DETERMINANTS OF HEALTH PRACTICES AMONG THE STUDENTS OF TERTIARY INSTITUTIONS IN KANO STATE

BY

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CERTIFICATION

This thesis entitled DETERMINANTS OF HEALTH PRACTICES AMONG THE STUDENTS OF TERTIARY INSTITUTIONS IN KANO STATE meets the regulations governing the award of the degree of M.Sc. (Ed) in Health Education of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DECLARATION

I declare that the work in the thesis entitled Determinants of Health Practices Among the Students of Tertiary Institutions in Kano State has been performed by me in the Department of Physical and Health Education under the supervision of Prof. (Mrs) F. B. Adeyanju and Prof. C. A. Okuofu. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this thesis was previously presented for another degree or diploma at any University.

_____	_____	_____
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DEDICATION

This work is dedicated to my dear wife (Medinat) and my children. It is also to the everlasting memory of my parents.

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Special thanks to Almighty Allah and profound thanks to my family as well as to all others who assisted me in one way or another for the success of this research work.

ABSTRACT

The Health practices in 4 (four) tertiary institutions in Kano state was appraised. A total of 400 Students were selected randomly from Beyero University Kano, F.C.E. Kano, College of Education Kumbotso and College of Health Sciences for the administration of a structured questionnaire.

Data collected were subjected to analyses by means of SPSS Computer Package 2002 edition. One major and four sub- hypotheses were raised concerning the health practices and other variables like health instruction, health services, healthful living in schools and home-community relationship.

Using the Pearson product Moment Correlation Procedure, it was observed that all the variables were significantly related to health practices in the institutions. So, the null hypotheses were rejected.

Therefore, it is recommended that health instruction, health services, healthful school living and school home and community relationship be emphsised in the chosen tertiary institutions in Kano State to improve the living standards of students.

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CHAPTER ONE

1.1 Introduction

Desirable health practices represent the application of good health habits to one's routine living. The health practices that a person adopts will determine in great measure the health of that person. Practices or habits which are harmful to optimum health, such as failure to obtain proper rest or exercise, overeating, over drinking and over smoking, or failure to observe certain precautions against contracting diseases, will usually result in poor health.

Knowledge does not necessarily ensure good health practices. An individual may have at his command all the statistics as to the results of speeding at 70 miles an hour, yet unless this information is applied, it is useless. The health of an individual can be affected only by applying that which is known. At the same time, knowledge will not usually be applied unless an incentive, interest, or attitude exists which impels its application.

It can be seen, therefore, that in order to have a good school health programme, it is important to recognize the close relationship that exists among health knowledge, health attitudes and health practices, (Bucher, 1979.

In order to accomplish the health knowledge objective, health education must present and interpret scientific health data which will then be used for personal guidance. Such information will help individuals to recognize health problems and solve them by utilizing information which is valid and helpful. It will also serve as a basis for the formulation of desirable health habits and practices. In the complex society that exists today, many choices confront the individual with regard to factors that affect his health. For this reason, a reliable store of knowledge is essential.

Turner (1971) posited that, the acquisition of knowledge alone does not and will not bring about health practices. He believes that, the application of the knowledge to everyday life brings about health practices.

Some of the areas of health knowledge that should be understood by students and adults include nutrition, the need for rest, sleep and exercise, protection of the body against changing temperature conditions, contagious disease control, the dangers of self medication and community resources for health. If such topics are brought to the attention of persons everywhere, and if the proper health attitudes and practices are developed, better health will result.

Previously in Nigeria, emphasis was placed on curative services. But of recent, emphasis is now shifting towards prevention of diseases through health education progrommes. Furthermore, the Nigeria National Health policy of 1988 as well as the strategy for achieving health for all by the year 2000 have to some extent, reduced to the minimum, some of the health problems, (Federal Ministry of Health, 1990). This has been achieved by education and made more effective through the primary health care strategy.

It is pertinent to note that only the appropriate health education of the public can induce the awareness, motivation, mobilization and practices needed. Since health education involves behavioural change and hence is a slow process, the impact of health education is not all that glaring in most of our society. This is because a lot of policies do hinder the role being played by health education. As such, there is clearly a need to formulate sound policy on health education with much emphasis on the practices.

The quality of an educational institution is reflected in the quality of students. This claim makes it of paramount importance the need to give priority attention to health knowledge and the practical application of the acquired knowledge in our tertiary institutions. Health education is

a programme of training and a study designed to equip the students with the knowledge, habit and practices that will enable them enjoy good health both during the school days and in later life. It is not just a body of knowledge studied in the school but that which through action of both members of the school and community transforms or changes people's health behaviour with good health practices. Health practices need a cooperative effort for positive change in health status of every individual. It is regarded as both a teaching process and performance process. This implies that the school health education programme should include the totality of health experiences (theoretical and practical, formal and informal) to which a child is exposed in the school environment with regard to the formation of positive health habits, knowledge and practices.

Health educators are by definition, promoters of good life style which seek to achieve optimal potential in the area of physical, spiritual, vocational, intellectual, emotional and social health (Ajala, 1986, Ajibola, 1998 & Ogunsakin, 1984). Health Educators not only promote healthy life styles, but strive to motivate individuals to foster positive attitudes towards the value of health through appropriate knowledge and

practices (National Task Force on the preparation and practice of Health Educators, 1982:49).

Given the level of education already attained by lecturers and learners in our tertiary institutions, one can say these people are aware that health is something an individual can achieve for himself or herself and not something to be provided by the doctors. One may also be tempted to say that most members of our tertiary institutions are aware of the fact very many diseases prevalent in our communities could have been avoided by observing basic rules of hygiene.

Health practice is part of Health Education which is a subject of primary importance that engages a multidimensional or multidisciplinary approach to our daily activities in the society, especially in our schools. As a result of its multi-disciplinary approach, everybody believed that he or she can teach the subject. This problem has been further compounded by the general misconceptions that health education could be equated to Biology or other science subjects.

According to Udoh (1991), Health Education is a relatively new discipline or area of knowledge whose contents have grown for the pulling together of ideals, facts and knowledge from research findings

and other disciplines, notably medical and biological sciences as well as the science that deal with human behaviour and people's culture.

One of the most significant actions affecting the programme of health generally is decision-making and the general utilization of knowledge, facilities and equipment in our schools. The choices and decisions we make can have a direct bearing on our health and effective living generally. In the light of the above discussions, the researcher finds it very important to study the determinants of health practices among the students of tertiary institutions in Kano State.

1.2 **Statement of the Problem**

By its virtue, health education is generally supposed to serve as role model being potential agent of promoting health knowledge, behaviour and health practices. During the researcher's twenty years of teaching in primary through the secondary and tertiary institutions, the researcher's observation has been that most of the teachings in our schools with respect to health education are more theoretical than practical.

It is also sad to note that although a greater percentage of the people in our tertiary institutions are literate, the health practices and attitudes of some of them could bring about health problems to the

individual as well as the general community. While one may admit that health education is better handled at the tertiary level than primary and secondary schools, one can regrettably note the lack of quality and availability of equipment and facilities. There are also some negative attitudes towards the proper utilization of these materials to promote healthy practices. It is a common knowledge that, there has been thorough teaching, provision of health facilities, equipment and proper campaign over medias, i.e. radio television, newspapers, magazines, etc. but still there is no significant positive change in the attitude of people, particularly students' towards healthful living practices, e.g. promotion of students environment, accident prevention, emotional climate of school, etc.

The present health situation in most of our tertiary institutions calls for the need to embark on and observe health practices that are purposeful in nature. In the light of the above, the researcher intends to find out the determinants of health practices among the students of tertiary institutions in Kano State.

1.3 **Research Questions**

Based on the above statement of problem, the following questions were formulated:

(1) Does the health instruction influence students' health practices?

(2) Are there available health services in the institutions of higher learning in Kano State?

(3) Does the healthful school living influence students' health practices?

(4) What are the roles of school, home and community in the health practices among students of higher learning in Kano State?

1.4 Research Hypothesis

The following hypothesis has been proposed for this study:-

Major Hypothesis

There is no significant relationship of Health instruction, Health services, Healthful school living, School-home and community environment with Health practices among students of tertiary institutions in Kano State.

Sub-Hypothesis

(1) Health instruction would not have significant relationship with health practices among students of tertiary institutions in Kano state.

(2) Health services would not have significant relationship with health practices among students of tertiary institutions in Kano State.

(3) Healthful school living would not have significant relationship with health practices among students of tertiary institutions in Kano State.

(4) Relationship between the school, home and community would not have significant relationship with health practices among students of tertiary institutions in Kano State.

1.5. **Objective of the Study**

The health of students is proper and primary concern of every management and therefore the objective of this study is to investigate on the health instruction, health services, healthful school living, school home and community relationship towards influencing students health practices to improve their living standards.

1.6 **Significance of Study**

The health of the students and other school workers is considered as a key factor in achieving the school objectives. Therefore, this study will enable the learners to think critically and make reasonable judgment concerning their health practices at school, home and society with the view of improving the practices.

It will also increase the likelihood of professional success in improving both the health of the students and other members of the school community.

This study, just like any research work, is meant among other things to help intending researchers wishing to carryout research on the similar area of study, thereby increasing the literature review. The findings will be beneficial to the students and other school workers in promoting their health.

1.7 **Delimitation of the Study**

The study is limited to selected four (4) tertiary institutions offering health education as part of their programme of study. The institutions include the following:-

(i) Bayero University, Kano

(ii) Federal College of Education, Kano

(iii) Kano State College of Education, Kumbotso

(iv) College of Environmental Technology (School of Hygiene), Kano.

The variable to be examined is delimited to the health practices through the available health education progrommes offered in the selected tertiary institutions in Kano – State:- The determinants of

Health practices include – Health instruction, Health services, Healthful school living, School-home and Community relations.

1.8 Limitation of the Study

This study is concerned with some students of Health and Physical Education Department in Kano State tertiary institutions. The findings are therefore limited to the selected group and within the state. The collection of the data was only possible after much protocol and even then, the researcher could not get the complete cooperation from some respondents.

1.9 Definition of Terms

(1) **Health:** A complete process of wellbeing and not merely the absence of disease or deformities.

(2) **Health Education:** This is the type of education received for the betterment of humanity.

(3) **School Health Programme:** It is the kind of programme in a school setting mainly to look into the wellbeing of the pupils/students and other members of the school community.

(4) **School Health Instruction:** This is the kind of instruction given to students in school especially in connection with health.

(5) **School Health Services:** These are the kind of services rendered in school, in connection to health.

(6) **Healthful School Living:** This is a conducive environment made available in school, pertaining to health.

(7) **Relationship between the School, Home and Community:** This includes the relationship that exists between the school, home and community.

CHAPTER TWO

2.0 REVIEW OF RELATED LITERATURE

2.1 Introduction

There has been in recent years a great awareness of the importance of Education in improving the lots of Nigerian populace and the important role which education plays in socio-economic system and development of any nation. The investment on education in recent budgets had further highlighted and re-emphasized the federal and state governments' intention to make education one of their priorities in the development of this country. This is adequately reflected in the large sums of money devoted to various programmes of education. However, in order to maximize the gains accruing from such a huge investment, the school children and personnel who attend and make proper use of the school environment must be in a good condition of health through various school health education progrommes. This chapter therefore reviews pertinent literature on the following areas:

- Determinants of health practices
- The concept of health
- An overview of Health Education programme
- A brief History of the selected tertiary institution

- Reasons for Health Education in our school
- Aims and objectives of health education
- Overview of school health programme
- The scope of school health programme
- Administration and planning of school health progrommes
- Healthful living and practice
- Summary

2.2 **A Review of the Concept of Health**

Several authorities have defined health in different ways. Health is a word with a wide range of meanings and interpretations. Health is a dynamic process not a static condition and it has positive as well as negative aspects. Therefore, it is regarded as a means to an end and not an end in itself.

Eroegbu, (1999) explained that each author defines health to suit his own concept of the term. What is important, however, is not the ability to recite what health means but to have a clear concept of what good health implies and conscious and serious efforts to secure and maintain good health. He believes that health is a relative term, hence what "A" may consider good health may mean a slightly or even completely different thing to "B". One point is clear here about the

definition given by World Health Organization (WHO) that health does not necessarily imply the absence of disease and infirmity, but a state of complete physical, mental, emotional and social wellbeing. Even this explanation has met some criticisms because of the use of the term complete. Some people believe that the word "complete" is absolute and unattainable. They agreed that it is very difficult or near impossible for man to attain a level of completeness in terms of health.

Other schools of thought, however, agree with WHO's definition. These people feel that good health implies the presence of all components i.e. physical, mental, emotional social wellbeing. To this group, the term "complete" does not necessarily mean a hundred percent absoluteness in each of the components but rather that all the ingredients, physical mental, emotional and social must be present. This school of thought contends that as long as an individual can live his life effectively and enjoyably with the entire component of health enumerated above to an appreciable degree, the individual can be said to enjoy good health. According to Nwana (1987), "Health is one of the cardinal objectives of education".

Without health life cannot offer vitality which accompanies well being. The National Policy on Education (1981), acknowledges this

when it ruled that “the quality of instruction at all levels of education has to be oriented towards inculcating the promotion of the emotional, physical and psychological health in all children”

Ajibola (1998) asserted that health is a functional activity. It deals with the process of living and its needs. Health is that quality of physical, emotional and mental well-being that enables one to live effectively and enjoyable. He further explained that the state of well-being that makes an individual live and work at his optimum efficiency is regarded as the functional health status of such a person. The attainment of maximum functional health status gives individual desirable quality of life zeal to face, with vigour the challenges of life.

Obisanya, (1998), in Oberteuffer, (1972) described health as “the quality of life that renders the individual fit to live most and to serve best: Also health is said to be the condition of the organism which measures the degree to which its aggregate powers are able to function”. Health according to Udoh & Ajala, (1987), is a quality resulting from the total functioning of the individual in his environment that empowers him to achieve a personally satisfying and socially useful life. They stated that certain concepts of health are clearly seen in the above definition. Such concepts include the perception of health:

(i) As the unity of the individual;

(ii) As a quality of life;

(iii) As an achievement of personally satisfying

(iv) Life and

(v) As an achievement of socially useful life.

Health is also described by Udoh & Ajala (1987) as that quality which enables an individual to face up to crisis, carry out his daily responsibilities efficiently and relate to other persons effectively. An individual, though of many parts, is made up physiologically of cells, organs and systems and having physical, mental and social dimension, and functioning as a unit. The implication of an individual functioning as an integrated unit means that whatever affects any part of the individual's make-up also affects other parts, brings about certain changes in other parts, brings about disequilibrium in the individual's constitution to a point whereby functioning is either slightly or grossly impaired. Being in health has to do with the degree of disequilibrium factors affecting an individual's normal life. This has nothing to do with whether an individual is strong or weak, a midget or giant or even physically disabled. We regard one as being in health if everything inside him is

functioning to an extent that is able of function effectively, physiologically, intellectually and socially. This means that health considers the totaling of an individual and not just a part of him.

Health is a quality of life is a result of one's total functioning within his environment. How effective an individual's level of living is, determines his quality of life. The implication of the quality of life is that an individual utilizes to the fullest his innate powers and all his capacity of living. Effective is a resultant of an individual's functioning in a variety of life activities including physical, mental, social and spiritual experiences. What an individual does such as his work, leisure activity, his food habits, his interactions with other persons, his successes and failure etc. all combine to determine his quality of life and how effectively an individual lives his life.

Ajala, (1987) opined that health is a phenomena on which is not restricted only to an individual. Although an individual is necessarily concerned with his own health, it also involves the home and the larger community to which an individual belongs and of which is an integral part. He stated that good health requires an achievement of a socially useful life, and just as an individual's culture and environment influence, the effectiveness of his life, he must also make an effective contribution

to the health and welfare of his society. An individual who works for a cause greater than himself is one who achieves a socially useful life.

Health as explained by Young & Durstan, (1987), is both the resource and source of growth for any nation. It is the base for economic efficiency, self satisfaction, effectiveness, satisfying life and self realization. They see health as a dynamic factor and not a static entity that ranges from zero level to the highest level.

Some other authorities in the field of health stress concepts such as the three dimensional make-up of health-physical, mental and social – and not merely the absence of disease or infirmity; the homeostatic balance that enables human beings to function; the adaptability of the individual to various environmental factors affecting his or her well-being and the readiness of the individual to meet present and future needs. All these concepts reflect what is meant by health (Obisanya 1998).

Adegbite, (2000) indicated that the notion that health is merely absence of disease is not adequate in terms of modern needs and present day understanding of health. It is a fact that anybody who is free from disease and disabling defects is considered to have an acceptable level of health, but the term health encompasses more than this. Today health is

viewed as a quality of being mentally, physically and emotionally well-being of individual which enables one to live effectively and enjoyable within the norms of the society. She also said that a healthy person should be able to adjust to his physical environment e.g. temperature and he/she should be able to carry out his/her daily work without undue fatigue.

From the above discussion one can deduce some points of agreement between the various schools of thought in their concept of health. First, that the individual should be able to live in the society where he or she belongs and function effectively and should not show signs of illness and infirmity as well as pronounced deviation from the norms of the society. Thus, this researcher sees health as that quality of physical, emotional, mental and social well-being that enables one to live effectively and enjoyably and get on well with his neighbours and other members of the society.

Health must be considered in relative terms since the final criteria of effective and enjoyable living are not absolute terms either quantitatively or qualitatively. Health should be viewed as a means to a more prosperous and fruitful living, hence the old adage that “health is wealth”. Anybody in possession of it has a priceless possession.

From the above definitions and explanation, one can see that health is influenced by the interaction of many hereditary and environmental factors and conditions over which the individual may exercise varying amounts of control. Therefore, we all have responsibilities for our health generally.

In related publications on the HIV/AIDS pandemic, (Anarfi, 2000; Barnes, 2000; Magambu, 2000; Mwape, & Kathuria, 2000; Nzioka, 2000; Otaala, 2000; Seclonde, 2000), the dangers of HIV/AIDS to all peoples around the world, but particularly to people in Africa are now a matter of public record. The dangers posed to institutions such as Universities which are vulnerable to many adverse effects of HIV/AIDS are also a matter of public record. In recognition of this situation the Working Group on Higher Education (WGHE) of the Association for the Development of Education in Africa (ADEA) decided to undertake case studies on the way HIV/AIDS affects some individual universities in Africa, and to document the responses and coping mechanisms that these institutions had developed. The purpose of the studies was described as to "generate understanding of the way that HIV/AIDS is affecting universities and to identify responses of staff, students, and management

that might profitably be shared with sister institutions in similar circumstances."

2.3 A Brief History of the Selected Tertiary Institutions

In its National Policy on Education (1980) the federal government has approved and Endorsed Health Education to be an aspect of the school certificate curriculum. This was as a result of the government's recognition of the importance of the subject to the generality of the Nigerian society (JORNASS, 2001).

According to Okunrotifa (1992), Health education is a discipline, which is directed at enhancing both the cognitive, affective and psychomotor domains as it relates to health. Health education is a subject that takes care of the human anatomy, physiology, etiology of diseases, epidemiology and bio-statistics. Health Education is also related to aspects of psychology, sociology and education. A realization therefore, is that health Education should be a subject of study throughout the levels of our educational institutions.

Comprehensive programme in Health education is given by the professional preparatory committee of the American School Health Association. This serves as a model for the nations where health education and physical education were combined. Not until 1989 when

the National Universities Commission developed different and separate programme, health and physical education were taught as a combined programme in Nigeria.

However, the new dimension introduced by the National Universities Commission whereby Health Education was treated as a separate subject gave her the impetus that she had long sought for. Thus, the degree awarded has changed from Bachelor of Education (B.Ed) with honour or pass in Physical and health education to Bachelor of Science (B.Sc) made it mandatory for all tertiary institutions to comply with this development, (NUC, 1989).

The release of the 3rd edition of the minimum standards Nigerian Certificate in Education (NCE) by the National Commission for colleges of Education in the year 2002, necessitated the teaching of various health Education courses at all level of NCE including general studies (i.e. Healthy living and National Development).

West Africa Health Examination Board (WAHEB) and National Board for Technical Education (NBTE) are responsible for the professional health courses being offered in the College of Health Sciences (School of hygiene). The school has various courses leading to

the award of certificate, diploma and Higher National Diploma in the field of Health.

2.3.1 **Bayero University, Kano:**

The nucleus of Bayero University was founded in October 1960 under the name of Ahmadu Bello College. When the Ahmadu Bello University was established in October 1962 with the headquarters in Zaria, the College was renamed Abdullahi Bayero college, after the late Venerable Alhaji Abdullahi Beyero, the Emir of Kano (from 1926 to 1953), and incorporated in the university. In October 1975 it was upgraded to a University and was renamed Bayero University, Kano.

The College attained full university status in October, 1977, the degree for which students are prepared in the university are whether honours (in one subject) or combined (in two subjects). There are eight (8) Faculties in the University namely: Faculty of Science, Faculty of Social and Management Sciences, Faculty of technology and a School of General Studies. Based on the NUC recommendation, health education courses are offered from diploma level through the undergraduate level to postgraduate level under physical and Health Education Department in the Faculty of Education. The following include some of the content offered in the area of Health Education:-

(1) Foundation of Health Education

(2) Mental Health

(3) Alcohol and Drug Education

(4) Nutrition

(5) Family life Education

(6) Consumer Health

(7) Health Careers

(8) Environmental Health

(9) First aid and Safety Education

(10) Community Health

(11) Anatomy and Physiology

(12) Education; and

(13) General Studies.

Therefore, today one can say that there is progressive improvement in the Health education programme as evident in the NUC recommendations on Health education.

2.3.2 **Federal College of Education, Kano:**

The great Federal college of education (formerly ATC/ABU) Kano, started from a very humble beginning in 1961 as Kano Men's Training College at the Native/authority loaned premises of Gwale

Senior Primary School before it moved to its permanent site in 1965. the College was established through the joint efforts of the United states Agency for International Aid (USAID) and the Ministry of Education of the then Northern Region under the distinguished leadership of Late Sir Ahmadu Bello, "Sardauna of Sakkwato".

The initial intake of 34 students was of pivotal student teachers that were usually those who had a teacher grade III certificate or those who had completed high school and desired to qualify as grade two teachers. The five year teacher training course began in January 1962 with an intake of 121 post-primary students. Exactly a year later, the name of the college changed from Kano Men's training college to Kano Teachers' College. In 1965, the Nigeria Certificate in Education programme was introduced in the College. This was based on the recommendations of the Ashby commission (1960). With the commencement of the NCE programme, the name of the college became Advanced Teachers' College, Kano.

In 1966, there was a change of government at the center which brought about a breaking up of the regions. This national development led to the change of proprietorship of the College. In 1968 therefore, the

Interim Common Services Agency (ICSA) took over the proprietorship of the College from the then Northern Nigerian Government.

In January 1970 however, ICSA itself relinquished the ownership of the College to Institute of Education, Ahmadu Bello University, Zaria, hence the name of the college was amended to reflect the name of the new proprietor of the College. In 1990, the federal government took over the college with the promulgation of Decree Number 4 of 1986. With this development, the name of the college once again and finally changed from ATC/ABU to its present name, Federal College of Education, Kano. The College has achieved autonomy in the running of the pre-NCE, Remedial Certificate, diploma and NCE Courses. The degree progrommes are still run in affiliation to A.B.U. Zaria, (FCE, Students Handbook 2004 – 2008).

2.3.3 **Kano State College of Education Kumbotso:**

The college is situated in Kumbotso Local Government at the southern end of Kano along Zaria Road. It was formerly called College of Education, Kano under the State Ministry of Education and later the defunct institute for Higher Education. It was established in 1981 following the recommendation of the eleven-man powered committee set up by the government to study and recommend possible means of

meeting the staffing needs in the state post-primary institutions. The College is now called Kano State College of Education under Edict No. 13 of 1987.

The main objectives of the college are to offer courses of study, training and research in both arts, science, vocational as well as languages leading to the award of NCE. Furthermore, the college should promote the advancement of knowledge and its practical application to the needs of the state through various means. Additionally, the college should be organizing in-service vocation course, seminars, conferences and workshops for serving teachers, educational administrators and to create facilities for research and dissemination of knowledge with respect to the teaching profession, (KSCOE, Student Handbook, 2000).

2.3.4 **College of Health Sciences (School of Hygiene) Kano:**

It is needless to deny that health industry every where is fast shifting from curative to preventive health services. In view of this, the college of Health Science (School of Hygiene) was established in the year 1932 by the Colonial Master under the governing body known as Royal Society of Health London (RSH).

However, the examination body is West African Health Examination Board (WAHEB) and National Board for Technical

Education (NBTE). With the creation of Kano State in 1967, the college came under the Interim Common Services Agency. On April 1st 1979, the college was transferred to Ahmadu Bello University, (ABU, Zaria). Consequently, it was taken over by Kano State Government on 1st January, 1985. The College was designed to train the preventive health services all over the federation. The private and government organizations are responsible for the sponsoring of their qualified candidates.

2.4 **An Overview of School Health Programme**

The school health programme involves many activities as it concerns many persons of different professions. It comprises all health activities which are planned, organized and carried out under the auspices of the school. It seeks to maintain and improve not only the health of the school children but also school staff through instruction, health services, healthful school living as well as through school community cooperation, (Nemir & warren, 1975).

The point made about the health of school staff is of particular importance. There is an erroneous assumption that the school health programme is directed specifically at the school age youth. Although is the central figure in the programme, his teachers and all those school

staff who interact with him in any capacity are also important. While the health programme seeks to maintain and promote the health of the school child, it extends such services to the teachers and other workers in the school. The school staff needs good health to be able to function well. They therefore need protection from communicable diseases that may be spread by the children just as the children need protection from those diseases that could also be spread by the staff in the school. According to Udoh, et al (1999), the school health programme therefore is directed to the total school community.

Sohi, (1991) described the school health programme as that section of the education process primarily concerned with developing an understanding of health and providing necessary experiences and services which play a key role in the maintenance and improvement of the health of both pupils and school personnel. He further explained that the nature of school health programme today is of the type that provides the child with the best possible healthful environment, including the proper maintenance and sanitation of school grounds, plant, classrooms, special facilities, Adequate health services, periodic medical examination, proper follow-up services, nurse services, supervision by all teachers and effective health instruction.

According to Bucher (1971), interest in the teaching of health in schools dates back hundred of years, and as man became knowledgeable of causes, prevention and cure of various diseases, the need to get the masses educated through the media of instruction became apparent. He also said that in the Greek golden days, health was accorded much recognition. The Greeks worshipped Hygecia, the goddess of health and most of their hygiene practices are still accepted today. The Romans built clean roads and made laws on health, provided clean water, public health, and made food laws. The early Greek ensured safety in games and sports competition.

In Nigeria, there were no schools but the home was the central point of health instruction. Foods were properly cooked, surroundings kept clean, and women learnt post-natal care from their mothers. There were dug-out wells to provide clean drinking water and isolation of patients with infectious or contagious diseases was practiced. In spite of these prevention measures in the home, wide-spread diseases claimed thousands of Nigerians annually. As time went on, the Missionaries and the colonial government started developing schools and wasted no time in introducing Hygiene and other health care topics in the school programme. Pupils were taught the care of the teeth, washing of their

clothes, maintaining clean surroundings in the school, use of first aid materials and many other health practices. Many wrong assumptions or traditional beliefs about sickness and diseases were dispelled and knowledge of personal as well as environmental health was inculcated in the learners (Udoh, Amusa, Duro & Sohil, 1991).

Today, health is given variety of places in the school programme, but lack of adequate infrastructure and personnel still pose a stiff challenge to the implementation of school health progrommes. Normally a major part of the health programme is carried on within the confines of the school, but some important aspects of the activities may be on a community wide basis and involve numerous persons, community organizations and agencies.

According to Cornacchia & Station (1974), the school health programme embodies the total school programme in health. It involves all health activities that are planned, organized and conducted by the school under the jurisdiction of the school. It includes all activities that contribute to understanding maintenance and improvement of the health of the school population including health services, health education, healthful school living and school problems. The National Education Association and the American Medical Association in 1969 described the

school health programme as including numerous activities in which many persons participate. And for convenience, the joint committee divided the programme into three inter-related parts namely: school health service, health education, and healthful school living.

In a related study on the need for tertiary institutions to participate in the awareness campaign on HIV, Kelly, (2000) observed that "One unsettling finding that emerges from the report concerns the social life of students on campus and the extreme vulnerability of female students, workers, and those in precarious circumstances". Kelly says the case studies "are short through with concern about the subordinate status of female students and, in particular, their inability to negotiate for either no sex or safer sexual practices". He speaks about "consensual rape", whereby, because of her lack of empowerment, the female partner consents under duress to intercourse in order to preserve a relationship, avoid a beating, ensure financial support, or repay favours. The case studies suggest the prevailing climate on university campuses may encourage such violence and thereby facilitate the spread of HIV/AIDS.

In relating the need for tertiary institutions to play a role in the healthful living practices of students, one of the most devastating criticisms of Universities and academics in Africa is that they do not play

a role in addressing some of the most critical problems in Africa, and hence do not make a contribution to development efforts. The most critical problems in Africa include the HIV/AIDS pandemic. But some good progress has been made. Also at a meeting in Nairobi, the Association of African Universities passed a declaration. In that declaration was an important resolution dealing with the issue of HIV/AIDS.

> *"To a greater degree than ever before, Africa Universities must renew their commitment to helping Africa find effective solutions to its perennial problems of hunger, poverty and disease. They must, by their research and teaching, strengthen their contribution to improvements in food production and distribution, disease control and health service delivery, and the general wellbeing of their people. In particular, the HIV/AIDS crisis poses a serious threat to African societies within which Universities are situated. Africa Universities must be in the forefront of research, education and action in this area. We recognize that the solution to this problem might well reside in".*

I am sure at this conference we wish to reaffirm that declaration. We are optimists by nature, and we believe in the three WWW's, that we were introduced to in Nairobi, last year. That is, we will win!, especially if we take to heart the challenges posed to us by Audience Africa (1995).

2.5 **Descriptions of Health Education**

Health is one of the cardinal objectives of education. Without health, life cannot offer vitality which accompanies well-being. The National Policy of Education (1981) acknowledges this when it ruled that "the quality of instruction at all levels (of Education) has to be oriented towards inculcating the promotion of the emotional, physical and psychological health in all children" (N.P.E., 1981:7).

One method of achieving this objective and developing one's full health potentials is to assist the individual to acquire knowledge on health matters and develop a life-style that is beneficial to health. The process is termed Health Education.

Udoh, (1987) explains health education as an integration between the practice of preventive and social medicine and the educational process. In other words, it is the application of educational strategies in getting people to adapt measures that promote their health and prevent disease and disability. Education is the appropriate route through which people learn new things. Health Education is an integral part of the school curriculum as well as an inevitable component of the activities of health workers. For example, the public health nurse engages in Health Education as part of her duties in maternal and child health (MCH); the

hospital nurse uses health education in educating food handlers in the principles of food hygiene. Similarly, the classroom teacher uses health education in educating and advising pupils on personal hygiene. These examples show that Health Education can be applied in any situation where the behaviour of an individual can affect his/her health.

Health education is that aspect of education which brings about behavioural and attitudinal changes in health knowledge and practices. It includes all those experiences of an individual, group or community that influence beliefs, attitudes and behaviour in relation to health. Health education is a programme of training and a study designed to equip the pupil with the habits and knowledge that will enable him to enjoy good health both during school day and in later life. It is not just a body studied in the school, but that which through action of both the members of the school and community, transforms or changes peoples' health behaviours – (Udoh, 1988). Health education is a process of working together for a positive change in health habits, attitudes and practices for a positive change in health status.

Adegbite (2000) described health education as both teaching processes and performance process. She said that health education is an aspect of the general education, a relative body of knowledge drawn from

notable disciplines such as biological and medical sciences as well as the scientific areas that deal with human behaviour and people's culture. Nwajei (1993) asserted that health education is a process of providing teaching-learning experiences and activities for the purpose of favourable influencing of knowledge, attitudes, practices and conduct with regard to individual family and community health. That is, health education is the sum of all experiences which favourably influence habits, attitudes and knowledge related to individual and community health.

Considering the above description of health education one can easily notice the fact that though they have been viewed from different perspectives, three common factors are associated with explanations. They are:

(i) Health education is focused on the individual and the community of which family and school are a part.

(ii) Health education is not necessarily limited to the school, but also extends to the family and the community.

(iii) Health education has to have a positive influence on the individual in such a way that such an individual can take care of his own health others and the general community (Udoh, et al 1991).

Health education may be thought of as a process, with intellectual, psychological and social dimensions relating to activities which increase the abilities of people to make informed decisions affecting their personal, family and community well-being. This process is based on scientific principles, both health personnel and consumers, including children and youth (Report of the Joint Committee, 1976). Udoh, Fawole, Ajala, Okafor & Nwana, (1999), gave the following statements to further describe Health education.

(1) Health education is a professional field and an academic discipline and is eclectic in nature for its scientific base.

(2) Health education strategies provide needed approaches to bridging the gap between scientific discovery and its application for everyday healthful purposes.

(3) Health education is an integral part of the school curriculum at all levels and an integral component of community based health progrommes.

(4) Health education contributes to the total education of the individual by providing meaningful experiences which can positively influence health behaviour.

(5) Health education principles and strategies are based upon and improved through both basic and applied research.

(6) Health education is most appropriately engaged in by a professionally prepared health education.

(7) Health education facilitates the primary prevention of health problems (Report of the ASHA Committee, 1975).

They further explained that the goals of health education are those of medicine as a whole (curative and preventive), that is, to reduce morbidity, mortality and disability, and more recently to reduce the costs of health care. Health education influences not only disease but also rates of population, growth, absenteeism from work, illegitimacy (unwanted children) and perhaps widowhood. Thus it has wide impacts.

Health education is a programme of training and a study designed to equate the pupil with the habit and knowledge that will enable him to enjoy good health both during school day and in later life. It is not just a body of knowledge studied in the school, but that which through action of both the members of the school and community, transforms or changes people's health behaviour. Health education is a process of working together for a positive change in health habits, attitudes and practices for a positive in health status. Health education is therefore regarded as both

teaching process and performance process (Ademuwagun & Odutan 1987).

Okafor (1991) also asserted that “Health education is a discipline or area of knowledge whose content has grown from the pulling together of ideas fact and knowledge from research findings from other disciplines notably medical and biological sciences as well as the sciences that deal with human behaviours and peoples’ culture”.

In its modern concept, health education deals mainly with the contribution of the behaviour of people their health states and is therefore concerned with the identification of health related behaviour and finding ways of influencing such behaviours to be compatible with health. In this wise, the knowledge of health science is supposed to equip the pupil with the basic scientific information about health problem such as identification of the disease organism, its occurrence, the infective agent, reservoir, mode of transmission, incubation period communicability, susceptibility, resistance and control measures. Health education deals with the role human behaviours of life styles play in the onset of a health problem or disease and how such behaviour or life style can be influenced or changed to overcome the problem (Adeniyi, 1993).

Health education has been defined by some authorities in various other ways as discipline subject area, a process etc. As a process it has been defined in various forms. For example, Galli (1978) thus defined Health Education as "a process whereby the individual in cooperation with the instructor, is provided an opportunity to apply new knowledge and act in healthful ways". This definition is functional and will enable any reader understand the skills required for effective teaching of Health Education. A critical analysis of the above definition of Health Education reveals four salient issues which tally with curriculum instruction process.

(i) The pupil (that is, the learner);

(ii) Provision of learning experiences

(iii) Methods and strategies of teaching health education

(iv) The outcome of teaching and learning, in other words achievement of objectives.

Sequel to this, the goal of the Health Education teacher therefore, should be to provide information that individuals could use through constructive patterns of behaviour to enhance their health status. This place behaviour changes paramount to attitude and knowledge of health matters.

Galli (1978), expressed that without knowledge the goals of Health Education are difficult to achieve and that knowledge reinforced already appropriate behaviours positively. The importance of health education is great in view of the fact that children constitute a vulnerable group. They are exposed to a wide variety of dangers; hence they need to be taught simple ways of taking care of themselves with regard to promotion and maintenance of health as well as prevention of infections.

In addition to the definitions, Greenberge (1989), described Health Education as "a process of influencing people to adopt behaviours which are beneficial to their health and to reject those behaviours that are detrimental to their health". This process can only succeed where the individual being persuaded has the right type of attitude and the environment permits the adoption of the desired behaviour. Daris (1975) emphasized that behaviour is the most influential factor in determining the health in pupils. Health education attempts to influence pupils' behaviour by dealing with their knowledge, attitude and practice, and by applying strategies that motivate them to adopt particular ideas or behaviours.

In conclusion, through the various definitions and explanations given by many authorities in the field of health and physical education

and other areas, we are made to understand that if one possesses knowledge about a situation, one is better able to make decisions affecting his or her personal well being as well as the well-being of the families and community. Facilities and equipment are necessary to ensure that Health Education takes places.

Ademuwagun (1975) suggested the health education can be said to have occurred only when health education has been transformed into health actions.

Achalu, (1993) also supported the above assertions by defining health education as a basic instrument for prevention of diseases as well as an important component of health promotion. He further explained that the best approach to prevention is to teach people to be responsible for their own health by providing information on what they can do to protect themselves or how to cope with their conditions.

WHO (Regional Office for Europe, 1982) proclaimed that health promotion is a strategy which is closely related to the condition of the individual and social group. Saminan & Paiko (1982) hold similar opinion by claiming that health promotion is based on the premise that individuals are responsible for their own health. Health Education, information dissemination and practices should therefore not be left to

the formal organization and designated structures alone. It should be seen from a holistic and informal point of view in which all actors must be encouraged contributing their positive quota. Health Education is generally the acquisition of positive health behaviour through the processes of education. And that for Health Education to be meaningful and have a bearing, it should be emphasized in the school through health education programme.

2.6. **Reseasons for Health Education in Schools**

In its National Policy on Education (1998) the Federal Government has approved and endorsed Health Education to be an aspect of the school certificate curriculum. This was as a result of the government's recognition of the importance of the subject to the generality of the Nigerian society. Therefore, the need for health education in our schools is of utmost importance.

Eroegbu (1999) claimed that Nigerians are still battling with the process of development; a lot of our citizens still live in rural communities where some traditional health practices and beliefs run against basic principles of good health. Even in urban centres many are still ignorant of the simple rules of hygiene. All these make it necessary that the school children should be provided with knowledge and basic

experiences that would help children to build desirable health attitudes, habits, skills and practices.

There is a need to develop the interest of the children in proper health habits in relation to balanced diet, exercise, work, rest, sleep and recreation. These can be inculcated through meaningful programme of health education in school (Nwajei, 1993). The real worth of health education is its preparation of a person to promote his own health and make the decisions necessary to protect promote and maintain not only his health but that of others and the general community. Ajibola, (1998) gave the following importance and functions of health education in the schools:

(i) **Promotion of Health Knowledge:**

Through health education programme in school adequate health knowledge can be attained. This is characterized by the understanding of health, disease; recognition of special health problems, using reliable medical services, safely promotions, understanding of first aid procedure.

(ii) **Promotion of Health Attitudes:**

Through health education programme positive health attitudes can be attained. The health attitudes are characterized by

acceptance of personal responsibility for personal health promotion, ideal high level of health, dissatisfaction with low vitality, awareness that prevention is preferable to treatment or cure, rejection of fads or quackery; regards for high standard of personal cause, and respect for the health of others.

(iii) **Ideal Health Practices:**

Health education programme in school can foster ideal health practice, characterized by good nutrition, rest sleep, undertaking regular activity, periodic health and dental examination, immunization, good emotional and social behaviour.

(iv) **Profitable Health Conditions:**

Profitable health education may promote understanding of health conditions, characterized by the need for adequate housing, safe water supply, sanitary sewage disposal, adequate recreational facilities, safe community, industrial school and home conditions and hygienic mental environment.

(v) **Health Education:**

Evaluation may be considered in the broadest sense as an appraisal, assessment, or measurement of school health. In school health programme, evaluation is a process of determining the

effectiveness of the programme and its several phases through the measurement of its progress and the extent to which the health objectives of the school are being achieved. It involves both subjective judgment and the highly scientific measurement of factors affecting health. Eroegbu (1999)further gave the purpose of Health evaluation as:

(i) Assessment of the health status of children

(ii) Assessment of all aspects of the health programme

(iii) Measurement of health programme

(iv) Assisting children in understanding their health condition and progress in health education

(v) Helping parents to understand the health of their children and the school, health programme

(vi) Giving the school opportunity for revision of the health programme for better standard.

(vii) Providing a basis for government and public supports and funds for school health programme.

The earlier one develops a positive attitude in relation to health behaviour the greater the chances of one living a happy and productive life. Therefore, the earlier the introduction of Health education in the

school system, the better the chances of helping youngsters to make intelligent decisions regarding their health behaviour (Udoh, 1987). In fact, there are many reasons why health education is necessary in school as stated by Udoh, Fawole, Ajalao, Okafor & Nwana (1987), they include the following:

(1) The child in contemporary or present day Nigeria is exposed to certain aspects of technological development which have implications or consequences for health. Examples of these aspects of technological development are advertisement on radio, television and magazine, and unwholesome or undesirable wall – writings on the streets. The effects of these can be counteracted or reduced through health education by providing accurate information on the matters involved.

(2) Misconceptions, misunderstanding, and misinformation are rampant in the Nigerian society due to ignorance and superstitions. Typical of these are the wrong notion that cat's whiskers cause tuberculosis, and too much palm oil in the food causes malaria. Health education can help correct these so that they are not transmitted to the younger generation.

(3) Health habits of many Nigerians are known to be poor and are capable of spreading diseases. For example, some people urinate and even defecate indiscriminately in public, some spit in the open, and some sneeze without covering their mouth. Health Education can help correct these poor habits so that they are not acquired by school children.

(4) Children of primary school age (6 – 11 years) are known to suffer from certain minor ailments by virtue of their age and stage of development. Through, the activities of Health Education in primary school, these conditions can be detected and prevented from getting worse.

(5) Majority of the diseases suffered by children and indeed by Nigerians as a whole are communicable, i.e. they can be passed on from one person to another. These diseases can be prevented by the application of simple sanitary measures which are taught through Health education.

(6) There are relatively very few health workers (doctors, nurses, etc), in Nigeria to cope with the existing numerous health problems. Therefore, the ability to prevent disease and to know what to do in

case of emergency should be an advantage. Health education can provide these abilities.

(7) Through Health Education the teacher can serve the pupils better because the teacher develops a greater insight into and becomes more sensitive to the health needs of the pupils.

(8) Through Health Education in School, the teacher benefits personally by progressively learning to promote his/her health status.

(9) Health Education seeks to improve the health of the pupils so that they can bear the burden of academic demands.

(10) The philosophical reasons to support Health education in school include the fact that childhood and the years during school have been identified as important for habit formation.

In addition it is the belief that Health Education provided in the school can equip a child to face social and health problems in later years.

Furthermore, according to Ademuwagun & Odutan (1987) the following are some of the reasons for Health education in the school:

(i) The study of health education in the school helps to fulfill the objective of general education that is the provision of good health.

(ii) It develops in the child positive health knowledge habits and practices which he needs to solve his problems and that of others.

(iii) It offers opportunity to the child for the realization of his health potentials.

(iv) It creates awareness for the child to realize the importance of keeping his environment clean and tidy.

(v) It is a forum for helping the child develop social and emotional stability.

(vi) The process is educative by itself.

(vii) As an aspect of community health education, it establishes avenues for forgoing meaningful development of healthful practices for the child and the parents.

(viii) A based for further Health Education for the child.

(ix) It is a means of protecting the child from communicable diseases.

(x) It helps to identify early defects of the growing child.

(xi) It helps to eliminate and control hazards in his environment and can treat emergency case.

(xii) It helps the child to be able to face the challenges ahead because of recent changes in the environment.

(xiii) It helps the child to deal with the present day poor health practices resulting form unhygienic living conditions.

The declaration adopted in 1978 at the Alma-Ata will forever remain a landmark in the history of health education. The declaration gave a place of prime importance to health education in promoting individual and community self-reliance and in developing people's ability to become personally involved in health promotion and care (alma-Ata 1978). Given the principles of this declaration and content of PHC, the role of health content of PHC, the role of health education in the promotion and protection of health evident for these reasons:

(1) Health education is an essential part of any activity for the promotion of human well-being.

(2) Health education develops awareness in the people involved in promotion and prevention of their health.

(3) Health education potentially brings about positive changes in the behaviours of the people.

(4) Health education brings about preventive intervention of ill-health by making people avoid those phenomena that give them health problems.

(5) Health education often motivates and mobilizes the members of education institutions and the community for concrete health development action (Akinbile, 1998).

Mahler (1983) also outlined the roles of Health education as follows:

(1) Health education shall develop new policies that are in tune with the prevailing lay person's and professional perceptions of health problems.

(2) Health education shall develop adequate human resources with the skills to translate the global strategy of health for all into educational objectives.

(3) Health education shall utilize technology and methods acceptable to individual, families and the community.

(4) Health education shall increase the coordination efforts through appropriate technology.

(5) Health education shall pay greater attention to monitoring and evaluation of health activity.

2.7 **Aims and Objectives of Health Education**

Generally health education is aimed at providing the necessary knowledge and experiences with a view to affecting a change in an

individual's own health behaviours in a way that will lead to the protection, promotion and maintenance of his own health condition as well as play part in that of the community.

Adeoye (1981) explained that, the general aim of health education is to enable one live an enriched and abundant life free from disease or infirmity. The objectives of health education are more definite and specific than this aim, and through these objectives the ultimate goal is brought nearer to realization. Brusse & Gay (1978) gave the following objectives of health education which include:

(i) Health education comprises a composite of the school curriculum because; it promotes social, mental, emotional and physical health.

(ii) Health education stresses the concept of optimum development of each student and seeks to inform he student and help him apply the knowledge he has gained.

(iii) Health education concerns itself with adjustments students make to their environments and to their problems.

(iv) Health Education seeks to help the students receive various facts and to provide experiences for practicing what he has learned.

(v) Health education consists, therefore, of teaching directed towards experiences which result in doing.

Udoh, et al (1999) also identify the objectives of Health Education as:

(1) To enable students appreciate the meaning of health and the scope of health education.

(2) To enable students gain understanding that will then improve their health habits and those of their pupils.

(3) To understand the relationship between sound health and education.

(4) To understand the extent of the health problems in the schools.

(5) To acquaint the students with the methods, procedures and materials in the teaching of health education in schools.

(6) To develop the kind of educated person who understands the basic facts about health and disease, protects and promotes his own health and that of his family.

(7) To contribute not only to healthful living but to the better understanding, appreciation and use of health services.

(8) To help pupils and students acquire knowledge, habits and attitudes this will contribute to individual, family and community health.

2.7.1 **Objective of School Health Programme**

According to Udoh, et al (1999) a statement of objectives in any programme is vital to the success of that programme because it necessarily sets out its aims in a precise manner. The statement of objectives does assist the personnel executing the programme in aiming at a target or goal. A statement of objectives is no less important in the school health programme which involves a variety of activities and many individuals, professional and voluntary groups, private and public agencies, because it gives significance of purpose to the programme.

The objectives of school health programme synthesized from several sources e.g. (Ademuwagun, 1987; Schram, 1971; Young & Durstan, 1987 & Udoh, et al, 1999) indicate that it seeks to:

(a) Provide healthful school living for both the school age youth and the school personnel;

(b) Protect children against communicable and other preventable diseases;

(c) Discover physical defects and other abnormal conditions in the school child and to promote their corrections where remediable;

(d) Develop knowledge and attitudes that will enable the individual to make intelligent health decisions and to promote desirable health habits;

(e) Develop school, home and community cooperation in health promotion;

(f) Provide for constant and continued appraisal of the school age child's health status;

(g) Provide for prompt emergency care due to sudden illness or injury;

(h) Provide for the establishment of a physical emotional climate and sanitary physical plant conducive to teaching and learning;

(i) Develop each child to his optimum health level through the efforts of home, school and community;

Udoh, et al (1999) further lamented that the objectives of the school health programme is not intended to take over the responsibilities of parents. The activities and objectives within the total school health programme are designed primarily to supplement the efforts of parents in obtaining optimum health for their children. In other words, the school health programme seeks to supplement and complement the responsibilities of parents. Kime (1977) also suggested that a well organized school health programme should aim at the development of

optimum physical, mental, emotional and social health among all pupils. He stated that the objectives of the school health programme cannot be achieved unless the various organs that constitute the health team function smoothly and effectively.

2.8 Scope of School Health Programme

Many authorities in the field of Education and Health like, Mayshark (1968), Bucher (1971), Nemir (1975), Udoh, et al (1999) and others described the school health programme as that aspect of the educational endeavour primarily concerned with developing and understanding of health and providing necessary experiences and services which play a vital role in the protection, promotion and maintenance of the health of school children and the school personnel. It therefore includes the following major areas of activities:

(i) The school health instructions

(ii) The school health services

(iii) The healthful school living

(iv) Home-school-community relationship

School Health Instruction

Health instruction embraces all activities related to the actual teaching of health, whether integrated, correlated, incidental or direct,

programme planning and development (Curriculum), selection of subject matter (content); methods and techniques of health teaching; resources and materials for teaching and evaluation, to assess whether or not the objectives set have been achieved. Discussions of the above which constitute the scope of the school health instruction are preceded by definitions and rationale for school for school health instruction (Udoh, et al, 1999).

Why School Health Instruction?

Udoh, et al, (1999) asserted that, today's school child spends approximately 180 school days per year in the school and its environs. The school therefore has the legal, social and moral responsibilities to provide not only for the safe and healthful environment and health services, but also for organized teaching procedures directed towards developing understanding, attitudes and practices relating to health and to factors which affect health.

They further comment that health is undoubtedly an important factor in any human endeavour. It has become a major objective in education because if a child is to get the most benefit from his schooling, he should be healthy. There is a general lack of basic information on matters relating to health. It is therefore imperative that there is a

systematic health instruction in schools, for this is the only sure way the school child can become aware of the scientific facts he needs to enable him to make intelligent decisions about his present and future health.

The following are specific reasons for advocating for school health instruction:

(i) The school is in a unique position in our complex society to obtain and to disseminate the latest reliable information about health.

(ii) The school is the most logical institution to find professionally qualified personnel to teach health education.

(iii) The school is the most appropriate place to inform the youths on the most significant health problems facing them.

(iv) The school is in a position to provide students with knowledge that can help them towards the prevention of communicable, chronic and degenerative diseases.

(v) The school can provide pupils with appropriate information aimed at helping them protect, promote and maintain their total health.

Pattern for Health Instruction

Obanya, (1999) suggested that health instruction can be incorporated into the school curriculum through one of the following patterns:

(i) The psychological (teachable moment) or incidental plan;

(ii) The integrated plan;

(iii) The correlated plan; and

(iv) The specific health course or direct health plan.

The Psychological Teachable Moment or Incident Play

In this plan, there is no health education scheduled on the time table, Rather, the teacher takes advantage of the 'teachable' moments as they arise. Such moments may arise from an accident, a national disaster or event such as flood or health drive.

Much as this approach is sometimes acclaimed, it is a poor approach to health instruction because if the entire health instruction is planned this way much of the needed instruction in health would be left to chance and would probably never be discussed. Experience shows that certain health areas must be deliberately structured into the health curriculum. According to UNESCO, (2003) pupils should learn relevant health knowledge, skills and attitudes that will benefit them and their families in the short and long term.

It is of paramount importance to note that with the growing array of demands on schools and school systems, school health progrommes are often overlooked. However, individual teachers, through their

advocacy and teaching, can make a difference in overcoming existing barriers and in creating school health progrommes.

2.8.1 **School Health Services:**

The school health services is another important component of the school health education programme which includes all school activities and procedures designed to influence the present or existing health status of the school children. This encompasses appraisal of student health, prevention and control of disease, prevention and correction of physical defects, health guidance and supervision and emergency care. The school health services may be classified into two broad components; appraisal health aspects and the preventive health aspects. (WHO, 2003 & UNESCO, 2003).

School health services has been defined by the Joint Committee on Health Problems in Education of the National Education Association (NEA) and the American Medical Association (AMA) as the part of the school health programme provided by physicians, nurse, dentists, health educators, other allied health personnel, social workers, teachers and others to appraise, protect and promote the health of students and the school personnel.

Udoh, et al, (1999) asserted that, school health services help to protect and improve the health of children thus aiding their growth and development and enabling them to benefit fully from school experiences. Specifically, the functions of the school health services programme include:

(i) Appraising the health status of pupils and school personnel;

(ii) Counseling pupils, teachers, parents and others for the purpose of helping pupils to obtain health care;

(iii) Helping to prevent and control communicable diseases;

(iv) Providing emergency care for injury or sudden slickness;

(v) Promoting and providing optimum sanitary conditions and safe Facilities;

(vi) Protecting and promoting the health of the school personnel;

(vii) Assisting in the identification and the education of handicapped children;

(viii) Adjusting individual school programme to meet the needs for children with health problems;

(ix) Encouraging the correct or remediable defects; and

(x) Providing learning opportunities which are conducive to the maintenance and promotion of individual and community health.

UNESCO, (2003) confirmed that, schools are on ideal location for the delivery of basic healthy services, including school feeding, immunization, and screening progrommes.

The Scope of School Health Services

The services include health appraisal, Health counseling and interpretation, Emergency care for injury and sudden illness, Communicable disease prevention and control (Iroeggbu, 1999; Udoh, et al, 1999; Adegbite, 2000 & UNESCO, 2003).

Appraisal Aspects of Health Services:

Ajibola (1998) described health appraisal as an evaluation or assessment of the present health status of a person. It deals with the relationship of a person's health attainment to the basic endowment and his adjustment to life needs. Appraisal of health service denotes a positive approach in which major emphasis is placed upon the health aspects of a person, and deviation or deficiencies are assessed in terms of the degree to which they obstruct or interface with enjoyable living.

Similarly, Udoh, et al (1999) proclaimed that health appraisal is a relatively new concept in school health programme which has now assumed a place of importance in countries that are concerned with determining the total health status of a school child in order to protect and improve his health. They further lamented that an appraisal of health is an evaluation of the current health status of an individual. It is much more than a static inventory since it deals with the relationship of an individual's health attainment to his basic heredity endowment and with his adjustment to his life's needs. Health appraisal has therefore been described as a process which seeks to determine the total health status of a pupil through such means as:

(i) Parent, teacher and nurse observations;

(ii) Screening tests for visual and auditory acuity;

(iii) Physical fitness tests;

(iv) Study of information concerning the pupils past health experiences (health history).

(v) Medical as well as dental examination.

Health Counseling and Interpretation

Health counseling procedures are carried out by doctors, nurses, counselors, teachers or other qualified personnel in order to interpret to pupils and parents the nature and significance of a health problem. Health counseling helps pupils and their parents to better understand how to formulate a plan of action which will lead to the solution of a problem. According to Udoh, et al (1999), the specific aims of health counseling includes:

(i) Giving pupils such information about their health status as revealed by appraisal procedures;

(ii) Interpreting to parents the significance of health problems and encourage their to obtain needed care for their children;

(iii) Motivating pupils so that they would accept needed treatment and care;

(iv) Encouraging and promoting each pupil's acceptance of responsibility for his own health in keeping with his maturity level;

(v) Contributing to the health education of pupils and parents through individual conferences concerning health problems of children and

(vi) Gaining understanding of the attitudes problems and needs of pupils which may be dealt with in groups or through changes in the environment.

Ajala, (1983), Fodor, et al (1974) and Oberteutfer, (1972) believed that it is very important that parents be informed of the health needs of their children so as to assist them in seeking for needed medical care making alternation in daily routine and taking other necessary steps aimed at improving the child's health.

Categories of Problems Needing Counseling:

Udoh, et al (1999) explained that emergency care for children who become sick or injured at school or at a school sponsored activity is the responsibility of school and an integral part of the school health services. The schools have the responsibility for giving immediate care in case of accident or sudden illness as well as notifying parents, for getting children home or to some other palace of safety and for guiding parents, where necessary, to sources of treatment.

The four major responsibilities in any emergency care programme our therefore the acceptance of school personnel of responsibility for:

(a) Giving immediate care;

(b) Notifying the parent of the child;

(c) Getting the child home; and

(d) Guiding parents to sources of treatment, where necessary.

Communicable Disease Prevention and Control

Nemilr, et al (1975), Udoh et al (1999) and Iroegbu (1999) stated that disease prevention and control requires the cooperation and coordination of the activities of health departments, doctors, medical societies, parents, schools and hospitals. The control of communicable disease in the community is the special responsibility for the health department. But the school responsibility for the prevention and control of communicable diseases stems principally from two factors. The first is that during the time the child is at school, the teacher is expected to protect his health. Secondly, the collection of children in a classroom makes it possible for the transmission of many diseases. These two basic considerations make it imperative for school health services to include efforts to control communicable diseases.

In conclusion, school health services aim at protecting and improving the health of children thereby aiding their growth and development and enabling them to derive full benefit from school experiences. School health services strive to reach all students and school personnel by providing essential services for the attainment of

high level, physical, emotional and mental health for every student and school personnel. The services may vary among schools, but the essentials of a good health service programme include those activities already listed.

However, a well organized school health service programme involves all school personnel, community agencies and medical personnel.

2.8.2 **Healthful School Living**

The average Nigerian child today spends a good part of his day in school, and walking to and from the school. This routine is carried out five days of the week and for nearly thirty six weeks of the year. Parents are often too busy to sit and discuss school problems with their children. The school is called upon to play an ever-increasing role of molding the child in order to become a useful citizen, a pride to himself and the family. The school not only has the obligation to make him aware of the fundamental obligation to protect and promote this own health. Health, whether physical, emotional or social, is a major factor in man's existence, and without good health, productivity in whatever sphere of activity is at its lowest ebb. The school is, therefore, under an obligation to promote health through an effective organization and management of

the school health programme of which healthful school living is an integral part.

Udoh, et al (1999) stated that pupils themselves can also contribute to the emotional and social environment. For this contribution to be positive, pupils should understand the cultural differences among people. They should learn that the needs of people of other races, religion and backgrounds are similar to their needs for achievement, respect and security.

According to Patrick (2000), the education of children and youths in healthful living is a mutual responsibility of schools, parents, and the community. Teachers lead a team of school staff, including school counselors, school nurses, school social workers, school safety officers, and food service personnel, in introducing students to the basic knowledge and skills needed to establish healthy living habits. Health professionals in the community provide supplemental classroom presentations on health topics, field trips, and resource materials, as well as introduction to various health services and careers. Parents, other significant adults, and community agencies/organizations reinforce and expand upon the basic competencies acquired by students through modeling and opportunities to practice positive healthy living behaviors.

Schools, parents, and communities can use the Coordinated School Health model and the School Health Index provided by the Centers for Disease Control and Prevention to further expand their efforts to ensure the health and wellness of children and youth.

In the observation of Patrick (2000), the Healthful Living curriculum standards outline the necessary knowledge and skills for healthy living that teachers can use to teach specific health topics and also identify where to integrate healthy living learning activities with the curriculum standards of other subject areas (e.g. language arts, mathematics, science, social studies, art, music, physical education, and technology). At the end of each healthful living standard is a cross-reference to the related standards of other subject areas. In addition, many of the performance indicators for each healthful living standard will be met through classroom learning activities that also introduce and assess students' knowledge and skills in other required subject areas.

Reporting on the HIV pandemic in African countries, Kelly (2001) stated that up to recently higher education institutions had done very little in terms of response to the pandemic. These responses dealt with not only the moral practices in the higher institutions but also the hygiene and other practices of the students. The Kelly report (Kelly 2001) as well

as reports from workshops sponsored by the Association of Commonwealth Universities (ACU) and the South African Vice Chancellors' Association (SAUVCA) indicate the serious impact of the pandemic in terms of the fiscal situation, and in terms of the negative social impacts on university communities. At the same time the reports indicate some good examples of what has been done by individuals or groups within the universities "with a fire in their belly". The examples cover a range of areas including what has been done in teaching, research, as well as among communities of which the institutions are a part. The central message of the paper is that higher education institutions must develop a comprehensive HIV prevention programme.

2.8.3 **Home-School Community Relationship**

The school, the home and the community play a vital role in determining the health status of the child. Ajibola (1998) pointed out that the child cannot perform effectively where the three fail to cooperate. They have to work together in harmony in the overall interest of the healthy existence of the child.

Achalu (1993) explained that the home, which is the entry point of a child into the world gives all necessary protections, nutrition, health care that the child needs for survival; while the school offers the formal

and functional experience and orientation which thus affect the child's health habits attitudes, knowledge, practices and conditions in his daily struggles.

Some authorities in health Education like Turner (1975), Williams (1978), & Udoh, et al, (1999) have considered home, school and community relationship as a division of the school health programme. In reality, the home and the community have enormous contribution to make in the realization of the purposes of the school health programme. This is because health instruction, health services and healthful school environment are all influenced by what goes on both in the home and the community.

According to Udoh, et al, (1999), health education of the youth and child is a shared responsibility among the home, school and community. The home and the family have the primary responsibility for the health of the individual. When the society was less complex, the home coped with the prevailing problems.

With the complex nature of today's society, it has become evident that the home cannot be relied upon for the efficient health education of the child. The school is thought to be the appropriate institution which is

suited to provide education for healthful and effective living because of the resources at its disposal.

He further lamented that schools have been invented to teach children and youth, education no matter on what, and does not end during the course of a child's school days nor does health education occur only during those hours when the child is at home or school; since health education is a process that takes place continuously throughout an individual's life, and is not by any means confined solely to the school or to the family. The setting includes the community as well. And to achieve the best result, there must be a clear understanding in the cooperative efforts of each of the health education settings.

An effective school-community and home coordination is attained through cooperative relationships based on mutual appreciation of each other's capacities and contributions in the community. A full understanding of the school community relationship requires that school health programme be viewed as part of the total community health programme. Health is said to be a social responsibility in and of the community. The experience could be positive or negative depending on the attitudes and practices of the model in these three health education settings. The school, home and community involvement in the health

education of the school age child school age child can be promoted through the Parent-Teacher Association or school health council and also through the community health council in which the school is represented,. (Turner, 1975, Williams, 1978 & Udoh, et al, 1999).

Finally, it is generally agreed that the health education of the child is a shared responsibility among home, school and community. Although the primary responsibility for the health of individual child rests with the home and the family, the school has an important coordinating role to bring the home and community working together. The following activities provide valuable opportunities for the school and parents working together for the improvement of Health Education of children and school parents working together for the improvement of health Education of children and school staff:

(1) Collaborating with health authorities

(2) Making contact with medical and para-medical professions.

(3) Home visiting by teachers

(4) Home visiting by school nurse of social worker

(5) Developing communications between school, home and community

(6) Visits to school by parents to acquit themselves

(7) Working for health Education promotion through a parent teacher association or school health council

(8) Establishing community health councils to consider community wide health problems.

(9) Cooperation between schools and voluntary health organizations, official health agencies, private industries, professional societies, youths, and religious groups, (Udoh, Fawole, Ajala, Okafor & Nwana, 1999).

2.9 **Administration and Planning of School Health Programme**

Udoh, et al, (1999) explained that school health is a child of two worlds; it belongs to both the departments of health and education. However, by virtue of the fact that the focus of school health is the school, the Education department could claim that the responsibility for school health programme must necessarily consider that the school, is an integral part of the total education programme.

So far as the schools are expected to safeguard the pupils in schools, the schools boards as the government's agencies responsible for education are directly responsible for school health activities just as they are responsible for other phases of the educational programme. But the health department has the legal responsibility to protect the health of the

individual in the society, including school children. The need for an organized school health programme has grown to the point where the services of the personnel to be required include several persons who will contribute their respective skills to individuals (Ajibola, 1998).

It was further emphasized by Udoh, et al, (1999) that the health department could claim that the authority of schools boards to deal with the health progrommes in schools is limited to some extent by the power invested on state or local health authorities. The state and local health authorities are responsible for protecting and conserving the health of the citizens within the community, of which the schools are a part. The authority of local and state health departments are also frequently active in the health education activities which are designed to improve the general health status of the people in the community to which the school population belongs.

Both the departments of education and health could claim that they are better equipped to effectively execute the school health programme. Each could also claim to have authority to administer the health programme in schools. The schools take care of the health instruction where this is included in the school curriculum while the health department takes care of whatever health services progrommes that exist

in the school. Some aspects of the healthful school environment again fall under the jurisdiction of the school authorities.

In Nemir & Warren (1985) view for effective execution of the school health programme, there must be cooperation between the schools boards responsible for schools, local and state health department invested with the authority to protect and conserve the health of the people in the community. There is also need to clearly identify which agency has the jurisdiction for administering school health programme. The question of who should legitimately run the school health programme has generated some controversy in those countries where a high premium has been placed on the value of health education in schools in practical. Such controversy has hardly begun in Nigeria, but it will no doubt come especially with the growth and development of school health programme.

The question of jurisdiction may appear solved when a consideration is given to the role of the government agency currently funded principally for purchasing the services, materials and equipment for the execution of health progrommes. But there should be room for local community and state governments to decide what administrative set-up to adopt. Each agency connected with school health has very strong claims.

Musa, et al, (1991) explained that the school health programme is a part of education and should be entrusted to the body directly charged with organizing and administering the school programme. This body may include qualified health and auxiliary health teachers. A board of Health comprising of health administrative specialists may be set up in place of local school board. Their wealth of experience may prove very useful to the programme.

They further explained that for better implementation of school health programme, it is suggested that each school should have a health council or health committee. Members may include the principal, the school doctor, the health coordinator, teachers, students/parents representative, school nurse, nutritionist and dentist. The health counselor or health coordinator is the person directly charged with the responsibility for the total school health programme.

Planning process should be accorded priority to ensure effectiveness in taking decisions on the topics of instruction, the learning experience to be provided, the instructional method required, the school and community resources to be utilized, and the health problems to be covered. The goal of every organization is to provide smooth and orderly

services to the people, and the school health programme should not be an exception.

2.10 **Summary**

School health programme is very important.

It is an aspect of the developing and understanding of health and providing necessary experiences and services which play a vital role in the protection, promotion and maintenance of the health of the school children, school personnel and other members of the school community. The success of the school health programme requires a greater effort and cooperation of the home, school and the community. It also requires the cooperation as well as contribution of many individuals.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the relevant procedures for collecting appropriate data on the 'Determinants of Health Practices Among the Students of Tertiary Institutions in Kano State. These include, research design, population, sample and sampling techniques, instrument for collecting data, validity of the instrument, procedure for collecting data and the statistical techniques used in the study.

3.2 Research Design

To achieve the purpose of this study, survey research design was used as recommended by Baumgartner & Strong (1994), who pointed out that information concerning opinion or practices could be obtained from a sample of the people thought to be representative of some population, using an instrument composed of closed structured or open item questions.

3.3 Population of the Study

Baumgartner & Strong (1994) defined population as an entire group or aggregate of people and things that have one or more common

characteristics. Therefore, the total population of this study consisted of all students of the selected tertiary institutions in Kano State.

3.4 Sample and Sampling Techniques

The researcher sampled six hundred (600) students out of the total population from the four (4) tertiary institutions selected using the stratified random sampling procedure. The schools were categorised into three (3) strata i.e. University, College of Education and College of Health Science strata. From each stratum i.e. University had a sample of 150, while Colleges of Education had 200 and 50 for College of Health Science. The reason for variation in the numbers is due to proportion of students in schools. The table below shows the distributions.

Table 3.1 **Selected Tertiary Institutions**

S/NO.	INSTITUTIONS	POPULA-TION	NO. OF QUESTIONNAIRE	SAMPLE RETURNED
1.	Bayero University, Kano	600	200	150
2.	Federal College of Education, Kano.	200	150	100
3.	KanoState College of Education, Kumbotso	300	150	100
4.	College of Health Science (School of Hygiene)	150	100	100
	Total	**1,250**	**600**	**400**

3.5 **Instrument for Data Collection**

A self developed close – ended questionnaire named (HPIHLQ) Health Practices among institutions of higher learning was used and administered to the selected tertiary institutions in Kano state. Morrow et al (1995) suggested that modified Likert scale of Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree can be used, because this allows the respondents to react to the statement that is favourable or unfavourable to them along the five points.

The questionnaire consisted of two parts: A and B. Part A is all about the personal information of the respondents, while part B consisted of questions and statements on the health practices of students of higher learning in Kano State. This contained five (5) sections which include Health Instructions, Health Services, Healthful School Living and School, Home and Community Relationship.

3.6 **Validation**

The questionnaire was validated by the research supervisors and other lecturers who constituted a jury of experts for proper scrutiny to find the construct validity in the department of Physical and Health Education, Ahmadu Bello University, Zaria.

3.7 Pilot Study

A pilot study was conducted using Kano State College of education, Kumbotso to estimate the reliability of the instrument. A reliability of 0.78 was obtained using split half method through Spearman Brown formula of reliability as given by (Philips & Hornak, 1979).

3.8 Procedure for Data Collection

Collection of data involved getting an introductory letter from the department, soliciting for cooperation and assistance of the selected tertiary institutions in Kano state. The data was collected with the help of research assistants including professional colleagues and few students from Physical and Health Education Department.

3.9 Procedure for Data Analysis

The research used descriptive statistics of simple frequency and percentage to summarize the data obtained on demographic information of the respondents after the completion of the questionnaires. In the statistical analysis of the data, means and standard deviation were used in describing the scores on the individual items. This approach was used because of the quantitative nature of the variables which were measured in interval scale. The Pearson Product Moment correlation procedure (PPMC) was used in the test of the hypothesis with the aid of the statistical package of social sciences (SPSS). All hypotheses were tested at 0.05 level of significance.

CHPATER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

The responses of the subjects on the health practices among institutions of higher learning in Kano state are statistically analyzed in this chapter. The instrument measured in Likert scale was scored along the five point interval options and the mean constituted the major tool for decision on each of the items in the analysis of the subjects' responses on the health practices in the selected tertiary institutions. The demographic characteristics of the subjects were however analyzed using frequencies and percentages. The observed means for each of the items are shown along their standard deviations. The chapter is organized in the following order.

4.1 Analysis of demographic characteristics of the subjects

4.2 Evaluation of the subjects' opinion on Health Instructions

4.3 Assessment of the subjects' opinion on Health services

4.4 Assessment of the subjects' opinion on Healthful school living

4.5 Assessment of the subjects' opinion on School Home and Community relationship to the promotion of Health Practices

4.6 Test of Hypotheses

4.7 Discussions

4.1 **Analysis of Demographic Characteristics of The Subjects:**

Some demographic characteristics of the respondents were selected for the analysis to give a clear picture of the type of respondents involved in the study. Among the selected variables were sex, age, marital status and the institutions of the respondents. Table 4.1 shows the frequency distribution of the respondents by their demographic characteristics.

Table 4:1 **Demographic Characteristics of the Respondents**

SEX	FREQUENCY	PERCENTAGE
Male	327	81.8
Female	73	18.3
Total	**400**	**100.0**
Age:		
18 – 29 years	279	69.8
30 – 41 years	101	25.3
Above 41 years	20	5.0
Total	**400**	**100.0**
Marital Status:		
Married	179	44.8
Single	217	54.3
Divorced	4	1.0
Total	**400**	**100.0**
Institution:		
University	150	36.8
College of Education	200	50.0
School of Health	50	13.3
Total	**400**	**100.0**

The distribution in Table 4.1 above shows that 81.8% of the respondents were males while 18.3% were female. The unequal

proportion of the sexes was really the true representation of the school population. The 18 – 29 years age range was the dominant group of among all the respondents. It accounts for 69.8% of the total respondents while those in the 30 – 41 years categories were 25.3%. Only 5.0% of the respondents were above 41 years. This age distribution is the reflection of the actual students' population in the selected institutions in the state and it would be expected that the subjects were mature enough to give valid response to the questions.

4.2 **Respondents' Opinion on Health Instructions:**

The concern of this section is the assessment of Health Instructions received by the subjects towards sustaining the health practices. The responses were measured in a five point Likert Scale. Among the items used in this assessment were the instructions on health practices, health progrommes and the time allocated for the teaching of health related practices in the selected tertiary institutions within the state. Others were the adequacy of the instructions relating to health practices and the capability of such instructions in the promotion of health practices among the students in the selected tertiary institutions within the state. Decision on each of the items is based on the mean being above the undecided option of 3.0 or below. A mean that is approximately 4.0 is on the

agreement side of the scale while a mean that is 3.0 or below could be regarded as disagreement. The mean on each Table 4.2 shows the mean scores and the standard deviations of the responses by the subjects on each of the items as they relate to health practices in the selected institutions.

Table 4.2 **Response on Health Instructions**

S/NO.	HEALTH INSTRUCTIONS	MEAN	SD
1.	Health instructions offered in my school in the area of Health Education are relevant and adequate to promote health practices.	4.353	0.674
2.	Health instructions and other Health Education programme in my institution is capable of preparing professional Health Educators.	4.353	0.674
3.	Time Allocated for Health instructions is adequate to promote health practices.	4.068	0.883
4.	Health instructions taught in my institutions meets the need of the society.	4.170	0.844
5.	Health instruction taught in my institution is capable of promoting students' practical experiences.	4.270	0.720
Aggregate Mean Score		**4.259**	**0.772**

The mean (4.435) response on item 1 in Table 4.2 shows that there was a consensus among the subjects on the Health instructions offered in the selected schools in the area of Health Education as to their relevant

and adequacy in promoting health practices. On the capability of Health instructions and other Health Education programmes in the institutions, the mean score for item 2 (4.353) shows that the subjects agreed that the health instructions are adequate in preparing the students as professional Health Educators. With a mean of 4.068 (item 3), the subjects could also be said to have agreed that the time allocated for Health instructions in the institutions is adequate in promoting health practices among the students.

The mean score (4.170) on item 4 shows an agreement by the students that the Health instructions taught in the institutions meets the need of the society. In item 5, there was a consensus among the students with a mean score of 4.270 that the Health instructions taught in the institutions are capable of promoting students' practical experiences. From the aggregate mean score of 4.259 in the table, it is clear that the students agreed that the Health instructions given in the schools adequately promote health practices among the students in the tertiary institutions.

4.3 **Respondents Opinion on Health Services**

Health services availability could go a long way in determining the health practices of students in any higher institution of learning. The availability or otherwise of such services could influence the health practices of individuals in relation to the environment. This could be in the interaction between students in terms of the games, and other activities in which they could indulge themselves and hope of remedies that could be available in cases of emergencies. The assessment here is based on the patronage of the available health services in the selected tertiary institutions. The opinion of the subjects on the health services provided in the institutions, are shown in mean scores and standard deviation computed along the Likert Scale in Table 4.3. The mean score for each of the items are tabled along their Standard Deviations.

Table 4.3 **Opinions of the Subjects on Health Services**

S/NO.	HEALTH SERVICES	MEAN	SD
1.	I attend school clinic or sickbay for medical attention which helps in promoting health practices.	3.923	0.982
2.	The health services provided in my school enable me to receive the prescribed drugs in the school clinic	3.788	0.977
3.	The health services are being provided by qualified health personnel.	4.088	0.913
4.	The health services provided enable me to go for regular medical check up for the promotion of health practices.	4.088	0.915
5.	I am satisfied with the general health services rendered in my school.	3.948	0.955
Aggregate Mean Score		**3.958**	**0.9484**

The mean score for item 1 (3.923) shows that the respondents attend their institutions' clinic or sickbay for medical attention, which helps in promoting health practices. In items 2, the mean score is 3.788, which also depicts agreement by the subjects that the health services provided in the selected school enables them to receive the prescribed drugs in the various schools' clinics. The mean score (4.043) for item 3 is even higher, indicating an agreement by the respondents that the health services offered in the various clinics were being provided by qualified health personnel. From the mean score of item 4 in the table, there was a

consensus agreement by the subjects that the health services provided in the clinics enable the students to go for regular medical check up towards the promotion of health practices. Thus item 5 showed that there was a general agreement by the students on the adequacy of the general health services rendered in the various schools.

The mean scores for the items in Table 4.3 implied some consensus on the patronage of the various health services in the institutions. For all the items in the table the mean scores were on the agreement side of the Likert Scale. The aggregate score (3.958) for the table is an indication that the subjects agreed with the adequacy of the services of the various health centers in the schools.

4.4 Assessment of the Subjects Opinion on the Healthful School Living

The activities of the subjects in terms of their environments, the available facilities and equipment that can aid their practices of health living and their personal involvement in activities that promote good health are evaluated in this section. Table 4.4 shows the respondents opinion on how they are involved in the practices of those health activities and the level of accessibility of the needed facilities and equipment that can aid them in their practices of healthful living. The table shows the subjects' mean scores on each of the items and the

corresponding standard deviations as they relate to the practice of healthful living in the selected tertiary institutions within the state.

Table 4.4 **Opinion of the Subjects on Healthful School Living**

S/NO.	HEALTHFUL SCHOOL LIVING	MEAN	SD
1.	I participated in the promotion of healthful school living environment in my institution	4.170	0.835
2.	For ensuring good healthful school living practices, my institution provides enough facilities and equipment	3.710	1.031
3.	I live in a well decorated and ventilated school building	3.945	0.992
4.	Generally, my school environment is clean and tidy for proper enhancement of healthful school living practices.	3.930	1.026
5.	Generally, my school environment is clean and tidy for proper enhancement of healthful school living practices.	3.823	1.079
Aggregate Mean Score		**3.916**	**0.993**

The mean score (4.170) for item 1 in table 4.4 shows that the subjects agreed that they do participate in the promotion of healthful school living environment in their institutions. The subjects also agreed that the institutions on the other hand provided some facilities and equipment towards ensuring good healthful school living practices among the students. The mean score for this item (2) is 3.710 with a

standard deviation of 1.301. From the mean score (3.945) on item 3, the students could be seen as agreeing to the notion that they live in well decorated and ventilated school buildings within the schools. The score (3.930) on item 4 also shows some agreement between the students that the sport arenas in the selected institutions were good enough to promote healthful school living practices among the students.

These perceptions informed the opinion of the respondents on the last item in the table in which they agreed (3.823) that their school environments were generally clean and tidy for proper enhancement of healthful school living practices. The aggregate mean score for the table (3.916) clearly shows that the students were in agreement with the opinion that they practice good healthful living practices in their various intuitions.

4.5 Assessment of the Subjects Opinion on School, Home and Community Relationship to the Promotion of Health Practices

The influences of school, the home and community relationship on the health practices of the students are assessed in this section. The interactions of the students with these agencies, the home, school and the community really affects the adopted condition of health practices by the students. In Table 4.5, respondents' opinions on the influences of the three agencies, on their health practices are shown along the Likert Scale

and the mean score for each of the items along with their standard deviation are shown.

Table 4.5 **Opinion of the Subjects on School Home and Community Relationship to the Promotion of Health Practices**

S/NO.	HEALTH SERVICES	MEAN	SD
1.	The school, home and community relation that exists between my institution is capable of promoting health practices.	4.138	0.831
2.	Through the school home and community relations, I learnt a lot of desirable health habits and practices.	4.215	0.849
3.	I participate in community works through voluntary organization activities based on what I have learnt with regard to school, home and community relations.	4.195	0.805
4.	The school, home and community relations encourage my parents to contribute to health practices.	4.213	0821
5.	The existence of school, home and community relations contribute to good health communication channel with my community	4.158	0.731
Aggregate Mean Score		**4.184**	**0.807**

From the score of 4.138 for item 1, in the table, it could be said that the respondents' school, home and community relation that exists between the various institutions were capable of promoting health practices among the students. The mean for item 2 is 4.215 with a

standard deviation of 0.849. This score implied that the students agreed that through the school, the home and community relations, they learn a lot of desirable health habits and practices.

The score to item 3 (4.195) shows a consensus agreement among the students with regard to their partilcipation in community works using their knowledge of the school background. From the table, it could be seen that the students agreed that they participate in community works through voluntary organization activities based on what they have learnt in school, home and community relations. From the score (4.213) on item 4, it is obvious that there was a consensus agreement between the students that the school, home and community relations encouraged their parents to contribute to healthy living practices of the students. Thus, the scores of (4.158) on item 5 in the table shows that the students agreed that the existence of school, home and community relations contribute to good health communication channel with their communities.

4.6 **Test of Hypotheses**

One major and four sub-hypotheses were tested in this study. The hypotheses are as follows:

Major Hypothesis:

There is no significant relationship of Health instruction, Health services, Healthful school living, School-home and Community environment with Health practices among students of tertiary institutions in Kano State.

Sub-Hypotheses:

(1) Health instructions would not have significant relationship with health practices among students of tertiary institutions in Kano – State.

(2) Health services would not have significant relationship with health practices among students of tertiary institutions in Kano – State.

(3) Healthful school living would not have significant relationship with health practices among students of tertiary institutions in Kano – State.

(4) Home – School and Community relations would not have significant relationship with health practices among students of tertiary institutions in Kano – State.

The hypotheses were tested with the Pearson Product Moment Correlation (PPMC) procedure. The use of the PPMC. was to enable the

determination of relationships between the health components and health practices among the students of tertiary institutions in Kano State.

Major Hypothesis:

There is no significant relationship of Health instruction, Health services, Healthful school living, School-home and Community environment with Health practices among students of tertiary institutions in Kano State.

This hypothesis was tested with the summation of the related items of Health practices and their determinants in Table 4.2 to 4.5. The Pearson Product Moment Correlation (PPMC) procedure was used in the test. The use of the PPMC was necessitated by the quantitative nature of the variables to be related in the test. The result is presented in Table 4.6.

Table 4.6: **Correlation between health practice and their determinants among students of tertiary institutions in Kano State**

Major Hypothesis:

There is no significant relationship of Health instruction, Health services, Healthful school living, School-home and Community environment with Health practices among students of tertiary institutions in Kano State.

Variable	Mean	Standard Deviation	Standard Error	DF	r
Determinants	3.8057	0.66887	0.04318	398	0.462
Health practices	3.5275	0.66640	0.04302		

r(398) = .098 < .05

The observed Correlation Coefficient (0.462) in the table is higher than the critical value of 0.098 at 398 degree of freedom (DF) and the observed level of significance is less than 0.05 (P < 0.05). This means that the determinant of Health practices is significantly correlated with their Health practices. The null-hypothesis is therefore rejected. A further breakdown of the Major hypothesis is presented in the subsequent sub-hypotheses.

Sub-Hypothesis I:

Health instruction would not have significant relationship with Health practices among students of tertiary institutions in Kano State.

This hypothesis was tested with the scores on table 4.2 along with the scores on item in Table 4.3, Table 4.4 and Table 4.5 respectively. The Pearson Product Moment correlation Procedure was used for the test. The result is shown in Table 4.7 below.

Table 4.7: **The relationship of Health instruction and Health practices**

Variable	**Mean**	**Standard Deviation**	**DF**	**r**
Instructions	4.2590	0.5105	398	0.4776
Practices	4.0493	0.5172		

r(398) = .098 < .05

The result revealed significant relationship between Health instructions and Health practices. The observed Correlation Coefficient in the table is 0.4776 and the critical value of r at the same degree of freedom is 0.098. The probability level of significance observed for the test of hypothesis is 0.00 ($P < 0.05$). This means that the relationship of health instructions and the health practices of the students in the selected tertiary institutions is statistically significant. The null hypothesis is thus

rejected. The implication here is that, health instruction to students could go a significant way in improving their health practices in the school.

Sub-Hypothesis II:

Health services would not have significant relationship with Health practices among students of tertiary institutions in Kano State.

The scores on the items in table 4.3 were used along the scores of items in table 4.4 and 5.5 in a relation to test for this hypothesis. The result of the test using the PPMC. is shown in table 4.8.

Table 4.8: **The Relationship of Health Services and Health Practices**

Variable	**Mean**	**Standard Deviation**	**DF**	**r**
Services	3.9575	06374	398	0.6024
Practices	4.0495	0.5172		

r(398) = .098 < .05

The result showed significant relationship between health services and health practices. This is because the observed correlation coefficient (r) is higher than the critical value (0.098) at the same degree of freedom (DF). The observed significant level (P) for the test is 0.00 ($P < 0.05$). This means that, the null hypothesis could therefore be rejected.

Sub-Hypothesis III:

Healthful school living would not have significant the health with health practices among students of tertiary institution in Kano State.

For this test, the scores on items in Table 4.4 and 4.3 were related using the PPMC. procedure. The result of the test is shown in Table 4.8

Table 4.9: **Relationship of Healthful Living and the Health Practices**

Variable	**Mean**	**Standard Deviation**	**DF**	**r**
Healthful Living	3.9155	0.6796	398	0.8800
Practices	4.0495	0.5172		

r(398) = .098 < .05

The observed correlation coefficient (r) for the test is 0.08800 and the observed significant level P for the test is 0.000 ($P < 0.05$). The result showed that the two variables are significantly related. The null hypothesis could therefore, be rejected, since school healthful living is significantly related to health practices of the students in the selected tertiary institutions.

Sub-Hypothesis IV:

Home-school community relation would not have significant relationship in determining the health practices of students in tertiary institutions in Kano State.

This hypothesis was tested with the scores on the items in Table 4.5 along the items of healthful living practices discussed in Table 4.3 and Table 4.4 above. The PPMC. was used in determining the relationship of the School, Home and Community relations on the health practices of the students from the selected tertiary institutions. Table 4.10 shows the result of the test.

Table 4.10: **Relationship of School, Home and Community Relations on Health Practices of the Students.**

Variables	Mean	SD	DF	r
Relations	4.1835	0.5427	398	0.8039
Practices	4.0495	0.5172		

r(398) = .098 < .05

The result shows that the school, home and community relations have significant influence on the health practices of the students. The observed correlation coefficient (0.8039) is higher than the critical value

(0.098) at the same degree of Freedom (DF) and the observed level of significance (P) is (0.00) $P < 0.05$. The null hypothesis is therefore rejected.

4.7 Summary of Findings

Considering the above analysis, interpretations and findings, there were significance relationship of health instruction, health services, healthful school living and school home and community relationship with health practices among the students of selected tertiary institutions in Kano State. Therefore, the null-hypotheses were rejected.

4.8 Discussion

The findings of the study revealed that health instruction has significant relationship on the health practices among the students of tertiary institutions in Kano – State. This finding is a reflection of the report by Athur (2000) in a paper presented at the AAU Conference of Rectors, Vice chancellors and President of the African Universities (COREVIP) Mauritius, where Education and instruction was described as a life sustaining and that it furnishes the tools with which children and young people carve out their lives, as is a life long source of comfort, renewal and strength. The study also lend credence to the findings of Adegbite (2001), Adeniyi, (1993) & Ajala, (1986) who stated that there is

a need for certain amount of health knowledge at all ages including kindergarten children, so as to lay a solid foundation for good health habits, attitudes, skills and practices. They all agreed that, to promote health practices generally among the learners, organised health instructions have to be emphasized at all levels of education. Similarly, Ogunsakin (1984) proclaimed that knowledge is basic and must be imparted to pupils and students before the hope of developing proper and desirable health habits, attitudes and practices.

The second objective of the study was the effect of health services on health practices of the students. The related question here was whether there is any significant influence of health services on the health practices of students. The result of the findings revealed that, health services were significantly related to the health practices of the students. Surprisingly, the findings corroborate with WHO, (2003) & UNESCO, (2003) which reported that the school health service is an important component of the school health programme which includes all the activities and procedures designed to influence the present or existing health status of the school children. In the same line Udoh, et al (1999) said that school health services help to protect and improve the health of children, thus aiding their growth and development and enabling them to

benefit fully from school experiences. In another development, Sohi, (1999) stated that adequate health services, including periodic medical examination, follow-up services, supervision by all teachers and effective health instructions lead to better health practices.

The findings of the study with regard to healthful school living showed that there is a significant relationship between the health practices and healthful school living among the students of higher learning in Kano – State. In the study of the effect of education on healthful living, Swain (2006), reported that the education of children and youths in healthful living is a mutual responsibility of schools, parents and the community. Teachers lead a team of school staff, including school counselors, school nurses, school social workers, school Safety Officers and food services Personnel, in introducing students to the basic knowledge and skills needed to establish healthy living habits. In addition, Sohi, (1991) explained that the nature of school health programme today is of the type that provides the child with the best possible healthful environment, including the proper maintenance and sanitation of the school grounds, plant, classrooms, special facilities, and adequate health services that can promote health practices among the students. In the observation of Patrick (2000), healthful school living is a

part of school health programme with a fundamental obligation of promoting and protecting the health of the school child through various health practices. Also according to Udoh, et al (1999) healthful school living helps to promote health and safety and it support the total educational programme.

The findings of the influence of home-school-community relationship on the health practices among students of higher learning in Kano – State showed that there is a significance relationship. This finding is in line with the opinion of Ajibola (1998) who pointed out that the home-school and community play a vital role in determining the health status of the child. He further explained that the child cannot perform effectively where the three fail to cooperate. They have to work in harmony in the overall interest of the healthy existence of the school child. Similarly, Achalu (1993) explained that the home, which is the entry point of a child into the world gives all necessary protections, nutrition and health care that the child needs for survival, while the school offers the formal and functional experiences and orientation which thus affect the child's health habits, attitudes, knowledge and practices in his daily struggles. Some authorities in the area of health education like Turner, (1975), Williams, (1978) & Udoh, et al, (1999) have considered

home, school and community relationship as a division of school health programme. This is because health instruction, health services and healthful school environment are all influenced by what goes on both in the home and community.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study investigated the health practices among students of tertiary institutions in Kano State – Nigeria. A total of 400 students from tertiary institutions in Kano State were involved in the study. Among the problems which lead to the data collection from the students were expected to provide answers on the relationship of the selected variables: Health instruction, Health services, Healthful school living and the relationship that exists between school home and community within the institutions for proper health practices.

There were also the solutions provided for the research questions raised in the study. At the end of the chapter, a discussion of the findings from the analysed data was presented and an attempt was made to give satisfactory solutions to the study.

5.2 Conclusion

In the study, the determinants of health practices among students of tertiary institutions in Kano State Nigeria was investigated. A total of 450 students from tertiary institutions in Kano State were involved in the study. The major purpose of the study was to find whether there is a

significant relationship between health instruction, health services, healthful school living, home-school-community relations on the students' health practices.

The findings of the study showed that there are significant relationships and the health components are significant factors in ensuring effective health practices among the students of tertiary institutions in the state. The findings call to attention the need to encourage health related provisions in all schools.

5.3 **Recommendations**

On the basis of the findings from the data analysed in this study, the following recommendations were made:

1. As this study revealed positive relationship between Health instruction and Health practices among students of tertiary institutions in Kano State, it is recommended that health instruction should be improved by providing adequate teaching materials and more qualified Health Educators to handle health courses in tertiary institutions.
2. Health facilities and services need to be made functional and available in all tertiary institutions to provide healthful living among students.

3. Efforts should be intensified in making the school environment clean and tidy through provision of adequate portable drinking water, lightening, good building structures, drainages, proper environmental sanitation and good climatic conditions to promote health practices.

4. A strong home-school and community relationship should be created through Parent-Teacher Association and involvement of community leaders and Elders in school health programme which could provide an enabling environment for the students to put what they have learnt into practice.

5.4 **Suggestion for Future Research**

An examination of the health Education progrommes in both primary and post primary institutions is suggested for future research.

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APPENDIX

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DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION

AHMADU BELLO UNIVERSITY, ZARIA

*VICE CHANCELLOR: **Professor Shehu U. Abdullahi, DVM, Ph.D.(Minn.), FIMC, mni***

*Head of Department: **Dr. A. I. Kabido, B.Ed., M.Ed., Ph.D.)***

Our Ref. No. M.SC/EDUC/74615/2004-2005

TO WHOM IT MAY CONCERN

The bearer, Mustapha Abdu with registration Number M.SC/EDUC/74615/2004-2005 is a Postgraduate student of the above named University. He is currently conducting a research on "Health Practices among Institutions of Higher Learning in Kano State".

Kindly assist him with any information that may be of relevance to his study.

You are assured that whatever information supplied will be treated with utmost confidentiality for the purpose of this research only.

Thanks for the usual cooperation.

(Sgd)
Prof. (Mrs) F. B. Adeyanju
(Major Supervisor)

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION

FACULTY OF EDUCATION

AHMADU BELLO UNIVERSITY

SAMARU (MAIN CAMPUS)

ZARIA - NIGERIA

Dear Respondents,

QUESTIONNAIRE

The researcher is a Master's student of this department. In partial fulfillment of the requirements for the award of Master's Degree in Health education, he is conducting a research on Health Practices among Institutions of Higher Learning in Kano State.

Therefore, he seeks your cooperation to respond to the following statements correctly based on your understanding. Your responses will be held strictly confidential.

The questionnaire is made up of two parts, A and B. Part A contains Statements of Health Practices among Institution of Higher Learning.

The responses are scored as follows:-

KEY:

SA	-	Strongly Agreed	-	5 Points
AG	-	Agree	-	4 Points
UD	-	Undecided	-	3 Points
D	-	Disagree	-	2 Points
SDA	-	Strongly Disagree	-	1 Point

Please tick (√) the column against each statement that best represents your feeling.

PART (A): PERSONAL INFORMATION

1. Sex Male ( ) Female ( )
2. Age:
   - (a) 18 - 29 years ( )
   - (b) 30 - 41 years ( )
   - (c) 42 years and above ( )
3. Marital Status:
   - Married ( ) Single ( )
   - Divorce ( )
4. Institution:
   - University ( )
   - College of Education ( )
   - College of Health Sciences (School of Hygiene) ( )

PART (B): HEALTH PRACTICE AMONG INSTITUTIONS OF HIGHER LEARNING IN KANO STATE

SECTION I: HEALTH INSTRUCTION

S/NO.	STATEMENT	SA	A	U	D	SD
1.	Health instructions offered in my school, in the area of health education are relevant and adequate to promote health practices.					
2.	Health instructions and other Health education progrommes in my institution prepare the students and the entire community for the practice of the healthful living.					
3.	Time allotted for health instructions is adequate promote health practices.					
4.	Health instructions taught in my institution meet the need of the society.					
5.	Health instruction taught in my institution enhances the health practice.					

SECTION 2: HEALTH SERVICES

S/NO.	STATEMENT	SA	A	U	D	SD
1.	Students attend school clinic or sickbay for medical attention which help in promoting health practices.					
2.	The Health Services provided in my school enable me to receive the prescribed treatment necessary for health practices.					
3.	The Health Services are being provided by qualified health personnel.					
4.	The various health activities provided in my school promote health practices.					
5.	The general health services rendered in my school impact a great deal on our day to day practice of healthy living.					

SECTION 3: HEALTHFUL SCHOOL LIVING

S/NO.	STATEMENT	SA	A	U	D	SD
1.	I participate in the promotion of good living environment in my institution by helping to keep the school clean and tidy.					
2.	For ensuring good healthful school practices, my institution provides enough facilities and equipment, e.g. water supply, acoustics, lighting, toilet lavatory facilities and waste disposal which to use instead of dropping wastes in inappropriate places.					
3.	I live in well decorated, ventilated and lighted school building.					
4.	The sport is arena good enough to promote the practice of healthful school living.					
5.	Generally, my school environment is clean and tidy for proper enhancement of healthful school living.					

SECTION 4: HOME – SCHOOL – COMMUNITY RELATIONSHIP

S/NO.	STATEMENT	SA	A	U	D	SD
1.	The good relationship between my institution and the community promotes healthful practices.					
2.	Through community, I learnt a lot of desirable health habits and practices.					
3.	I participate in community works through voluntary organization activities for the purpose of promoting health practices.					
4.	The institution encourages our community to practice healthful living.					
5.	Good communication channel exist between the institution and the community in promoting health practices.					