Original Article

http://jbrcp.org

2018 Journal Impact Factor: 1.10
Print ISSN: 2636-7378 | Online ISSN: 2651-5865

Assessment of School Health Programme in Benue South Senatorial District, Nigeria

Owoicho Akpa[1]*Audu Onyemocho[2], Emmanuel Odu[3], Kabiru Nazifi Wada[4]

[1]*University of Jos, Plateau State, Nigeria. Affiliation. Federal University of Health Sciences, Otukpo, Benue State Nigeria.*
[2]*Department of Community Medicine, College of Health Sciences, Federal University of Health Sciences, Otukpo, Benue State Nigeria.*
[3]*Institute of Global Health and Health Security, Federal University of Health Sciences, Otukpo, Benue State Nigeria.*
[4]*Faculty of Science, Federal University of Health Sciences, Otukpo, Benue State Nigeria.*

***Correspondence**: Owoicho Akpa. **Email**: g.o.akpa@gmail.com*
University of Jos, Plateau State, Nigeria. Affiliation. Federal University of Health Sciences, Otukpo, Benue State Nigeria.

Article information
Date Submitted: 08/10/2025
Date Accepted: 23/10/2025
Date Published: 20/11/2025

ABSTRACT

Background: Children of school-going age constitute approximately 18% of the global population and about 23% of Nigeria's population. The education and health of this growing demographic are critical to the sustainable development of individuals and society. In Nigeria, efforts to implement the School Health Programme have primarily remained at the policy level, with limited practical implementation. This study was therefore designed to assess the availability and effectiveness of the School Health Programme in Benue South Senatorial District, Nigeria.

Methods: A comparative cross-sectional descriptive survey design was employed in 60 schools across the nine local government areas of Benue South Senatorial District, using a multi-stage sampling technique. Data were collected through a structured, self-administered questionnaire and a checklist administered to head teachers, who served as respondents. Data analysis was conducted using SPSS version 25.0.

Results: The mean age of respondents was 45 ± 8.7 years; 71.7% were male, 96.7% had attained tertiary education, 93.3% were Christians, and the Idoma ethnic group accounted for 91.7%. Most schools (43.3%) operated only a primary section, while 3.3% offered both primary and secondary education. Nearly all schools (96.7%) admitted both male and female students. The average annual enrolment was 70.5 ± 49.0 students, with an average of fewer than 40 students per class. Slightly less than two-thirds (62.9%) of public schools and 50.0% of faith-based schools had 10 or fewer full-time teachers, compared to 47.4% of private schools. The proportion of schools with designated health facilities was highest among faith-based schools (66.7%), followed by private (36.8%) and public schools (31.4%). Public and faith-based schools primarily relied on water sources located outside the school premises (64.7% and 57.1%, respectively), while most private schools accessed water from within the premises (68.4%). The majority of students in public, private, and faith-based schools had access to one toilet for approximately every 30 students (68.6%, 89.5%, and 26.7%, respectively). All schools (100.0%) disposed of refuse through open dumping or burning.

Public schools had the most space for outdoor games (82.9%), followed by private (57.9%) and faith-based schools (50.0%). Overall, the implementation and assessment of the School Health Programme were more favourable in faith-based schools compared to public and private schools in Benue South Senatorial District, Nigeria.

Keywords: Benue South, Programme, School Health, Nigeria.

How to cite this article

*Owoicho Akpa, Audu Onyemocho, Emmanuel Odu, Kabiru Nazifi Wada. Assessment of School Health Programme in Benue South Senatorial District, Nigeria. J Biomed Res Clin Pract: 2025;8(3):32-41. DOI: https://doi.org/10.5281/zenodo.17690203

Access to the article

Website: http://www.jbrcp.org
: DOI: 10.5281/zenodo.17690203

INTRODUCTION

The number of children reaching schoolage over the past decade has been estimated to be approximately 18% and 23% of the world's and Nigeria's populations, respectively [1,2]. The educational achievement and health status of these emerging populations are vital tools for the sustainable development of both individuals and society.[3,4] In recognition of this fact, Nigeria has entrenched education as a right of all citizens, irrespective of their social, political, religious, or economic standing.[5] Most communities have a primary school, but not every community has a functional primary healthcare facility. Where they exist, these facilities often cannot meet the immediate needs of pupils because they are located at a distance from most schools. [6-8]

The School Health Programme (SHP) is an essential component of health promotion and disease prevention in educational settings. In Nigeria, the SHP aims to enhance the health and well-being of students by integrating health education, promoting hygiene, and providing essential medical services in schools. [10] All efforts to address the SHP in Nigeria have remained largely at the policy level, with minimal implementation. Where implementation has been attempted, the emphasis has been on external rather than internal measures within schools.[11,12]

The population of Benue South Senatorial District, situated in the Middle Belt region of Nigeria, is predominantly rural, and many students face health challenges that impact their learning and overall development.[13] Ensuring proper health facilities and education programs in schools can play a significant role in mitigating these challenges. The assessment of the SHP in this district is crucial for understanding its effectiveness, identifying gaps, and suggesting improvements.

METHODOLOGY

Study Area: The study was conducted in the Benue South senatorial district from November 13, 2023, to December 20, 2023. Benue State is one of the 36 states in Nigeria, located in the North Central Zone. Its geographic coordinates are between 7° 47' and 10° 0' East longitude, and 6° 25' and 8° 8' North latitude. The state shares borders with five other states: Nasarawa State to the north, Taraba State to the east, Cross River State to the south, Enugu State to the southwest, and Kogi State to the west. Additionally, it shares a boundary with the Republic of Cameroon to the southeast. Benue State covers an area of 34,059 square kilometres and has 23 Local Government Areas (LGAs) distributed across three senatorial districts. The Benue South senatorial district comprises the local government areas (LGAs) of Agatu, Apa, Ohimini, Otukpo, Obi, Oju, Ado, Okpokwu, and Ogbadigbo. This district contains 102 political wards and has an estimated population of 3,407,839, projected from the 2006 National Census. In the Benue South senatorial district, there are a total of 2,142 schools. This includes 957 Local Government Education Authority (LGEA) primary schools, 18 government secondary schools, 135 Universal Basic Education (UBE) junior secondary schools, 96 grant-aided secondary schools, 523 private primary schools, and 429 private secondary schools.

Study Population: The study population included all head teachers and students from the 2,142 primary and secondary schools located in the nine Local Government Areas (LGAs) of the Benue South Senatorial District. Only schools registered with the Benue State Government and those that obtained informed consent from their management were included in the study.

Study Design: The study employed a comparative cross-sectional descriptive survey involving public, private, and faith-based primary and secondary schools across the nine Local Government Areas (LGAs) of the Benue South senatorial district in Nigeria.

Sample Size determination:A minimum sample size of 60 was determined using Slovin's formula ($n=N / (1 + Ne^2)$), where n = minimum number of samples, N = total population, and e = error tolerance level)

Sampling Technique: A multi-stage sampling technique was employed for the study.

Stage 1(Selection of LGAs). Out of the nine Local Government Areas (LGAs), five were selected using a

simple random sampling method. The sampling frame was derived from a list of LGAs obtained from the State Ministry of Education (MOE). The selected Local Government Areas (LGAs) are Otukpo, Ohimini, Apa, Okpokwu, and Ogbadigbo.

Stage 2 (selection of wards). From each of the five selected LGAs, six political wards were chosen based on the number of schools present. Priority was given to wards with both public and private schools for ease of access.

Stage 3 (Selection of schools). In each of the selected wards, two schools were chosen (one private and one public). In total, thirty-five public schools, nineteen private schools, and six faith-based schools were selected and examined.

Data Collection Tools: The study utilized a self-administered questionnaire and an observational checklist. We adopted the school health program evaluation scale, originally described by Anderson and Cresswell in the UK, and later modified by Akani and Nkanginieme in 2007 to better fit the Nigerian context and economic conditions. This scale includes three sections: school administration data, school health services, and the healthful school environment.

Data Analysis: The quantitative data collected were thoroughly checked for errors, cleaned, entered, and analysed using the Statistical Package for Social Sciences (SPSS) version 25.0. The data was summarized and presented in exploratory formats, including frequency tables and charts. The practice of the school health program was described in accordance with the adopted school health program evaluation scale. A chi-square test was utilized to compare the availability and effectiveness of school health programs in public, private, and faith-based schools. The level of statistical significance was set at 0.05

Ethical Approval: Ethical approval for the study was obtained from the Health Research Ethics Committee (HREC) of the Federal University of Health Sciences, Otukpo (FUHSO-HREC/02/05/2023-08/05/2023). Informed consent was obtained from all participants and the heads of the selected institutions before the commencement of the study. The objectives of the study were explained, and participants were assured that their involvement was voluntary, meaning they would not face any consequences for choosing not to participate. Research assistants were trained to maintain confidentiality and not disclose any information shared by respondents during the interviews.

RESULTS

Sociodemographic Characteristics

Table 1 presents the sociodemographic characteristics of the respondents. The study achieved a 100% response rate. Respondents' ages ranged from 25 to 65 years, with a mean age of 45 ± 8.7 years. The majority of respondents were male (71.7%), and a substantial proportion (96.7%) had attained tertiary education. Most participants identified as Christians (93.3%), and the Idoma ethnic group was the most represented, accounting for 91.7% of the sample.

Table 1: Socio-demographic Characteristics of Respondents

Characteristics	Government (Public) N=35 (%)	Private N=19(%)	Faith-based (Religious) N=6(5)	Total N=60(%)	Test Statistic	P value
Age (years)						
≤ 29	0(0.0)	1(5.3)	1(16.7)	2(3.3)	22.162	0.002
30-39	3(8.6)	7(36.8)	1(16.7)	11(18.3)		
40-49	11(31.4)	8(42.1)	4(66.7)	23(38.3)		
≥50	21(60.0)	3(15.8)	0(0.0)	24(40.0)		
Sex						
Male	26(74.3)	13(68.4)	4(66.7)	43(71.7)	0.291	0.865
Female	9(25.7)	6(31.6)	2(33.3)	17(28.3)		
Educational Qualification						
Secondary	1(2.9)	1(5.3)	0(0.0)	2(3.3)	1.296	0.862
Tertiary	34(97.1)	18(94.7)	6(100.0)	58(96.7)		
Religion						
Christianity	32(91.4)	18(94.7)	6(100.0)	56(93.3)	0.693	0.707
Islam	3(8.6)	1(5.3)	0(0.0)	4(6.7)		
Tribe						
Idoma	33(94.3)	16(84.2)	6(100.0)	55(91.7)	2.651	0.618
Igede	1(2.9)	1(5.3)	0(0.0)	2(3.3)		
Others**	1(2.9)	2(10.5)	0(0.0)	3(5.0)		

**Other tribes (Igbo, Igala and Attakar)

School Administration

Table 2 summarizes information about the schools, students, and teachers. A total of 43.3% of schools operate only a primary section, while 3.3% have both primary and secondary sections. Additionally, 11.7% are Junior Secondary Schools (JSS), and 41.7% are Senior Secondary Schools (SSS). Almost all schools (96.7%) admit both male and female students, while 1.7% admit only male students and 1.7% admit only female students.In terms of enrolment, the majority of schools (28.3%) have 90 or more students, followed by 26.7% with 60–89 students, 23.3% with 30–59 students, and 21.7% with 29 or fewer students. Among the 35 public schools surveyed, 34.3% reported accommodating 30–39 students per class, followed by 25.7% with 20–29 students, and 17.1% with 40–49 students per class.The student-to-teacher ratio appears reasonable in both public and faith-based schools. Specifically, 62.9% of public schools and 50.0% of faith-based schools have 10 or fewer full-time teachers, compared to 47.4% of private schools. However, a greater proportion of private schools have 11–30 full-time teachers compared to public and faith-based schools.There were no statistically significant differences between school type and most school characteristics, except for attendees' age and the number of students per class, both of which showed significance at $p = 0.042$

Table 2: Summary of Information on theSchool Administration Data

Variables	Nature of School			Total (n=60)	Test Statistic	
	Public (n=35)	Private(n=19)	Faith-based (n=6)			
	Freq. (%)	Freq. (%)	Freq. (%)	Freq. (%)	χ^2	P-value
School Sections						
Primary Only	18(51.4)	6(31.6)	2(33.3)	26(43.3)		
JSS only	6(17.1)	1(5.3)	0(0.0)	7(11.7)		
JSS and SSS	11(31.4)	10(52.6)	4(66.7)	25(41.7)	11.174	0.083
Primary and Secondary	0(0.0)	2(10.5)	0(0.0)	2(3.3)		
Sex of School Attendees						
Male and Females	35(100.0)	19(100.0)	4(66.7)	58(96.7)		
Males only	0(0.0)	0(0.0)	1(16.7)	1(1.7)	9.899	0.042**
Females only	0(0.0)	0(0.0)	1(16.7)	1(1.7)		
Students Enrollment						
≤29	10(28.6)	3(15.8)	0(0.0)	13(21.7)		
30-59	8(22.9)	5(26.3)	1(16.7)	14(23.3)		
60-89	7(20.0)	8(42.1)	1(16.7)	16(26.7)	9.237	0.161
≥90	10(28.6)	3(15.8)	4(66.7)	17(28.3)		
Mean	66.5 (±49.0)	(±49.0)	(±49.0)	70.5(±49.0)		
Number of Students Per Class						
10-19	5(14.3)	7(36.8)	0(0.0)	12(20.0)		
20-29	9(25.7)	2(10.5)	2(33.3)	13(21.7)	16.04	0.042**
30-39	12(34.3)	2(10.5)	0(0.0)	14(23.3)		
40-49	6(17.1)	5(26.3)	2(33.3)	13(21.7)		
≥50	3(8.6)	3(15.3)	2(33.3)	8(13.3)		
Full-time Teachers						
≤10	22(62.9)	9(47.4)	3(50.0)	34(56.7)		
11-20	10(28.6)	8(42.1)	2(33.3)	20(33.3)		
21-30	2(5.7)	2(10.5)	1(16.7)	5(8.3)	**11.837**	**0.421**
31 and above	1(2.9)	0(0.0)	0(0.0)	1(1.7)		
Total	35(100.0)	9(100.0)	6(100.0)	60(100.0)		

School Health Services and Nutrition

The percentage of schools with designated health facilities was highest among faith-based schools (66.7%), followed by private schools (36.8%) and public schools (31.4%). Private schools recorded the highest proportion of professional development opportunities for health personnel (11.4%). Faith-based schools also had the highest percentage of schools conducting preventive health check-ups before student enrolment. All school types observed designated health days for students, with faith-based schools reporting the highest participation rate at 66.6%. Additionally, 50.0% of faith-based schools had an individual officially responsible for managing or coordinating school health services, compared to 25.7% in public schools and 4.2% in private schools. Overall, most indicators used to assess school health services showed higher performance in faith-based schools compared to public and private schools. However, the relationship between the assessed health service variables and the type of school was not statistically significant. With respect to school feeding programs, all school types reported having policies or guidelines for food and nutrition services (100% coverage). However, only public schools had benefited from the National Home-Grown School Feeding Programme, with an implementation rate of 42.5%. Among these, only 20.0% of the schools provided meals fortified with micronutrients.

Table 3: School Health Services and Nutritional Feeding Programmes by Nature of School

Variables	Nature of School		
	Public (n=35)	Private (n=19)	Faith-Based (n=6)
Health Services School has			
Designated Health Facility	11(31.4)	7(36.8)	4(66.7)
Preventive health check-upsbefore enrolment in the school	12(34.3)	11(57.9)	4(66.7)
Health day for students' participation	17(48.6)	11(57.9)	4(66.7)
The person officially responsible for managing or coordinating the school health services	9(25.7)	8(4.2)	3(50.0)
Professional development opportunities for health Workers, to improve the quality of health services for students	4(11.4)	1(5.6)	1(6.7)
$\times^2$= 19.74; df = 12; p-value = 0.0721			
Nutritional Feeding Program			
School has a Policy that provides a specific plan or guidelines for implementing food and nutrition services for students	35(100.0)	19(100.0)	6(100.0)
Schools benefit from the national school feeding policy	15(42.9)	0(0.0)	0(0.0)
Foods served as part of the school's food and Nutrition services fortified with micronutrients*(such as iron, iodine, zinc, or Vitamin A) (n=15)	3(20.0)	0(0.0)	0(0.0)
$\times^2$ = 19.74; df = 12; p-value = 0.0721			

a) Sources of Water

The source of water varies depending on the nature of the school. Public and faith-based schools primarily rely on sources outside the school premises (64.7%, n = 22 and 57.1%, n = 4, respectively), while private schools predominantly access water from within the school premises (68.4%, n = 13). The relationship between the nature of the school and the sources/location was statistically significant (X2=34.096; df=3; p-value = 0.000).

Table 4: Sources and Location of Water by Nature of Schools

Nature of School	Sources of Water	Location of Water Source		
		Within the School Freq (%)	Outside the School Freq (%)	Total Freq (%)
Public	Well	9(75.0)	5(22.7)	14(41.2)
	Pipe borne	1(8.3)	0(0.0)	1(2.9)
	Bore hole/Mono-Pump	1(8.3)	0(0.0)	1(2.9)
	Water vendor	1(8.3)	17(77.3)	18(52.9)
	Total	**12(100.0)**	**22(100.0)**	**34(100.0)**
Private	Well	10(76.9)	1(16.7)	11(57.9)
	Pipe borne	2(15.4)	0(0.0)	2(10.5)
	Bore hole/mono pump	1(7.7)	0().0)	1(5.3)
	Water vendor	0(0.0)	5(83.3)	5(26.3)
	Total	**13(100.0)**	**6(100.0)**	**19(100.0)**
Faith-based	Well	2(66.7)	2(50.0)	4(57.1)
	Pipe borne	1(33.3)	0(0.0)	1(14.3)
	Water Vendor	0(0.0)	2(50.0)	2(28.6)
	Total	**3(100.0)**	**4(100.0)**	**7(100.0)**
Total	Well	21(75.0)	8(25.0)	29(48.3)
	Water vendor	1(3.6)	24(75.0)	25(41.7)
	Pipe borne	4(14.3)	0(0.0)	4(6.7)
	Borehole/mono pump	2(7.1)	0(0.0)	2(3.3)
	Total	**28(100.0)**	**32(100.0)**	**60(100.0)**
	$\times^2$ = 34.096; df = 3; p-value = 0.000)			

Toilet Facilities Refuse Disposal Method

Table 5 presents the distribution of toilet facilities used by students and the method of refuse disposal across different school types. Among public schools, the majority (45.7%) used pit/trench latrines, followed by surface disposal or no toilet facility (40.0%), and water closet connected to a septic tank (14.3%). In contrast, the water closet/septic tank was the predominant type of toilet facility in private and faith-based schools, reported in 52.6% and 50.0% of these schools, respectively. There was a statistically significant relationship between the type of toilet facility used and the nature of the school ($\chi^2 = 13.267$; df = 4; p = 0.010). Regarding the toilet-to-student ratio, the majority of students in public, private, and faith-based schools had access to one toilet per approximately 30 students (68.6%, 89.5%, and 26.7%, respectively). About 2.9% of public schools reported a toilet-to-student ratio of 1:60 or more, while 33.3% of faith-based schools had a ratio of 1:31–45. However, this association was not statistically significant ($\chi^2 = 8.336$; df = 4; p = 0.080). All schools (100.0%) dispose of their refuse by dumping or burning it. No physical waste bins were observed in any of the schools. Solid wastes were piled up awaiting burning.

Table 5: Toilet Facility and Method of Refuse Disposal by Nature of School

Variables	Nature of School			
	Public (n=35) Freq (%)	Private (n=19) Freq (%)	Faith-based (n=6) Freq (%)	Total Freq (%)
Type of Toilet Facility				
Pit/trench	16(45.7)	8(42.1)	1(16.7)	25(41.7)
Water closet/septic tank	5(14.3)	10(52.6)	3(50.0)	18(30.0)
Surface/none	14(40.0)	1(5.3)	2(33.3)	17(28.3)
Test Statistics	**$\times^2$ = 13.267; df = 4; p-value = 0.010**			
Number of Students Per Toilet				
1:≤ 30	24(68.6)	17(89.5)	4(66.7)	16(26.7)
1: 31-45	10(28.6)	2(10.5)	2(33.3)	43(71.7)
1: ≥60	1(2.9)	0(0.0)	0(0.0)	1(1.7)
Total	35(100.0)	19(100.0)	6(100.0)	60(100.0)
Test Statistics	**$\times^2$ = 8.336; df = 4; p-value = 0.080**			

a) Roofing Materials

More than two-thirds (73.3%) of the schools have no buildings with fire-resistant roofing materials, 21.7% have some buildings with fire-resistant roofing materials, and 5.0% have all their buildings with fire-resistant roofing materials. The relationship was not statistically significant (Table 6)

Table 6: School Buildings with Fire-Resistant Materials

Variables	Nature of School				Statistical Values
	Public	Private	Faith-Based	Total N=60	
School buildings have fire-resistant Materials	N=35	N=19	N= 6	N=16	$\times^2$ =3.141; df = 2; p-value = 0.534
Yes	7(20.0)	6(31.6)	3(50.0)	16(26.7)	
No	28(77.1)	13(63.2)	3(50.0)	42(70.0)	
Type of Protection Materials	**N=7**	**N=6**	**N=3**		$\times^2$ = 5.689; df = 2; p-value = 0.224
All Buildings	7(100.0)	4(66.7)	2(66.6)	13(81.2)	
Some pre-fab building	0(0.0)	2(33.2)	1(33.3)	3(18.8)	

Public schools offer more outdoor game space, with 82.9% of them available, compared to 57.9% in private schools and only 50.0% in faith-based schools. However, when it comes to indoor physical education classes, faith-based schools lead with a higher proportion of 50.0%, followed by private schools at 47.4%, while public schools have the least at 22.9%. (See Fig. 4)

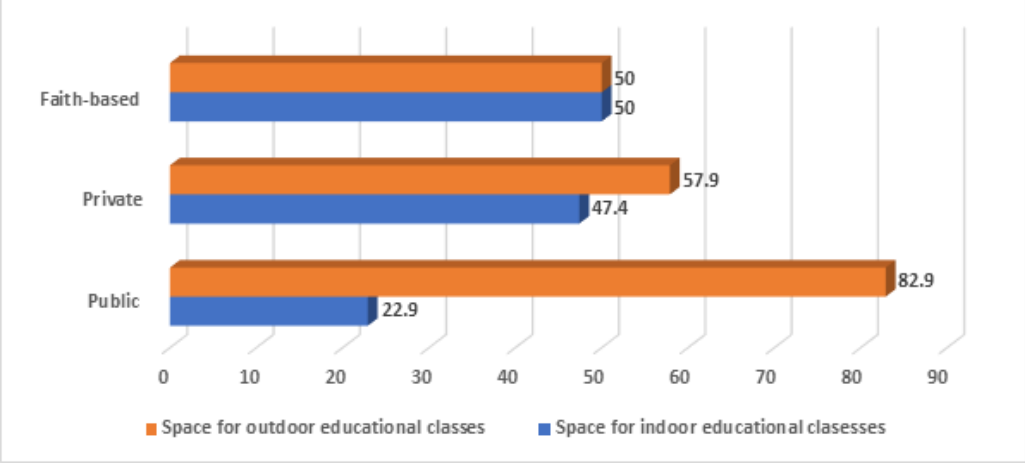

Fig 4: Frequency Distribution of space for indoor and outdoor games facilities by type of schools

DISCUSSIONS

The socio-demographic characteristics of the respondents in our study are consistent with those outlined in Nigerian civil service regulations. This implies that the school teachers are within their most productive age range, making them well-positioned to have a positive impact on their students.[14-17]

In our study, the majority of schools have primary sections, and a few have both primary and secondary sections (Table 2). All schools have evidence of registration with the Benue State School Board. This is consistent with the laws and acts guiding the establishment of schools in the state. By implication, the schools are under the state's guidance and, by extension, are subject to periodic monitoring and quality assurance evaluation.[18]

In our study, more than two-thirds of the teachers had the minimum educational requirement to be engaged as teachers. The findings are higher than the 40% reported in a similar study conducted by Akiyemi et al.In another study, poor qualifications were reported,[19]. The Nigerian National Certificate of Education (NCE) is the minimum requirement, and almost all teachers hold it. Aside from the minimum requirement, which applies to all schools, teachers with higher levels of tertiary education were more prevalent in private and faith-based schools. This is likely due to the high emoluments that private and faith-based school owners may pay, as most of these institutions are business-oriented. These additional qualifications can be a significant advantage in enhancing teaching quality, learning outcomes, and school effectiveness. To achieve this, public schools should consider implementing public-private partnership models to improve teacher salaries.

In this study, almost all schools admit both males and females, and they accommodate fewer than 40 students per class. In Nigeria, the recommended teacher-to-student ratio in primary schools is 1:35. The study's findings indicate an improvement over the results reported in the 2018 nationwide survey conducted by the World Bank, which found that many Nigerian states exceed the international benchmark ratio of 1:40, particularly in Northern Nigeria.[20,21]

Dedicated health facilities have been reported to enhance responsiveness to student illnesses. In our study, the percentage of schools with designated health facilities was highest in faith-based schools (66.7%), followed by private schools (36.8%) and public schools (31.4%). This finding is consistent with reports from similar studies conducted in Nigeria. [22-24] The presence of such facilities will contribute to the better handling of minor illnesses and provide for practical first aid. Furthermore, schools with a functional health facility are more likely to have early illness detection, reduced absenteeism, and better overall student health outcomes. In this regard, there should be reinforcement of policies guiding the establishment of such programs in all schools, whether they are private or public.

The World Health Organization (WHO) emphasizes universal access to safe water, sanitation, and hygiene for all by 2030, in line with Sustainable Development Goal 6 (SDG 6). This goal is foundational to the achievement of many other Sustainable Development Goals (SDGs), including health (SDG 3), quality education (SDG 4), gender equality (SDG 5), and climate action (SDG 13). [25] In our study, the majority of schools relied on hand-dug wells and water from public vendors. Access to safe water sources, such as boreholes or piped water, was more commonly available in private and faith-based schools(Table 4). Similar studies conducted in Nigeria report comparable findings.[26-28] However, the availability of safe water in our study is comparatively lower than reported in some of those studies. This suggests that students in public schools are more vulnerable to waterborne diseases. When combined with the limited number of functional, dedicated health facilities, this increases the risk of water- and hygiene-related illnesses among school children.

In the present study, the majority of students in public, private, and faith-based schools had access to approximately one toilet per 30 students, with respective rates of 68.6%, 89.5%, and 26.7%. Notably, private schools had significantly more toilets, and these facilities were better maintained compared to those in public and faith-based schools. These findings align with both national and international standards for school sanitation.[29] They are also consistent with a similar study conducted in Ogun State, which reported that many public schools had non-functional or unhygienic toilet facilities.[29-31]On the other hand, all schools (100.0%) dispose of their refuse by dumping or burning it. This is slightly at variance with standard practice, as it poses a significant risk to students.

In our study, public schools had more space allocated for outdoor games compared to private and faith-based schools. The availability of adequate space supports the inclusion of multi-use fields, basketball and volleyball courts, as well as indoor activity areas. The reduced space observed in private and faith-based schools may be attributed to limited funding or land constraints. However, this issue should be appropriately addressed

and considered as a critical criterion in the establishment and accreditation of schools.

CONCLUSION

Overall, the assessment of the School Health Programme in Benue South Senatorial District revealed that faith-based schools demonstrated better implementation and adherence to school health standards compared to public and private schools. This suggests that faith-based institutions may have stronger structures, policies, or resource allocation in support of school health initiatives. The findings underscore the need for targeted interventions and increased government commitment to improve school health services, particularly in public and private schools, to ensure equitable health and learning outcomes for all pupils in the region.

REFERENCES

1. United Nations, Department of Economic and Social Affairs, Population Division. (2022). *World Population Prospects 2022: Summary of Results*. Retrieved from https://population.un.org/wpp
2. National Bureau of Statistics (NBS) & United Nations Children's Fund (UNICEF). *Multiple Indicator Cluster Survey (MICS) 2021 – Nigeria Summary Report*. Abuja, Nigeria. Retrieved from https://www.unicef.org/nigeria/reports/multiple-indicator-cluster-survey-2021
3. UNESCO. *Global Education Monitoring Report 2016: Education for People and Planet – Creating Sustainable Futures for All*. Paris:UNESCO Publishing. 2016. Retrieved from: https://unesdoc.unesco.org/ark:/48223/pf0000245752
4. WHO & UNESCO. *Making Every School a Health-Promoting School: Global Standards and Indicators*. Geneva: World Health Organization and United Nations Educational, Scientific, and Cultural Organization. 2021. Retrieved from : https://www.who.int/publications/i/item/9789240025059
5. Federal Republic of Nigeria. *Constitution of the Federal Republic of Nigeria (as amended)*. Abuja: Government Printer. 1999 [Available online at: https://publicofficialsfinancialdisclosure.org/standards/nigeria-constitution-1999/]
6. National Primary Health Care Development Agency (NPHCDA). (2017). *Minimum Standards for Primary Health Care in Nigeria*. Abuja: NPHCDA. [Available at: https://nphcda.gov.ng
7. UNICEF Nigeria & Federal Ministry of Health. *Assessment of Primary Health Care Facilities in Nigeria*. Abuja: UNICEF and FMOH. 2018 [Available via UNICEF Nigeria or Ministry of Health websites]
8. World Bank. *Service Delivery Indicators: Nigeria Healthcare and Education Survey Report*. Washington, DC: World Bank Group. 2018. Retrieved from: https//documents.worldbank.org
9. World Health Organization & UNESCO. (2021). *Making Every School a Health-Promoting School: Global Standards and Indicators*. Geneva: WHO and UNESCO. Retrieved from: https://www.who.int/publications/i/item/9789240025059
10. Federal Ministry of Education. *National School Health Policy*. Abuja, Nigeria: Federal Government of Nigeria. 2006
11. Odetola, T.D. Implementation of the School Health Programme in Nigeria: Issues and Challenges. *Nigerian Journal of Clinical and Biomedical Research*, 2015. 8(1), 24–30.
12. UNICEF Nigeria. *Assessment of School Health and Nutrition in Nigeria*. Abuja, Nigeria: United Nations Children's Fund (UNICEF). 2013
13. National Population Commission (NPC) [Nigeria] & ICF. *Nigeria Demographic and Health Survey*

2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF. 2019. Available at: https://dhsprogram.com/publications/publication-fr359-dhs-final-reports.cfm

14. Federal Republic of Nigeria. *Education (National Minimum Standards and Establishment of Institutions) Act*, Cap. E3, Laws of the Federation of Nigeria. 2004
15. Federal Republic of Nigeria. *National Policy on Education* (6th ed.). Lagos: Nigerian Educational Research and Development Council (NERDC). 2014
16. National Policy on Education (NPE) – revised editions (most recently in 2014).
17. Nigerian Public Service Rules (2008 Edition), Office of the Head of Civil Service of the Federation.
18. Universal Basic Education Commission. *UBE Programme Monitoring Report*. Abuja: UBEC, 2018.
19. Ejieh, M. U. C. Attitudes of student teachers towards teaching practice: Implications for teacher education in Nigeria. *College Student Journal*, 37(3), 437–442. 2003
20. World Bank Annual Report. Report No: PAD2605. 2018:https://documents.worldbank.org
21. UBEC. National Personnel Audit (NPA) Report of Basic Education Institutions in Nigeria 2018. Accessed at: https://www.ubec.gov.ng
22. Osungbade, K.O., &Ogundiran, A.O. School health services in Nigeria: a comparative study of public and private primary schools in Ibadan North Local Government Area *Nigerian Journal of Medicine*, 2013. 22(2), 105–110
23. Abdulraheem, I.S., & Oluwagbemiga, O.A. School health services and its practice among public and private primary schools in Ilorin, Nigeria. *African Journal of Medicine and Medical Sciences*, 2011. 40(3), 267–273
24. Nwachukwu, C., &Umeokonkwo, A.A. Assessment of the Implementation of School Health Programme in Primary Schools in Enugu State, Nigeria. *Journal of Education and Practice*, 2020; 11(8), 65–73.
25. United Nations. *Transforming our world: the 2030 Agenda for Sustainable Development*. A/RES/70/1. United Nations General Assembly. 2015 .Accessed at: https://sdgs.un.org/2030agenda
26. Abubakar, I.R. *Access to sanitation facilities among Nigerian primary school children: Insights from the Demographic and Health Survey. Children and Youth Services Review, 2017; 73, 29–35.*
27. Adegun, O.A. *Availability of Water and Sanitation Facilities in Public Primary Schools in South-West Nigeria. Journal of Educational and Social Research*,2014, 4(3), 293–300.
28. Ibitola, O. & Akintola, B.*Assessment of Water and Sanitation Facilities in Public Primary Schools in Lagos State, Nigeria. International Journal of Public Health and Epidemiology, 2020. 9(4), 123–130.*
29. Oloruntoba, E.O., Folarin, T.B., &Ayede, A.I.Assessment of sanitation facilities in public and private primary schools in Osogbo, Nigeria. *Journal of Community Medicine and Primary Health Care*, 2014, 26(2), 1–10.
30. UNICEF & WHO.*Core Questions and Indicators for Monitoring WASH in Schools in the Sustainable Development Goals*. 2018. Genevamhttps://washdata.org/sites/default/files/documents/reports/2022-03/JMP-2022-WinS-core-questions.pdf
31. Oloruntoba, E.O., Folarin, T.B., &Ayede, A.I. Assessment of sanitation facilities in public and private primary schools in Osogbo, Nigeria. *Journal of Community Medicine and Primary Health Care*, 2014, 26(2), 1–10.