AKENTEN APPIAH-MENKA UNIVERSITY OF SKILLS TRAINING AND

ENTREPRENEURIAL DEVELOPMENT

CHALLENGES ASSOCIATED WITH THE IMPLEMENTATION OF THE

SCHOOL HEALTH EDUCATION PROGRAM (SHEP) IN PUBLIC BASIC

SCHOOLS IN THE EJISU CIRCUIT.

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Studies, University of Education, Winneba, in partial fulfilment of the

requirements for award of the Master of Arts in (Educational Leadership)

degree

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DECLARATION

STUDENT'S DECLARATION

I, JOANA AMOAH, declare that this dissertation, with the exception of quotations references contained in published works which have been identified and duly acknowledged, is entirely the result of my own original research work, and it has not been submitted either in part or whole for another degree elsewhere.

SIGNATURE: ………………………………

DATE: …………………………………………

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines on supervision of dissertation as laid down by the University of Education, Winneba.

NAME OF SUPERVISOR: DR. PHILIP OTI-AGYEN

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DATE: ……………………………………….

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DEDICATION

To my husband; Mr. Richard Opuni and my children; Reacheal, Melchisedek,

Williams, Christopher and Owusu Bada.

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LIST OF ACRONYMS

CSHP   Coordinated School Health Program

GES   Ghana Education Service

GSHI   Global School Health Initiative

FRESH   Focus Resources on Effective School Health

MOE   Ministry Of Education

SHEP   School Health Education Program

UNESCO   United Nations Educational Science and Cultural Organisation

UNICEF   United Nations International Children's Emergency Fund

WHO   World Health Organization

ABSTRACT

The purpose of this study was to find out the challenges that militate against the effective implementation of School Health Education Program (SHEP) in public basic schools in Ejisu Circuit. The objectives of the study were to find out the state of physical environment of schools that practice SHEP, the roles of SHEP coordinators in schools and lastly to find out the challenges that affect SHEP implementation. Descriptive survey design using the quantitative approach was employed for the study. The population of the study was 284. Census sampling technique was used to select a sample size of two hundred and seventy-four (274) respondents for the study. Questionnaire was used to collect data for the study. The data from the study were analyzed using descriptively statistics such as frequencies and percentages. The study revealed that public basic schools in Ejisu circuit are located in spacious and less noisy environment; however the toilet and urinal facilities provided for students are not in the best of shape and conditions. Finally the study revealed that public basic schools in Ejisu circuit are confronted with challenges as far as the implementation of SHEP is concern, the challenges include: inadequate funds to support SHEP; inadequate teaching and learning materials to support; lack of confidence in teaching topics under SHEP among other factors. The study recommends that Government of Ghana through Ghana Education Service should make funds and relevant teaching and learning materials available to support the effective implementation of SHEP.

CHAPTER ONE

INTRODUCTION

This chapter described the Background to the study, followed by Statement of the Problem. The Purposes of the study, Research objectives, Research questions, Significance of the study have also been explained. Again, Delimitation, Limitation and Organization of the study have been discussed.

1.1 Background to the Study

Ensuring that children are healthy and able to learn is an indispensable component of an effective education system. This is particularly most relevant to efforts at achieving education for all in the most deprived areas. (Estyn, 2017a). It is these children who are often the least healthy and malnourished, who have the most to gain from improved health, and who need health related school policies that, when effectively endorsed can lead to better educational outcomes. Health problems interfere with students' ability to come to school, stay in health, or make the most of their opportunity to learn. (UNESCO, 2009). If unhealthy behaviours remain unchanged throughout the life course they can lead to chronic diseases, which limit people's quality of life in old age and pose a challenge for healthcare provision. (Brooks, Slujis, Klemera, Morgan, Magnusson, Gabhainn, Smith, & Curri, 2016). According to a socio-ecological (SE) perspective, health behaviours are shaped by multiple influences located at the intra- and interpersonal level, the organisation- as well as wider community- and policy contexts (McLeroy, Bibeau Steckler, & Glanz, 2018)

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Good health increases enrolment, reduces absenteeism and brings more of the poorest and most disadvantaged children, many of which are girls to school. It is for this reason that Health policies in schools, including skilled based health education and the provision of some health services can help promote the overall health, hygiene and nutrition of children are necessary to be implemented to help promote the health of these children. (Cornwell, 2017) The School Health Education Program (SHEP) activities are supportive of the Millennium Development Goals, (MDGs), especially those covering universal primary education (MDG 2), promoting gender equality (MDG 3), reducing child mortality (MDG 4) and combating HIV/AIDS, malaria and other infectious diseases (MDG 6). The School Health Education Program (SHEP) is an "organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff. This program traditionally included three components: health education, a healthful school environment, and the provision of health services. It was expanded in 1987 to include physical education, nutrition services, counseling services, community and family involvement, and health promotion for faculty. Since students spend a major part of their lives in school, schools are a good place to influence healthful living before harmful habits are established. (Howard - Barr 2008).

SHEP was instituted to encourage all schools to address their students' health on various levels/classes. The program's mission is to promote wellness, motivate health improvement, and offer educational opportunities for students, families, and community members. By implementing the planned, ongoing services of the SHEP, schools have the ability to improve both education and the health of students and school personnel. (Howard-Barr, 2008). To be effective, the School Health Education Program needs adequate or equitable resources for its implementation. These

resources must be available at the national, regional, district and local levels. It must therefore be supported by key stakeholders; for example there should be an established framework of responsibility, policies and action between the key government ministries such as the Health and Education ministries. It is against this background that the current study seeks to find out the challenges associated with the implementation of the School Health Education Program in public basic schools in the Ejisu Circuit.

1.2 Statement of the Problem

In Ghana, the School Health Education Program (SHEP) unit under the Ghana Education Service is tasked with the responsibility for Health Promotion in schools up-to Pre-tertiary level. The program sought to: inculcate into school children health-promoting habits and values of good hygiene and sanitation practices; bring health education and related health services to the doorsteps of school children for early detection of defects and disability for prompt referral and management; assist in the prevention and management of communicable and non-communicable diseases among others. Despite putting in place these elaborate objectives , SHEP has failed to live up to expectation and also seem not to institute mandatorily a school-based health centers/sickbay which are avenues through which schools and the health care system can cooperate very efficiently to tackle the difficult health needs of students. Several studies (Acosta -Price, 2016). Several studies (Strolin-Goltzman, 2010; Keeton, Soleimanpour & Brindis, 2012; Basch, 2011; Toma, Oyebode, Toma, & Agaba, 2014; Olugbenga, Olorunfemi, & Opeyemi, 2016; Bains, & Diallo, 2016;Ran, Chattopadhyay, & Hahn, 2016) conducted elsewhere have assess school-based health services and the relevant role it plays on students wellbeing.

In the Ghanaian context, Nyonator, Awoonor-Williams, Phillips, Jones, and Miller (2005) and Tierozie (2011) conducted studies on community-based health planning and service deliveries but the concentration was not on health delivery in schools. Boateng (2008) also looked at the implementation and practice of school health program in some basic schools in the Greater Accra Region in Ghana. Results from his study revealed weak collaboration between implementers, inadequate funding, and inadequate support from the health sector as challenges affecting the program. However, it appears little is known about the state of the SHEP program in Ejisu Municipal. A personal observation reveals that SHEP program in the Municipality seems not to receive the needed attention from the policymakers and the implementers, hence a seemingly weak implementation and compromise on the comprehensive practice of the program, it as a result of this that this current study seeks to find out the challenges associated with the effective implementation of the School Health Education Program (SHEP) in public basic schools in the Ejisu Circuit and the way forward.

1.3 Purpose of the Study

The purpose of the study was to investigate the challenges associated with the implementation of the School Health Education Program (SHEP) in public basic schools in Ejisu circuit.

1.4 Objectives of the Study

The study sought to achieve the following:

1. to find out the state of physical environment of public basic schools that practice SHEP at Ejisu Circuit?

2. to identify the roles played by School Health Education Program (SHEP) coordinators in the effective implementation of SHEP in public basic schools in the Ejisu Circuit.

3. to identify the challenges associated with the implementation of SHEP in public basic schools in the Ejisu Circuit.

1.5 Research Questions

The study was guided by the following questions:

1. What is the state of the physical environment of public basic schools that practice SHEP at Ejisu Circuit?

2. What are the roles played by SHEP coordinators towards the effective implementation of SHEP in public basic schools in the Ejisu Circuit?

3. What challenges militate against the implementation of SHEP in public basic schools in Ejisu Circuit?

1.6 Significance of the Study

The outcome of the study will highlights the effectiveness of the country's school health program and how it is incorporated into the education curriculum, as well as the critical role that schools and school health programmes play in meeting the health-related needs of children and adolescents in the country.

This study and others like it are needed to stimulate discussion and dialogue among researchers, health educators and other stakeholders who have either an interest in children and adolescents in Ghana and in sub Saharan Africa.

The outcome of the study will inform policy makers and stakeholders in education about the challenges affecting the implementation of SHEP and the need to come out with effective policies to minimize the challenges.

The outcome of the study will contribute to literature and serve as a blueprint/ reference tool for future researchers on SHEP.

1.7 Delimitation of the Study

The study was delimited to the challenges associated with the implementation of SHEP in public basic schools in the Ejisu Circuit, even though other aspect of SHEP could have been explored. The respondents of the study were also delimited to head teachers and teachers in the selected schools only, therefore the findings of the study may be generalized with caution.

1.8 Limitations of the Study

Academic work of this nature is not without limitations. A classical limitation of this study had to do with the likert–scale type of questionnaire adopted in this study. This type of questionnaire did not allow respondents to explain further than the limits of the question items as they were closed in nature. Another limitation of the study was that some respondents were uncooperative and unwilling to provide data for the study and to overcome this limitation the respondents were assured of their confidentiality, privacy and anonymity of their identity. The data collection was also carried out during the working hours hence there was a clash with the respondents'

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working activities. To minimize this bias, the researcher made arrangements with respondents as to the time that was convenient for them. These limitations notwithstanding, the researcher was able to gather the necessary data for the study to achieve the objectives of the study.

1.9 Organization of the Study

The study was organized into five chapters. Chapter one dealt with the introduction which consisted of the background to the study, statement of problem, purpose of the study, objectives of the study, significance of the study, limitations of the study, delimitation of the study and the organization of the study.

Chapter two presented the review of the relevant literature. It reviewed related literature by other researchers on absenteeism in school. Chapter three dealt with the methodology which comprised the introduction, research design, population, sample and sampling techniques, research instrument, reliability and validity of the instrument, data collection procedure, data analysis and ethical considerations. Chapter four presented the results and discussions of the data collected while Chapter five covered the summary of findings, conclusions, recommendations and suggestions for further study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews the literature from previous studies and the works of other scholars. The review is done under the following key headings:, Global school health initiatives, Healthy and Safe environment, Comprehensive School Health Approach, Ghana School Health Education Program (SHEP), Objectives of School-Health Education Program in Ghana, Content of School-Health Education Program in Ghana, Structure of Ghana's School Health Education Program, Roles and Responsibilities of a School Health Coordinator, Usefulness and Influence of School-Based SHEP Education, Sources and extent of support for School Health Program, Parent and Community Involvement and Challenges associated with School Health Education Program.
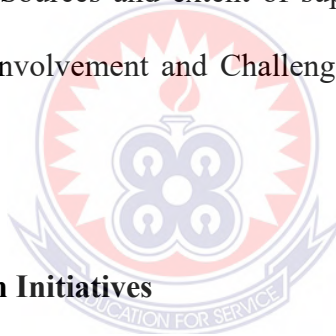
2.1 Global School Health Initiatives

For many years the concept of health promotion, especially promoting the health of children, adolescents and the youth has been a primary focus of international organizations such as the World Health Organization (WHO). This long-standing focus on health promotion by the WHO culminated in the formal launching of the Global School Health Initiative (GSHI) in 1995. According to the WHO the ongoing GSHI is guided by three previous policy decisions by the organization: the 1986 Ottawa Charter for Health Promotion, the 1997 Jakarta Declaration of the Fourth International Conference on Health Promotion and the 1995 WHO'S Expert Committee Recommendation on Comprehensive School Health Education and Promotion.

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The primary objective of GSHI, according to the WHO is to initiate, strengthen and promote health education effectively through mobilization of resources at all levels—local, national, regional and global. Using the school setting, the primary goal is to improve the health of not only students but also school personnel, parents and other family members as well as members of the larger community. Since the launching of the GSHI various regional offices of the WHO have initiated regional plans of action to implement its goals and objectives. In this regard, the Africa Regional Office of WHO has initiated a regional plan for developing health-promoting schools on the continent (Cerqueira 2016).

This regional plan includes country-specific activities in which the Regional Office works with individual countries to initiate or improve school health programmes, preferably through community action. The regional plan has been in place since the mid-1990s, yet very little is known about the status and viability of school health education programmes in many sub Saharan African countries, including whether or not the programmes are meeting the goals and objectives set by the WHO and other international agencies. The April 2000 launching of Focus Resources on Effective School Health (FRESH), a joint partnership initiative by the WHO, UNESCO, the World Bank and Education International, sought in many ways to further and consolidate the goals and objectives of the GSHI (World Bank Report.).

Both the GSHI and FRESH describe the ideal components of an effective school health education program. These components include the development of health-related school education policies that emphasize the development of life skills through participatory teaching methods which enable students to acquire these life skills. The skills-based approach also emphasizes the development of knowledge, attitudes and values that in the end lead to the establishment of lifelong healthy

lifestyles. Furthermore, it emphasizes active learning and the full involvement of students, teachers, parents and the community in the development and implementation of program activities.

2.2 Healthy and Safe Environment

A safe school is foundation to the success of the academic mission .School safety should be addressed through a comprehensive approach that focuses on prevention, intervention and response planning. Systems and programs should be in place that creates caring school communities where all students and staff feel safe and supported (Stephens, 2005). Key to the process of building and maintaining safe schools is the development of active partnerships between schools and communities. A school's environment is the thread that connects the multitude of activities on a campus. In many respects this thread is almost invisible, yet everyone experiences its influence. Positive social relationships and attitudes about the school are as important to the environment as are safe and well-kept buildings and grounds. A safe, clean, and well-maintained school with a positive psychosocial climate and culture can foster school connectedness, which in turn boosts student and staff health as well as students' educational achievement. In an article (Boateng, 2008) published in the 'Gender and Children' column of the Daily Graphic on the topic 'Caring for truant children', the author noted that making the school environment friendly for school children helps keep them in school and checks truancy. It was explained that parents, youth organizations, social workers and other related agencies all need to work together to develop programs and establish services that will help in the proper upbringing of children. A school's physical environment includes the school building and the surrounding grounds, such as noise, temperature, and lighting as well as

physical, biological, or chemical agents. The alarming increase in the number of students with asthma is one problem that may, in part, be affected by poor physical conditions in schools (Environmental Protection Agency. USA). The psychosocial school environment encompasses the attitudes, feelings, and values of students and staff. Physical and psychological safety, positive interpersonal relationships, recognition of the needs and success of the individual, and support for learning are all part of the psychosocial environment. Other factors that can affect a school's environment include: the economy; social, cultural, and religious influences; geography; socioeconomic status of students' families; tax bases; and legal, political, and social institutions. (Environmental Protection Agency. USA)

2.3 Comprehensive School Health Approach

To encourage educational and health institutions and agencies to coordinate their efforts to promote health through schools, the World Health Organization (WHO) convened an Expert Committee on Comprehensive School Health Education and Promotion in Geneva, Switzerland, from 18 to 22 September 1995. The overall objective of the Expert Committee was to make recommendations for policy measures and actions that the WHO, other United Nations Agencies, national governments and nongovernmental organizations could apply to enable schools to use their full potential to improve the health of children and young people, school staff, families and community members. (WHO, Technical Report 2014) A school health education that is not reinforced and supported by other health-promoting actions and aspects of the school environment may increase students' knowledge of health issues, but is less likely to result in the adoption of health-promoting attitudes and the development and consistent practice of health skills which is the ultimate goal of health education.

Effective school health education must, therefore, be implemented within the broader context of a comprehensive school health approach covering a combination of skills-based health education with school health policies, safe and secure learning environments and school health services. (UNESCO, 2019). Schools have long played an important role in providing students with healthy physical activity. However, the decline in population-level physical activity suggests that schools should play an even greater role in providing and promoting physical activity. Recently, the American Heart Association issued a set of recommendations that, if implemented, would position schools as leaders in helping children and youth become more physically active. (Pate & O'Neill, 2007)

2.4 The Ghana School Health Education Program (SHEP).

In 1992, recognizing the need to promote the health of school-age children and adolescents, Ghana established the Ghana School Health Education Program (SHEP). Globally, there is a general awareness of the central role that schools play in promoting and addressing the health needs of children and adolescents. Effective health education programmes in schools are considered to be among the key forces in addressing the health risks and needs of school age children and adolescents (Allensworth & Kolbe (2017) Fabiyi and Blumenthal (2011) Kolbe, Kan, & Brener, (2011), Lohrman Gold, & Jubb, (2017), Marshall, Johnson, & Kolodn (2015.)

There are a number of reasons why schools are vital to promoting the health of school age children and adolescents. First, in societies where a significant number of parents provide limited information about health and healthcare to their children because of their own high rates of illiteracy, schools provide the infrastructure and

personnel, together with a cost effective mechanism to disseminate health information and also address the health needs of children and adolescents (World Bank 2017).

Secondly, previous research has noted that healthy children are more likely to attend school regularly and they are also more likely to perform better in their academic work (Del Rosso & Marek 2016).

Thirdly, children who are taught in schools to acquire essential health related knowledge and skills are not only less likely to engage in health-compromising behavior as adolescents, but they are more likely to carry the knowledge and skills into adulthood and lead healthier lifestyles (Del Rosso & Marek 2016). Finally, children often pass on health-related knowledge and skills acquired from schools to parents and other members of the household. As a result, school-based health education programmes benefit not only students but family members and the community at large (WHO 2018). Specifically, it examines the implementation of National School Health Education policies and the coverage of required health topics at the district level. The district level was selected as the focus of this preliminary study because there is a need to obtain information that would provide a national picture of the program. In addition, some district co-coordinators are knowledgeable about the program guidelines and activities and they serve as key resource personnel at the local level.

For the implementation of this program, there is the need for an effective partnership between the health and education sectors, teachers and health workers, schools and community groups and between the pupils and those responsible for implementing school health programs. Some countries in Africa such as Kenya have started addressing this issue by introducing school health policies. In Pennsylvania, the School Health Program facilitates the healthy growth and development of children

of school age. The program serves all children of school age attending public and non-public schools. This program prevents and detects health problems, and maintains and improves the health status of students. School health programs and services impact on the health status and well-being of more than 2.1 million school age children in the Commonwealth's public and non-public schools. The Pennsylvania Public School Code provides that all children attending public, private, and parochial schools receive school health services (Martin, & Scheet, 2012). A policy such as this is likely to go a long way to improve the health of pupils and have a positive impact on their lives in general. The School Health Program as practiced in India, aims at providing medical examination of school children to identify ailments in them and to provide treatment and referral services. The activities undertaken under the program entail medical examination of all primary school children at least thrice during their primary school (thus from nursery to primary 6) life, treatment for minor ailments on the spot and to provide referral services to the sick children. It is done at two levels, thus, the block level and the district level. At the block level, the Senior Medical Officer (SMO) of the Block is entirely responsible for implementation of the school health program in her/his respective block.

At the district level, the District Senior Medical Officer (DSMO) is directly responsible for implementation of school health program in their respective districts. Medical Officers at these levels are responsible for carrying out the medical inspections of the schools falling in their respective sectors. The monthly reports on the prescribed performance are being regularly submitted to the government of India. Monitoring is an essential component in the implementation of the program. The Senior Medical officer ensures to regularly monitor the program at his/her block and sends a detailed report to the DSMO. The DSMO monitors the program and identifies

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bottlenecks in the smooth implementation of the program and suggests remedial measures accordingly. (Felix, 2005)

In Ghana, however, the SHEP program seems not to receive the needed attention from the policy makers and the implementers hence a seemingly weak implementation and compromise on the comprehensive practice of the program. There seem to be lack of collaboration between the health and education ministries. The program itself is apparently not fully practiced in most schools. There also seem to be a major systemic problem due to the fact that there is no budget line for School Health activities, resulting in a seemingly poor monitoring and evaluation procedures to help ensure the sustainability of the program.

2.5 Objectives of School-Health Education Program in Ghana

Conduct training to build capacity of teachers, school children and community members for effective implementation of school health programmes; Develop appropriate Information, Education and Communication (IEC) materials; Inculcate into school children health-promoting habits and values of good hygiene and sanitation practices including hand washing with soap; Ring health education and related health services to the doorsteps of school children for early detection of defects and disability for prompt referral and management; Assist in the prevention and management of communicable and non-communicable diseases; Promote the provision of adequate, safe and sustainable water and sanitation facilities in schools, which will reinforce the practice of learnt skills for hygiene; Promote good environmental sanitation and hygiene practices in schools, which are gender, child and disability friendly; Promote healthy lifestyles including healthy diet, avoiding alcohol and tobacco consumption, illicit drugs, physical inactivity and pre-marital sex; Promote safety and prevent injury within the school environment and the general

community; Provide nutrition and food safety education and ensure that food vendors and cooks are medically screed and certified to prepare, handle and sell food under hygienic conditions; Promote the provision of safe school infrastructure that is age-appropriate, well ventilated, well illuminated, disability and gender-friendly; Promote educational programmes that will assist in the prevention and management of HIV and AIDS, malaria prevention and other locally endemic diseases; Motivate school children to become change agents to their peers and in their homes and communities.; Promote effective school-community and parent-teacher partnerships to address issues that will enhance the health and development of children; Use the school as a medium to disseminate health messages to communities; Promote research and studies on school health issues in support of program implementation.

2.6 Content of School-Health Education Program in Ghana

The introduction of school health education program in Ghana is in line with the content and perspectives as outlined by United Nations Educational, Science and Cultural Organisation (UNESCO), dubbed an International Technical Guidance on Sexuality Education. This program has the aim to provide schools, teachers and SHEP educators/coordinators with an evidence-informed approach to the imparting of SHEP knowledge. Contained in the Guidelines are four components of the learning process. These are;

i. Information: sexuality education provides accurate information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights

empowerment; nondiscrimination, equality and gender roles; sexual behaviour; sexual diversity; sexual abuse; gender-based violence; and harmful practices(MoE, 2007).

ii. Values, attitudes and social norms: sexuality education offers students opportunities to explore values, attitudes and norms (personal, family, peer and community) in relation to sexual behavior, health, risk-taking and decision-making and in consideration of the principles of tolerance, respect, gender equality, human rights, and equality.

iii. Interpersonal and relationship skills: sexuality education promotes the acquisition of skills in relation to: decision-making; assertiveness; communication; negotiation; and refusal. Such skills can contribute to better and more productive relationships with family members, peers, friends and romantic or sexual partners (MOE, 2007a).

iv. Responsibility: sexuality education encourages students to assume responsibility for their own behaviour as well as their behaviour towards other people through respect; acceptance; tolerance and empathy for all people regardless of their health status or sexual orientation. Sexuality education also insists on gender equality; resisting early, unwanted or coerced sex and rejecting violence in relationships; and the practice of safer sex, including the correct and consistent use of condoms and contraceptives (UNESCO, 2009, Vol.1, p. 5).

These four major components of the learning process are further divided into six key concepts for the SHEP education of children and adolescents from the ages of 5 to 18 years. These are: relationships, values, attitudes and skills, culture, society and human rights, human development, sexual behaviour and sexual and reproductive health (UNESCO, 2009). The SHEP concept as explained by the international

technical guidance, states that abstinence is the most effective form of contraception. It is intended to teach adolescents how peer norms can influence the decision of both men and women to use contraception and condoms. It is also intended to teach adolescents how unplanned pregnancy at an early age can bring about negative health and social consequences. Furthermore, the SHEP concept is intended to inform adolescents about the effective methods of preventing unplanned pregnancy and their related efficacy. In addition, it is designed to describe to adolescents personal benefits as well as likely risks concerning methods of contraception. Last but not the least of the provisions of the SHEP concept, is the provision to explain how STIs, including HIV are transmitted, treated and prevented. In India, a reproductive health education program designed in consultation with parents and teachers to suit the sensitiveness of their culture consisted of the anatomy and physiology of male and female reproductive system, physical and sexual changes during adolescence, menstrual cycle, conception and contraception, nutritional requirements, immunizations, provisions of Child Marriage Restraint Act and Medical Termination of Pregnancy Act, reproductive tract infections and sexually transmitted diseases including HIV/AIDS (Parwej et al., 2015).

In Ghana, the specific contents of the Adolescent Sexual and Reproductive Health topic taught under the School Health Education Program (SHEP) curriculum are parts of the reproductive system and their functions, and stages of reproduction. Also included in the curriculum is, the dangers of indiscriminate sex such as unwanted teenage pregnancies on the part of girls, abortion, dropout of school, early fatherhood for boys, possibility of contracting sexually transmitted diseases, including HIV/AIDS (Adu-Mireku, 2013). The students are also taught the various types of STIs, including their causative organisms as well as the various types of

contraception. However, Adu-Mireku (2013) has argued that the coverage of these health topics by some schools was less than required by the national policy guidelines. Reasons for this shortfall included inadequate materials, especially instructional materials, and the variations in the knowledge and competence of health promoters at local schools due to training. The Ghanaian culture, not being open to issues of sex and reproduction with children and adolescents could also be a reason. Inferring from the contents of school-based SHEP education, across the globe, the syllabus for SHEP education in schools is similar. They all seem to touch on the anatomy of the reproductive system and the changes that occur as an individual matures, the stages of pregnancy, teenage pregnancy, including its consequences and prevention, the causes, effects treatment and prevention of STIs including HIV/AIDs. In as much as the contents are similar, in some places educators tend to stress more on abstinence from sex can be said to be as a result of the predominant culture of those settings or the personal values of the educators (Iyer & Aggleton, 2013; Kibombo, Neema, Moore & Ahmed, 2008).

2.7 The Structure of Ghana's School Health Education Program

The national headquarters of SHEP, established under the Ghana Education Service, which is part of the Ministry of Education, has a coordinator and staff and an 18-member National Steering Committee (NSC). Members of the NSC are appointed from the two constituent ministries, other governmental and non-governmental organizations and representatives of donor organizations. The NSC is responsible for the overall formulation of policies and guidelines for SHEP and it also serves as a co-coordinating and overseeing body for the national, regional, district and local levels of SHEP (Ghana Education Service, 2016). The country's 10 administrative regions have

regional SHEP co-coordinators and each of the 110 administrative districts has a district SHEP co-coordinator. At the local level, schools across the country—from elementary to senior secondary schools—have teachers who have been appointed as school health promoters/coordinators (Ghana Education Service.).

Consistent with WHO (2018) recommendations, the district coordinators play a pivotal role in the structure and function of SHEP. The district co-coordinators oversee and work with the school health promoters in their districts to implement SHEP policies and program activities at the local level. In addition, the district co-coordinators organize training health education information to schools within their districts. Furthermore, the district co-coordinators are required to collaborate with district assemblies and Ministry of Health workers to establish district teams to implement and promote overall health education program activities, including school health education program activities.

Finally, the district co-coordinators receive both oral and written reports from the school health promoters in their districts and they are also required to conduct on-site visits to ensure that SHEP policies and guidelines are being implemented by the school health promoters or coordinators.. In turn the coordinators are required to submit local inputs to their regional co-coordinators and the national headquarters to aid in policy formulation and the revision of program guidelines and activities.

The introduction of health-related topics into the SHEP curriculum is effected through the educational program referred to as Population and Family Life Education. SHEP's information documents list the following health issues that are required to be covered in the curriculum at the basic level: personal hygiene, environmental sanitation, the nutritional needs of individuals, avoiding diseases associated with

contaminated food, food hygiene, water-borne diseases, adolescent sexual reproductive health, STD, HIV/AIDS, adolescent pregnancy, abortion, female genital mutilation, pre-marital sex, drug and substance use and abuse, rape and sexual abuse, good grooming, accidents in the home and the school and child labour (Ghana School Health Education Program , 1992).

The curriculum guidelines of SHEP also require that schools use two strategies to cover health issues in the curriculum. The first strategy— the Unit Course Approach—is designed to introduce health issues under specific units of the course syllabi of core subjects (environmental studies, integrated science, English, social studies, science, agricultural science, geography and life skills). The second strategy—the Integrated/ Infusion Approach—is designed to integrate or infuse health issues into the core subjects in a topical fashion (Ghana School Health Education Program 1992). Finally, SHEP curriculum guidelines recommend the use of the following participatory teaching methods in the curriculum: role play, dramatization, case study, values clarification, future's wheel, brainstorming, storytelling and discussion.

2.8 Roles and Responsibilities of a School Health Coordinator:

The following are the roles and responsibilities performed by school health coordinators or promoters. Establishment of a School Health Committee and formation of a School Health Club; Conducting health education sessions with technical support from the nearest health centers; Observing Global Days such World Water Day, World AIDS Day, World Health Day, World Sight Day, World TB Day; Organising health related competitions, campaigns; Promotion and maintenance of proper sanitation and safe drinking water in the schools; Carrying ⌉out action projects such as protecting water sources; conducting cleaning campaigns within the local

community, educating the local community; Provision screening,⌉ of health services at the school level such as visual oral screening, de-worming, First Aid, Iron Folic Acid supplementation; Conduct environmental hygiene inspection of general school environment condition (classroom, compound, toilet facilities etc); Ensure that schools meet safety and health promotion specification (Lighting, ventilation, recreational grounds; Monitor activities of food vendors and ensure the use of iodated salt (SHEP Handbook 1992).

2.9 Usefulness and Influence of School-Based SHEP Education

Schools, according to Goldman (2006) are the places for imparting timely, independent, higher order, sequential and replicable learning. According to UNESCO (2009), in many countries, children between the ages of 5 and 13 spend a considerable amount of time in school. SHEP education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships, by providing scientifically accurate, realistic, non-judgmental information. It has been noted that schools are the ideal place for the impartation of evidential and age-specific sexual and reproductive health knowledge to adolescents (Lloyd, 2010).

In the words of Goldman and Collier-Harris (2012), In order to be effective, sexual and reproductive health education has to be scientifically and evidentially based, be tailored by professional educators to the specific needs within each educational authority, and content has to be delivered sequentially and consistently in every grade level. The young adolescents who are most at risk of uninformed and/or too early sexual activity, that is, those who have reached reproductive fertility at puberty, should be the first group to have their human rights to such information and understanding fulfilled by education systems. Effective sexual and reproductive

health education has been shown to "reduce misinformation; increase correct knowledge; clarify and strengthen positive values and attitudes; increase skills to make informed decisions and act upon them; improve perceptions about peer groups and social norms; and increase communication with parents or other trusted adults" (UNESCO, 2009). Hence, sexual and reproductive health education is useful in curbing the sexual activities of adolescents rather than influencing them to initiate sex or engage in casual sex. Some studies have found that sexual and reproductive health education has helped to promote abstinence until marriage and in other instances where adolescents do engage in sex, they are able to practice safe sex with the use of condoms and other barrier methods to prevent teenage pregnancies and the contraction of STIs.

For instance, in a study conducted by Saaka (2015), it was found that in comparison to adolescents in schools, adolescents out of school were more likely to be engaged in sexual intercourse. The results indicate that in-school respondents (100%) had a high knowledge of HIV/AIDS than did their out- of- school counterparts (97%). Almost half (46%) of out-of-school adolescents were sexually active as compared with participants in school (22%). Majority of the respondents in both groups also wanted to be screened and tested for HIV/STIs [in-school (97%), out-of-school (57%)]. In school adolescents had better knowledge of the causes of STIs than those out of school. According to the study, adolescents who are not in school often practiced risky sexual behaviours that could lead to acquisition of HIV/STIs than in-school adolescents. More students (77%) were willing to undergo Voluntary Counselling and Testing (VCT), compared with their out-of-school counterparts (57%).

Another study by Menezes, Ribeiro and Cabral-Gouveia (2013) has also shown the usefulness of SHEP education. In the study, school-based exhibition of prevention materials designed by adolescents was found to help improve students', particularly, females' knowledge on AIDS related issues. Aside the improved knowledge, the findings of the study contributed to the development of AIDS education initiatives in participating schools. Hence, school-based AIDs prevention projects do not just benefit students only in terms of informed decision making, but also help in policy formulation.

On the other hand, some studies such as one by Kumi-Kyereme et al. (2014) observed that parents perceived providing adolescents and young people with SHEP information encourages them to engage in early sex activity, as a result of putting into practice what they have been taught. Whiles some researchers have shown the benefits of SHEP education in the sexual and reproductive wellbeing of adolescents, others have reported that it adds nothing to reduce the risk-taking behaviours of learners or to reduce the incidence of teen pregnancies and STIs among them. Thus, school based SHEP education has received its share of criticisms, regarding its importance based on the findings of some researches. However, it must be noted that reports on the positive influence or impact of SHEP education in the sexual behavior of adolescents and young people outweighs the negative ones.

In the view of Bains, & Diallo, (2016) successful school health program can achieve the following:

Responds to a need: The success of the education sector has resulted in numerous schools being established and a great proportion of children attending school. School is therefore the key setting where the health and education sectors can jointly take

action to improve and sustain the health, nutrition and education of children easily and previously beyond reach, thus contributing to quality and wholesome education.

Ensures better educational outcomes: School children can suffer from highly prevalent conditions that can adversely affect their development. Micronutrient deficiencies, common parasitic infections, poor vision and hearing, and disability can have a detrimental effect on school enrolment and attendance, and on cognition and educational achievement. In older children, avoidance of risky behaviors can reduce dropping–out from school. Ensuring good health at school age can boost school enrolment and attendance, reduce the need for repetition and increase educational attainment, while good health practices can promote reproductive health and prevent HIV/AIDS.

Increases the efficacy of other investments in child development: School health programs are the essential sequel and complement to early child care and development programs. School health programs hence not only ensures that children enjoy continuing good health but that those children who enter without the benefit of early development programs receive the attention they may need to take full advantage of their educational opportunity.

Highly cost effective strategy: School health programs can help link the resources of the ministries of health and education in infrastructures (school) that is already in place, is pervasive and is sustained. Whilst we are all committed to the "Education for All" goals and increasing access and quality of education for our children, one of the key elements that we should not forget is to provide them with appropriate school health education and services. If we are neglecting this, and if we are not sufficiently providing healthier learning environments, it would be very difficult to achieve our

education priorities. A child's ability to attain her/his full potential is directly related to the synergistic effect of good health, good nutrition and appropriate education. Good health and good education are not only ends in themselves, but also means which provide individuals with the chance to lead productive and satisfying lives.

2.10 Sources and extent of support for School Health Program

Supervision and funds for the program could be managed by (Adams, 2008) the District Health Services (DHS) as done in the Illinios, where the DHS handles approximately 38 School Health Centers statewide. A School Health Center, located in, or near a school provides the following services: routine medical care, school/sports physicals, immunizations, nutrition counseling, health education, sexually transmitted disease testing and pregnancy testing. Each local community decides what other services will be provided. The health center has a Medical Director and is staffed by a Nurse Practitioner or Physician Assistant who is qualified to provide medical care to children.

She noted that it was expedient that the school children have access to medical services so as to help control the prevalence of diseases. Some medical services include: Well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance.

2.11 Parent and Community Involvement

In their article, Maenpaa, and Astedt-Kurki, (2008) researched on the cooperation between pupils' parents and school nurses as an important part of health promotion in primary schools. The aim of the article was to report on parents' views on cooperation with school nurses in primary schools. The study was aimed at

contributing to school nurses' work so that instead of focusing only on the children, family nursing approaches could be improved. Six concepts describing parents' views on cooperation were generated on the basis of the data. They also found out that, cooperation consists of supporting the child's well-being. They also realized that parents are the initiators of cooperation within school health care and parents describe this by the concept of one-sided communication. They therefore concluded that parents do not know about school nurses' work and school health services. And that, they would like to be more involved in school nursing activities. The researchers hoped that when developing children's health services, parents' expertise in their children's well-being should be paid more attention.

A significant increase in the number of profoundly disabled children who require healthcare interventions may mean that school nursing services can no longer provide a direct service to facilitate each child's full access to the curriculum, especially support for out-of-school activities for children with complex medical needs. With the support of the Local Education Authority, education staffs in one area in England were trained by school nurses to undertake a number of healthcare interventions. This training program is underway and is proving to be effective: pupils have been able to go out of school and have had their varying healthcare needs met by education staffs that have been assessed as competent in their care. This can be seen as a good example of inter-agency collaboration in an effort to provide a needs-led, seamless service.

In their work, Cornwell, (2017) sought to find out whether the Coordinated School Health Programs (CSHPs) bring together educational and community resources in the school environment. The Straford school had began a multi-year CSHPS development process, which required adaptations for implementation in a

rural area. A CSHPS team was formed of community and administrative stakeholders as well as school system representatives. They assessed school demographics so the program framework could target health needs. They eventually determined four priority areas for program development, as limited staff and funds precluded developing programs in all traditional CSHPS areas.

The program outcomes were supported by School Health Index (SHI) data. Of the 8 CSHP focus areas, the SHI found high scores in 3 of the Stafford CSHP's priority areas: Health Services; Psychological, Counseling, and Social Services; and Physical Education. The fourth Stafford CSHP priority area, Nutrition Services, scored similarly to the less prioritized areas. They therefore concluded that the process by which the Stafford school district modified and implemented CSHP methods can serve as a model for CSHPs in other rural, high-need areas. Such a procedure could also be implemented in Ghana to enhance the areas of priority that the School Health Program could be aim at improving the health of pupils.
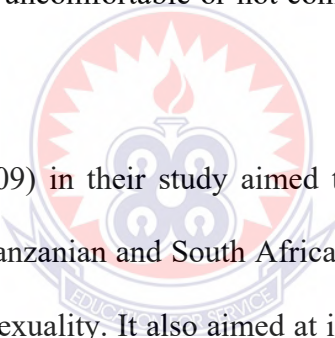
2.12 Challenges associated with School Health Education Program

Sexual and reproductive health education has proven to be beneficial to the health of adolescents, hence its promotion in schools. However, certain factors and situations have been identified as hindrances to the effectiveness of SHEP education in schools. Some of these hindrances are the absence of confidence in teaching the topic, shyness, and also the absence of teaching and learning materials (TLMs). These factors or hindrances are further expounded in the subsequent sub headings.

2.12.1 Lack of confidence in teaching SHEP

How comfortable or confident teachers are in imparting knowledge on SHEP to adolescents is key to the amount of information adolescents receive to enable them

to be empowered to make informed decisions about their SHEP. Many studies have been conducted to investigate how true this assertion is. For instance, Kibombo et al. (2008) in their research to investigate adult adolescent communication on issues related to sexual and reproductive health from adults' perspectives found, among other things, that teachers were not comfortable or confident in teaching students SHEP. This was because it conflicted with their tradition, which was not in support of public discussions of sex. This is not surprising, as this revelation was made in a rural community where it is believed, inhabitants find discussion on sexual issues to be unacceptable. In urban settings, people are likely to be found to be more open to new approaches to dealing with issues. However, the above mentioned research is not proof that all teachers are uncomfortable or not confident in teaching SHEP topics to adolescents.

Helleve et al. (2009) in their study aimed to investigate how confident and comfortable teachers in Tanzanian and South African urban and rural schools were in teaching HIV/AIDS and sexuality. It also aimed at identifying factors associated with teacher confidence, such as gender, age, years of teaching and religion. The study also investigated how the confidence reported by teachers influenced the implementation of HIV/AIDS and sexuality educational programmes. The outcome of this study was that teachers were fairly confident in teaching HIV/AIDS and sexuality. The finding of the study was more general, as it was not clear if the teachers' confidence was specific to their provision of HIV/AIDS education or other subjects in general. Another study supporting the findings of Helleve et al. (2009) is the research conducted by Ahmed et al. (2006) to describe the knowledge, skills and confidence of teachers after undergoing an HIV education program. It was revealed that teachers reported being confident to impart SRH knowledge to their students. Again, the

teachers' reported confidence in the study by Ahmed et al. (2006) could have been as a result of the training the teachers received. Thus, the self-reported confidence of teachers who had not undergone the training was not included.

2.12.2 Shyness of students as an influence on teachers' lack of confidence

Shyness on the part of students can sometimes disrupt the teaching of SHEP. For some teachers, when the students seem to be shy in the reproductive health class, they tend to be uncomfortable teaching them and this may lead to skipping or abandoning some important topics which may be very sensitive but beneficial to the students. For instance, Kibombo et al. (2008) found among other things that when teachers are imparting lessons on SHEP, some of the students tend to be shy or become shocked that their teacher who they hold in such high esteem could be talking with them matters of SHEP.

Similarly, Herman, Ovuga , Mshilla, Ojara, Kimbugwe, Adrawa and Mahuro (2013) found that in Gulu District, Northern Uganda, a major barrier to SHEP education was students feeling shy to learn about SHEP from their teachers. A possible implication of the students being shy in an SHEP class is that they would not be able to ask questions when they need to get their thoughts clarified, thereby contributing to the ineffectiveness of the SHEP education.

2.12.3 Inadequate teaching and learning materials (TLMs)

In the process of education, certain facilities are necessary to ensure effective teaching and learning. Among these are adequate facilities such as shelter, furniture, and materials such as books and other learning aids. Bilinga and Mabula (2014) in their study on the challenges and implications of teaching sexuality education in primary schools in Tanzania found that unavailability of learning facilities hindered

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effective teaching of SHEP to students. Other studies conducted in the field of SHEP education have also shown similar results.

In Kibombo et al. (2008) and Hashimoto et al. (2012) teachers reported that among the challenges they faced with SHEP education was lack of relevant supplies such as condoms and dummy penises, insufficient materials and information needed for effective impartation of knowledge. TLMs help to demonstrate to students how these items look like and also how they are used. There is no doubt that appropriate teaching and learning materials when available will facilitate the effective delivery of the SHEP education to students; hence, they must be supplied to schools.

2.12.4 Time Constraints

In Ghana, the SHEP topic is taught under the umbrella of Integrated Science subject and also in the Social Studies subject. It lasts approximately for five weeks in the school term. Considering the benefits of the SHEP education to the health and wellbeing of adolescents, this time may be regarded as inadequate to enable teachers effectively impart knowledge on SHEP matters to the students. Hashimoto et al. (2012) found that in Japan, the time allocated for SHEP education in school was minimal, that is about three hours for the whole school year, compared to other countries such as Finland, which allocates about 17 hours.

Thus, in some studies, participants asked for the duration for the SHEP topic to be extended. For instance, in a study by Smith (2011), it was recommended that SHEP education should be taught earlier than it is normally done, so that teachers and students will be able to spend more time imparting and receiving SHEP information respectively. Time constraints are an important factor that affects the content and

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depth of SHEP education. Thus, adequate time needs to be allocated for SHEP education, in order for all the contents to be covered.

In another research, due to time limitations, the content of stand-alone SHEP programmes or those that were built into broader programmes or subjects, as in the case of Ghana, had to be reduced to ensure that such courses were treated during the allocated time (Ott, Rouse, Resseguie, Smith & Wood cox, 2011). Beginning SHEP education before students reach pubescence or initiate sexual activity will be more useful in helping to reduce the incidence of teenage pregnancies and the possible contracting of STIs and it will also enable teachers to adequately treat each aspect of the SHEP topic without having to rush through the topic. From the literature reviewed in this section, there is indication that some contributions have been made to SHEP knowledge. Thus, various authors have provided knowledge on the benefits of SHEP education to adolescents, as well as some socio-cultural factors that affect SHEP education.
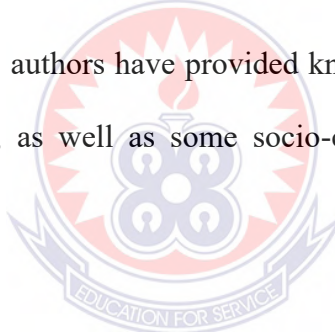
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter provides the methodology employed for the study. It consists of the research design, population, sample and sampling techniques, data collection instrument, pilot testing validity and reliability of the instrument, data collection procedure, data analysis procedure and ethical consideration.

3.1 Research Design

Creswell (2012), described research design as the overall strategy that one chooses to integrate the different components of the study in a coherent and logical way, thereby, ensuring the research problem is addressed effectively. It constitutes the blueprint for the collection, measurement, and analysis of data. Further, in the view of Welman et al (2009), research design is the overall plan, according to which the respondents of a proposed study are selected, data collection procedure and how the data are analysed. LoBiondo-Wood and Haber (1998) indicated that selecting a good research design should be guided by an overarching consideration, namely whether the design does the best possible job of providing trustworthy answers to the research questions. To achieve the research objectives and to address the research problem the researcher adopted the descriptive survey design using the quantitative approach. According to Robson (2002) descriptive research is aimed at seeking new insights or assessing phenomena in a new light. Gay and Airasian (2003) indicated that descriptive survey design is concerned with conditions that exist, practices that prevail, beliefs and attitude that are held, processes that are on-going and trends that are developing. Therefore descriptive survey design was considered appropriate for

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the study because the researcher wanted to find out the views and opinions of teachers and head teachers about the challenges associated with the implementation of the SHEP program in their schools, therefore making descriptive survey the propitious research design to use. Again, this design was selected because of its high degree of representativeness and the ease in which a researcher could obtain the participants' opinion (Polit & Beck 2004).

Like any other research design, the descriptive survey has its own strengths and weaknesses. The major strength for using the descriptive design is the fact that it provides researchers with a lot of information from various respondents and the data collected are easy to analyze, (Maxwell, 1998). Conversely, descriptive survey design is not without weaknesses. One of such weakness is difficulty in retrieving all questionnaires that have been administered to respondents. Again, it fails to capture the values, beliefs, reaction of people in their specific and accurate forms.

Quantitative approach on the other hand was considered appropriate for this study because of the fact that, it has an advantage of saving time and resources. In the view of Bryman, (2001), quantitative research approach is the research that places emphasis on numbers and figures in the collection and analysis of data. Imperatively, quantitative research approach can be seen as being scientific in nature. The use of statistical data for the research descriptions and analysis reduces the time and effort which the researcher would have invested in describing his/her result.

3.2 Population of the Study

Population is a group of individuals or people with the same characteristics and in whom the researcher is interested (Kusi, 2014). Babbie (2007) also describes the population of a study as that group of people regarding whom we want to draw

conclusions. In like manner, Gay and Airasian (2003) defined population as the group of concern to the researcher, the group to which the outcome of the study will be preferably generalised. That is any group of individuals that have one or more characteristics that are of the interest to the investigator. A target population is the total sum of members of the real population or a set of people, events or objects to which a research wishes to generalize the results of the study (Borg & Gall, 2007). The target population of the study consisted of all 282 teachers and head teachers in Public Basic Schools in the Ejisu Circuit.

Kusi (2012) defines sample as a subset of the population of interest, it is the chosen group of all the subjects of the population that the researcher wishes to know more about. Further, Gall and Borg (2007) defined sampling as a technique used for selecting a given number of subjects from a target population as a representative of the population in research. The sample technique used for the study was census sampling technique. According to Creswell (2005) census sampling is used when all members of the population are studied and this ensures a better coverage than sample surveys. In this study the census sampling was considered appropriate because the population was not vast, not equal as well as heterogeneous and due to the level of accuracy the study seeks to achieve. There was also enough time for the researcher to engage in this technique to collect the data. To this regard, all the two hundred and eighty-two (282) teachers and head teachers in the Ejisu Circuit were used for the study. Out of the two hundred and eighty- two (282) participants, fifteen (15) were head teachers and two- hundred and sixty-seven (267) were teachers.

3.4. Data Collection Instrument

A research tool is a specific mechanism or strategy, the researcher uses to collect, manipulate, or interpret data (Leedy & Ormrod, 2005)**.** The researcher used questionnaire as the data collection instrument for the study. White (2005), described questionnaires as instrument designed to collect data for decision making in research. A questionnaire can also be described as a systematic compilation of questions that are administered to a sample of a population in research. The questionnaire was a self-administered, designed by the researcher on a 4-point Likert scale of 4= Strongly Agree, 3 = Agree, 2 = Disagree, 1= Strongly Disagree. Section 'A' of the questionnaire gathers data on the demographic characteristics of respondents, Section B, dealt with the physical state of schools that practice SHEP, Section C sought to find out the roles played by SHEP coordinators towards the effective implementation of the program. Section D looked at the influence of SHEP on the health needs of students whereas section E dealt with the challenges associated with the implementation of SHEP in Ejisu Circuit. Questionnaire was selected as the main instrument because they are easy to administer, often most efficient, less time consuming and cost- effective research tool. Questionnaire also provides a high degree of respondent's objectivity and also enhances easy processing of responses (Bell, 2005).The close-ended questionnaire type was also meant to assist respondents to provide uniformity of response. One major disadvantage of questionnaire is difficulty in retrieving all questionnaires administered to respondents (Bell, 2005)

3.5 Pilot Testing

A pilot study was conducted at Bonwire M/A basic school before the actual data collection was done. This was done to ascertain the validity and the reliability of the

questions. According to Orodho (2009), validity is concerned with establishing whether the instrument content is measuring what it is supposed to measure. To determine the validity of the instrument the prepared questionnaires were given to 25 teachers in the school to respond to, this was to find out if the instrument was serving its purpose. The responses from the teachers and head teachers helped the researcher to modify some questions to suit the research objectives. Reliability on the other hand refers to the degree of consistency with which an instrument measures the attribute designed to measure (Polit & Hungler, 1999). In a similar manner, Leedy and Ormrod (2005) define reliability as the measure of the degree to which a research instrument yields consistent results or data after repeated trials. If a study results will be reliable, then it implies that it can be replicated somewhere else given the same method. Hence the pilot study was done to determine the clarity and consistency of responses of teachers who were not part of the actual research. The test re-test method was used to determine the reliability of the instrument. The questionnaire was administered to the same group of respondents twice in the pilot study with a two weeks grace period between the first and the second test. The completed data from the piloted questionnaire yielded similar responses. This was subjected to the Cronbach's Alpha reliability analysis, and reliability coefficient (r) of 0.821 was obtained. This indicated that the instrument was highly reliable (Fraenkel & Wallen, 2009).

3.6 Data Collection Procedure

The researcher presented an introductory letter approving the research work from the Department of Educational Leadership of Akenten Appiah Menka University of Skills Training and Entrepreneurial Development to seek permission from Ejisu Municipal Education Office to conduct the study. The Education officer then

introduced the researcher to the head teachers of the various schools. The head teachers also introduced the researcher to the teachers and days were set aside for the data to be collected. The researcher then visited the various schools and homes of the teachers who were not available in schools on the approved dates and briefed the sampled population about the study after which the questionnaires were administered. The whole data collection took four weeks. However, an extension of one week was given to participants who could not complete the questionnaire to do so. Out of the 282 questionnaires distributed, 274 were retrieved given a response rate of 97%. According to Bowling (2004), a response rate of 75% is good in Social Science research, though he admits that the higher the response rate, the better the analysis.

3.9 Data Analysis Procedure

Data analysis is defined as all the statistical procedures or methods that simultaneously examine data collected on each individual, object, and institution under investigation through research. Leedy and Ormrod (2005) explain the analysis of data to be the conscious efforts of which researchers rigorously process raw facts and figures to make meaning and interpret such findings. Analysis of data implies the procedure of reducing or splitting large data to make sense out of them. Leedy and Ormrod (2005) argues that data analysis goes through three facets; organization of data, reduction of data by summarizing and finally categorizing and linking them up to make meaning. The data collected were edited to check contradictions to ensure consistency. Edited responses were then computed and analyzed using the Statistical Package for Social Science (SPSS) version 20.0. The data were analyzed descriptively and presented in tables, frequencies and percentages based on the research questions.

The analysis was precise descriptions, clear and comprehensible for conclusions to be drawn to achieve the expected results.

3.8 Ethical Considerations

The researcher in no way forced the respondents to participate in the study. The respondents took part in the study on their own wish. The researcher explained the purpose of the study personally to respondents. The confidentiality of the information collected from respondents was considered by ensuring that their names and other information that could bring out their identities were not disclosed in the questionnaire used to collect data for the study. Respondents were given the freedom to opt out if they wish to do so. The respondents were further assured of confidentiality of the information provided and that the information they would be given would be used for academic purposes only.
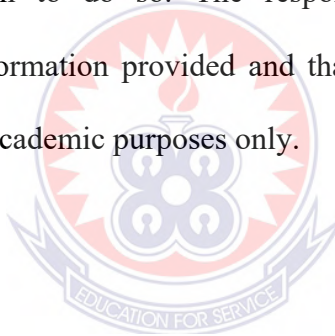
CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.0 Introduction

This chapter presents the findings, interpretations and discussion according to the objectives and research questions. The results from the field and the relevant sources were organized into tables, in order to bring out a more logical and meaningful image from the data gathered by the researcher. Data was then analyzed and interpreted which helped the researcher relate the research objectives with the assumptions and the reality on the ground as well. Discussion related to the data was provided in this chapter as well.

4.1 Demographic Profile of the Respondents

The tables below throws light on the demographic profile of the respondents who took part in the study.

Table 4.1: Gender of Respondents

Gender	Frequency	Percent (%)
Female	134	49
Male	140	51
Total	274	100

Source: Field Data, 2020

Table 4.1.1 displays the results on gender distributions of the respondents of the study. From the table, 140 of the total respondents were males representing 51% whilst 134 out of the total respondents representing 49% were females. These figures show that, even though equal chance were given to the respondents, males dominated in the contribution of information in this study. This simply means more males

participated in the study than females. The study however was not biased in terms of gender as just a little higher number of males exceeded that of the males, which implies that the female views were also added.

Table 4.1.2: Age of Respondents

Age	No. of Teachers & Head teachers	(%)
20-30	52	19
31-35	78	28
36-40	82	30
Above 40	62	23
Total	274	100

Source: Field Data, 2020

On the age of the respondents most of the respondents 82(30%) were between the ages of 36 and 40 years, 78(28%) of the respondents were between the ages of 31 and 35 years 62 (28%) of the respondents were above 40 whereas 52(19%) were between 20 and 30 years. This result therefore indicates that most of the teachers in the study areas are relatively young and could participate immensely in the study.

Table 4.1.3: Qualification of Respondents

Qualification	Frequency	Percent (%)
Diploma	142	52
Bachelor's Degree	102	37
Master's Degree	30	11
Total	274	100

Source: Field Data, 2020

On respondents' academic qualification, majority of the respondent 142(52%) possessed Diploma certificate, 102(37%) of the respondents had bachelor's degree while 30(11%) of the respondents possessed the Master's degree. This result implies that all the respondents were seasoned professional head teachers who have the requisite professional certificates and experience to participate in the study.

Research Question One: What is the state of the physical environment of public basic schools that practice SHEP at Ejisu Circuit?

To answer research question one, respondents were ask to indicate the state of the physical environment of their schools. The responses provided by them are shown in the tables below.

Table 4.2.1 Compound of the School.

ITEM(S)	Frequency	Percentage
Location of the school		
Is the compound noisy		
Yes	45	16
No	218	80
Not sure	11	4
Total	**274**	**100**
Is the compound spacious?		
Yes	186	68
No	76	28
Not sure	12	**4**
Total	**274**	**100**
Is the compound dusty?		
Yes	158	58
No	94	34
Not sure	22	8
Total	**274**	**100**
Are there enough trees/ lawns		
Yes	168	61
	82	30
No	24	9
Not sure		
Total	**274**	**100**

Source: Field data, 2020

Table 4.2.1 shows that majority 218(80%) of the respondents affirmed that their schools are located in an area with little or no noise, few of the respondents 45(15%) indicated that their school is located in an area with a lot of noise, however 11(4%) of the respondents were not sure about this statement. This finding therefore indicates that public basic schools within Ejisu circuit are situated in an environment with no noise making it conducive for teaching and learning activities. Further, 186(58%) revealed that their school compound is spacious whilst 76(28%) of the

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respondents indicated otherwise, few of the respondents remain neutral about it. This finding indicates that public basic schools in Ejisu circuit have a spacious environment which is a positive sign of a healthy school environment. It was also impressive to find out that most schools with spacious compounds also had enough trees/lawns which constitute a good source of ventilation to students and staff. Ventilation is a natural disinfectant hence the compound and classrooms of the students must be airy in order to maintain hygienic respiration among the school children. However, the study revealed that the compound/playing grounds of most schools were found to be very dusty because the playing grounds were not cemented nor filled with gravels. This, therefore, poses both long and short term threat to the health of pupils who virtually spend a chunk of the day in school.

Table 4.2.2: Sanitary Facilities

ITEM(S)	Frequency	Percentage
Source of water for the children		
Pipe borne	94	34
Bore hole	88	32
Well	34	12
No source of water at the school premises	58	22
	274	**100**
Total		
Are toilet facilities accessible to pupils and staff?		
Yes	249	91
No	25	9
Not sure	0	
Total	**274**	**100**
Type of toilet facility is provided for the school		
KVIP	165	60
Pit Latrine	86	32
Water closet	23	8
Total	**274**	**100**
Are these facilities conducive to health and maintained well?		
Yes	62	23
No	198	72
Not sure	14	5
Total	**274**	**100**
Is there a functional urinal?		
Yes	210	77
No	64	23
Not sure	-	-
Total	**274**	**100**

Source: Field data, 2020

From table 4.2.2 the study revealed that the sources of water for the students at the study area were pipe borne (32%), borehole (32%), and well (12%). However 22% of the respondents indicated there was no source of water in the school premise for students and staff usage. This means that the probability that a pupil refuses to wash his/hers visiting attending to natures call is alarmingly very high. This is finding is in line with an assertion by Tierozie (2011) who indicated that schools that had boreholes, and wells as source of water for school children are usually not user

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friendly especially for the little children because of their inability to draw water on their own.

Greater percent of the respondents (91%) revealed that toilet facilities are accessible to pupils and staff. Adding that, the type of toilet facilities available were KVIP (60%), pit latrine (32%), and water closet (8%). The dominance of KVIP facility in the study area could be attributed to the fact that some schools immensely benefitted from the Highly Indebted Poor Country (HIPC) initiative of which Ghana was one of such countries.

Most of the respondents (72%) said that these facilities were not conducive to health and were not maintained well, which could pose a threat to the health of students and staff. This therefore implies that appropriate measures need to be taken to curb the menace of any outbreak of disease in schools in the study area. This finding therefore is in agreement with a study conducted by Keeton, Soleimanpour & Brindis, (2012). Finding from their study revealed that because of poor maintenance of toilet and urinal facilities in schools most pupils resulted to responding to natures call at different places other than the facilities provided for them. To them availability of health facilities as well as their accessibility to children is a very important aspect of the School Health Program.

Finally most of the respondents (77%) indicated that their schools had functional urinal for teachers and students, where as few of the respondents (23%) indicating otherwise. This finding means that public basic schools in the Ejisu circuit have urinal facilities operating in their schools.

Research Question Two: **What are the roles played by SHEP coordinators towards the effective implementation of SHEP in public basic schools in the Ejisu Circuit?**

The respondents were asked to agree or disagree on the following statements on the role played by SHEP coordinators towards effective implementation of the program in Ejisu public basic schools in Ejisu Circuit. The responses are indicated in table 4.

Table 4.3: Roles Performed by SHEP Coordinators in Public Basic Schools in Ejisu Circuit

Roles of SHEP Coordinators in Schools	Strongly Agree N (%)	Agree N (%)	Disagree N (%)	Strongly Disagree N(%)	Total N(%)
Organize orientation and training for teachers, students and food vendors on maintaining a healthy living	125(46)	98(36)	32(12)	19(7)	274(100)
Ensure that schools have functioning first aid boxes at all times	96(35)	90(33)	62(23)	26(9)	274(100)
Monitor activities of food vendors and ensure the use of iodated salt	97(35)	125(46)	30(11)	22(8)	274(100)
Assess the school environment and structures and report to the appropriate authority.	14(42)	98(36)	40(15)	22(8)	274(100)
Ensure the provision and maintenance of water and sanitation facilities in the school	49(18)	65(24)	82(30)	78(28)	274(100)
Organize school children/students for de worming and other health activities	108(39)	99(36)	38(14)	29(11)	274(100)

Source: Field data, 2020

Table 4.3 indicates that 125 representing 46% of the respondents strongly agreed that one of the roles performed by SHEP coordinators in schools is to organize orientation and training for teachers, students and food vendors on maintaining a healthy living, 98 of the respondents representing 36% also agreed to this assertion. However few of the respondent 12% and 7% disagreed and strongly disagreed to this statement. The result therefore implies that SHEP coordinators are charged with the responsibility of organizing training and orientation for teachers, students and other non teaching staff with the aim of promoting a healthy living. This finding is in agreement with the roles of SHEP coordinators that are clearly spelt out by in Ghana Education Service in SHEP handbook for teachers and students.

Further, most of the respondents 35% and 33% strongly agreed and agreed respectfully that SHEP coordinators are responsible for ensuring that schools have functioning first aid boxes at all times, however, 23% and 9% of the respondent disagreed and strongly disagreed to this assertion as been one of the roles performed by SHEP coordinators. The implication of this finding is that most teachers in public basic schools in the Ejisu Circuit believe that SHEP coordinators are suppose to make sure that there is the provision of first aid box in schools to minimize injury and future disability.

Moreover, when respondent were asked to indicate whether or not it is the responsibility of SHEP coordinators to monitor activities of food vendors and ensure the use of iodated salt , most of them were in agreement with this opinion as 35% and 46% of the respondent strongly agreed and agreed respectfully. Conversely, few of the respondents 19 % indicated otherwise. This finding concurs with an assertion made by Pate and O'Neill, (2007) According to them the American Heart Association

has issued a set of recommendations that, if implemented, would position schools as leaders in helping children and youth become more physically active, one of such recommendations was to make sure that meals that are served in schools are carefully monitored by Health coordinators to make school children are taking the right amount of nutritional balance.

Again, most of the respondents 42% and 36% strongly agreed and agreed respectfully that SHEP coordinators are responsible for assessing the school environment and structures to make sure they are in good shape and to report any problem to the appropriate authority. However, few of the respondents thus 15% and 8% disagreed and strongly disagreed to this statement. This therefore means SHEP coordinators are responsible for assessing the school structures and environment to make sure they are functioning well and report any irregularity to the appropriate authority. This finding confirms the roles of SHEP Coordinators as stated in SHEP handbook issued by the Ghana Education Service.

Further, respondents were asked to indicate their agreement or disagreement on whether SHEP Coordinators are responsible for ensuring the provision and maintenance of water and sanitation facilities in the school. Most of respondents thus 30% and 28% disagreed and strongly disagreed to the fact the SHEP coordinators are responsible for ensuring the provision of water and sanitation facilities in schools, however 18% and 24% of the respondents strongly agreed and agreed to this statement. The implication of this finding is that public basic school teachers in Ejisu Circuit do not see SHEP coordinators as those responsible for the provision of water and sanitation facilities in schools. Most teachers and stakeholders of education

believe that it is the responsibility of government through the district and municipal education directors to make such provisions.

Finally, majority of the respondent 39% and 36% strongly agreed and agreed respectfully that SHEP coordinators mobilize school children for de worming and other health related activities where as 14% and 11% disagreeing and strongly disagreeing to this opinion. This result means that SHEP coordinators are charged with the responsibility of organizing school children for de worming and other health related activities.

Research Question Three: What are the influences of SHEP on Students Health Needs and Welfare in Public Basic Schools in Ejisu Circuit?

To answer this research question, respondents were asked to indicate the extent to which they agree or disagree on the influence of SHEP on the health needs of students in public basic schools in the Ejisu circuit of the Ejisu Municipal. Their responses are indicated in table 4.4.
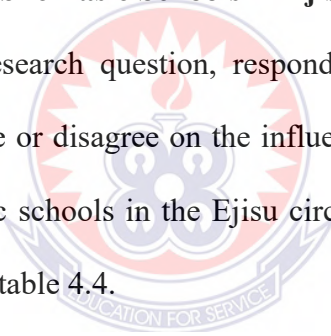
Research Question Three: What challenges militate against the implementation of SHEP in public basic schools in Ejisu Circuit.

To answer this research question, respondents were asked to indicate the extent to which they agree or disagree on the challenges associated with the implementation of SHEP in public basic schools in the Ejisu circuit of the Ejisu Municipal. The responses given by the participants are shown in table 4.4.

Table 4.4: Challenges Militating against the Implementation of SHEP in Public Basic Schools in Ejisu Circuit.

Challenges Associated with the Implementation of SHEP	Strongly Agree N (%)	Agree N (%)	Disagree N (%)	Strongly Disagree N(%)	Total
Inadequate funds to support SHEP healthy life style and the general physical health of students in	125(46)	102(37)	29(11)	18(7)	274(100)
Inadequate teaching and learning materials to support SHEP	122(45)	99(36)	33(12)	20(7)	274(100)
Lack of confidence in teaching topics under SHEP	119(43)	96(35)	41(15)	18(7)	274(100)
Lack of the requisite logistics to monitor and evaluate the program	120(44)	96(35)	37(14)	21(8)	274(100)
Shyness on the part of students.	105(38)	98(36)	47(17)	24(9)	274(100)
Inadequate time allotted for teaching SHEP topics	98(36)	92(34)	52(19)	32(12)	274(100)
Inadequate attention/apathy towards the implementation of the program	92(33)	98(36)	48(18)	36(13)	274(100)

Source: Field data 2020

Table 4.4 reveals the responses provided by participants who took part in the challenges militating against the implementation of SHEP. Result from the table shows that most of the respondents representing 46% and 37% strongly agreed and agreed respectfully that inadequate fund to support the program was one of the challenges that affect the effective implementation of SHEP, however of the respondent 18% were not in support of this statement. This finding is in agreement with a study conducted by Boateng (2008). The findings from his study revealed weak collaboration between implementers, inadequate funding, and inadequate support from the health sector among others as the main challenges affecting the school health program.

Again, majority of the respondents representing 45% and 36% strongly agreed and agreed respectfully that one of the challenges associated with the implementation of SHEP was inadequate teaching and learning materials, whereas 12% and 7% (disagreed and strongly disagreed) of the respondents opposed to this statement. It therefore implies that public basic school teachers in Ejisu circuit agree that inadequate teaching and learning materials constitute one of the challenges associated with the implementation of SHEP. This finding confirms that of Bilinga and Mabula (2014). In their study on the challenges and implications of teaching sexuality education in primary schools in Tanzania found that unavailability of learning facilities hindered effective teaching of SHEP to students.

Similarly a study by Kibombo et al. (2008) and Hashimoto et al. (2012) also reveals that teachers reported that among the challenges they faced with SHEP education was lack of relevant supplies such as condoms and dummy penises, insufficient materials and information needed for effective impartation of knowledge.

TLMs help to demonstrate to students how these items look like and also how they are used.

In addition, lack of confidence in teaching topics under SHEP was also revealed from the study as one of the challenges that affect the implementation of SHEP in public basic school in Ejisu circuit as majority of the respondent 43% and 35% strongly agreed and agreed to this statement. However few of the respondents (15% and 7% disagreed and strongly disagreed) were not in support of this statement. This finding is in contradiction to a study conducted by Ahmed et al. (2006). The focus of the study was to describe the knowledge, skills and confidence of teachers after undergoing an HIV and STIs education program to teach school children. It was revealed that teachers reported being confident to impart SRH knowledge to their students. Again, the confidence of the teachers after the study could have been as a result of the training the teachers received.

Further, 44% and 35% of the respondent strongly agreed and agreed respectfully that lack of the requisite logistics to monitor and evaluate the program was one of the challenges that affect SHEP. Contrary, 14% and 8% of the respondents disagreed and strongly disagreed to this assertion. This implies public basic schools in the Ejisu circuit do not have the requisite logistics to monitor and evaluate SHEP hence posing a challenge in its implementation.

Again, when respondent were asked to indicate the extent to which they agree or disagree to the fact that shyness on the part of students affects the smooth implementation of SHEP, majority of them 38% and 36% strongly agreed and agreed to the view that, indeed students gets shy when some topics under SHEP are been discussed and hence affect its smooth implementation. However some of the

respondents 17% and 9% disagreed and strongly disagreed to this statement. The result form this study is in agreement to a study conducted by Herman, Ovuga , Mshilla, Ojara, Kimbugwe, Adrawa and Mahuro (2013) in Gulu District, Northern Uganda. The study found that in, a major barrier to SHEP education was students feeling shy to learn about SHEP from their teachers. A possible implication of the students being shy in an SHEP class is that they would not be able to ask questions when they need to get their thoughts clarified, thereby contributing to the ineffectiveness of the SHEP education.

Furthermore, another challenge that the respondents agreed as militating against the implementation of SHEP in public basic school in Ejisu circuit was that the time allotted for teaching SHEP topics. Majority of the respondents 36% strongly agreed and 34% agreed to the statement.

However few of the respondents 19% and 12% disagreed and strongly disagreed respectfully to this statement and that they do not see this as a challenge that can affect the implementation of SHEP. This finding confirm a study by Hashimoto et al. (2012).The study found out that in Japan, the time allocated for SHEP education in school was minimal, that is about three hours for the whole school year, compared to other countries such as Finland, which allocates about 17 hours.

Finally, 33% and 36% of the respondents strongly agreed and agreed respectfully that inadequate attention and apathy towards the implementation of the program has become one of the challenges that affect SHEP implementation; however 18% and 13% of the respondent disagreed and strongly disagreed to this statement.

This finding therefore implies that public basic school teachers in Ejisu circuit perceive apathy and inadequate attention as a challenge militating against SHEP.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

5.0 Introduction

This final chapter summaries the findings and concludes the study. It then ends with recommendations of the study, supporting the main objective of the study which aims to discover the challenges affecting the implementation of School Health Education Program in Public Basic Schools in the Ejisu Circuit.

5.1 Summary of the study

The purpose of this study was to find out the challenges that militate against the effective implementation of SHEP in public basic schools in Ejisu Circuit. The specific objectives of the study were to find out the state of physical environment of schools that practice SHEP, the roles of SHEP coordinators in schools, the influence of SHEP on the health needs and welfare of students and lastly to find out the challenges that affect SHEP implementation. Descriptive survey design using the quantitative approach was employed for the study. Census sampling technique was used to select a sample size of two hundred and seventy-four (274) respondents for the study. Questionnaire was used to collect data for the study. The data from the study were analyzed descriptively and presented in tables, frequencies and percentages based on the research questions. The analysis was precise descriptions, clear and comprehensible for conclusions to be drawn to achieve the expected results.

The findings of the study revealed that the location and compound of the schools were conducive as most schools were situated in an environment with less noise and spacious environment, most schools also had adequate trees and lawns that provide adequate ventilation , however the toilet and urinal facilities provided for the

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school children were not in the best of conditions as of the time the research was carried , as these facilities were poorly maintained posing a threat to the health of teachers and students. Again, the study revealed the following as the roles and responsibilities performed by SHEP coordinators that are appointed in various schools ; organize orientation and training for students and staff on healthy life style, monitor food vendor in the school, make provision for functional first aid box, organize students for de worming exercise among other roles. Further, the study revealed that SHEP has a positive influence on the health needs and welfare of students, thus schools that practice SHEP equip students with knowledge on the importance of healthy lifestyle, prevent and reduce health problems of students in their school environment, SHEP reduce misinformation on STIs and strengthen positive values and attitude among students and finally SHEP empowers students to become an agents of change for their families and communities at large. Finally the study revealed the following as challenges that affects the implementation of SHEP in public basic schools in the Ejisu circuit: inadequate funds to support SHEP, inadequate teaching and learning materials to support SHEP, lack of confidence in teaching topics under SHEP, shyness on the part of students, inadequate time allotted for teaching SHEP topics among other factors.

5.2 Conclusion

Based on the objectives and findings for this study, several conclusions have been made.

Successive governments have made laudable progress on improving provision of basic health and education services, spurred by strong aspirations for inclusive national development. Under the SHEP, Ghana has committed not only to expand

these achievements but also to 'leave no one behind' in doing so. However, as this study shows, there are several twists to this tale of progress, suggesting that urgent reforms are needed in the design and resourcing of some key health and education policies if this commitment is to be met.

It can be concluded from the study that public basic schools in Ejisu circuit are located in spacious and less noisy environment; however the toilet and urinal facilities provided for students are not in the best of shape and conditions.

Again, it can be concluded from the findings of the study that SHEP coordinators at public basic schools in Ejisu circuit perform the following roles and responsibilities; organization of orientation and training for students and staff on how to lead a healthy life style, monitor food vendors in the school, make provision for first aid box, organize students for de worming exercise and ensure the provision and maintenance of water and sanitation facilities in the school.

It can further be concluded form the study that SHEP has a positive influence on the health needs and welfare of public basic school students in Ejisu Circuit, this is because SHEP equip students with knowledge on the importance of healthy lifestyle; prevent and reduce health problems of students in their school environment; reduce misinformation on STIs among students and finally empowers students to become an agents of change for their families and communities at large.

Finally, the study conclude that public basic schools in Ejisu circuit are confronted with some challenges as far as the implementation of SHEP is concern, the challenges include: inadequate funds to support SHEP; inadequate teaching and learning materials to support; lack of confidence in teaching topics under SHEP;

students feeling shy for some topics under SHEP topics; and inadequate time allotted for teaching SHEP topics.

5.3 Recommendations

The following recommendations are made based on the conclusions of the study

1. The Ghana Education Service (GES) should make available copies of the SHEP guidelines in all Regional, Metropolitan, Municipal, District Offices as well as schools so as to make it handy for teachers and students who are the owners of the program.

2. Government of Ghana through Ghana Education Service should make funds available to help support the program, it is acceptable that agencies could help fund the program but the main source of funding should be made clear and there should be some kind of consistency in the release of funds for SHEP implementation.

3. With regard to inadequate teaching and learning materials, it is recommended that the Government of Ghana through GES should supply schools with teaching and learning aids in the form of books, diagrams, educative videos on SHEP, condoms and sanitary pads which will be used for practical teaching. The availability of these TLMs for illustrations will also enable students to get a clear and vivid picture of what they are being taught in school. Also, when pictures and images are formed in their memories, they are more likely to live a healthy sexual and reproductive life, which they can in turn teach their children.

4. Since it is in the power of the Local Government to ensure that the physical infrastructure of schools are in good shape, the office of the Environmental Health should be adequately staffed and well equipped to facilitate routine checks on schools.

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APPENDIX A

QUESTIONNAIRE FOR RESPONDENTS

My name is Joana Amoah a postgraduate programme (Master of Arts in Educational Leadership). This questionnaire is therefore to help me complete a project work intended to explore the challenges associated implementation of School Health Education Program (SHEP) in Public Basic Schools in Ejisu Circuit. Your name and school are NOT to be disclosed here as the study is purely for academic purposes and your identity is highly confidential. Thanks for your co-operation.

Please (√) tick the most appropriate response. Your Confidentiality is ASSURED

SECTION A: **Demographic Information**

1. Gender :

   Female [   ]

   Male [   ]

2. Age:

   21-30 [   ]

   31-40 [   ]

   41-50 [   ]

   51-60   ]

3. Educational Qualification:

Diploma/HND [   ]

Bachelor Degree[   ]

Masters Degree [   ]

SECTION B: Physical Environment of Schools that practice SHEP in Public Basic Schools in Ejisu Circuit.

Tick the appropriate option that corresponds with your answer to the following questions on the state of physical environment in your school. Respond with options 1 = Yes   2= No 3=Not sure

	Compound of the School	Yes	No	Not sure
1	Is the compound noisy			
2	Is the compound spacious			
3	Is the compound dusty			
4	Are there enough trees/ lawns			
	Sanitary Facilities			
5	What is the source of water for the children			
	a. Pipe borne water			
	b. Bore hole			
	c. Well			
	d. No source of water			
6	Are toilet facilities accessible to school children and staff			
7	What type of toilet facility is provided for the school a. KVIP b. Pit Latrine c. Water closet			
8	Are these facilities conducive and well maintained?			
9	Is the urinal separate from the toilet facility			

SECTION C: Roles played by SHEP coordinators towards the effective implementation of SHEP in public basic schools in the Ejisu Circuit.

Tick the appropriate option that corresponds with your answer on the roles played by SHEP Coordinators in your school. Respond with 1= Strongly agree, 2=Agree, 3 = Disagree, 4 = Strongly Disagree.

	Roles of SHEP Coordinators	SA	A	D	SD
1.	Organize orientation and training for teachers, students and food vendors on maintaining a healthy living				
2.	Ensure that schools have functioning first aid boxes at all times				
3.	Monitor activities of food vendors and ensure the use of iodated salt				
4	Assess the school environment and structures and report to the appropriate authority				
5	Ensure the provision and maintenance of water and sanitation facilities in the school				
6	Organize school children for de worming and other health activities				

SECTION E: Challenges associated with the implementation of School Health Education Program in Public Basic Schools in Ejisu Circuit.

Tick the appropriate option that corresponds with your answer on the challenges associated with the implementation of SHEP in your school. Respond with 1= Strongly agree, 2=Agree, 3 = Disagree, 4 = Strongly Disagree

	Challenges associated with SHEP Implementation	SA	A	D	SD
1.	Inadequate funds for the program				
2.	Inadequate teaching and learning materials				
3.	Lack of confidence in teaching topics under SHEP				
4	Lack of the requisite logistics to monitor and evaluate the program				
5.	Shyness on the part of students				
6	Inadequate time allotted for teaching SHEP topics				
7	Inadequate attention/apathy towards the implementation of the program				

Thanks for your cooperation