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Treatment facilities and Content of First Aid Box in Public and Private Primary Schools within Owerri Municipal, Imo State, Nigeria.

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ABSTRACT

School health services are the curative and preventive health services, provided for the promotion of the health of school population to enable them benefit maximally from the school system. The aim of the study was to assess the treatment facilities and content of first aid box in public and private primary schools within Owerri municipal, Imo State, Nigeria. A cross sectional descriptive study was carried out to assess school health services in 36 government approved primary (12 public and 24 private) schools within Owerri Municipal LGA. Relevant data was obtained from school head teachers using an evaluation scale and direct observation was done where applicable. The responses were scored using the School Health Programme evaluation scale. Thereafter, a prospective (pre-test – post-test) study was carried out in two public primary schools between May to December 2017 (two academic terms). Within the period (September to December 2017) an intervention was carried out which involved the running of school clinics in two selected public primary schools. School attendances were kept during the pre- intervention and intervention periods using a check off list for monitoring daily attendances and reasons for absenteeism. School health personnel were available in fourteen (38.9%) schools, out of which one (8.3%) public school had health personnel. All (100%) schools had first aid boxes, but none of the schools had the boxes completely stocked. School health clinics were available in one (8.3%) public school and 5 (20.8%) private schools. The private schools performed comparatively better than public schools in terms of treatment facilities and content of first aid box. These findings therefore portray the need for implementation of the National School Health Policy by the State Ministries of Education and Health.

Keywords: Treatment facilities, First Aid Box, Public, Private and Primary Schools.

INTRODUCTION

School health service is an essential component of the school health programme [1]. The other three major components are Healthful School Environment; Health Instruction and School-Home-Community relationship [2,3,4]. Each component interrelates with the others and their objective generally is to enhance the health of the school population [5,6,7]. Globally, as at 2012, there were about 226 million children of primary school age, out of which 136 million were in Sub-Saharan Africa [4]. In Nigeria, the estimated primary school age population was 24.7 million, out of which 17.4 million (70.4%) were enrolled in school [5]. In essence, schools reach millions of pupils and through them their families and communities. The school is a place where education and health programmes can have their greatest impact because it reaches them at influential stages of their lives [6,7]. These programmes are of great importance to productivity later in life and also help improve the economy of a nation [8].

School health service is an intervention in primary health care. [6] stated that SHS can be utilized to provide school care, immunization against infectious diseases, prevention and control of locally endemic diseases, provide appropriate treatment of common diseases and provision of essential drugs and supplies. Therefore, since almost every small community in Nigeria has one primary school, it is possible to use these schools as a centre for primary health care delivery [7]. Studies conducted by Bonnel et al in London, United Kingdom and Freudenberg et al in United States Of America [8,9] indicate that effective school health service helps to increase school attendance, academic performance, decrease school dropout rates, and additionally plays a role in identifying children with emotional, behavioural, and mental health problems for proper

assessment and appropriate interventions [10].

In most developing countries, the need for school health services are particularly critical because the school children are the survivors of a high childhood mortality rate [11,12]. In addition, with the success of child survival programs, the number of children reaching school age are on the increase, thereby making continued care very essential [5,11]. Furthermore, the routine health services (primary health care centres, comprehensive health care centres, and general hospitals in the communities are suboptimal or even non-existent leaving the children at the mercy of expensive private medical care. Health is a recognized limiting factor in the educational progress of any child. [12,13] noted a high frequency of diseases and disabilities among apparently well school children in Ibadan and that about 95.6% of children who were absent from school did so for medical reasons. School based clinics can be involved in the management of a wide range of health care need of the school children [14]. There are published works that have shown that where medical facilities are in close proximity for children to receive prompt medical attention and report back to class, school attendance rates are high [15,16]. In Nigeria, regrettably, many authors across the country have observed that the School Health Service is a neglected aspect of the health and education sector [10, 21,22,23,24,25]. However, to the best of my knowledge, there is no documented study on the status of School Health Services as practiced in primary schools in Imo State, Nigeria. This study was undertaken to evaluate the treatment facilities and Content of First Aid Box in Public and Private Primary Schools within Owerri Municipal, Imo State, Nigeria.

MATERIALS AND METHODS

THE STUDY AREA

This study was conducted in public and private primary schools in Owerri Municipal Local Government Area [LGA]. Owerri is the capital of Imo State in the South Eastern part of Nigeria. Owerri has three LGA namely Owerri West, Owerri North and Owerri Municipal. Imo State has a population of 3.93 million while Owerri Municipal has population of 125,337. Owerri is mostly inhabited by civil servants with traders, other businessmen and various categories of artisans. There are 2 tertiary institutions located within the study area, the Imo State University and Alvan Ikoku Federal College of Education. It also has a tertiary health facility, the Federal Medical Centre Owerri, two primary health care centres, many private clinics and a lot of patent medicine shops.

STUDY DESIGN

The study was a cross sectional descriptive study for assessment of School Health Services and a prospective pretest - posttest study to determine the effect of school health clinic on school attendance.

SELECTION OF STUDY POPULATION (SAMPLING METHOD)

Multi stage sampling method was used to select the schools for the assessment of SHS. The list of approved public and private schools in Owerri municipal LGA obtained from Imo State Ministry of Education was used as the sampling frame.

STAGE 1: (Stratification into public and private schools).

There are 48 Government approved primary schools in Owerri Municipal LGA, 16 public and 32 private schools which represents a 1:2 ratio by proportionate allocation. 12 schools were chosen from public schools and 24 schools from private schools which also represent 1:2 ratios giving a total of 36 schools that were studied.

STAGE 2: (Stratification into areas in Owerri Municipal). The schools within the Local Government were stratified into 5 areas.

-TransEgbu Area	- 0 public and 3 private schools
-World bank/New Owerri Area	- 2 public and 8 private schools
-Ikenegbu/Aladinma Area	- 3 public and 9 private schools
-Orlu Road Area	-2 public and 4 private schools
- Douglas Area	- 9 public and 8 private schools.

STAGE 3: (Selection of number of schools studied in an area)
The total number of schools studied in an area was selected based on the ratio of schools in the areas using simple proportions as follows.

FOR PUBLIC SCHOOLS:

$$\frac{\text{Total No of Selected Public Schools}}{\text{Total No of Public Schools}} \times \text{No of schools in an area}$$

FOR PRIVATE SCHOOLS:

$$\frac{\text{Total No of Selected Private Schools}}{\text{Total No of Private Schools}} \times \text{No of schools in an area}$$

NOTE: Total No of private Schools - 32
Total No of selected private Schools - 24
Total No of public Schools - 16
Total No of selected public Schools - 12

	Public : Private		Public : Private
TransEgbu Area	0 : 3		0 : 2
World bank/New Owerri Area	2 : 8		2 : 6
Ikenegbu/Aladinma Area	3 : 9		2 : 7
Orlu Area	2 : 4	⇒	2 : 3
Douglas Area	9 : 8		6 : 6

Therefore, public schools were selected in a ratio of 0:2:2:2:6 making a total of 12 schools while private schools were in a ratio of 2:6:7:3:6 with a total of 24 schools.
STAGE 4: The schools that were selected in each area to make up the total sample for that area was done using simple random sampling. The names of the schools in an area were written on pieces of papers, folded and put in a non-transparent bag. Thereafter, the number of schools selected in an area was picked by an independent person to eliminate bias.

FOR THE INTERVENTIONAL STUDY:
A purposive sample of two (2) public schools was used. The population for the study consist of all the pupils in those selected schools.

Criteria for selection

- Both schools were public schools
- Selected from two different areas
- Without pre-existing school clinic
- The schools have school population of not less than 400 pupils

ETHICAL CONSIDERATIONS

Ethical approval for this study was obtained from the Ethics and Research Committee of the Federal Medical Centre, Owerri. Approval to study the government owned (public) and private schools was obtained from the Executive Chairman Imo State Universal Basic Education Board (IMSUBEB) and State Ministry of Education. Approval to run the school clinics in two public schools was also obtained from IMSUBEB. Written consent was obtained from the two head teachers where the school clinics were ran and the parents/guardians of the pupils in the selected public schools where the intervention was undertaken. Assent was equally obtained from the school children to examine and treat.

RESEARCH INSTRUMENT

(a) The School Health Evaluation Scale:

The evaluation scale was administered to each head teacher or his/her representative. The respondents were properly educated on the objectives and relevance of the assessment to gain their confidence. The scale is weighted and has 5 parts which include sections for data on School administration, the 3 main components of SHP [SHS, School health Instruction, healthful school environment] and collation of scores. For the purpose of this study, the use of the evaluation scale was limited to School Health Services, section A. The section A has 8 parts comprising Health personnel, Health Appraisal, Treatment facilities within the school, Care of emergency illness/injury, Control of communicable diseases, Record keeping, Nutrition services and Guidance and Counselling services. The Health

Personnel was graded with maximum score of 10 and minimum of 0. Health Appraisal, Treatment Facilities and Care of Emergency Illness were itemised and each scored 1 with a maximum score of 5. Graded scoring was done for Control of Communicable Diseases with maximum score of 8 while minimum was 0. Record keeping was not graded. Maximum score was 3. This was because it is expected that a school performs only one of the three forms of record keeping. Guidance and Counselling Services scored either 1[with teachers] or 2[with parents]. The score for Nutritional services was graded and maximum score was 7. An extra [+1] score was given for schools that gave nutritional supplement. The cumulative score for SHS after adding up all the scores was a maximum of 45 and the minimum acceptable value was 19.

(b) Check Off List for monitoring school attendance:

The check off list was distributed on weekly basis to all the class teachers and the attendances marked per week. A total of 12 attendance sheets per class in each school per term were distributed. Each attendance sheet contained the record for one (1) week. Data collected by using this instrument include: The class; week; year; date; month; number of pupils in the class; the serial number of pupils in the rows; names of all the pupils in a class written serially as they appeared on the class register; attendance for every day of the week (Monday – Friday) against which was marked present (P) or absent (A) in school for each pupil and the reasons for absenteeism in the last column. At the end of each list, there was a summary for the week.

THE INTERVENTION

The period of study was two academic terms (6 months). A term is made up of twelve (12) weeks. Two schools were selected (Uzzi Primary School and World Bank Primary School) and the study was carried out simultaneously in both schools. The intervention was situating a school based health clinic in those two selected public schools (Picture I). First twelve weeks (one term) which was the third term of the 2016/2017 academic session between May-July 2017 was the pre intervention period and the next term which was the first term of the 2017/2018 academic session between September-December 2017 was the period of intervention in each of the schools. Before commencement of the study, having obtained approval from State Education Board and written consent from both head teachers the researcher held meetings with the teachers in both schools to inform them of the study and equally appealed for their assistance and cooperation during the two terms. In the pre intervention period only daily attendance records using the check off list for school attendance in all the classes (primary 1-6) were obtained in both selected primary schools concurrently. The record was taken to obtain baseline pupils' attendance, absenteeism and the reason for absenteeism. The check off list was shared to all the class teachers in both schools at the beginning of every school week. All the class teachers assisted in keeping the records. The researcher or research assistants visit the schools on alternate days to move round the classes and ensure the attendance and reason for absenteeism were properly documented. At the end of each school week, the attendance record sheets were retrieved from all class teachers. The intervention which spanned from September to December 2017 involved situating a school health clinic in the two selected public schools. During this period, the recording of the daily attendance using the check off list as in the pre intervention period was continued. However, the week prior to the end of the pre intervention term, pupils were informed during the morning assembly of the researcher's mission in their schools the next term and they were encouraged to inform their parents. In the first week of resumption (the intervention term), the researcher met with the teachers and pupils again during morning assembly to inform them of the school clinic and the consent forms were shared for all the parents/guardians of the pupils. This was repeated in various classes in case of those absent during assembly to be sure that all the pupils got the information. During the intervention, the room, seats and desks for the clinics were provided by the school head teachers. However, medical materials (First aid box with wound dressing materials, Examination couch, Nebulizer) and drugs (such as Antibiotics, Analgesics, Antimalarial, ORS, Haematinics, Anthelminthic, Antifungals) were provided

free by the researcher to pupils and staff who attended the clinic.

The clinic ran two days per school (Monday to Thursday) in each school week by the researcher or research assistants between 9am-12.30pm. However, Friday was not for full clinic in any of the school but set aside to visit any of the two schools in case of any emergency. Days for clinics differed in each school to allow the researcher or the research assistant run clinics in the two centres. Uzzi Primary School clinic days were Mondays and Wednesdays while World Bank Primary School clinic days were Tuesdays and Thursdays. Two residents and a post National Youth Service Corp doctors assisted the researcher in running the clinics to ensure the clinics are run regularly. Any member of the school community who became ill visited the school clinic. Each patient was duly examined (Picture VII) and a record of the name of pupil, sex, class, presenting complaint and treatment given were obtained. However, the provision of care in the clinic covered only common acute childhood illnesses using the Integrated Management of Childhood Illnesses (IMCI) algorithm. Information about the outcome of the child's visit and the drugs being given was communicated to the class teacher and to the parent/guardian through a note that had the researcher's phone number to aid the parents easily get more clarifications if need be. Any illness which could not be taken care of in the school clinic was duly referred to Federal Medical Centre, Owerri for appropriate specialist care. As part of sustainability after the project, the cooperation of the State Ministry of Health was sought through a request/appeal for a possible deployment of a School Health Nurse to ensure the clinics remain viable. However, despite several promises made by the State Ministry of Health to post health personnel to these schools for continuity of these clinics, as at the time of completion of this project, there is no positive response.

STUDY PROCEDURE

Training of Research Assistants

Two resident doctors and a post National Youth Service Corps doctor were recruited and trained as research assistants. They underwent four hour training per day for two days at the seminar room, Department of Paediatrics, Federal Medical Centre, Owerri one week prior to the field work. The training was carried out by the researcher on administration of School Health Service Evaluation Scale and Check Off list to monitor school attendance, running of the school clinic and records of relevant information. The research assistants helped in carrying out the research throughout the study period. Their assistance helped in regular data collection and equally allowed the researcher discharge her duties at her training centre.

Pilot Study

A pilot study was conducted one week prior to commencement of the project using one primary school in TransEgbu area that is not amongst the 36 selected schools. The objective was to check the quality of the information that was obtained and modifications made where necessary to make the questions clearer.

Data collection

An interview of the respective school head teachers in all the thirty six schools was done by the researcher. The interview was done face to face and the responses filled on the spot into the school health service evaluation scale. The researcher also carried out direct observation of the different components of the SHS where necessary with clarifications sought from the respondents where applicable. Information about school attendance and reason for absenteeism was gathered from each class pre and during intervention using the check off list to monitor school attendance. The study check off list on school attendance was distributed weekly to all class teachers to record attendance/ absenteeism and reason for absenteeism every day for all classes for a period of two school terms (twenty four weeks). Meanwhile, the class teachers' cooperation was sought to keep records of all reasons for absenteeism every day from the commencement of this study. The reason for absenteeism was obtained by asking the pupil directly the reason for his/her absence the previous school day. The pupils who were absent up to three consecutive days in a week, the researcher contacted the parents/caregivers on phone or went for home visits. However, during the research period, the researcher visited twelve homes. The pupils whom the researcher did not meet anybody in their

homes or those children who were not visited due to nonspecific addresses, the reasons for their absenteeism were obtained when they eventually returned back to school.

DATA ANALYSIS

Data obtained was coded and analysed using the Statistical Package for Social Sciences [SPSS] version 20. The results were presented in prose and tables. Mean, median, mode and standard deviation were calculated for continuous variables. Proportions were calculated for categorical variables. Student test was used to compare difference in mean score between public and private schools while chi square was used to test for association between categorical variables. Wilcoxon test was used to compare frequency of absenteeism before commencement of school health clinic and during the intervention. The level of significance was set at p value <0.05.

RESULTS

SCHOOL ADMINISTRATIVE DATA

Thirty six (36) Government recognized private and public schools were assessed. The ratio was 2:1 giving 24 private and 12 public schools.

Distribution of pupils in the schools

There were a total of 15,269 pupils comprising 7341 males and 7928 females with a male pupil to female pupil ratio of 1:1.07

Staff distribution of schools

There was a total of 1108 staff in all the schools. This comprises 923 teaching staff (312 public and 611 private) and 185 non-teaching staff (5 public and 180 private).

Forms of health appraisal done

Routine inspection of the pupils' clothes, nails, teeth, et cetera was done in all the schools by the teachers. None of the schools did pre entry screening, periodic medical examination and supervision of health of the handicapped.

Treatment facilities within the School

Table 1 show that all the schools had first aid boxes. Five (20.83%) private schools and one (8.33%) public schools had health rooms. School buses were available in thirteen (54.17%) private schools but none in public schools.

Table 1: Treatment facilities in Public and Private Schools

Health Facilities	No Public Schools n=12(%)	No Private Schools n=24(%)	Total School n=36(%)	χ^2	P-value
First Aid Box	12(100)	24(100)	36 (100)	-	-
Presence of Essential drugs	10(83.33)	23 (95.83)	33 (91.67)	Fischer Exact Test	0.235
Presence of Health Room	1(8.33)	5 (20.83)	6 (16.67)		0.64
Presence of School bus	0	13 (54.17)	13 (36.11)		0.002
Presence of Telephone	0	1(4.16)	1 (2.78)		1.00

Contents of the first aid box

The most commonly stocked first aid materials were wound dressing materials such as cotton wool, bandage, plaster, and disinfectant in both public and private schools. Drugs such as antimalarial, haematinics, oral rehydration salts and antihelminthic were sparingly stocked. None of the schools stocked multivitamin, antifungal and scabicide medications. There was no statistically significant difference in the content of first aid box in both Private and Public Schools as shown in Table 2.

Table 2: Content of First Aid Box in Public and Private Schools

Essential drugs/Material	No Public Schools (n = 12)	No Private Schools (n = 24)	Total School (n=36)	p-value
Cotton wool	9	23	32	0.10
Plaster	8	21	29	0.19
Bandage	8	11	19	0.24
Disinfectants	9	18	27	1.00
Analgesics	5	15	20	0.24
Antimalarial	0	1	1	1.00
Multivitamins	0	0	0	-
Haematinics	0	1	1	1.00
ORS	0	7	7	0.07
Anti-helminthic	0	4	4	0.28
Antifungal	0	0	0	-
Scabicides	0	0	0	-

Care of emergency illness/injury

All the schools gave first aid treatment in emergency illness or injury. Five (20.83%) private and one (8.33%) public school had record of treatment given. All the head teachers in both public and private schools reported that they notified parents if their children suddenly fall ill. 72.22% of the schools transported the child to the nearest health post even when parents had been notified.

Control of communicable diseases

All the schools (100%) practiced isolation of children with suspected communicable diseases by sending the child home. None of the schools gave health talks or immunized school children for the prevention of communicable diseases.

Health Record keeping

Six (16.67%) schools, five (20.83%) private and one (8.33%) public school had health records. These were the schools that had health rooms and they kept records of treatment given to pupils who visited the health rooms. None of the records were both cumulative and transferrable.

Nutrition services

Eight (66.67%) of the public schools had a school farm when compared to two (8.33%) in private schools and their difference was statistically significant (p <0.001). Six schools which represent 25% of the private schools and 16.67% of the overall schools offered school meal.

Guidance and counselling

Guidance and counselling services with teachers was offered in ten (27.77%) schools. Out of which were seven (29.12%) private and three (25.00%) public schools. Guidance and counselling services with parents were done in nine (37.50%) private schools by the school health personnel or the head teachers. None of the public schools did guidance and counselling with parents. The difference was statistically significant (p=0.016)

DISCUSSION

In this study 16.7% schools had a teacher trained in first aid and these were in private schools. This finding is higher than report by [26] in Obio-Akpor LGA of Rivers State, Nigeria where 7% of schools had trained first aid personnel. Notable though is the fact that Akani's [26] study recruited only public schools. The poor involvement of health personnel in school health services in Owerri Municipal LGA deprives the programme of the relevant expertise. The implication of this is that the pupils in the study area may be at risk of not having their minor ailments attended to, and according to [16] these may progress to debilitating illness leading to school absenteeism and poor school performance. In this study, all the schools both public and private conducted routine morning inspection of the pupils. This is comparable to findings by Alex-Hart et al [17] in Rivers State and [27] in Ebonyi State, Nigeria. Furthermore, none of the schools studied requested for Pre entry medical examination. This observation is lower than 12.9% recorded in Ebonyi State [28]

eight years ago. The reason for not performing pre entry screening in schools is not clear. The plausible reason could be that there was no authorization by the Imo State Ministry of Education to conduct the examination. Similarly, Periodic medical examination for staff and pupils was not implemented in all the schools in the study area. This finding is comparable to observation by [29] but higher value though poor was observed by [21] in 5.5% schools. The higher value reported by [21] may be because the study was carried out in both primary and secondary schools. These low figures suggest that with the apparent lack of health personnel and non-implementation of pre entry screening and periodic medical examinations, most handicaps and disabilities like hearing and visual impairments would be discovered much late. This may be at a time when they might have impaired learning and affected school performance. In this study, none of the schools practiced supervision of children with special needs and handicaps. This contrasts with 5.8% reported by [9] and 6.8% [30]. Part of the reason for lack of supervision of children with special needs may be because none of the schools in this study area had children with special needs and handicaps. This may be as a result of lack of specialized skills and expertise in teaching them. The implication is that the practice of all inclusive education in the schools is not supported.

It was observed that First Aid boxes were found in all the schools. This is comparable to reports by Oluwakemi et al [20] in Oyo State (90%) and Toma et al [3] in Plateau State (89.4%) but contrasts the report by [20] in Rivers State (39.3%) [20,39]. In this study area, first aid boxes are mandatory by the Ministry of Education in all schools. Unfortunately, not all the fist aid boxes in the present study were stocked with essential first aid materials, three (8.3%) of these boxes were actually empty. The boxes were commonly stocked with wound dressing materials whereas drugs like antimalarials, Oral Rehydration Salts and haematinics were sparingly stocked. Some of the reasons given for lack of these materials in this study were non replacement of used consumables; lack of funds; lack of expertise on the use of some of the medications and the No drug policy of the State Ministry of Education. The latter is based on fear of being culpable in the eyes of the law, in terms of possible accusation of wrong administration of drugs. Contrarily, in the USA, the department of public health promulgated regulations governing the administration of medication in schools by the school health personnel ranging from analgesics to psychotropic drugs. This therefore calls for improved collaboration between State Ministries of Health, Education and Justice for enactment of such policies. In this study, six (16.7%) schools had a health room for treatment of minor ailments and emergency first aid to the pupils. Out of which five (20.8%) were private and one (8.3%) public school. The only public school that had a sick bay was erected by a Non-Governmental Organization. The poor availability of health rooms are also noted in studies by [31] in Ogun State (25.8%), [33] in Edo State (31.6%) and [32] in Rivers State (0). The paucity of health rooms in these studies is unsatisfactory because the school has the responsibility of giving immediate care to pupils in case of injury or sudden illness. This may curb early dismissal from school or school absenteeism. Furthermore, in this study, school buses were available in 36.1% schools. They were exclusively in private schools. This value is lower than 89% reported by [21] but higher than 13.6% reported by [22] both in Ogun State [21]. However, in all the studies, none reported the painting of the school buses in the conventional school bus yellow to ensure safety. The higher value reported by [21] may be because the study involved both Nursery, primary and secondary schools [21]. The availability of school bus may aid in conveying pupils who suddenly fall ill to the nearest health post to ensure prompt medical attention. In the present study, all the schools gave first aid treatment in case of emergency injury. This finding is comparable to 75.8% reported by [3] but contrasts 10% reported by Alex-Hart et al [3,17] The lower value obtained in the study by Alex-Hart et al [17] may be because there was lack of first aid boxes in the schools studied [17]. Furthermore, six (16.7%) schools had record of treatment given in this study. This finding is higher than none observed by Alex-Hart et al [17] but comparable to 19.7% reported by Toma et al [3]. It was observed in this study that the schools that had records after treatment were the schools that had health rooms with health personnel who appreciate the importance of record keeping. Whereas the present study and the study by Toma et al [3] reported

availability of health rooms, the study by Alex-Hart et al[17] reported none.

CONCLUSION

School health services in both public and private primary schools within Owerri Municipal LGA is poor. The private schools performed better than the public schools in provision of school health services. School health appraisal services were generally poor especially with respect to pre entry medical screening and periodic medical examination.

RECOMMENDATION

In view of the poor status of School Health Services, there is urgent need for the implementation of the SHS in primary schools in Owerri Municipal LGA. The government should take responsibility to implement existing policies and guidelines on School Health Services.Pre entry medical examination and periodic medical examination of staff and pupils by a certified physician should be carried out in all schools. Advocate for provision of school based health clinics in all the schools in the study area.

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APPENDIX
PLATE 1

PLATE 2: THE CLINIC IN ONE OF THE SCHOOLS

PLATE 3 ESSENTIAL DRUGS MADE AVAILABLE FOR THE CLINIC

PLATE 4: RESEARCHER WITH A SCHOOL TEACHER IN THE CLINIC

PLATE 5: RESEARCHER INFORMING PUPILS OF THE SCHOOL CLINIC DURING ASSEMBLY

PLATE 6: RESEARCHER SHARING CONSENT FOR PARENTS TO PUPILS

PLATE 7:RESEARCHER EXAMINING A PUPIL IN THE CLINIC.

PLATE 8: THE SICK BAY IN ONLY ONE OF THE PUBLIC SCHOOLS

PLATE 9: SIGNAGE IN FRONT OF THE SICK BAY IN PLATE 8

LIST OF 36 SELECTED SCHOOLS

PRIVATE SCHOOLS

1. Unity Primary School, Trans-Egbu, Owerri.
2. Eton Day Primary School, Area L World Bank, Owerri.
3. Christ Foundation Primary School (St. John's), Area N World Bank, Owerri.
4. Kingdom Heritage Primary School, New Owerri.
5. Nice Primary School, World Bank area, Owerri.
6. St. Michael's & All Angels Primary School, World Bank area, Owerri.
7. Queens Primary School, World Bank area, Owerri.
8. Living Word Academy, Ikenegbu, Owerri.
9. International Organization of Good Templar Primary School, Ikenegbu, Owerri.
10. St. Juliana Primary School, Ikenegbu, Owerri.
11. Start Right Primary School, Ikenegbu/ Aladinma, Owerri.
12. Foundation Primary School, Ikenegbu extention, Owerri.
13. HHCJ Assumpta International, Prefab, Owerri.
14. Fair Child Boarding Primary School, Ikenegbu, Owerri.
15. Alvan Ikoku COE Primary School, Orlu road, Owerri.
16. Police Children School, Orlu road area, Owerri.
17. Dora Amako Primary School, Orlu road area, Owerri.
18. Holiness Primary School, Douglas area, Owerri.
19. Kings Primary School, Douglas area, Owerri.
20. Divinity Primary School, Douglas area, Owerri.
21. Wisdom Primary School, Douglas area, Owerri.
22. Missionary Primary School, Douglas area, Owerri.
23. Arise & Shine Nursery and Primary School, Trans-Egbu, Owerri.
24. Good Shepherd Primary School, Douglas area, Owerri.

PUBLIC SCHOOLS

1. Model Primary School, New Owerri.
2. World Bank Primary School, World Bank.
3. Ikenegbu Layout Primary School, Ikenegbu area
4. Township Primary School, Ikenegbu/Aladinma area.
5. Shell Camp Primary School, Orlu area
6. Model Primary School, Orlu area, Owerri
7. Central Primary School, Douglas area
8. Development Primary School, Douglas area
9. Waterside Primary School, Douglas area
10. Uzii Layout Primary School, Douglas area
11. Mann Street Primary School, Douglas area
12. Urban Primary School, Douglas area