational research (or field research) is a social research technique that involves the direct observation of phenomena in their natural setting. Apart from the checklist that was designed for the study, a checklist was teased from the guidelines of the School Health Program for the Schools and used to observe the compound/environment of the schools.

In a similar study conducted by (Grossman, 2007) to describe an innovative clinical experience for graduate students to shape the role of advanced psychiatric mental health nurses in rural minority schools, evidence-based approaches were used. This study was based on the fact that seventy to eighty percent of youth receiving mental health services receive these services in schools. Nurses have been identified as the second major provider of mental health services in the schools, yet little has been written about the role of psychiatric mental health nurses in rural school-based clinics or how they were trained in this role.

3.3 DATA COLLECTION TECHNIQUES AND TOOLS

Some aspect of the data collection techniques was based on observing the schools environment. Checklists and structured questionnaire were used to collect data from the 30 head

teachers/teachers and the 30 health staff. Completed forms were numbered and stored in a file sequentially.

Pretesting of the study tools was done to check the appropriateness of the study tools in the Ejisu- Juabeng district. Three field assistants were engaged for the data collection exercise. They were trained and supervised on how to observe the schools' environment as well as how to conduct the interviews using the guide. The major feedback among others from the pretesting pre-supposed that the interviewees especially parents/community needed leading questions. Amendments were therefore made to the study tools before the actual data collection.

Four sets of structured questionnaires were used; one for the head teachers/teachers, another for the health workers, the community members/parents and the last for the School Health Coordinator of the district. The key informants were also interviewed. A checklist was used for the observation of the schools.

All complete interviewed questionnaires were checked for accuracy before computing. Data collected were analysed using Epi-info version 3.9.1. The study was carried out over a period of 12 weeks.

3.4 STUDY POPULATION

The study population involved the heads of schools, teachers, the community/parents and the health staff in the district who participate in the implementation of program. The school children were only observed during the school visits.

3.5 STUDY VARIABLES

- The study variables included the following; The level of collaboration of the implementers in the implementation of the program.
- Educational background of staff
- Motivation
- The socio-economic factors that affect the program
- Number of years in the implementation of the program
- The involvement of the school children/parents

- The work-load of implementers
- Training of teachers and health workers to implement the program

TABLE 3.1 Study Variables

| VARIABLE | OPERATIONAL DEFINITION | SCALE OF MEASUREMENT |
|--|---|--|
| Standard of educational facilities | Ability to contribute to the health of the school children | Ordinal Excellent Satisfactory Unsatisfactory |
| Provision of a hygienic school environment | An environment that affects a child's health positively | Ordinal Excellent Satisfactory Unsatisfactory |
| Level of collaboration between teachers and health workers | Clarity of roles played by the implementers | Ordinal Excellent Satisfactory Unsatisfactory |
| Frequency of screening exercise | Number of times the schools are visited in a specified period | Ordinal Once Twice More than twice |
| Referrals | Referring an ailment of the pupil to the hospital | Ordinal Once Twice More than twice |
| Timeliness of referrals | When needed | Ordinal Excellent Good Poor |
| Accuracy of records of the school children | Correct and Exact | Ordinal Excellent Good Poor |
| Complete follow-up of referral cases | Including all check-ups and visits | Ordinal Excellent Good Poor |
| Communication | Means of dialoguing with the school children | Ordinal Excellent Good Poor |
| Motivation | Stimulation of the interest of the school children | Nominal Yes No |
| Workload | Amount of work to be done by teachers and health workers | Ordinal Good Poor |
| Logistics | Screening instruments, first aid box etc | Nominal Yes No |
| Availability of adequate health facilities | To offer treatment to all referrals | Nominal Yes No |
| Use of HMIS | Making decision from data generated. | Nominal Yes No |

Source: Compiled by the researcher:

3.6 PROFILE OF THE STUDY AREA

3.6.1 Geography

Kwabre is a peri-urban district in the Ashanti Region. It is closest and shares boundary on the south with the regional capital, Kumasi. On the north of the district is the Afigya-Sekyere District. East is Ejisu-Juaben district and on the West are Offinso and Atwima District. The district has a total land area of 1254.06km. The district capital is Mampong, situated 14.4km on the Kumasi-Mampong trunk road.

Kwabre has a very good trunk road running from Kumasi to Mampong. Meanwhile most of the feeder roads are not motorable and also do not have public transport plying on them.

Kwabre district has two (2) well defined seasons which begins from December to February with the North winds.

3.6.2 Demographic Data

The district is made up of eighty-nine (89) communities and has a total population of 201,249. The district is divided into five sub-districts or health areas after considering how accessible static health facility is to the people living in the various parts of the district. These are Mampongten, Aboaso, Asonomaso, Aboabogya and Afrancho.

The district was geographically restructured just before the end of the study. Thus, the new Kwabre district has only four sub districts but the district capital is the same.

Table 3.2 Demographic Data of the District

| TARGET POPULATION | WIFA 15-49 (24%) | EXPECTED PREGNANCY/DELIVERY (4%) | CHILDREN 0-59 (16.5%) | TOTAL |
|--------------------------|-------------------------|---|------------------------------|--------------|
| Mampong | 19,320 | 3,220 | 13,081 | 80,500 |
| Aboaso | 6,762 | 1,127 | 4,578 | 28,175 |
| Asonomaso | 8,694 | 1,449 | 5,887 | 36,225 |
| Aboabogya | 4,830 | 805 | 3,270 | 20,125 |
| Afrancho | 8,694 | 1,449 | 5,887 | 36,225 |
| Total | 48,300 | 8,050 | 32,703 | 201,249 |

Source: District Health Directorate, Mampong. 2008

3.6.3 The Socio-Economic Activities

A great number of people in the district are cash crop farmers. Their main produce is palm nuts. Also everyone in the district is a subsistence farmer. Foodstuffs grown include plantain, cassava and maize.

The District Health Administration, Ghana Education Service and other educational institutions offer a few clerical jobs existing in the district.

Most of the women engage in petty trading whilst most of the men are wood carvers, stone and sand winners and Kente weavers. A pipe borne water project, which was constructed, could only benefit inhabitants of Mampong, the district capital. Majority of the inhabitants therefore obtain water mainly from streams whilst a few others depend on hand dug wells.

3.6.4 Distribution of health facilities in the districts

The district has two (2) hospitals, ten (10) Health Centers, ten (10) maternity homes and four (4) clinics.

Table 3.3 Distribution of health facilities in the districts

| Facility | Government | Mission | Private | Total |
|----------------|------------|---------|---------|-------|
| Hospital | 1 | 1 | - | 2 |
| Health Centre | 10 | - | - | 10 |
| RCH | - | - | - | - |
| CHPS | - | - | - | - |
| Clinic | - | 1 | 3 | 4 |
| Maternity Home | - | - | 10 | 10 |
| Total | 11 | 2 | 13 | 26 |

Source: District Health Directorate, Mampongeng. 2008

3.6.5 Distribution of Health Services Personnel in the district

Health Services Personnel in the district is inadequate. The problem is compounded by the inequitable distribution of health facilities in the district.

Table 3.4 Distribution of Health Services Personnel in the district

| Health Personnel | Number |
|--------------------------|-----------|
| Medical Officers | 6 |
| Medical Assistants | 6 |
| Nurses (General) | 12 |
| Pharmacists | 2 |
| Dispensing Technicians | 7 |
| Disease Control Officers | 9 |
| Laboratory Technicians | 2 |
| Laboratory Assistants | 4 |
| Nutrition Officer | 1 |
| Ward Assistants | 7 |
| Community Health Nurses | 16 |
| Public Health | 2 |
| Ward Orderlies | 11 |
| Record Officers | 8 |
| Total | 91 |

Source: District Health Directorate, Mampongeng. 2008

3.6.6 Educational Facilities

Table 3.5 Distribution of Educational facilities

| Educational facility | Number |
|-----------------------------|---------------|
| Senior High School | 7 |
| Junior High School | 5 |
| Primary | 91 |
| Nursery | 83 |
| Total | 329 |

Source: District Health Directorate, Mampongeng, 2008

3.7 Sampling Techniques

The WHO EPI cluster survey (30 x 7) was used in selecting the schools, health workers and the community members/parents to be interviewed.

The 30 x 7 cluster sample was developed by WHO in 1978. The goal of this sampling design was to estimate immunization coverage to within ± 10 percentage points of the true proportion, with 95% confidence. Before the sampling begins, the population needs to be divided into a complete set of non-overlapping subpopulations, usually defined by geographic or political boundaries. In the first stage, 30 of these clusters are sampled with probability proportionate to the size (PPS) of the population in the cluster. Sampling with probability proportionate to size allows the greater clusters to have a greater chance of being selected.

The list of all the basic schools, according to the GES classification (thus circuits) in the district was entered into the STATA version 9, and the 30 schools were derived. The 30 schools included twenty (20) public schools and ten (10) private schools. They included selected schools in all the five districts, thus nine schools in Mampongten, four in Aboaso, five in Asonomaso, four in Aboabogya and eight in Afrancho. In each school, a head teacher/class teacher/school health teacher was interviewed. The same procedure was used in deriving the thirty (30) community health workers who were interviewed.

Seven (7) school children in each school, picked at random, took the research team to their various houses where their parents/guardians/community members were interviewed.

This study was carried out in all the four (4) sub-districts, comprising of two hospitals and three hundred and twenty-nine (329) schools. Three (3) data collectors (community health workers) in the district were recruited and trained to assist in the data collection.

3.8 Sampling size

The sample size for the study was a total of 273, comprising 30 community health workers, 30 head teachers/teachers, 210 community members/parents, the District Coordinator of the School Health Program, the District Director of Nursing Services and the Environmental Health Officer.

3.9 PRE TESTING

Questionnaire for the study was pre-tested at the Ejisu-Juabeng district in the Ashanti Region. Four basic schools were visited and their head teachers interviewed. 10 parents were interviewed as well. Based on the feedback from the pre-test, it appeared that the interviewees needed leading questions. Again, some issues came up, that needed to be looked into. The study tools were then modified to suit the objective of the study. As much as possible inconsistencies and biases were eliminated from the study.

3.10 DATA COLLECTION AND ANALYSIS

During the first two weeks, the researcher officially introduced herself and the objective of the study to the District Director of Health Services and the District Director of the Ghana Education Service. The investigator visited the main health facilities in the five sub districts for reconnaissance. Three field assistants were recruited and trained about the administration of the questionnaires. Issues about language were made clear especially the questionnaires for the community/parents before the field assistants assisted in the data collection.

The actual data collection exercise took place in the 3rd to 5th weeks. To ensure accuracy and reliability of response, questionnaires were screened before they were accepted. A qualified Data Analyst was employed to perform the analysis.

3.11 STATISTICAL PACKAGE

Data was analysed using Epi Info version 3.9.1 and Excel Spreadsheet.

3.12 ETHICAL CONSIDERATION

In fulfillment of ethical requirement, permission to conduct the study was requested from the District Directorate of Health Services (DDHS), Ghana Education Service (GES), the office of the District Chief Executive (DCE), Management of the various health institutions, and management of the various schools. Consent was sought from individual respondents especially the community members/parents.

In addition to the above, at any point during the interview, the researcher introduced herself and explained the objectives of the study to respondents before data were collected. Information collected was treated with strict confidentiality.

3.13. LIMITATIONS OF THE STUDY

3.13.1 Respondent Bias

Some respondents, especially the head teachers were a bit skeptical and seemed to shield some information. It seemed that they shelved some information that appeared negative and that might affect the credibility of their schools. This became obvious due to the inconsistencies in the flow of the information they gave during the pretesting. To reduce this bias, the researcher sought to assure respondents of the confidentiality of the information they gave and stressed that it was purely for academic purposes.

Some health personnel attributed their inability to support the implementation of the program to the working conditions in order to press for improvement in the working conditions.

3.13.2 Time Constraint

The data collection was carried out during the working hours hence there was a clash with the respondents' working activities. To minimize this bias, the researcher made arrangements with respondents as to the time that was convenient for them.

3.14 ASSUMPTIONS

The usefulness and substance of the findings of the study is based on the assumption that the views expressed by the interviewers were a true reflection of the situation on the ground. It is

also assumed that the opinions will therefore be an accurate measurement of the variables under study.

CHAPTER FOUR: RESULTS

4.1 INTRODUCTION

This chapter is a summary of the findings obtained during the field investigations on the implementation of the School Health Program (SHEP) at the Kwabre District, August-October 2008. The survey was conducted among the implementers of the program namely; the head teachers/teachers of the schools that were sampled, the community health nurses and some community members/parents of school children. The key informants were the SHEP coordinator, the Public Health Nurse and the Environmental Health Officer of the district. In all, 273 respondents were interviewed; 210 community members/parents, 30 community health nurses, 30 head teachers/teachers of 30 different schools and the 3 key informants. The findings are based on the pre-determined objectives as indicated in chapter one. They are presented in tables and graphs.

4.2 BACKGROUND INFORMATION

The gender distribution of respondents, the occupation of the community members/parents and the length of service of the community health nurses and head teachers/teachers is as indicated in tables 4.1, 4.2 and table 4.3 below. 67.4% of respondents were females. Out of the community members/parents interviewed, 50.9% were peasant farmers. The study also revealed that 70.0% of the head teachers/teachers and the community health nurses had been at post between 1-4 years.

Table 4.1 Summary of findings of gender distribution of respondents

| Category | Male | Percentage | Female | Percentage |
|------------------------------|-----------|-------------|------------|-------------|
| Parents | 73 | 26.7 | 137 | 50.2 |
| Environmental Health Officer | 1 | 0.4 | - | - |
| Teachers | 14 | 5.1 | 16 | 5.9 |
| SHEP Coordinator | - | - | 1 | 0.4 |
| Community Health Nurses | - | - | 30 | 11 |
| Public Health Nurse | - | - | 1 | 0.4 |
| Total | 88 | 32.2 | 185 | 67.8 |

Source: Field Data, 2008

Table 4.2 Length of Service at post of respondents (teachers and nurses)

| Years at Post | Nurses | Percentage | Teachers | Percentage |
|---------------|-----------|------------|-----------|------------|
| Below 1 | - | - | 4 | 13.3 |
| 1 - 4 | 25 | 83.3 | 17 | 56.7 |
| 5 - 9 | 5 | 16.7 | 6 | 20.0 |
| 10 -14 | - | - | 2 | 6.7 |
| 15 + | - | - | 1 | 3.3 |
| Total | 30 | 100 | 30 | 100 |

Source: Field Data, 2008

Table 4.3 Occupation of Parents/community members

| Occupation | Freq | % |
|------------|------|------|
| Farmers | 107 | 50.9 |
| Traders | 46 | 21.9 |
| Artisans | 42 | 20 |
| Teachers | 6 | 2.9 |
| Others | 9 | 4.3 |

Compiled by researcher

4.3 THE STRUCTURE OF SCHOOL HEALTH PROGRAM (SHEP) IN THE DISTRICT

4.3.1 The purpose and levels of prevention of SHEP in the district

To a larger extent, the School Health Program is not unknown in the district and some aspects of it are practiced. Table 4.4 illustrates the purpose of the program according to the key implementers of the program. Table 4.5 illustrates the levels at the program seeks to prevent ill health as done in the various schools. About 20% of teachers and 40% of nurses thought that the purpose of the program is to ensure the totality of all health services that improves the physical, social and mental health and development of the pupils in their school environment.

Table 4.4 Responses on the purpose of the School Health Program

| Purpose | Nurses | Percentage | Teachers | Percentage |
|---|--------|------------|----------|------------|
| To ensure the totality of all health services that improve physical, social and mental health and development | 9 | 30% | 11 | 36.7% |
| To ensure the general physical health of pupils in school environment | 13 | 43.3% | 11 | 36.7% |
| To treat, prevent and reduce the health problems of Pupils in school Environment | 8 | 26.7% | 8 | 26.7% |

Compiled by researcher

Table 4.5 Responses on the focus of SHEP on levels Prevention of ill health

| Level | Nurses | % | Teachers | % | Total | % |
|--|-----------|------------|-----------|------------|-----------|------------|
| Only Health promotion and prevention of diseases | 5 | 16.7 | 9 | 30.0 | 14 | 23.3 |
| Only identification of problems and early intervention | 13 | 43.3 | 15 | 50.0 | 28 | 46.7 |
| Only management of long term diseases | 0 | 0 | 0 | 0 | 0 | 0 |
| All the Levels | 12 | 40.0 | 5 | 16.7 | 17 | 28.3 |
| Others | | | 1 | 3.3 | 1 | 1.7 |
| Total | 30 | 100 | 30 | 100 | 60 | 100 |

Source: Field Data, 2008

About 59% of the implementers focus their attention on all kinds of diseases that occur in pupils. 38% focus only on communicable diseases and 8.3%, on non-communicable diseases.

Again, the program is known among the teachers to cover all pupils but about 21.7% of nurses, thought the program covers only pupils in pre-school, primary classes 1,2,3,6 and first year pupils in Junior High School.

4.3.2 Ownership of the Program in the district

Table 4.6 illustrates who the key implementers (teachers and the community health nurses) felt owned the SHEP. A total of 61% actually thought that the Ghana Health Service owned the program.

Table 4.6 Responses about the ownership of the SHEP

| | Nurses | % | Teachers | % |
|-------------------|--------|------|----------|------|
| GHS | 25 | 83.3 | 12 | 40.0 |
| GES | 5 | 16.7 | 14 | 46.7 |
| District Assembly | | | 4 | 13.3 |
| Total | 30 | 100 | 30 | 100 |

Source: Field Data, 2008

4.3.3 Monitoring and Evaluation of the School Health Program in the district

There is no known mechanism or system in place in the district to monitor and evaluate the program. 46.7% of implementers attributed the reason of this constraint to the lack of requisite logistics. 15%, however, believed that there is no mechanism for monitoring and evaluation because of the apathy displayed by policy makers, particularly the government, towards the implementation of the program. This is illustrated in table 4.7 below.

Table 4.7 Responses about the Monitoring and Evaluation of the SHEP

| | Nurses | % | Teachers | % |
|-----|--------|-----|----------|-----|
| Yes | - | - | - | - |
| No | 30 | 100 | 30 | 100 |

Reasons

| | | | | |
|-----------------------------|----|------|----|------|
| Lack of trained Personnel | 15 | 50 | 8 | 26.7 |
| Lack of requisite Logistics | 11 | 36.7 | 17 | 56.7 |
| Inadequate Attention/Apathy | 4 | 13.3 | 5 | 16.7 |

Source: Field data, 2008

4.3.4 Review and frequency of review of SHEP in the district

Even though, 90% of the nurses believed that the program is subject to review, 33.3% teachers felt it was not reviewed at all. Table 4.8 illustrates the review and frequency of review of the program in the district.

Table 4.8 Review and Responses on whether reviews are carried out

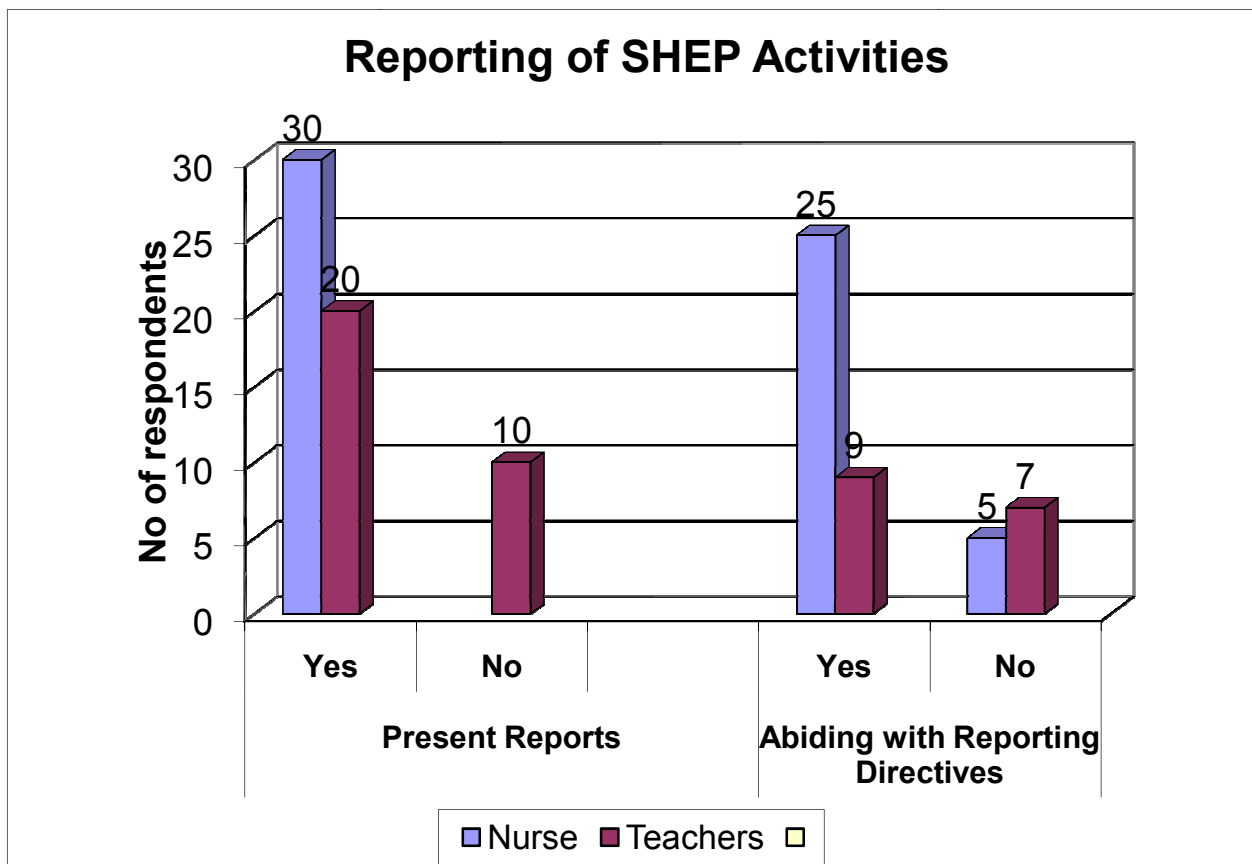
| Review | Nurses | % | Teachers | % |
|-----------------------|--------|------|----------|------|
| Yes | 27 | 90 | 20 | 67.7 |
| No | 3 | 10 | 10 | 33.3 |
| Frequency of review | | | | |
| Yearly | 16 | 53.3 | 18 | 60.0 |
| Every Five Years | 14 | 46.7 | 4 | 13.3 |
| As and When necessary | - | - | 1 | 3.3 |
| Not at All | | | 7 | 23.3 |

Source: Field data, 2008

4.3.5 Role definition and reporting of activities among implementers in the district

Whilst all the nurses agreed that the roles of implementers are clearly defined, 70% of the teachers thought otherwise. Again, all the nurses admitted that they needed to present reports on their activities regularly but 46.7% of the teachers confessed they were not aware. 86.7% community health nurses answered they abided by the directive, 43.7% of the teachers did not. This is displayed in Table 4.9 below.

Fig 4.1 Reporting on activities by implementers



Source: Field Data, 2008

4.4 THE KNOWLEDGE, ATTITUDES AND PRACTICES OF IMPLEMENTERS (GHS AND GES) OF THE SHEP

The knowledge, attitudes and practices of both the key implementers, thus, the community health nurses and the head teachers/teachers were assessed separately. The results of this has been categorized and presented below.

4.4.1 The knowledge, attitude and practices of head teachers/teachers (GES)

About 90% (27 of 30) of head teachers/teachers agreed that their schools practice the program. The 10% cited reasons as lack of trained personnel, apathy, lack of funds and lack of knowledge as their inability to practice the program. Of the 90.0% that practiced the program, 55.5% agreed that the main aspect of the program practiced was to ensure a healthy school environment, 18%

dwelt on health education, 14.8% focused on health services and 11.1% centered on school-home coordination. None of the schools practiced a comprehensive school health program.

Quite a number of schools (76.7%) had a school health teacher but their roles differed from school to school. About 37% explained their major role as, continually observing the school children to determine their health status. Table 4.9 illustrates the roles of school health teachers.

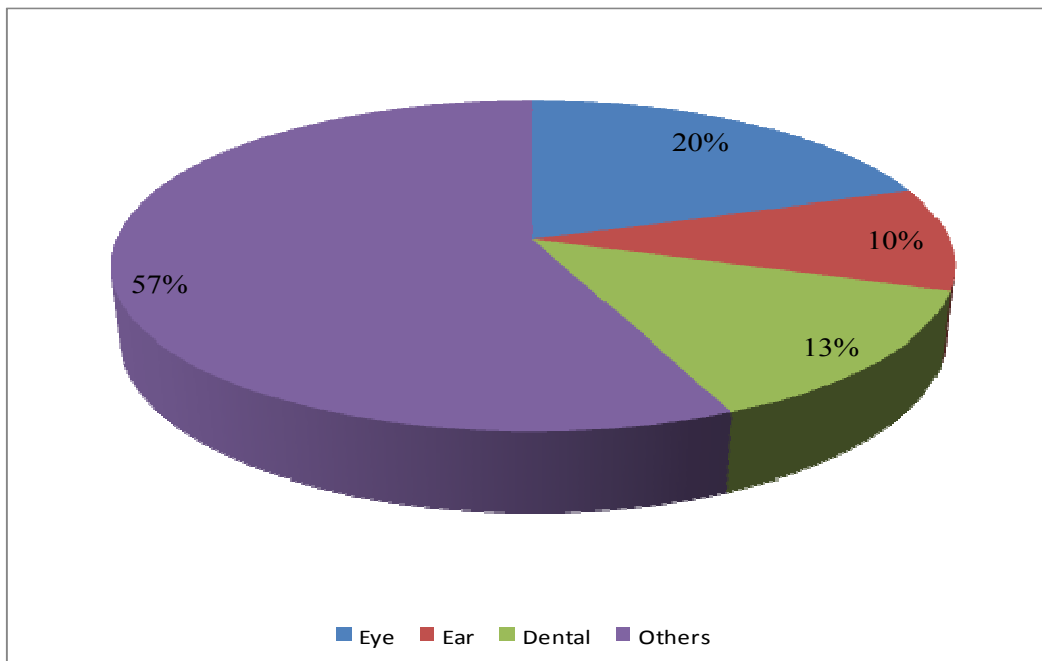
Table 4.9 Responses on the roles of school health teachers

| Role | Teachers | % |
|--|----------|------|
| Conferring with School Health Personnel | 3 | 11.1 |
| Developing meaningful health instruction | 7 | 25.9 |
| Continually observe children | 10 | 37.0 |
| Understanding the growth and development | 7 | 25.9 |

Source: Field Data, 2008

About 15 out of the 27 schools that practiced the program, representing 55.6%, noted they had no support from any health service personnel regarding the implementation of the program. About 73.3% of the schools that had the support of the health workers admitted that the latter visited their schools once a term for inspection/screening exercises. The teachers of 2 schools (6.7%) confessed that pupils sometimes paid for deworming exercises that are conducted for the latter. The pupils paid less than 20Gh pesewas or more in either schools. The pupils of the remaining 93.3% schools paid nothing for deworming exercises. Figure 4.2 illustrates the cases that are normally screened.

Fig 4.2 Cases that are normally screened



Source: Field Data, 2008

Table 4.10 shows deworming exercises that normally take place over a period. 50.0% schools had undertaken a deworming exercise in the year of this study.

Table 4.10 Responses on whether Deworming exercises are carried out

| | Schools | % |
|-----------------------|-----------|------------|
| Yes | 15 | 50.0 |
| No | 15 | 50.0 |
| Frequency | | |
| Once a year | 13 | 86.7 |
| More than Once a year | 2 | 13.3 |
| Total | 15 | 100 |

Source: Field Data, 2008

The availability of health facilities to facilitate the implementation of the program varied among the schools. About 46.7% schools noted that there had no access to a health facility. Again,

13.3% schools had no first aid box. Table 4.11 illustrates the distribution of the availability of health facilities among the schools.

Table 4.11 Distribution of health facilities in the reach of schools in the district

| Type | Schools | % |
|---------------------------|---------|------|
| Health Centre | 11 | 36.7 |
| Hospital | 3 | 10.0 |
| Licensed Chemical Sellers | 2 | 6.7 |
| None At All | 14 | 46.7 |

Source: Field Data, 2008

4.4.2 The availability of First Aid boxes

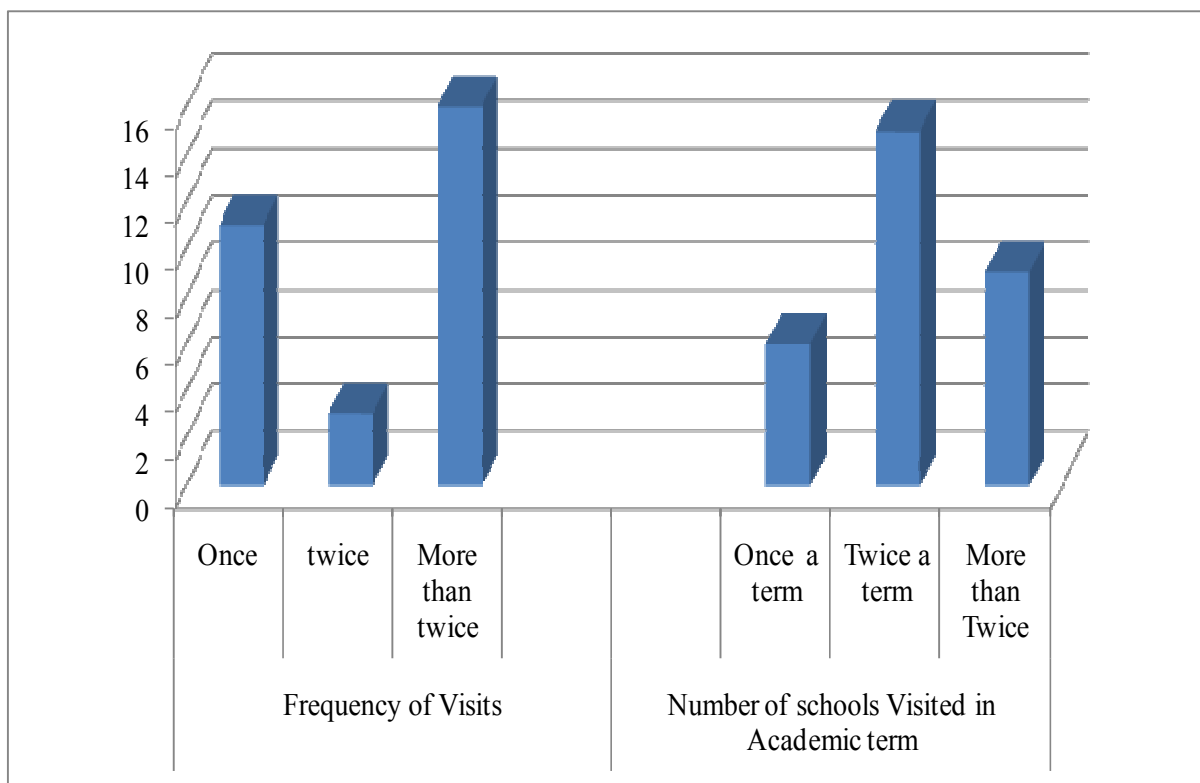
The study revealed that 53.3% schools had first aid boxes. The remaining schools could not be bothered about the need and use of first aid boxes. Most teachers (93.3%) were of the view that the SHEP program was having a positive impact on the pupils. The remaining 6.7% who thought otherwise attributed the reasons to lack of funds for the implementation of the program. Whiles 76.7% agreed that they involved parents in the health affairs of pupils, 33.3% thought otherwise.

4.4.3 The knowledge, attitude and practices of community health nurses (GHS)

Figure 4.3 illustrates the frequency and number of visits made by the community health nurses.

Fig 4.3 Frequency of visits and number of schools visited

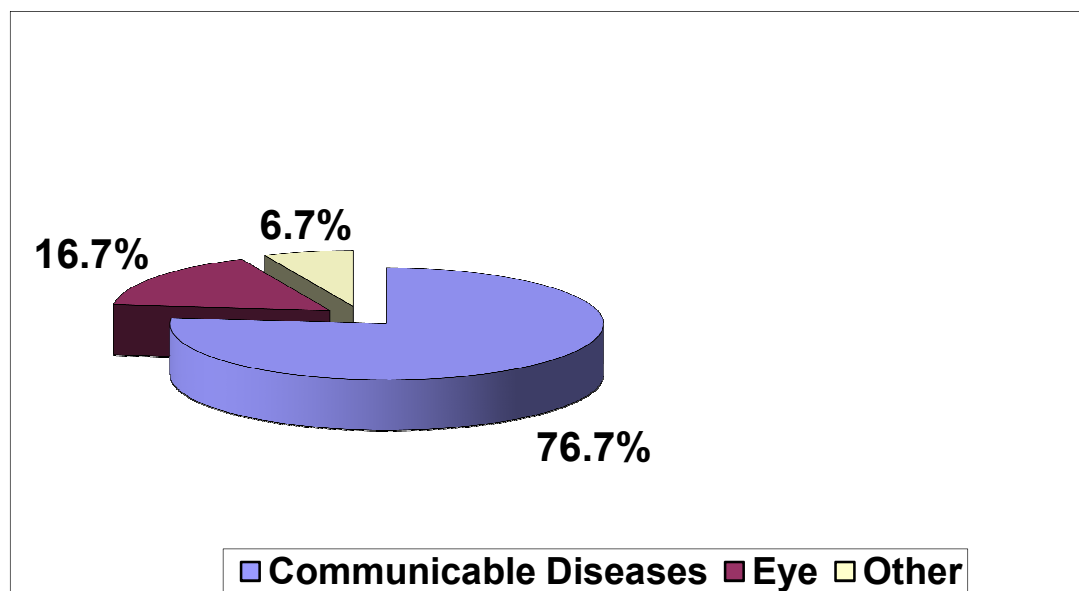
10 community health nurses went to the schools once a term for screening exercises, 2 said they went twice a term and 18 said they visited each school more than twice a term for screening exercises.



Source: Field data, 2008

The figure below shows the prevalence of diseases in a term that call for referrals.

Fig 4.4 Prevalence of diseases that call for referrals.



Source: Field Data, 2008

4.4.4 Referral cases

The nurses noted that on the average, the number of referral cases that occur in a term was quite minimal. They however added that, if a condition called for a referral, they followed-up on the victim until he/she got better. Table 4.12 shows the referral procedure.

Table 4.12 Referral procedure

| Average Number of Referral in a term | Nurses | % |
|--------------------------------------|--------|----------|
| Below 5 | 20 | 66.7 |
| Between 5 -10 | 3 | 10.0 |
| More than 10 | 7 | 23.3 |
| Get Feedback after referral | | % |
| Yes | 27 | 90 |
| No | 3 | 10 |

Source: Field data, 2008

About 74% nurses felt that it is only health workers who do follow-ups and 25.9% thought the follow up was done by parents, teachers and health workers only.

4.4.5 Collaboration between teachers and nurses

The study revealed that 63.3% of the nurses admitted that they received the co-operation of teachers. Those who said otherwise attributed the reason as the lack of funds. About 96.7% answered there was no conflict of roles between the GES and GHS. The nurses recounted the challenges they are faced with. About 36.7% complained about the lack of the logistics for screening exercises, 16.7% complained about transportation, 33.3% thought the organization of training sessions for the implementers was inadequate and 13.3% felt there was a lack of collaboration between the GES and GHS.

4.4.6 Impact of School Health Program

All the nurses answered that the School Health Program was having a positive impact on the pupils. Among other reasons given as some of the successes of the program, 33% of the nurses felt the program has improved personal hygiene of pupils and 20% said the program has improved the health status of pupils.

4.5 THE PHYSICAL ENVIRONMENT OF SCHOOLS THAT PRACTICE THE PROGRAM

An observation was made in all the schools using a checklist.

4.5.1 Location of schools

The study revealed that 86.7% of the schools were located in areas with little noise from activities of the communities. Also, about 96.7% schools had spacious compounds and about 56.7% had adequate trees/lawns on their compounds. Notwithstanding this, about 86.7% schools had dusty compounds.

4.5.2 Ventilation/lighting of schools

The study revealed that about 83.7% schools had normal classroom sizes (10m x 5m) but 93.3% schools did not have adequate windows for proper ventilation. Thus, apart from the door, most classrooms had one window/an opening on the wall serving the purpose for ventilation. Among the schools that were visited, about 46.7% housed between 45-50 pupils in a class with two

pupils using the same chair and table. Hence, about 50% of schools had pupils not well spaced in the classrooms. About 86.7% had inadequate lighting in the classrooms.

4.5.3 Food Vendors

About 93.3% schools had vendors providing pupils with food. The study revealed that about 70% failed to renew their health certificates yearly. The personal hygiene of about 56.7% leaves much to be desired. Even though, 70% kept their surroundings clean, 90% had no washing bowls, soap and napkins for pupils to wash their hands before and after eating.

4.5.4 Sanitary facilities

The table below illustrates the availability and accessibility of sanitary facilities provided for pupils in the 30 schools as of the time the study was conducted.

Table 4.13 Summary of Sanitary facilities

| Source of Water | Schools | % |
|--|----------------|----------|
| Pipe Borne | 1 | 3.3 |
| Bore Hole | 5 | 16.7 |
| Well | 6 | 20 |
| No Source of Water | 18 | 60 |
| Availability of Hand Washing Facilities | | |
| Yes | 9 | 30 |
| No | 21 | 70 |
| Accessibility of Toilets | | |
| Yes | 15 | 50 |
| No | 15 | 50 |
| Type of Toilet Facilities | | |
| KVIP | 2 | 13.3 |
| Pit Latrine | 12 | 80 |
| Water Closet | 1 | 6.7 |
| Conduciveness to Health and Maintenance of Facilities | | |
| No | 18 | 60 |
| Yes | 12 | 40 |
| Availability of Functional Urinal | | |
| Yes | 8 | 26.7 |
| No | 22 | 73.3 |

Source: Field Data, 2008

4.6 SOURCES AND EXTENT OF SUPPORT FOR THE SHEP

Enquiries were made as to the sources of funding for the schools that practice the program and how often the funds are received, from the schools, the SHEP Coordinator and the District Public Health Nurse. The source as well as the flow of funds differed among the nurses and the teachers. The table below throws more light on this issue.

Table 4.14 Sources of funds and the period of release

| | Nurses | % | Teachers | % |
|--------------------------------|---------------|----------|-----------------|----------|
| GoG | 18 | 60 | 12 | 44.4 |
| IGF | 12 | 40 | 11 | 40.7 |
| PTA | - | - | 4 | 14.8 |
| When funds are released | | | | |
| On Request | 15 | 50 | 14 | 51.8 |
| Quarterly | 9 | 30 | 9 | 33.3 |
| Yearly | 6 | 20 | 4 | 14.8 |

Source: Field Data, 2008

Whilst 93.3% of the teachers felt there was the availability of the necessary logistics, 60% of the nurses thought otherwise. The 6.7% teachers (who) also thought otherwise quoted the following as challenges:

- Lack of sick bay in schools
- Unavailability of portable water for school children
- No record cards
- Lack of drugs
- No first aid box
- Lack of hand washing equipment
- No trained personnel

All the nurses agreed that training workshops were periodically organized for them but 40% of the teachers disagreed. Even though about 95% of both teachers and nurses felt there is no

conflict in the roles they play in the implementation of the program, there was no clear cut line in the level of their involvement. 85% of both teachers and nurses agreed that parents show interest in the health of their children.

4.7 THE ROLES PLAYED BY THE COMMUNITY/PARENTS IN THE IMPLEMENTATION OF THE PROGRAM

Among the community members/parents interviewed, 40.5% had no idea about the School Health Program. The table below shows the level of knowledge of some community members/parents.

Table 4.15 Awareness and level of knowledge about SHEP

| Awareness | Freq | % |
|------------------|-------------|----------|
| Yes | 85 | 40.5 |
| No | 125 | 59.5 |

| Role | Freq | % |
|--|-------------|----------|
| Promote Personal Hygiene | 25 | 29.4 |
| Provide nutritious Food | 18 | 21.2 |
| Ensure regular School Attendance | 19 | 22.3 |
| Ensure Cleanliness of Children | 17 | 20.0 |
| Promote Handing washing behaviour among children | 6 | 7.1 |

Source: Field Data, 2008

4.7.1 The support of parents/community towards the program

Over 29.4% of the parents noted that they ensure personal hygiene of their children, 21.2% said they provide nutritious food, 22.3% ensured their children attended school regularly, 22.0% ensured the cleanliness of their children and 7.1% indicated they ensure that their children washed their hands regularly. However, 79.0% revealed that they and their children are covered under the National Health Insurance Scheme (NHIS). The Table below shows the ability of parents to meet the health needs of the children.

Table 4.16 Ability of parents to meet the health needs of their children

| Able to Meet Health Needs | Freq | % |
|--|-------------|----------|
| Yes | 195 | 91.4 |
| No | 15 | 8.6 |
| What is done when unable to meet health needs | | |
| Buy Drugs from pharmacy/drug store | 6 | 40 |
| Use either herbal/traditional medicine | 9 | 60 |

Source: Field Data, 2000

4.7.2 The involvement of parents/community in the health affairs of their (school) children

Some parents (56.2%) attested to the fact that the schools do not involve them in the affairs of their children especially in the area of health. Again, 73.7% said they received no feedback from schools on the School Health Program.

4.8 FEEDBACK FROM KEY INFORMANTS

In order to confirm the extent to which the program is being implemented in the district, the SHEP coordinator, the Public Health Nurse, and the Environmental Health Officer of the district were also interviewed.

The SHEP coordinator and the Public Health nurse had different views about the implementation and practice of the program, to some extent.

4.8.1 The purpose of SHEP

Both the SHEP coordinator and the Public Health Nurse thought that the purpose of the program was to ensure the totality of all health services that improves the physical, social and mental development of the pupils in the school environment. Whiles the Public Health Nurse thought that the program focus on all levels of prevention of ill health as well as all disease conditions but the SHEP coordinator felt it was focused only on promotion and prevention of diseases and

only on communicable diseases. The SHEP coordinator maintained that the program covers all pupils but the Public health nurse maintained that it covers only pupils in Pre-school, P1, P2, P3, P6 and JHS 1.

4.8.2 Monitoring and evaluation

The Public Health Nurse felt that there were no structures to monitor and evaluate the program but the SHEP coordinator thought otherwise. The former cited reasons as lack of the requisite logistics to monitor and evaluate the program. However, the SHEP coordinator felt that the availability of school based health teachers, sanitary facilities, good landscaping of schools and the school buildings are alright to monitor and evaluate the program. Both thought that the program is subject to review, but the Public Health nurse felt the review was done yearly and the SHEP coordinator felt it was done as and when necessary.

4.8.3 Reporting on SHEP Activities

Both key informants felt that implementers are expected to present reports on their activities but both confessed that they do not abide by the directive. Regarding what is done about this issue, the Public health nurse stated that there was training and sensitization about the program and stressed that indeed there was not enough logistics are provided for proper implementation. The SHEP coordinator stated that trained health-based teachers are maintained in the schools and also they teachers are prompted occasionally about the directive. Unlike the Public health nurse, the SHEP coordinator felt the roles of implementers are clearly defined. Both of them felt the program is owned by the Ghana Education Service.

4.8.4 Extent and support for SHEP from the perspective of key informants

Both the SHEP and the Public Health nurse disclosed that the even though implementers undergo some periodic training, the necessary logistics required for the running of the program are not available. They cited some challenges such as lack of funds, transportation and equipment/stationery. They were of the view that there were no conflict in the roles played by the GES and the GHS and that parents also support and show interest in the health of their children. However whiles the SHEP coordinator thought the program was being funded by donor agencies, the Public Health nurse said the program was funded by the Government of Ghana and also Internally Generated Funds. The former revealed the money was released yearly and the latter said quarterly.

4.8.5 Activities of the Environmental Health Officer

The activities of the Environmental Health Officer were assessed in an interview using a checklist teased from the SHEP guidelines. These are as detailed in the table below.

Table 4.17 Activities of the Environmental Health Officer

| Activities | Frequency | Frequency As Practiced |
|---|--|--|
| Conduct environmental hygiene inspection of general school environment condition (classroom, compound, toilet facilities etc) | Daily/Weekly | Monthly |
| Provision and maintenance of sanitary sites | As and when necessary | Daily and weekly maintenance |
| Ensure provision and maintenance of waste disposal sites | When the need arises and as per assemblies development plan | Depends on availability of funds |
| Ensure that schools meet safety and health promotion specification (Lighting, ventilation, recreational grounds | Before the issue of building permit and during periodic inspection | Strict inspection and enforcement on periodic visits |
| Organize environmental inspection and certification of schools | Once a year | Yearly |
| Ensure the provision of portable water, sanitary facilities and recreational grounds | As and when necessary, during celebration of district sanitation week/ school hygiene inspection | Strict inspection and enforcement before festive occasions |
| Liaise with Ghana Health Service in certifying food vendors | Annually | Yearly |
| Inspect school sports filed and physical exercise equipment | Annually | Quarterly |
| Enact bye-laws to ensure safety | As and when necessary | Bye-laws in place since June 2005 |

Source: Field data, 2008

CHAPTER FIVE: DISCUSSION

5.1 INTRODUCTION

The discussions are reflections on the analysis of data/findings, literature, personal observation and informal interactions during the data collection process. They are presented according to the pre- determined objectives as indicated in chapter one.

5.2 THE STRUCTURE OF THE SCHOOL HEALTH PROGRAM

The design as well as the understanding, in detail, of a program by policy makers and implementers is very crucial for successful implementation of the School Health Program. The activities as outlined in the guidelines of the program is very good but knowledge of it as well as its implementation by the implementers leaves much to be desired as gathered from this study. It is therefore very important that the implementers of the SHEP must be informed about what the program is all about. This means that copies of the guidelines must be handy. However, it was very difficult getting a copy of the guidelines for this study. A copy of the documented policy of the program could only be got from the head office of the GES in Accra. There was no copy at the regional office, not to talk about the district office.

The study revealed that there were divergent ideas from implementers as to what the whole program is about. The core purpose of the program is not well known to implementers as only 33.3% (thus for both teachers and nurses) agreed with what is stated in the guidelines that the purpose is to ensure the totality of all health services that improves the physical, social and mental health and development of pupils in their school environment. This study therefore buttresses the conclusion made by (Oforwe GE, Ofili AN, September, 2007) in a similar study that the poor status of the School Health Program (SHP) in Nigeria may be attributed to failure of policy enunciation, poor primary health care base and lack of supervision. This assertion was made after they found out that none of the head teachers had adequate knowledge of SHEP

No doubt that, in order to encourage educational and health institutions/agencies to coordinate their efforts to promote health through schools, the (WHO) convened an expert committee on Comprehensive School Health Education and Promotion to look into this issue and make

recommendations for policy measures and actions that the former and other agencies could apply to enable schools use their full potential to improve the health of children and young people, school staff, families and community members.

5.2.1 Reasons for poor implementation

As illustrated in Table 4.6 in chapter 4, it was clear there is no clear proof of who owns the School Health Program as 61.7% of teachers and nurses thought that the GHS owns the program and the others thought otherwise. Even though, to a large extent, implementers knew they were expected to report on the duties, quite a sizeable number (86.6%) have overlooked this directive and according to them nothing at all has been done about the situation. From investigations gathered, this situation persists because there are no structures in place for monitoring and evaluating the activities of implementers (GES and GHS). The situation worsens in the wake of inadequate logistics for running the program by both the education and the health sectors.

The health workers could be justified to say that the program covers only pupils in pre-school, pupils in primary 1,2,3,6 and first year pupils in Junior High School because that is what is stated in the guidelines for them, even though, for the GES the program is for all pupils. A lapse, such as this, will definitely bring some kind of confusion in the implementation of the program. The big question is, 'What happens to pupils in the other classes, who equally have a right to health care'? The study revealed that about (10%) schools do not practice the SHEP. Hence, pupils who move, for example, from such schools to the ones that practice SHEP half way are most likely not to benefit from SHEP.

5.3 THE KNOWLEDGE, ATTITUDES AND PRACTICES OF IMPLEMENTERS OF THE PROGRAM

The study revealed that most schools (90%) practice the School Health Program but none practices a comprehensive school health services. About 55% schools seem to agree with (Ronald Stephens) that, "A safe school is foundational to the success of the academic mission" since they dwell solely on keeping a healthy school environment at the expense of the other aspects of the program.

As of the month of the research, September 2008, only 50% schools had embarked on deworming exercises and the other half had no hope for any prior to the end of the year. If 2 out of the 30 schools (6.7%) visited claim that pupils pay for screening/deworming exercises and there are about 322 basic schools in the district, then proportionally, about 21.5% schools collect money from pupils for such health services.

Again, the Guideline stipulates that the following conditions (ear, eye, dental) which, as a matter of fact, require screening should be handled, but this study revealed that due to the lack of logistics other diseases which do not require screening are rather considered. As illustrated in Figure 4.2, over 57% efforts are expended on other conditions such as skin rashes and other physical inspection.

5.3.1 Health Services

Unlike the research carried out (Adams, 2008) in Illinois, USA, where a School Health Center, located in, or near a school provides the following services: routine medical care, school/sports physicals, immunizations, nutrition counseling, health education, sexually transmitted disease testing and pregnancy testing, this study revealed otherwise. Table 4.11 shows that about 46.7% schools have no immediate access to a health facility. Thus, they are located miles away from a health facility. Such schools require vehicles/ambulances to rush a pupil to the nearest health care facility in case of an emergency. It was gathered that such schools only hope and pray against any health emergency because, it could be fatal since there were no means to curb such an incidence.

This study therefore agrees with (Lee, 2006) whose research results indicated a substantial lack of health policies in schools; it also indicated health services in schools not readily accessible to students and staff, and insufficient staff training in health promotion and education.

5.4 THE PHYSICAL ENVIRONMENT OF SCHOOLS THAT PRACTICE THE PROGRAM

As indicated by (Environmental Protection Agency., USA), a school's physical environment includes the school building and the surrounding grounds, such as noise, temperature, and lighting as well as physical, biological, or chemical agents. The checklist for this section was therefore tailored along this assertion.

5.4.1 Location/compound of the school

It was impressive to find that most schools (96.7% and 56.7% respectively) had spacious compounds with enough trees/lawns. However, the compound/playing grounds of most schools (86.7%) were found to be very dusty because the playing grounds were not cemented/filled with gravels. This, therefore, poses both long and short term threat to the health of pupils who virtually spend a chunk of the day in school.

Another aspect that came to bear was the fact that most schools had classrooms with inadequate windows. Pupils were crowded in classrooms. In some of the schools, two pupils shared a table and chair. From informal discussions held with some heads of schools, this situation had cropped up in the advent of the government's policy for free primary education for all. They disclosed the situation could worsen if urgent measures were not taken to match logistics with the level of intake of pupils. It became clear that some rooms did not qualify to be called classrooms because of the simple fact that they were comparatively small and had only one opening serving as a window apart from the door. When it was not very sunny, such 'classrooms' became dark making it almost impossible to aid reading. To make matters worse most schools had faulty/no electricity bulbs at all for lighting. Yet, the Environmental health officer said he embarked on strict inspection and enforcement of these on periodic visits.

5.4.2 Food Vendors

The guidelines require School health teachers to ensure the use of iodated salt in the preparation of food to be served the school children. This has almost become impossibility since most schools (93.3%) did not provide canteen services hence pupils relied on food vendors who brought food to the school compound for food. Interviews with most food vendors revealed that no attention at all is paid to the kind of salt used in food preparation.

Even though, all the food vendors answered they had health certificates, about 70% had never renewed their certificates and they have gotten away with it. (According to the Environmental Health Officer, the certificates are to be renewed within a period of six months). The food vendors were carefully observed taking note of their finger nails, whether they had covered their hair, their clothes etc. These were captured as personal hygiene. About 56.7% had long and dirty

finger nails, they had not covered their hair and their clothes were not neat. Even though, 90% kept their surroundings clean, the remaining 10% simply did not have waste bins for left-over foods and other rubbish. It was shocking to note that about 70% of the food vendors had no washing bowls, soaps and towels for the pupils to wash their hands after eating.

5.4.3 Sanitary Facilities

It was amazing to find out that about 60% schools did not have portable water on the compound for the school children. The pupils had to buy from ice water sellers in the compound. This meant that the probability that a pupil refuses to wash his/hers visiting attending to nature's call is alarmingly very high. Out of the schools (5) that had boreholes, the nature of that of 3 schools were not user friendly especially for the little children because of their inability to draw the water on their own.

Indeed, 9 schools had washing bowls for pupils to wash their hands but none had put them in use as of the time their schools were visited. These bowls were locked up in offices for keep. Enquiries were made why that was so, the answers were same. Thus, either there was no water or issues about the maintenance of these bowls.

Strangely enough, as much as 15 out of the 30 schools had no toilet facilities. Pupils also used the toilet for the whole community. The question here is, 'What happens to a pupil who develops diarrhea'? In several interactions, most school children hinted that they eased themselves in nearby bushes. Among the 15 schools that had toilet facilities only 2 kept this facility well maintained and clean. These were the schools that had benefitted from the Highly Indebted Poor Country (HIPC) initiative for that facility. It was gathered that the teachers ensured that the school children cleaned the facility daily. Why this cannot be done in the other schools, no one knows. It was observed that both the toilet and urinal facilities were poorly maintained making it un conducive to the health of pupils. Hence most pupils have resulted to responding to nature's call at different places other than the facilities provided for them. It was strange however to gather from the Environmental health Officer that he ensured the provision and maintenance of sanitary sites.

Again, an inspection of the waste disposal sites of the schools revealed poor maintenance and littering around the site. No wonder, the health officer said his checks depended on the availability of funds.

5.5 THE SOURCES AND EXTENT OF SUPPORT FOR THE PROGRAM

There were different ideas about who funded the program. Both nurses and teachers quoted different sources of funds for the implementation of the program. Even though, 52.6% and 40.4% teachers and nurses quoted the Government of Ghana (GoG) and Internally Generated Funds (IGF) respectively as the sources of funds, none could give the value/idea about how much is received. It was gathered from informal interviews conducted with the heads of schools that the flow of funds is not fixed. It was therefore not surprising to note that about 50.9% of both teachers and nurses stated that a program such as this, is funded on request.

In a similar study (Adams, 2008) the District Health services, DHS, funded and provided oversight to approximately 38 School Health Centers statewide in Illinois, USA. Such cannot be said about this study. This is another area where the issue of decentralization could help a great deal. The government could disburse monies for the implementation of the School Health Program to the districts so that there could be easy access by the implementers. Since the major implementers are the education and health sectors, the District GES and the GHS could work together and allocate the funds equitably among themselves to ensure an effective implementation.

Among all the health services that could be offered to school children, such as: Child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance, Immunizations, Health education, Nutrition counseling and education, the preventive services specified by the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program etc, only a hand full is provided for the school children.

Even though, the health workers knew they offered technical support in the implementation of the program, the level at which the GES comes in and ends was very clear. From informal discussions, most teachers could not believe that a lot of the work lied on their shoulders. They speculated that unless the orientation of the program changes, for an effective implementation of the program, the health sector should be made to own the program since the latter was comparatively more resourced.

5.6 THE ROLES PLAYED BY THE COMMUNITY/PARENTS IN THE IMPLEMENTATION OF THE PROGRAM

It was interesting to gather that about 59.5% knew nothing about the School Health Program. The 40.5% that felt they knew about it only based their facts on the feedback they received from the children whenever there was screening/deworming exercise in their schools. Arguably, none of the community/parents knew anything about the “School Health Program’ but they expressed desire to be involved in the implementation of the program. Table 4.11 throws more light on this issue.

This study therefore agrees with the conclusion drawn by (Maenpaa T, Astedt-Kurki P, 2008) that, parents do not know about school nurses' work and school health services. And that, they would like to be more involved in school nursing activities. The researchers hoped that when developing children's health services, parents' expertise in their children's well-being should be paid more attention.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

On the strength of the study, these conclusions and recommendations are made to facilitate and enhance the effective implementation of the School Health Program in the Kwabre District in particular and the country as a whole.

6.2 CONCLUSION

The conclusions are based on the review of the implementation of the School Health Program in the Kwabre District.

6.2.1 Structure of the School Health Program

- The study revealed that implementers are not well informed about the concept of the program. Hence some essential aspects of the program are being left out due to obvious challenges. Nonetheless, the guidelines for the program could only be got from the GES head office in Accra. There were absolutely no copies at the regional office not to mention the district office.
- What is more the program is being undermined due to a systemic problem that needs redress. It is not well funded amidst the absence of the necessary logistics for its implementation. Again, there are no structures put in place to monitor the activities of implementers.
- There is a clear uncertainty as to who owns the program. This therefore affects the delivery of services by the sectors who are actively involved in the implementation of the program.
- To the nurses who give technical support in the implementation of the program, some school children are left out. This does not auger well for the realization of the desired results/impact.

6.2.2 The Knowledge, attitude and practices of implementers

- It became evident that none of the schools practice a comprehensive School Health program. As a result the very purpose of the program is not being achieved as desired.
- Most schools do not have access to health facilities. This serves as a major weakness confronting the effective implementation of the program.

6.2.3 The Physical Environment

- The physical infrastructure and health facilities provided for school children were not in the best of conditions as of the time the research was carried out. They either endangered the lives of pupils or were simply not conducive for them. The role played by food vendors in the implementation of the program is utterly overlooked.
- The attention of the Environmental Health Officer towards ensuring an environmentally friendly compound in schools has been reduced and drifted/focused more on the compound at the expense of the former.

6.2.4 The sources and extent of support for the School Health program

- The program is not adequately funded and the necessary logistics are not provided for. Again, there are no systems/structures in place to monitor the activities of implementers, hence there is no enforcement/motivation on the part of implementers to effectively render services that uplifts the image of the program.

6.2.5 The role of the Community/parents in the implementation of the program

- The study revealed that the community/parents are unaware of the existence of such a program. As a result there is a big gap in the collaboration between them and the GES/GHS.

6.3 RECOMMENDATION

The following recommendations are made based on the conclusions of the study.

6.3.1 The Ghana Education Service

- Copies of the guidelines must be made available at the GES regional and district offices so as to make it handy for the teachers who are the owners of the program.
- There is the need for the GES (Owners of the program) to organize a rigorous sensitization/training of implementers, thus, the teachers and the Community Health Nurses (GHS) about the concept and purpose of the program. Issues about who owns the program must be trashed out as stipulated in the guidelines.
- It is acceptable that agencies could help fund the program but the main source of funding should be made clear and there should be some kind of consistency in the release of funds for implementation.
- The guidelines should be amended so that the program covers all pupils from both angles, that is, GHS or GES.
- The GES must involve the parents/community in developing health programs for schools children in order to facilitate the home-school co-ordination aspect of the school health program.

6.3.2 The Schools

- The schools must be encouraged to practice a comprehensive School Health Program in order to achieve the desired impact of the program.
- Teachers must seriously monitor the activities of food vendors.
- The schools must give feedback to parents about the welfare of their children.

6.3.3 The Ghana Health Service

- Screening/deworming exercises must be absolutely and strictly free for all pupils. Deworming exercises must be conducted in all schools nationwide at least once a year.

- Health service delivery must cover all pupils (pre-school, primary and JHS)
- Community Health Nurses should monitor the activities of food vendors.

6.3.4 The Local Government (District Assemblies)

- Since it is in the power of the Local Government to ensure that the physical infrastructure of schools are in good shape, the office of the Environmental Health Officer should be adequately staffed and well equipped to facilitate routine checks on schools.
- The activities of food vendors must be seriously monitored by the Environmental Health officers, to ensure that they renew their health certificates.
- An informal discussion with the Environmental Health Officers revealed that his office was under staffed since he had lot to concentrate on in the larger communities in the district. He cited another major challenge as transportation. As such there must be the provision of vehicle(s) to facilitate his movement around the schools.

6.3.5 The Community/Parents

- The community/parents must actively collaborate with the teachers and nurses to ensure successful implementation of the program. They could pay regular visits to the schools to find out about the welfare of their children.
- The Parent Teacher Association must ensure that the schools practice a comprehensive School Health Program.

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QUESTIONNAIRES

1. To describe the structure of the School Health Program (Class teacher/head teacher/School health teacher)

Background information (personal details)

Name of interviewee.....

Name of School.....

Position in the school.....

Number of years at post

Please tick or give answers as appropriate

1. What is the purpose of the School Health Program?
 - a. To ensure the general physical health of pupils in their school environment
 - b. To ensure the totality of all health services that improves the physical, social and mental health and development of the pupils/students in their school environment
 - a. To treat, prevent and reduce the health problems of pupils/students in their school environment
 - b. Other
Please specify,
.....

2. At what level(s) are School Health Services on prevention of ill health required?
 - a. Only Health Promotion and Prevention of diseases (i.e. immunization, nutrition, environment)
 - b. Only the Identification of problems and early intervention (health checks and appropriate action, helping children with mental and emotional problems, providing first aid, treatment and referral where necessary)
 - c. Only the management of long term problems
 - d. All the above
 - e. Other
Please specify,
.....

3. What are the main disease areas it seeks to handle?
 - a. All disease conditions
 - b. Only communicable diseases
 - c. Only non-communicable diseases
 - d. Other
Please specify,
.....

4. Which category of school children does the program cover?
 - a. All pupils (preschool, primary, JHS, SHS)
 - b. Only pupils in Pre-school, P1, P2, P3, P6 and JHS 1

- c. Only pupils in the Junior High School
 - d. Only Pupils in primary school
5. Are there structures in place for quality monitoring and evaluation?
 YES NO
6. If no, what is/are some of the reason(s)?
- a. Lack of trained personnel to facilitate the monitoring and evaluation of the program
 - b. Lack of the requisite logistics to monitor and evaluate the program
 - c. Inadequate attention/apathy towards the implementation of the program
 - d. Other
 Please specify.....
7. If yes, list the facility(ies) available for this purpose

8. Is the program subject to review?
 YES NO
9. If yes, how often is it reviewed over what period?
- a. Yearly
 - b. Every five years
 - c. As and when necessary
 - d. Not at all
10. Are implementers expected to present reports on their activities?
 YES NO
11. If yes, do they abide by this directive?
 YES NO
12. If no, what has been done about the situation so far?

13. Are the roles of implementers clearly defined?
 YES NO
14. Who owns the School Health Program?
- a. GES
 - b. GHS
 - c. District Assembly
 - d. Community

**1. To describe the structure of the School Health Program
 (Public/Community Health Nurses)
Background information (personal details)**

Name of interviewee.....
attached.....

Name of Health facility

Position in the service.....
post.....

Number of years at

Please tick or give answers as appropriate

1. What is the purpose of the School Health Program?

- c. To ensure the general physical health of pupils in their school environment
- d. To ensure the totality of all health services that improves the physical, social and mental health and development of the pupils/students in their school environment
- c. To treat, prevent and reduce the health problems of pupils/students in their school environment
- d. Other
Please specify,
.....

2. At what level are School Health Services on prevention of ill health required?

- f. Only Health Promotion and Prevention of diseases (i.e. immunization, nutrition, environment)
- g. Only the Identification of problems and early intervention (health checks and appropriate action, helping children with mental and emotional problems, providing first aid, treatment and referral where necessary)
- h. Only the management of long term problems
- i. All the above
- j. Other
Please specify,
.....

3. What are the main disease areas it seeks to handle?

- e. All disease conditions
- f. Only communicable diseases
- g. Only non-communicable diseases
- h. Other
Please specify,
.....

4. Which category of school children does the program cover?

- e. All pupils (preschool, primary, JHS, SHS)
- f. Only pupils in Pre-school, P1, P2, P3, P6 and JHS 1
- g. Only pupils in the Junior High School
- h. Only Pupils in primary school

5. Are there structures in place for quality monitoring and evaluation?
 YES NO
6. If no, what is/are some of the reason(s)?
 e. Lack of trained personnel to facilitate the monitoring and evaluation of the program
 f. Lack of the requisite logistics to monitor and evaluate the program
 g. Inadequate attention/apathy towards the implementation of the program
 h. Other
 Please specify.....

7. If yes, list the facility(ies) available for this purpose

8. Is the program subject to review?
 YES NO
9. If yes, how often is it reviewed over what period?
 b. Yearly b. Every five years c. As and when necessary d. Not at all
10. Are implementers expected to present reports on their activities?
 YES NO
11. If yes, do they abide by this directive?
 YES NO
12. If no, what has been done about the situation so far?

13. Are the roles of implementers clearly defined?
 YES NO
14. Who owns the School Health Program?
 a. GES
 b. GHS
 c. District Assembly
 d. Community

1. To describe the structure of the School Health Program

(School Health Program Coordinator/Public Health Nurse)

Background information (personal details)

Name of interviewee.....

Number of years at post.....

Please tick or give answers as appropriate

1. What is the purpose of the School Health Program?
 - a. To ensure the general physical health of pupils in their school environment
 - b. To ensure the totality of all health services that improves the physical, social and mental health and development of the pupils/students in their school environment
 - c. To treat, prevent and reduce the health problems of pupils/students in their school environment
 - d. Other
Please specify,
.....

2. At what level are School Health Services on prevention of ill health required?
 - a. Only Health Promotion and Prevention of diseases (i.e. immunization, nutrition, environment)
 - b. Only the Identification of problems and early intervention (health checks and appropriate action, helping children with mental and emotional problems, providing first aid, treatment and referral where necessary)
 - c. Only the management of long term problems
 - d. All the above
 - e. Other
Please specify,
.....

3. What are the main disease areas it seeks to handle?
 - a. All disease conditions
 - b. Only communicable diseases
 - c. Only non-communicable diseases
 - d. Other
Please specify,
.....
.....

4. Which category of school children does the program cover?
 - a. All pupils (preschool, primary, JHS, SHS)
 - b. Only pupils in Pre-school, P1, P2, P3, P6 and JHS 1
 - c. Only pupils in the Junior High School
 - d. Only Pupils in primary school

5. Are there structures in place for quality monitoring and evaluation?
 YES NO

6. If no, what is/are some of the reason(s)?
 - a. Lack of trained personnel to facilitate the monitoring and evaluation of the program
 - b. Lack of the requisite logistics to monitor and evaluate the program
 - c. Inadequate attention/apathy towards the implementation of the program
 - d. Other
 Please specify.....

7. If yes, list the facility(ies) available for this purpose

8. Is the program subject to review?
 YES NO

9. If yes, how often is it reviewed over what period?
 a. Yearly b. Every five years c. As and when necessary d. Not at all

10. Are implementers expected to present reports on their activities?
 YES NO

11. If yes, do they abide by this directive?
 YES NO

12. If no, what has been done about the situation so far?

13. Are the roles of implementers clearly defined?
 YES NO

14. Who owns the School Health Program?
 - a. GES
 - b. GHS
 - c. District Assembly
 - d. Community

2. To assess the knowledge, attitudes and practices of implementers of the School Health Program.

(Class teacher/ head teacher/ school health teacher)

1. Does your school practice the School Health Program?

YES NO

2. If no, why?

.....

3. If yes, what aspect (s) of it is practiced mainly?

- a. Health Instruction
- b. Healthful School Environment
- c. Health Services
- d. School-Home Coordination

4. Is there a school health teacher in this school?

YES NO

5. What are his/her role(s) and responsibility (ies)?

- a. To confer with the school medical personnel when the health status of the child is under threat
- b. To develop meaningful health instruction program and serve as a model of good health habits
- c. To continually observe the children to determine their health status
- d. To understand the growth and development characteristics as well as the health needs of the children
- e. Other, please specify.....

6. Are there any other supporting staff?

YES NO

7. Are there health service personnel who come in to support the program?

YES NO

8. Do the children (sometimes) pay for screening/deworming exercises?

YES NO

9. If yes, about how much does each child pay for such a service?

- a. Less than 20Gh pesewas
- b. More than 20Gh pesewas

10. How many times do the health workers come for inspection/screening?

Once/term

Rarely

22. How does your office monitor the implementation of the program by the teachers and the health service personnel?

.....
.....
.....

23. Are parents involved in the health affairs of their children?

YES NO

24. If yes, how do they offer their support?

- a. They collaborate with teachers in managing the health needs of their children
- b. They show concern about how best to meet the health needs of their children
- c. They provide home care
- d. All the above
- e. Other

please

specify.....

25. Are parents given feedback/reports on their children about School Health programs?

YES NO

26. Do you think the School Health Program is having any positive impact on the children?

YES NO

27. If no, what do you think is the problem and in your opinion what can be done to remedy the situation?

.....
.....
.....

28. If yes, what has/have been the success (es)?

.....
.....
.....

2. To assess the knowledge, attitudes and practices of implementers of the School Health Program.

(Public/Community Health Nurse)

Please tick or give answers as appropriate

1. How often do you visit a school for screening/inspection?

Once/term

Twice/term

More than twice/term

2. Averagely about how many referral cases occur in a term in the district?
 - a. Below 5
 - b. Between 5-10
 - c. More than 10

3. What are the most prevalent cases that call for referrals?
 - a. Communicable diseases(skin rashes, etc)
 - b. Eye problems
 - c. Ear problems
 - d. Dental problems
 - e. Other please specify.....

4. Do you get any feedback from referrals?
 YES NO

5. In case of a referral, who does the follow-up?
 - a. The parents of the children
 - b. The teachers
 - c. The health workers
 - d. All the above
 - e. Other please specify.....

6. Do you receive cooperation from the heads/teachers of the various schools?
 YES NO

7. If no, what is the cause/problem

8. How many schools are you able to visit in an academic term?
 - a. Below 5 schools b. Between 6-10 schools c. More than 10 schools

9. Do you have the necessary logistics to embark on screening programs?
 YES NO

10. If no, what is/are lacking?

11. Is there any flow of funds for the School Health Program?
 YES NO

12. What are some of the health education topics you normally handle when you visit the school?
- a. Reproductive Health topics
 - b. Personal hygiene
 - c. Management of some disease condition
 - d. All the above
 - e. Other, please specify.....

13. Is the School Health Program serving its purpose?

YES NO

14. If no, what should be done to remedy the situation?

.....
.....
.....

15. If yes, give some achievement(s) or positive impact of the program.

.....
.....
.....

16. Is there any conflict in roles between the GHS and the GES in the implementation of the program?

YES NO

17. If yes, what is/are some of the conflicts?

.....
.....
.....
.....

18. Do you write reports on your activities?

YES NO

19. How often do you do this?

- a. Monthly
- b. Quarterly
- c. every six months
- d. yearly

20. Who do you write the reports to?

.....
.....

**3. To describe the physical environment of schools that practice the program?
(Investigator)**

| ISSUE | GRADING |
|---|--|
| LOCATION/COMPOUND OF THE SCHOOL | |
| 1. Where is the school located? | a. an area with a lot of noise b. an area with little/no noise |
| 2. Is the compound spacious | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 3. Is the compound dusty? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 4. Are there enough trees/lawns? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| VENTILATION/LIGHTING | |
| 1. What is the size of the classrooms? | |
| 2. Are there enough windows in each classroom/is there means to ensure proper ventilation? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. How many pupils sit in a class? | |
| 4. Are they well spaced? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 5. Is there enough lighting in the classrooms? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| FOOD VENDORS | |
| 1. Do food vendors look healthy? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| Have/do they renew their health certificates yearly as required? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 2. Do they maintain personal hygiene?(indicators: short finger nails, covered hair, neat clothes) | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 3. Do they keep their surroundings clean? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 4. Do they have washing bowls, soaps, neat towels, etc. | NOT QUITE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |
| SANITARY FACILITIES | |
| 1. What is the source of water for the children? | a. Pipe borne b. Bore hole c. Well d. No source of water at school premise d. other, please state..... |
| 2. Are there washing bowls, soaps and towels for the school children to wash their hands after they visit the toilet, play etc? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 3. Are toilet facilities accessible to pupils and staff? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 4. What type of toilet facility is provided for the school? | a. KVIP b. Pit Latrine c. Water closet d. other please state..... |
| 5. Are these facilities conducive to health and maintained well? | NO <input type="checkbox"/> YES <input type="checkbox"/> |
| 6. Is the urinal separate from the toilet facility? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 7. Is there a functional urinal? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

4. To determine the sources and the extent of support for the School Health Program. (Public/Community Health Nurse),

1. What is/are the source(s) of funding of the School Health Program?
 - a. From the Government of Ghana
 - b. From the PTA
 - c. Donor Agencies
 - d. Internally Generated funds
 - e. Children contribute/pay for health services
2. How often does this fund come to the implementers?
 - a. On request
 - b. Quarterly
 - c. No support
 - d. Yearly

3. Are there the necessary logistics for the implementation of the program?
 YES NO

4. If no, what essential logistic(s) is/are not available?

5. Do implementers undergo some periodic training?
 YES NO

6. What is the level of involvement of GHS?

7. Is/are there any conflict in the roles played by the GHS and GES?
 YES NO

8. If yes, what is/are the conflict in roles?

9. What can be done to remedy the situation?

10. Do parents show interest and support in maintaining the health of their children?
 YES NO

**4. To determine the sources and the extent of support for the School Health Program.
 (School health teacher, head master)**

1. What is/are the source(s) of funding of the School Health Program?
 - a. From the Government of Ghana
 - b. From the PTA
 - c. Donor Agencies
 - d. Internally Generated funds
 - e. Children contribute/pay for health services

2. How often does this fund come to the implementers?
 - a. On request
 - b. Quarterly
 - c. No support
 - d. Yearly

3. Are there the necessary logistics for the implementation of the program?
 YES NO

4. If no, what essential logistic(s) is/are not available?

5. Do implementers undergo some periodic training?
 YES NO

6. What is the level of involvement of GES?

7. Is/are there any conflict in the roles played by the GES and GHS?
 YES NO

8. If yes, what is/are the conflict in roles?

9. What can be done to remedy the situation?

10. Do parents show interest and support in maintaining the health of their children?
 YES NO

**4. To determine the sources and the extent of support for the School Health Program.
 (SHEP Cordinator)**

1. What is/are the source(s) of funding of the School Health Program?
- a. From the Government of Ghana
 - b. From the PTA
 - c. Donor Agencies
 - d. Internally Generated funds
 - e. Children contribute/pay for health services

2. How often does this fund come to the implementers?
- a. On request
 - b. Quarterly
 - c. No support
 - d. Yearly

3. Are there the necessary logistics for the implementation of the program?
- YES NO

4. If no, what essential logistic(s) is/are not available?

.....
.....

5. Do implementers undergo some periodic training?

YES NO

6. What is the level of involvement of GES?

.....
.....
.....
.....

7. Is/are there any conflict in the roles played by the GES and GHS?

YES NO

8. If yes, what is/are the conflict in roles?

.....
.....
.....

9. What can be done to remedy the situation?

.....
.....
.....
.....

10. Do parents show interest and support in maintaining the health of their children?

YES NO

5. To describe the roles played by the community and parents in the implementation of the program.

(Parent/some community elders)

Background information (personal details)

Name of parent..... Name of community.....

Position of interviewee in the community.....

.....

Name of School attended by child (ren).....

Please tick appropriately.

1. Do you know about the School Health Program?

YES NO

2. If yes, what do you know about it?

- a. To ensure the general physical health of pupils in their school environment
- b. To ensure the totality of all health services that improves the physical, social and mental health and development of the pupils/students in their school environment
- c. To treat, prevent and reduce the health problems of pupils/students in their school environment
- d. Other please specify.....

3. What role do you play as a parent/community to support the program?

.....
.....
.....
.....

4. Are you able to meet the health needs of your child/children as a parent/community?

YES NO

5. If no, what happens to the child/children when he/she/they fall(s) sick?

.....
.....
.....

6. Have you and your children registered with the National Health Insurance Scheme?

YES NO

7. Does the school involve you in your child's/children's wellbeing regarding his/her health?

YES

8. If yes, how do you offer your support?

- a. Monitor my child(ren)'s health (in terms of diet, personal hygiene etc)
- b. Takes him/her/them to the medical facility for frequent check-ups
- c. Collaborate with teachers and nurses to improve my child(ren)'s health, development and growth
- d. Other please
specify.....
.....

9. Does the school bring you feedback/report on School Health Programs concerning your child (ren)?

YES

NO

TABLE 1: MINISTRY OF LOCAL GOVERNMENT AND RURAL DEVELOPMENT

Target: immediate School environment and larger community

Persons responsible: Environmental Health officers, Assembly members

| No | ACTIVITIES | PERSON RESPONSIBLE | FREQUENCY | FREQUENCY AS PRACTICED |
|----|---|---|---|------------------------|
| 1 | *Conduct environmental hygiene inspection of general school environmental conditions (classroom, compound, toilet facilities etc) | Teachers/Environmental health Officers | Daily/weekly | |
| 2 | *Provision and maintenance of sanitary sites | District assembly/GES | As and when necessary | |
| 3 | *Ensure provision and maintenance of waste disposal sites | District assembly/GES | As and when necessary | |
| 4 | *Ensure provision and maintenance of school structure | District assembly/GES/community | When the need arises and as per assemblies development plan | |
| 5 | *Ensure that schools meet safety and health promotion specification (lighting, ventilation, recreational grounds etc) | District assembly/GES/EPA | Before the issue of building permit and during periodic inspection | |
| 6 | Organize environmental inspection and certification of schools | Environmental health officer | Once a year | |
| 7 | Ensure the provision of portable water, sanitary facilities and recreational grounds | District assembly/GES | As and when necessary, during celebration of district sanitation week/school hygiene inspection | |
| 8 | Liaise with GHS in certifying food vendors | Environmental health officers/ medical officers | Annually | |
| 9 | Inspect school sports field and physical exercise equipments | Environmental health officers/ medical officers | Annually | |
| 10 | Enact bye-laws to ensure safety | District assembly/GES | As and when necessary | |

Source: Guidelines for provision of School Health Service in Ghana

TABLE 2: GHANA EDUCATION SERVICE

Target classes: All classes

Persons Responsible: Class teacher, School Health Teacher, Head teacher

| NO | ACTIVITIES | FREQUENCY | AS PRACTICED |
|----|---|---|--------------|
| 1 | Organize general hygiene inspection eg hair, nails, clothing, check skin for rashes, sores or dryness, the teeth etc | Twice a week | |
| 2 | Observe and monitor hearing speech and language abnormalities for referral and management | Daily | |
| 3 | Observe and monitor visual impairment, eye disorders like redness, eye discharge etc for referral and management | Daily | |
| 4 | Look out for mental health and behavioral problems | Daily | |
| 5 | Monitor activities of food vendors and ensure the use of iodated salt. Also if possible the food preparation area | Daily/weekly | |
| 6 | Ensure the provision and maintenance of water and sanitation facilities in the school | Daily | |
| 7 | Ensure hand washing of children after defecation, play and before meals | Daily | |
| 8 | Ensure daily supply of water | Daily | |
| 9 | Organize personal hygiene and general health promotion activities | once a month | |
| 10 | Liaise with the local Ghana Health Service (GHS) at the various levels for a meaningful celebration of District, Regional, National and International Health Days | as and when necessary | |
| 11 | Organize a School Health promotion week | Once a year | |
| 12 | Assess the school environment and structures and report to the appropriate authority | Once a year | |
| 13 | Ensure that all school children have health record cards, filled and updated regularly | Beginning of term and as and when necessary | |
| 14 | Plan and see to the implementation of in-school and community health promotion activities collaborating with the GHS and District Assemblies | Quarterly | |
| 15 | Observe, record and report episodes of communicable diseases and other suspected diseases for disease surveillance | as and when necessary | |
| 16 | Liaise with GHS Health Promotion Unit and CRDD (GES) to collect and develop child friendly appropriate IE&C materials for the school children | as and when necessary | |
| 17 | Organize school children for Vitamin a supplementation programs | as and when necessary | |
| 18 | Organize school children for deworming and other health activities | Twice a year | |
| 19 | Plan and budget for equipment and logistic for School Health activities | Once a year | |
| 20 | Ensure that schools have functioning first aid boxes at all times | Once a month | |
| 21 | Provide facility for emergency care | During emergencies, as and when necessary | |
| 22 | Organize orientation and training for teachers, food vendors, domestic bursars and matrons on food hygiene, food storage and presentation | Once a year | |
| 23 | Ensure health screening of food vendors, personnel of canteens, school kitchens etc in boarding schools | Once a year | |
| 24 | Ensure every child gets adequate physical exercise | Once a week | |

Source: Guidelines for provision of School Health Service in Ghana

TABLE 3: GHANA HEALTH SERVICE

Target Classes: Preschool P.1, P.3, JSS 1, SSS 1 including vocational and technical

Frequency: Once, upon entry into the above classes

Persons responsible: Public /Community Health Nurses

| NO | ACTIVITIES | FREQUENCY | AS PRACTICED |
|----|---|--|--------------|
| 1 | Conduct general physical examination | Once a year for those classes(pre-school, p.1,p.3,JSS 1, SSS1/vocational and technical students) | |
| 2 | Organize vision testing | Same | |
| 3 | Organize hearing speech and language screening | Same | |
| 4 | Check immunization status | Pre-school 2X a year JSS/SSS for TT/CSM and YF | |
| 5 | Organize Psychiatry and behavioral problem screening | Once a year for the selected classes but for SSS all classes | |
| 6 | Organize oral health screening | Once a year | |
| 7 | Organize selective deworming of school children | Once a year | |
| 8 | Organize consultation and referrals | As and when necessary(on demand) | |
| 9 | Organize orientation and training for teachers and food vendors, domestic bursars and matrons on food hygiene, personal hygiene food storage and presentation | Once a year | |
| 10 | Health screening for food vendors, personnel of canteens, school kitchen, etc in boarding schools | Once a year | |
| 11 | Organize health screening for teachers | Once a year | |
| 12 | With the support of Environmental Health unit of the District Assembly, award health certificates to food vendors | Once a year | |
| 13 | Provide Vitamin A supplements and any drugs required for mass treatment/immunization e.g. deworming | Twice a year/ as specified | |
| 14 | Collect, analyze and submit data on the health profile of pupils and students | Quarterly and annually | |
| 15 | Growth promotion (weight/height measurement and provide appropriate/ relevant health education) | Once a year | |
| 16 | Liaise with GES to organize Health promotion activities | Three times a year(once a term) | |
| 17 | Liaise with the GES/SHEP coordinators to educate and involve schools in the celebration of district/regional/national and international health day celebrations | As and when necessary | |
| 18 | Provide health certificates | Once a year | |
| 19 | Advice on general health issues during each school visit | Once a year | |
| 20 | Provide clinical care and assistance during school visit | Once a year | |
| 21 | Plan and budget for equipment and logistics for school health activities | Once a year | |
| 22 | Advice and monitor contents of first aid box | Once year | |
| 23 | Ensure the use of iodated in cooking in school canteens, boarding houses | Daily | |
| 24 | Ensure adequate physical exercise through health promotion activities | Once a term | |

Source: Guidelines for provision of School Health Service in Ghana

