European Journal of Education Studies
ISSN: 2501 - 1111
ISSN-L: 2501 - 1111
Available online at: www.oapub.org/edu

DOI: 10.46827/ejes.v12i11.6301 Volume 12 | Issue 11 | 2025

IMPLEMENTATION OF THE NATIONAL SCHOOL HEALTH POLICY IN OSUN STATE SECONDARY SCHOOLS: AN ASSESSMENT

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Abstract:
This study assessed the implementation of the National School Health Policy in Osun State secondary schools. It examined the extent to which Osun State Secondary schools implemented the various components of the National School Health Policies, determined the component with the highest and lowest levels of implementation, and identified the challenges to implementation of the policy in the study area. Employing the descriptive survey research design, using a questionnaire and standardized checklist as instruments for data collection, Principals and teachers, purposively selected from thirty-six schools, were the sample for the study. The data were descriptively analysed using frequency counts, percentages and statistical mean. The study found that there was a low (41.33%) to moderate (53.33%) level of implementation of the National School Health Policy in the study area. Healthful School Environment (53.33%) and Skill-based Health Education (49.67%) were the most implemented components of the policy. School–Home and Community Relationship (43%) and School Feeding Services (41.33%) were the least implemented components of the policy. It was found that challenges to implementation included inadequate funding of policy implementation and inadequate human and material resources. The study recommended that the Government should prioritise funding, policy implementation monitoring and resource allocation for critical components like health personnel to support effective policy implementation. Also, principals as school leaders should contribute their quota to ensuring the effective implementation of the policy in schools.

Keywords: National School Health Policy, secondary schools, school health policy implementation, challenges to implementation

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1. Introduction

Across the globe, one of the obligations of every government is to ensure the health and well-being of its citizens. School health policies are structured frameworks that are purposefully designed by governments to promote the physical, mental, emotional, and social well-being of students and staff who operate and interact with the students within educational settings, as a precursor to enhancing the health of the general population. These policies are made up of a range of initiatives which are targeted at integrating health promotion into the schools' daily operations in order to ensure that children and adolescents get the necessary support to thrive academically and personally. Specifically, school health policies seek to bring about environments where health is a core aspect of education, tackling issues from preventive care to emergency responses and promoting lifetime healthy habits.

Globally, the formulation and implementation of such policies are usually influenced by certain organisations such as the World Health Organisation (WHO) and United Nations Educational, Scientific and Cultural Organisation (UNESCO), which defined school health policies as choices, plans and actions which are officially included in school programme to promote health and wellbeing. It is expected to contribute to the establishment of holistic health-promoting school environments by integrating health, education, and inclusion of school stakeholders. The policy is expected to enhance the establishment of healthful environments that promote the overall well-being and dignity of staff and students. (WHO & UNESCO, 2021). This definition pinpoints schools as a platform for effective health intervention, particularly for children, as they spend a significant portion of their formative years in educational settings.

The 1920s birthed the standardization of health curricula in Nigeria. By the 1960s, the involvement of the Federal Government in school health programmes became evident. The federal involvement was through initiatives that proffered solutions to social issues such as mental health and substance abuse. By the 1980s, the model evolved into a comprehensive school health programme with eight components, reflecting a shift from reactive medical services to proactive, integrated health promotion (Allensworth *et al.*, 1997). Internationally, the World Health Organisation's Global School Health Initiative, launched in 1995, emphasised strengthening health promotion in schools to safeguard student well-being and reduce dropout rates, linking health directly to educational outcomes like improved performance and productivity (WHO, 2021).

The development of the National School Health Policy in Nigeria was in line with global trends. The National School Health Policy was officially adopted by the Federal Ministry of Education in 2006. It was, in part, to enhance earlier efforts to integrate health into education as part of broader national development strategies (Federal Ministry of Education [FME], 2006). This policy was thought out from the perspective that healthy students would be better learners, which was emulated from the frameworks of international bodies such as the WHO and the United Nations Educational, Scientific and Cultural Organisation (UNESCO).

The adoption of the policy was influenced by Nigeria's commitment to the goals of Education for All and the need to address child health in the context of poverty and environmental hazards. This development brought about a shift from ad hoc interventions to a structured national framework in Nigeria, though the level of implementation may be varied across states.

School health policies entail key components, which serve as a blueprint for action. Traditionally, these include health education, which involves a planned curriculum covering physical, mental, emotional, and social dimensions of health to build knowledge and skills for healthy living. Health services encompass preventive measures such as screenings, immunisations, and referrals for acute or chronic conditions. A healthful school environment is to ensure physical safety through proper sanitation, safe water, and psycho social support aimed at preventing unfavourable experiences such as bullying or stress. The nutrition services are aimed at promoting the students' access to balanced meals and education on healthy eating, while physical education is aimed at encouraging lifelong fitness.

Additional elements often include counselling for psychological needs, staff health promotion to model positive behaviours, and community involvement to extend support beyond school walls (WHO, 2021). In the Nigerian context, the National School Health Policy outlined five main components: healthful school environment, school feeding services, skill-based health education, school health services, and school-home-community relationships. These are meant to emphasise preventive and curative services, environmental sanitation, and partnerships to enhance health outcomes (Obembe *et al.*, 2016). For example, skill-based health education in Nigeria includes the teaching of health-related topics such as hygiene, HIV prevention, and nutrition, by certificated health educators. The topics are integrated into the school curriculum to foster learners' healthful behavioural changes.

The importance of school health policies cannot be overstated, as they directly contribute to improved educational attainment and societal well-being. Research has shown that healthy students tend to have better attendance in school, concentration in class, and academic performance, which ultimately brings about a reduction in dropout rates and enhances long-term productivity (Lombardo *et al.,* 2019; Ndagana, 2024). Only the proper implementation of the NSHP will result in the achievement of the laudable goals set for it. At the same time, the NSHP provides a road map for ensuring and maintaining high health quality in schools and, by extension, to the general populace. There may be varying levels of implementation and types of challenges encountered in the implementation process in the different areas of the country. There is therefore a need to add to the available empirical evidence of NSHP implementation in Nigeria.

2. Literature Review

Tomokawa *et al*. (2018) investigated the main factors for school health policy implementation in Thailand. The study found that NSHP was effectively promoted and

implemented nationwide. Seven positive factors that enhanced NSHP implementation all through the country were identified as: alignment with current educational strategies, competition and motivation through an awards system, sustainable human capacity development at the school level, involvement of diverse stakeholders, adequate comprehension and acceptance of school health concepts, information sharing and collaboration among schools within the same clusters, and effective fundraising activities. The study also identified three challenging factors to implementation. These were: insufficient institutional sustainability, ambiguous roles of regional authorities, and varied health issues among Thai learners.

Warnaini *et al.* (2025), in a related study, assessed the implementation status of components of the National School Health Policy and challenges encountered in Indonesian schools. Findings of the study showed that the policy was properly integrated into teaching and learning activities, the schools in the study area were regularly involved in healthy school competition programmes, effective coordination existed between the schools and relevant stakeholders (Primary Health Centres and Local Health Offices), and Community participation and engagement were also appropriately undertaken. Officials of the Primary Health Centres and Local Health Offices regularly monitored school cafeterias and promoted awareness to school stakeholders on reproductive health, prevention of drug use and addiction. The challenges to NSHP implementation were discovered to be a lack of detailed guidelines for the implementation of NSHP and insufficient funding for consistent policy implementation.

In a similar research that investigated challenges to the implementation of School Health Policy in Namibian schools, Katangolo-Nakashwa and Mfidi (2025) identified substantial obstacles to the proper implementation of the school health policy. Barriers discovered included personnel shortages, inadequate resources, little student awareness of health rights, and insufficient teacher well-being. Further constraints to implementation included resource limitations, insufficient monitoring and evaluation, and inadequate collaboration between the education and health sectors. In a related study that assessed health practices in Nigerian primary and secondary schools, Ukpabio *et al.* (2023) found that challenges were a lack of awareness of the necessary practices by school leaders, inadequate personnel to undertake health practices, insufficient funding for implementation, poor facilities and weak inter-sectoral cooperation, which resulted in poor implementation of health practices in the schools.

Other studies have also shown that levels of awareness and execution of the NSHP vary; for example, in the Ibadan metropolitan area, only around one-third of teaching staff were found to be aware of the policy, in spite of the discovery that more than half of this number had a good understanding of its components (Obembe *et al.*, 2016). Strengths of implementation in that area included a comprehensive health curriculum taught across the country and gender mainstreaming, although obstacles remained in terms of reaching full coverage for amenities such as potable water (42% of schools) and sanitation (38%). In a related study undertaken to appraise the strengths and weaknesses of the implementation of the policy in Delta State, Nigeria, Ogbe (2020) found that the majority

of secondary school principals and teachers in the study area were uninformed about the NSHP, and schools did not possess copies of the policy document. Government oversight was inadequate; despite Health Education being a mandatory subject in schools, it was not consistently taught by skilled health educators, indicating a lack of comprehensive implementation of the skills-based health education component of the policy.

In a related study undertaken in Ilesa East Area of Osun State, Okewole *et al*. (2023) assessed the implementation of the NSHP among primary schools. Results from the study showed that: school environments in the study area were moderately healthy, school feeding services were not adequately provided, the schools did not adequately engage in school health practices, and only the skills-based health education aspect of the policy was sufficiently implemented. Akinola (2025) investigated school leaders' level of awareness and the composite extent of the NSHP implementation for health security in Osun State. Results of the study showed that the level of school leaders' awareness and composite implementation of NSHP were high.

Although studies from Indonesia, Thailand, Namibia and even parts of Nigeria examined and the level of awareness and implementation of the NSHP, thus provided insights to these factors, they cannot be directly applied to the specific evidence for each component which may be different within the current context which may be due to differing contextual systems which may impact implementation and challenges encountered therein. This study thus addressed that gap.

2. Objectives of the Study

This study, therefore:

1) assessed the extent to which Osun State Secondary Schools implemented the various components of the National School Health Policy;
2) identified the components of NSHP with the lowest and highest levels of implementation in schools in the study area; and
3) identified challenges to the implementation of NSHP in the study area.

These translated to the following research questions:

1) To what extent did Osun State Secondary Schools implement the various components of the National School Health Policy?
2) What are the components of the NSHP with the lowest and highest levels of implementation in schools in the study area?
3) What are the challenges to the implementation of NSHP in the study area?

3. Methodology

The descriptive survey research design was adopted for the study. The population for the study comprised all the principals and teachers of the 387 public secondary schools in Osun State. The multi-stage sampling procedure was used to select the sample for the study in three stages. From each of the three Senatorial Districts of Osun State, two zones

were selected, making a sample of six zones of the state. From each of the zones, three Local Government Areas (LGAs) with the highest number of schools were purposively selected, adding up to 18 LGAs. From each of the LGAs with the highest number of schools per zone, three schools were selected, totalling 36 schools. The principals and two Health Education Teachers (where Health Education Teachers were not available, two Science Teachers) were purposively selected as the sample for the study. This was based on the assumption that this category of school staff should be able to provide reliable information about the NSHP and other health-related aspects of the school. A total of 108 respondents, 36 principals and 72 teachers were used for the study.

The data for the study were gathered by means of a tripolar-type questionnaire that had high extent, moderate extent and low extent options and a few open-ended items, titled "Implementation and Challenges of National School Health Policy Questionnaire" and an observation checklist titled "School Health Policy Implementation Checklist" designed by the researchers. The items of the instruments were generated using the items under characteristics of each of the five components within the scope of the School Health Programme in the National School Health Policy Document (FME, 2006). The questionnaire was validated by two experts. Reliability of the questionnaire was ascertained by administering the instrument to two Principals and four teachers from two schools within the population but outside the sample for the study, at a two-week interval. The data collected were subjected to the Pearson Product-Moment analysis. A reliability index of 0.84 was obtained, which confirmed the reliability of the questionnaire. The observation checklist was validated by ascertaining the credibility of the items from the source document considered for implementation. The use of different data sources was to enhance the reliability and accuracy of the data collected, as this served as a source of cross-validation for the data collected. Data collected were analysed using percentages, mean scores and ranking.

4. Results

4.1 Research Question One: To what extent did Osun State Secondary Schools implement the various components of the National School Health Policy?

To answer this research question, data collected on the items of Section C of the instrument on the extent to which Osun State secondary schools implemented the National School Health Policy for health security were scored. All to a high extent, moderate extent and low extent responses to the 71 items under school plant physical and maintenance compliance with NSHP as regards regular maintenance of school plant, refuse disposal management, observation of annual school health day, possession of water source within school premises; availability of functional toilets, sporting facilities and other aspects of implementation of the policy; School Feeding Services; Skills based Health Education; School Health Services and School Home and Community, of the questionnaire and the 29 items to assess healthful school environment of the observation checklist were allotted three, two and one scores respectively. To categorize the level of

implementation of NSHP in schools, responses to each item were computed, and the mean scores were obtained. On the three-point scale, mean points ranging from 1.0 to 1.49 were categorised as low, 1.5 to 1.99, moderate, and scores from 2.00 were regarded as high. The summary of the results is shown in Table 1.

Table 1: Summary of implementation of components of National School Health Policy

Components	Mean Score	Rank
Healthful School Environment	1.60	Moderate
School Feeding Services	1.24	Low
Skill-based Health Education	1.49	Low
School Health Services	1.38	Low
School–Home & Community Relationship	1.29	Low

4.1.2 Interpretation of Results

A. Healthful School Environment (Mean = 1.60, Moderate Extent)

The results showed that the component of healthful school environment was implemented to a moderate extent. It was the only component with a mean score above the average score of 1.5. Most schools had toilet facilities with ventilation and separate toilets for staff and learners, but most of the toilets were not functional or accessible because there was no running water. As a result, the toilets had to be locked up, leaving students and staff with the option of defecating wherever. Sporting facilities were available in some schools, but the annual observation of School Health Day was rare. This suggested that while infrastructural provisions such as toilets were in place, provision of running water to make the toilets functional and accessible for use and health awareness activities remained poor. The toilets were just physical buildings that could not be used for the purposes for which they were built. The schools implemented the healthful school environment component of the NSHP moderately because, aside from the issue of toilets, other sanitary facilities such as a within-school water source, waste bins, proper refuse management, distance of school from major road and maintenance of school plant, were observed to be in line with the dictates of the policy.

B. School Feeding Services (Mean = 1.24, Low Extent)

The component of School feeding services was poorly implemented. None of the schools provided daily meals or food supplements to students and staff. There were food vendors who sold food and snacks in the school premises. Students and staff who could afford these services could buy from the vendors. Routine vaccinations for food handlers were not practiced. Although most learners brought food from home, and some vendors were medically examined, the absence of structured school feeding services indicated a gap in nutritional support as specified by the policy. This low mean reflects inadequate attention to learners' nutritional welfare, which may have negative consequences on concentration, learning outcomes, and overall health.

C. Skill-Based Health Education (Mean = 1.49, Low Extent)

Health education was taught in most of the schools, with teachers drawn from Physical and Health Education, Biology, Chemistry, and Integrated Science backgrounds. The curriculum was fairly comprehensive, covering issues such as malaria, typhoid, HIV/AIDS, personal hygiene, nutrition, and drug abuse, all aspects specified by the NSHP. However, coverage of areas like yellow fever, mental health, maternal and child health, and bereavement was weak. Practical components — such as health and safety trips, celebration of School Health Day, and health clubs — were minimally implemented. Only very few of the schools had teachers with qualifications in either Physical and Health Education or Health Education. This indicated that while health education was taught in the schools, the teachers could not be considered skilled, as they did not possess the requisite qualifications to be considered professionals. Also, theoretical health knowledge was imparted, experiential and practical health education in terms of schools having health clubs, organising health and safety trips for learners outside the school and celebration of school health day remained limited, thus restricting the level of implementation of this component to the very last score on the range for low, an addition of a 0.01 score would have increased the level of implementation of this component to a moderate extent.

D. School Health Services (Mean = 1.38, Low Extent)

The implementation of school health services was generally weak. Although first aid for injured learners was well attended to, sick learners were asked to go home or to neighbouring government clinics. They were not given any first aid support in schools, as principals claimed that they were instructed not to administer drugs as they were not health personnel, and the schools did not have trained health personnel on ground. They could only clean and bandage minor injuries that students sustained in schools. The first aid boxes, therefore, only contained cotton wool, spirit and sometimes iodine. None of the schools had nurses or medical doctors. Other critical services and infrastructure, such as sick bays, follow-up health care, and referrals, were also poorly implemented. Pre-entry screening and routine health examinations for both learners and staff were inconsistently carried out. Immunization programmes were also infrequent; even when they occurred, they were not organised directly by the schools, nor did the schools provide health advisory and counselling services to parents or community members. Overall, school health services existed in fragmented forms, addressing immediate issues such as injuries but lacking health records, preventive, referral, long-term, and structured health care forms.

E. School–Home and Community Relationship (Mean = 1.29, Low Extent)

The relationship between schools, homes, and communities in health matters was weak. While teachers and health personnel sometimes communicated learners' health status to parents, and parents occasionally visited schools, community involvement in outreach, health planning, health counselling, health advisory, monitoring, and advocacy was very

minimal. The weak collaboration suggests that health promotion was largely school-centred, with limited integration of parental and community structures. This lack of synergy must have undermined the holistic implementation of the school-home and community health relationship, and it portrayed the fact that the school-home and community relationship component of the NSHP was poorly implemented.

4.2 Research Question Two: Which components of NSHP had the lowest and highest levels of implementation in schools in the study area?

Table 2: Summary of the level of implementation of NSHP Components (Ranks)

Components	Mean Score	Rank
Healthful School Environment	1.60	First
School Feeding Services	1.24	Fifth
Skill-based Health Education	1.49	Second
School Health Services	1.38	Third
School–Home & Community Relationship	1.29	Fourth

Table 2 presents a summary of the level of implementation of the various components of the National School Health Policy. The results showed that Healthful School Environment was the component with the highest level of implementation, with a mean score of 1.60 on a scale of three, indicating a 53.33% level of implementation, ranked first. Skill-based Health Education also showed a low tilting toward a moderate level of implementation with a mean score of 1.49 (49.67%), ranked second. School Health Services, with a mean score of 1.38 (46%), also showed a low level of implementation, ranked third.

At the bottom of the ranking scale, School–Home and Community Relationship, with a mean score of 1.29 (43%), ranked fourth, and School Feeding Services, the component with the lowest level of implementation, had a mean score of 1.24 (41.33%), ranked fifth. The results implied that even the component with the highest level of implementation was merely implemented at just above average level in the schools, while on the other hand, the components with the lowest levels of implementation were close to not being implemented at all in the schools.

4.3 Research Question Three: What are the challenges to the implementation of NSHP in the study area?

To answer this research question, all the challenges stated by the respondents in the open-ended part of the questionnaire were classified and presented in themes. It should be noted that all the respondents reported more than one challenge to the implementation of NSHP in the study area; this, therefore, made the frequency summation of challenges higher than the number of respondents.

Table 3: Descriptive analysis of the challenges to the implementation of the National School Health Policy for health security in the study area

S/N	Challenge	Teachers	Principals
		f(%)	f(%)
1.	Lack of awareness of the policy expectations	62(86.0)	29(10.4)
2.	Inadequate health infrastructure	31(43.1)	17(47.2)
3.	Lack of financial support from the Government	66(92.0)	32(89.0)
4.	Lack of Government support for policies	54(75.0)	26 (72.2)
5.	Inadequate funding	72 (100)	36 (100)
6.	Inadequate number of skilled human resources	52(72.3	26(72.2)
7.	Limited material resources	60(83.4)	32(88.9)
8.	Inconsistency of Government policies	10(13.9)	2(5.6)
9.	Inability of the schools to provide free food	72(100)	36(100)
10.	Lack of synergy between the school and the government-owned health institutions	60(83.4)	36(100)
11.	Lack of Government monitoring of the policy	72(100)	36(100)

Results in Table 3 showed the descriptive analysis of the challenges to the effective implementation of the NSHP in the study area. All the respondents 100% indicated inadequate funding to support implementation of the policy as a major challenge to the effective implementation of the policy in schools in the study area. All the respondents also noted that the lack of monitoring of the policy on the part of the Government was a challenge, that if Government officials monitored the implementation of the policy, reports would lead to the Government knowing where there are lapses and thus provide interventions that will enhance the implementation of the policy. Another challenge that many of the respondents pointed out was the lack of synergy between stakeholders and financial support for policy implementation by the Government, Parents and other Education stakeholders.

5. Discussion

The results of this study showed that the components of the National School Health Policy were implemented in Osun State secondary schools at low to moderate levels. In fact, only one component, a healthful school environment, was implemented moderately. All four other components had low levels of implementation. This is consistent with the findings of Katangolo-Nakashwa and Mfidi's (2025) study, which found that the components of the school health policy were not properly implemented in Namibian schools. The findings of this study are also similar to those of Ogbe (2020), who found a lack of comprehensive implementation of the policy in the schools in Delta State, Nigeria. The results of this study also corroborate those of Okewole *et al. (*2023), who found that Primary schools in Ilesa East Local Government Area of Osun State, moderately implemented the healthful school environment component of the NSHP. The findings of this study, on the other hand, are contrary to those of Tomokawa *et al. (*2018), who found that NHSP was effectively promoted and implemented throughout Thailand. The

government of that area: ensured the proper alignment of NSHP components with educational strategies, engaged in sustainable human capacity development to enhance implementation of the policy and made sure schools within the same cluster were involved in information sharing and collaboration. The findings of this study are also different from those of Warnaini *et al*. (2025), who discovered that the policy was adequately incorporated into teaching and learning in Indonesian schools. Also, the Indonesian Government ensured effective collaboration between schools and pertinent stakeholders such as Primary Health Centres. The government of that area encouraged community participation, regular monitoring of schools by officials of Primary Health Centres and Local Health Officials. Health Officials further promoted school stakeholders' awareness of reproductive health, aiding the prevention of drug use and addiction. In Nigeria, within the same State as that of the current study, Okewole *et al*.'s finding that only the skills-based health education component of the NSHP was adequately implemented in primary schools in Ilesa East Local Government Area of Osun State is also dissimilar to the findings of the current study.

In a bid to determine the components of NSHP that had the highest and lowest levels of implementation in Osun State Secondary schools, the results of this study showed that the healthful school environment was the component that had the highest level of implementation, and the school feeding services component was the least implemented. These findings are not similar to those of any of the reviewed studies because in Indonesian and Thai schools, all components of the NSHP were properly implemented. In the primary schools in Ilesa, Okewole *et al*. (2023) found skills-based health education to be sufficiently implemented, healthful school environment was also moderately implemented, but all other components of the National School Health Policy were not implemented.

This study found challenges to the implementation of the NSHP to be:

1) Lack of awareness of the Policy expectations;
2) Inadequate health infrastructure;
3) Lack of financial support from the Government;
4) Lack of Government support for policies;
5) Inadequate funding;
6) Inadequate number of skilled human resources;
7) Limited material resources;
8) Inconsistency of Government policies;
9) Lack of synergy between schools and relevant stakeholders, and
10) Lack of Government monitoring of the policy implementation.

These findings mirror those of Warnaini *et al*.'s (2025) study, which found insufficient funding for consistent policy implementation to be one of the challenges encountered in the implementation of NSHP in Indonesian schools. They are also comparable with that of Katangolo - Nakashwa and Mfidi (2025) study, which identified inadequate resources and personnel shortages as some of the impediments of NSHP implementation in Namibian schools. The challenges identified in this study are

analogous to those found by the Ukpabio *et al*. (2023) study, where inadequate personnel to undertake health practices, insufficient funding, inadequate facilities and poor inter-sectoral cooperation hindered the proper implementation of NSHP. The results are also akin to those of Ogbe (2020), who found that in spite of the fact that Health Education was a compulsory subject, it was not taught by skilled Health Educators in Delta State schools, and that Government oversight of policy implementation was insufficient.

The findings of just a moderate level of implementation of NSHP in the study area might have been a result of the impact of the challenges found, which are likely to have been impediments to successful implementation of the policy.

5. Conclusion and Recommendations

The study concluded that the extent of implementation of the policy in the study area was too low for comfort. In line with the findings of this study, it was therefore recommended that:

- Government should ensure proper alignment of NSHP components with education strategies adopted in the state;
- Government should ensure proper funding of policy implementation, make provision for adequate human and material resources needed for policy implementation available to schools;
- Government schools ensure proper synergy between schools and relevant stakeholders such as government-owned hospitals and health offices;
- The government should promote health awareness in schools;
- The government should engage in proper regular monitoring of the health policy;
- The government should motivate schools that are implementing the policy properly by giving them incentives, thereby encouraging other schools to follow suit;
- School principals and teachers should encourage community participation in school health programmes;
- Principals should encourage the introduction of functional health clubs in the schools;
- Principals as school leaders should ensure that, with the funds within their reach, they make all available resources such as toilets functional and accessible.

To ensure the proper implementation of the NSHP and achievement of the vital goals set for it, it is compelling that all hands must be on deck. All stakeholders, the government, school principals, teachers, and community members should contribute their quota to the achievement of these goals, as waiting on the government alone will not lead to attainment.

Conflict of Interest Statement

The authors declare no conflict of interest.

About the Authors

Dr. Oluwatoyin B. Akinola, an Associate professor holds two Master degrees—one in Educational Administration and another in Early Childhood Development—and earned her Doctor of Philosophy (PhD) in Educational Administration. With a strong academic background and deep commitment to advancing educational leadership, policy, and success of all school levels, Dr. Akinola's research focuses on school leadership, educational quality assurance, and school effectiveness. Her work explores the dynamics of effective school management, the role of leadership in promoting learning outcomes, and the implementation of quality assurance mechanisms, and policies in educational institutions. Dr. Akinola has contributed to both national and international academic discourse through her research, publications, and presentations. She is passionate about improving educational systems and shaping policies that promote equity, excellence, and sustainability in education, particularly within the context of developing nations. Her academic contributions continue to inform educational reforms and the professional development of school leaders across various levels of education.
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