SKILL-BASED HEALTH EDUCATION FOR AMELIORATING SCHOOL CHALLENGES OF SCHOOL HEALTH PROGRAMME TO MEET SCHOOL NEEDS

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Abstract
The MDGs directed toward health promotion were not fully achieved, as health promotion through well implemented and functional school health programme, was far from reach. This is presumed to have necessitated the myriad of school challenges which affect school needs. The skill-based health education was therefore developed as a model to ameliorate the school challenges to meet school needs. The model exists in three phases with the first being healthful school living needs, second health instruction needs and lastly health service needs. The model also has a pool of school challenges of school health programme and instructional skills which run reciprocally to dynamically connect the three phases. In order to realize the purpose of the paper, instructors or other personnel concerned with health and instruction of leaners in the school are required to follow the procedure of use of the model. The instructors and others must first be acquainted with detailed understanding of the concept of instructional skills and the rudiments of their use in order to effectively use the model to meet the purpose of health promotion and disease prevention. Supervision, monitoring and assessment of progress can also be done with specific methods which are suggested in the paper.

Keywords: skills, health, programme, challenges, diseases

Introduction

Unmet school needs and challenges associated with achieving the Millenium Development Goals (MDGs) at 2015 shifted attention to Sustainable Development Goals (SDGs) proposed to be fully achieved by 2030. Unfortunately, its goals for health promotion were not fully achieved, and hence the objectives of skill-based health education (SBHE) were consequently not realized. One goal of SBHE is to develop correct health knowledge, favourable attitudes, right skills and healthy practices among school students.

SBHE goal is crucial to the extent that it should not be undermined by any government policy. Moreover, it is the totality of all experiences that assist the pupil/student to attain high level of wellness while acquiring not only knowledge and attitudes but also skills necessary to avoid diseases while navigating through life changes. It is only the healthy pupil that can benefit effectively from the educational process. Thus, SBHE utilizes experiences for favourably influencing understanding, attitudes and practices relating to the learner's wellness.

One reason for the input of SBHE in school health policy is to reach best practices in terms of implementation standards of SHP. However, it has been recorded by Sarkin-Kebbi and Kwashabawa (2017) that school challenges confronting SHP in Nigeria including inadequate/lack of health staff, inadequate facilities for health and lack of interest in providing SHP are still commonplace. The shortfall of the National Health Policy goal of the Federal Ministry of Education (2006) could be traced to less emphasis on SBHE in the Nigerian school system. Hence, Nigeria could hardly achieve the MDGs for health promotion with probable consequence from poor implementation.

Poorly implemented health instruction, otherwise called SBHE, has implications for learners' school needs. It was documented by Olatunya, Oseni, Oyelami and Akani (2014) that poor implementation of health instruction exists in Nigerian schools with only 3.0% of the teachers having in-service training on health-related issues, 4.7% private schools had health instruction given by qualified health education personnel with no school rendering health instruction at least three times a week. This challenge is an abysmal to students/pupils' school needs.

Students/pupils spend a major part of their lives in school exposed to a variety of school challenges and dilemma including inadequate basic needs of portable water, nutrition, unhealthful school environment, and substance abuse which are economic and psychosocial issues in the school system. More of these challenges confront the education sector including a range of issues concerning drug addiction, Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome pandemic, and poverty. Other environmental, physical, emotional and social influences such as examination malpractices, risky sexual behaviour, and learner physical abuse are all worrisome challenges. Some of the leaners lack the skill-related capacity to avoid some or all of the challenges. Hence, for learners to benefit maximally from the educational system with those myriad challenges, an adequate SHP with effective SBHS is necessary. The aforementioned, therefore informed the basis for which the SBHE will be used to ameliorate school challenges, especially those connected with SHP, in order to meet school needs of learners. To adequately realize the purpose of the paper, SHP's definition, history and phases; school challenges and needs and the use of the SBHE to ameliorate school challenges of the SHP were addressed. In addition, potential merits and demerits of SBHE in meeting school needs were also highlighted.

School Health Programme: Definition, History and Phases

SHP is a health and educational programme met to prevent disease and promote health of members of the school. Health education can occur in the community, industry, school or anywhere individuals exist. In the school, it is

qualified as school health education with SHP being the composite of procedures and activities designed to achieve the aim of health education, protection and promotion of the well-being of students and school personnel.

The brief history of SHP is traceable to the 20th Century; as early as 1948, Health Education became a school subject instead of hygiene and sanitation. It was emphasized that the health education syllabus was meant as a syllabus upon which instruction should be impacted to children. Although, physical and health education was a compulsory subject in Teacher Training Colleges in 1980, the Joint Consultative Committee on Education (JCC) modified the curriculum so that Physical and Health Education (PHE) became an elective for students wishing to write the final senior school certificate examination. Consequently, the daily inspection of pupils' finger nails, teeth, hair and overall cleanliness phased out of the system. After many decades, health education came on board, not subsumed under other school subjects but one of its own existence to be certifiable school subject.

SHP exist in different phases with the traditional model being in three phases namely healthful school living, school health services and health instruction. In 2006, the Federal Ministry of Education (2006) provided five components including school health services, school-home-community relationships, healthful school environment, school feeding services and skill-based health education. Recently, Public Health Nigeria (2020) noted that SHP has been expanded to include school health services, nutritional services, healthful school environment, physical education, counselling and psychological services and health education and promotion. Irrespective of the number of components in which SHP exist, one thing is central that health education is meant to promote total and optimal wellness for individuals in the community, home and school. of all the phases that exist, the present paper is adapting the five-point model of the National School Health Policy of Nigeria.

School challenges and needs

School challenges and needs appear to be synonymous but are different in meaning. First school needs, according to Strauss (2022), are things leaners require to survive in school to make them safe, stable and healthy, with well-being being one such need. Second, school challenges include but not limited to poor funding, subnormal classroom size, economic hardship, out-of-date facilities and equipment, students' family dysfunction, bullying, and student health (Chen, 2022). In both definitions, students' health and wellbeing is a common factor.

Educational system has policy statements that support the common factor of health and well-being of individuals. One such statement is SDG 3. Another can be localized in the following example. The Federal Ministry of Education with United Nations International Children's Emergency Fund (UNICEF) launched two

important policy documents in support of school need: the integration of health into the educational system called the National School Health Policy and the National Education sector HIV/AIDS strategic plan. These new policies were designed to put in place a national framework for the formulation, coordination, implementation and effective monitoring and evolution of SHP including an elaborate and concrete response to the HIV-AIDS scourge. The launch came against the backdrop of poor health status of school pupils and the impact of HIV-AIDS on the school system. Together with the two policies, the Federal Ministry of Education also launched the National Guidelines for School Meal Planning with the objective to reduce malnutrition and hunger among school children. Ofovwe and Ofili (2007), further added that in the year 2001 through the use of the Rapid Assessment and Action Planning Process (RAAP), in collaboration with the World Health Organization (WHO) and the Education Development Centre, Nigeria developed an action plan which will serve as a foundation for infrastructure development for school health in Nigeria. One of such action plans is the development of a comprehensive school health policy at the national level, with appropriate legal support, to guide the management of SHP.

Despite these, health education is still bedeviled with school challenges in Nigeria school system especially poor state of the SHP. Dania and Adebayo (2019) emphasized the poor state of SHP in Nigeria as inactive with low level of implementation. It was also recorded that mental and psychological challenges including suicide, depression, 8% attention deficit hyperactivity disorder (ADHD) in primary schools and 50% mental disorders beginning before age 14 are inclusive of the school challenges (Kessler et al. 2005; Omigbodun et al. 2008; Ibeziako et al. 2009). In addition, there are 1-3% individuals living with disabilities and an increasing conflict and violence mostly in Northern Nigeria (Adebayo, Bella-Awusah, Adediran & Omigbodun, 2023).

Many of the above school challenges still appreciably exist till date. No wonder evidence has shown that there is an increased challenge of undernourishment and overweight/obesity among school children aged 6 – 19years in Osun and Gombe States with consequent effect on leaning in Nigeria among children and adolescents (Adeomi, Fatusi & Klipstein-Grobusch, 2021; Adebayo, Bella-Awusah, Adediran et al. 2023).

Challenges are also documented to be evident in the practice and implementation of SHP in Nigeria with school needs appearing to be grossly undermined. The implementation of SHP targets only school pupils at the expense of staffers and ineffective coordination of stakeholders (Adebayo, Bella-Awusah, Adediran & Omigbodun, 2023). Many or all of the school challenges will continue to increase unless urgent steps are taken to ameliorate them. To ameliorate the myriad of school challenges, the SBHE is an option to be considered.

Skilled-Based Health Education to ameliorate school challenges of the school health programme

SHP is an important programme through which SDGs 2, 3, 4 and 6 can be partly achieved. For the progress of society of which Nigeria is not an exception, Olagoke (2017) documented goals 2 (no hunger), 3 (improved health and well-being), 4 (educational advancement), and 6 (pure water and proper sanitation) are not out of place.

Therefore, the need to improve SHP should begin with giving greater attention to preschool, elementary/primary, secondary and vocational schools.

Basic, secondary and vocational schools are the building blocks of society's educational foundation. This is because, not everyone needs a university education. School children need to be equipped with skills that will help them face these myriad problems and assist them in adopting healthy life-styles. Hence the skill-based health education of the National School Policy of Nigeria (2006) gave birth to the initiation of the Skill-Based Health Education (SBHE).

A skill is one's capacity to effectively perform a task. In the context of this paper, SBHE involves instructional skills which instructors, instructor trainees, learners and stakes who are concerned with an adequate and effective SHP can use for self, other's and school's development. SBHE delivered through the schools is a strategy through which school challenges, which can affect the school community, can be ameliorated in order to meet school needs (see Figure 1).

The SBHE is a triangular paradigm that consists of three separate interacting phases but includes needs of the three phases of SHP with each phase existing as: (1) healthful school living needs, (2) health service needs, and (3) health instruction needs. At the middle of the model is the pool of school challenges of the SHP. It contains challenges which can be resolved at specific phases of the model using instructional skills. The connecting arrows indicate that the instructional skills run reciprocally to connect each phase of the model where it is required. The middle arrows move forward in one direction, from the centre and these show that school challenges flow from that point to the three phases. For example, lack of water supply as a school challenge can be resolved through instructional skills. In a termly Parent-Teacher Association meeting or newsletter, school administrators and parents/guardians can be informed of the impact of lack of water supply in the school by preparing learners to dramatize the impact in a role play.

The participation of teachers, parents, school administrators, health counselors and learners themselves are critical to the successful use of the model to meet school needs. Teachers and credible significant others need to be well-equipped with detailed knowledge of instructional skills in order to drive home the message of specific school challenge as it emerges. Details of knowledge of the skills are beyond the purview of this paper.

According to Primary and Secondary Teacher Education Project (PASTEP, 2002) instructional skills include communication, explanation, demonstration, reinforcement, evaluation, maximization of leaner involvement, variation in teaching, as well as question and responding. These skills were used to describe the amelioration of school challenges of the SHP in order to meet school needs.

Procedure of use of SBHE

The skills are met to be learnt for eight weeks of sixteen sessions. One week of two sessions, with the first session of 40 minutes, slated for teaching a skill and the demonstration of the skill with role play in the second session of another 40 minutes. The second session of the same week must be tilted towards the specific school challenge identified in any of the phases of the SHP. For example, healthful school living needs, to a large extent, can be met as follows:

Healthful School Living Needs

With a checklist or questionnaire, some school needs of a healthful school can be determined. With reference to Figure 1, the following are priorities: daily cleanliness and disinfection of classroom and removal of unwanted items from school surrounding; school gardeners to use mower weekly, clean water availability and hygienic luncheon.

School Challenge Identification

Of all *t*he needs pointed out, corresponding school challenge could be (1) school: potential hazard of infection and injuries; (2) lack or insufficient supply of clean water; and (3) food poisoning in school. Any or all of these can be taught through instructional skills.

Targeting Group

Choosing any of the school challenge, for example 'school: potential hazard of infection and injuries', the instructor selects a target group that will be exposed to the instruction. For example, instructor trainees including school administrators (head teacher, teachers, school nurse and/or school cleaner, gardeners).

Ascertaining previous knowledge

The instructor quickly introduces him or herself by telling the audience his or her name, expertise and the purpose of the gathering. The instructor makes the instructor trainees to also introduce themselves in the same way. Thereafter, existing experiences regarding what school administrators are aware of in a healthful school are quickly re-affirmed. For example, everyone is assumed to be aware that a healthful school has sufficient number of well-spaced classrooms, toilet facilities, waste bins, and play field. The instructor quickly reviews these with the instructor trainees in 5 minutes.

Goal Setting

The instructor presents the aim of the workshop, for example as: the aim of the instruction is to enable audience use instructional skills acquired to prevent the school from being a potential hazard of infection and injuries for members of the school community.

Objectives setting

At the end of the lesson, audience will be able to:

1. Define instructional skills;
2. Identify eight basic instructional skills
3. Describe eight basic instructional skills

Res***ource Collection***

Note pads, biro, pencil, marker, Markerboard, flip book, flip chart,

Delivering Instruction

Section 1

Step I (8 minutes): The instructor distributes the pre-test form to the audience to determine their level of knowledge regarding instructional skills. For example, a multiple choice and 'yes/no' type pre-test form can cover:

1. definition of instructional skills;
2. enumeration of eight basic instructional skills participants know;
3. description of eight basic instructional skills participants know;
4. demonstration of one basic instructional skill participants know;
5. application of one or more of instructional skills to meet two or more of the aforementioned school needs which are related to a healthful school living.

Step II (5 minutes): The instructor introduces the lesson by first gaining participants' attention and interests. Then, using the flip book the instructor displays the definition of instructional skills as: 'specific attributes for teaching experiences for behaviour change'. Participants notes the definition into their notepads

Step III (5 minutes): The instructor opens the flip book and writes one instructional skill on the markerboard with the marker. For example, 'communication'. He does this for the other seven basic skills, one on each flip. The participants write the skills down.

Step IV (17 minutes): The instructor goes back to the first page of the flip and opens to the first skill, 'communication'. He defines the concept of communication and describes clearly with examples how the skill is effectively used. He does the same activity for the other seven instructional skills which are explanation; demonstration; reinforcement; evaluation; maximization of leaner involvement; variation in teaching; and question and responding.

Section 2

Ascertaining previous knowledge

The instructor quickly reviews the what was taught in Section 1 by asking participants questions and they respond. Incorrect responses were corrected by the instructor in 5 minutes.

Goal setting

The instructor presents the aim of the workshop again, for example as: the aim of the instruction is to enable audience use instructional skills acquired to prevent the school from being a potential hazard of infection and injuries for members of the school community.

Objectives Setting

At the end of the lesson, participants will be able to: demonstrate

eight basic instructional skills to meet the goal set.

Resource Collection

Flip book, table, plastic chairs, costumes for teacher, school nurse/doctor and others depending on the role to be taken.

Delivering Instruction

Step I (3 minutes): The instructor quickly displays the flip with the first page showing 'communication'. He briefly reminds participants what the concept is and how they are to use it effectively to dramatize the prevention of school from being a potential hazard of infection and injuries for members of the school community.

Step II (15 minutes): Participants organize themselves while the instructor moderates the activities and keep them focused on the goal of the skill of 'communication' and the goal of the workshop directed towards the amelioration of potential hazards of infections and injuries in the school.

Step III (15 minutes): Other sets of participants take their turn to act out the same roles but with any one of the other instructional skills such as explanation; demonstration; reinforcement; evaluation; maximization of leaner involvement; variation in teaching; and question and responding.

Evaluation

Finally, the instructor conducts a post-test with the same pretest form in seven minutes. Any difference recorded between the pre- and post-test indicates that the teaching of the skill has produced an effect on the identified school challenge.

Each phase needs prompt and effective monitoring, supervision and evaluation by the health teacher (for the health instruction), the health coordinator (for the healthful school living) and/or the health counselor (for the health services). Through active and self-directed instructional skills in role plays, games, and group discussions, the level of success of the use of SBHE in reducing school challenges of the SHP in order meet school needs will largely be achieved. However, this is not to say that each member does not complement the efforts of the other members.

Potential merits of SBHE in meeting school needs

The following section examined the potential merits of SBHE in meeting school needs under three categories with each using one sub-need for emphasis:

1. **Health instruction needs**: The SBHE can meeting health instruction needs. As earlier noted, SBHE which involves instructional skills that instructors, learners, and other stakeholders with interest in SHP can use for self, other's and school's development. For HIV/AIDS prevention campaign Figure 1, the SBHE has the potential of reducing the number of school individuals who are vulnerable to the infection, from being infected. Through the SBHE, instructional skills specifically 'communication' are

also used to reach learner, for example, to imbibe the skills of assertiveness or negotiation in order to prevent infection. In addition, the 'maximization of learner involvement' as another instructional skill. Participants can get involved in acting roles relating to the skills of assertiveness and negotiation in preventing HIV/AIDS. This also applies to the prevention of sexually transmitted infections (STIs), social and peer pressure. The model can also address HIV/AIDS and STIs transmission, and risk factors. Kelly (2000), stated that children between the ages of 5 and 14 have the lowest prevalence of HIV infection; below the age of 5 they are susceptible to mother to child transmission, and after they become sexually active, the rate of infection increases rapidly especially for girls. Children between 5-14 years need to be reached at this stage of development in order to stop the spread of HIV/AIDS and STIs. The prevention paradigm is done through promoting skill enhancement in changing the behaviours of school community members such as responsibility for personal, and school needs.

2. **Healthful school living needs**: can also be met with SBHE. In Figure 1, SBHE can be helpful in the provision of waste bins, incinerators, and mowers in the school. With 'explanation' and 'demonstration' as instructional skills, instructors can mobilize learners to develop a drama piece where players logically explain the school needs and demonstrate the importance of the equipment in the school to the Ministries of Education and Health.
3. **Health service needs**: Health service needs can also be met with SBHE. In Figure 1, the need for health counseling unit in a school can also be met with instructional skills under the SBHE. Through the skills of 'question and responding' and 'reinforcement', message regarding the importance of health counseling unit in a school can be sent. For instance, an instructor can use 'questioning and responding' to ask learners what they think the benefits of guiding and counseling students who have emotional or social conflicts in the unit are. Learners who are able to respond correctly are reinforced with praises and notebooks. Information collected from the section can be forwarded to the school authority for onward passage to a higher authority concerned with education and health of learners.

Potential demerit of SBHE in meeting school needs

The following is the possible disadvantage of the SBHE in meeting school needs are provided below:

1. Detailed provision of instructional skills is not provided for instructors to use the model. Efforts have to be

made to read materials concerning communication; reinforcement; explanation; questioning and responding demonstration; evaluation; maximization of leaner involvement and variation in teaching.

Conclusion

A number of school challenges of the SHP which affect to health and well-being of leaners, and other members of the school community is a subject of amelioration in order to meet school needs. The paper therefore advanced the SBHE as a strategy to achieve the amelioration to be used not only in the school but anywhere individuals congregate. The SBHE is made up of three phases in accordance with the fundamental basis of SHP to include healthful school living needs, health service needs and health instruction needs. To a large extent, these form the basis upon which school needs can be met. Instructional skills were provided (communication; demonstration; explanation; reinforcement; evaluation; maximization of leaner involvement; variation in teaching; questioning and responding) from which health educators, and instructor including teachers, health counselors and any credible significant other can use to ameliorate a specific school challenge as the circumstance arises. Supervision, monitoring and assessment of progress through active and self-directed instructional skills in role plays was also established. Thus, the level of success of the use of SBHE in reducing school challenges of the SHP in order meet school needs was largely achieved.

Recommendations

The SBHE is therefore recommended for the generality of instructors including health educators, health counselors and teachers as well as and pupils/students who are at the receiving end of school challenges. Instructors will find the SBHE model useful in training instructor trainees, leaners on the use of instructional skills to ameliorate school challenges of SHP in order to meet school needs. Learners will benefit from the SBHE model by enjoying the schools under SHP. Educational planners and other stakeholders should use the SBHE model to train and retrain members of the school during educational workshop. It can also serve as a guide for monitoring and assessing the implementation of the components of SHP by educational planners and implementers.

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