# PERCEIVED HEALTH CONCERNS AND CARE SEEKING BEHAVIOUR OF SECONDARY SCHOOL STUDENTS IN THE CROSS RIVER STATE

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DEDICATED TO

MY HUSBAND - JOE AND

MY CHILDREN - EKEM, USILF AND EDIDIONG

WHO BORE MY ABSENCE WITH PATIENCE

# C E R T I F I C A T I O N

We certify that this work was carried out by Maria J. Okure in the Department of Preventive and Social Medicine, University of Ibadan, Ibadan.

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# A B S T R A C T

This study of the secondary school students' perceived health concerns and their care seeking behaviour was conducted in the Cross River State over a six-months period.

Interviews were conducted among 600 secondary school youths aged 13 to 18 years, randomly selected from 10 secondary schools in Uyo Local Government area.

The findings of the study indicated that although the students presented with numerous perceived health problems such as malaria related problems, abdominal pains, eye problems, there were generally no health facilities in their schools with which these problems might be solved. The students therefore sought health care from the available health institutions outside the schools. These institutions include hospitals and private clinics, chemist/patent medicine stores, traditional healers and spiritual healing homes.

Most respondents considered finance as the most important factor when seeking health care. Thus, the following recommendations were made by the researcher:

(a) provision of adequately equipped first aid boxes for all secondary schools;

(b) compulsory health education course for all secondary school students;

(c) an urgent review of the present health education curriculum to reflect the needs of the secondary school students;

(d) provision of health counselling services for the secondary school students in order to assist in the solution of their health problems;

(e) environmental modification to protect the students from mosquito bites and epidemics of communicable diseases;

(f) provision of a school dispensary with trained personnel in every school to cater for the students' health needs;

(g) health education of the parents and teachers.

It is hoped that the findings of this study will be useful to those responsible for improving the delivery of health care services for students in the secondary school.

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# INTRODUCTION

## HISTORICAL PERSPECTIVE

As early as 1779, Johann Peter Frank, a German physician, had published four volumes of a work in Mannheim, entitled "System einer volistandingen medicinische polizey" - (Datzel - Ward 1976). Frank advocated the supervision of the health of school children, laid down programmes for school meals and specifications for school furniture and also urged the instruction of boys and girls in hygiene, including sexual hygiene (Datzel Ward 1976) Regular medical inspection was an important part of the programme. Frank's thinking is significant in that it was the first declaration that the health of school children should be included as part of the education process. The idea that children's health should be part of the responsibility of a school has been accepted only in recent times. The idea that prevention of illness and the promotion of health and general well-being could be achieved partly by what is termed 'health education,' has been accepted even more recently.

It is remarkable that Frank could have had such ideas at a time when the scientific, economic, social and political scene was so under-developed that such ideas could not have been put into effect.

Investment in state education had not yet begun in most countries in Europe - the small kingdoms of the German States being a notable exception.

There was a long lapse between Frank's treatise and the setting up of the school health service in 1907.

In the United States, the school health programme dates as far back as 1896 when the school physicians first appeared on the school scene (Cromwell, 1963). They were hired to assist in the control of communicable diseases among pupils and to exclude those infected from the school. In 1902, public health nurses in New York City began to take note of many children wandering around the streets who should have been in school. Most of these children were not acutely ill but rather suffered from one or more of what were known as "nuisance diseases." At the request of the nurses, Miss Lillian Ward of Henry Street, Nureing Association, persuaded the Commissioner of Health to allow her put a nurse in one school district to demonstrate what might be done by a nureing follow-up of these excluded children.

Miss Lina Rogers began a month demonstration programme on November 7, 1902, and the success of the venture was so immediately impressive that on December 12, 1903, the Commissioner of Health appointed twenty-five (25) nurses to work in the various schools of the City (Ibid).

In the United Kingdom, the prevention of diseases in school children has been the concern of all branches of health services, but special arrangements were made under the Education Act 1944 to safe-guard the health of children at School (Davis - 1978). Each Area Health Authority must organize a comprehensive range of integrated

health services for children including a school health service run in conjunction with the relevant local education authority.

In Nigeria, the first school services was instituted in Lagos (Oduntan, 1973). Starting with a small school clinic, the service has steadily grown and in 1971, had eleven established centres catering for a total of 134,349 children (Annual Reports, Lagos City Council, 1971). The Lagos programme is the most highly developed school health service in the country (Oduntan, op. cit.). Special school health services have also been organized in some other Nigerian cities and towns such as Ibadan, Aba, Benin, Enugu and Zaria.

These services have a school clinic which provides simple treatment for minor ailments, and also some form of periodic medical examination of school children. Mostly, the services are given by nurses under the supervision of medical officers of health.

In the Cross River State, the school Health Services began in 1976* with special training organized for staff nurses and auxiliaries at the State School of Health Technology. These nurses then function in the School Health Services Unit of the Ministry of Health providing care mainly for Elementary School children.

As at the time of this study, there were only three zonal school Health Services Units in the State located at Uyo, Calabar and Abak

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*Information obtained from an interview with the Health Sister of Uyo School Health Unit.

with one school Health Doctor supervising the whole State. Uyo Zonal Office is managed by a Health Sister with fourteen (14) staff nurses and health auxilliaries who function mainly in the Elementary Schools. During an interview with the Health Sister, she regretted their inability to extend their services to the Secondary Schools because of poor staffing of the Unit and lack of facilities such as drugs, transport and other equipment. But she pointed out that "if a sick secondary school student reports at our Unit, we do not send him back to school untreated."

None of the ten secondary schools visited by the researcher, possesses an organized clinic or any system of special care for the children. Therefore, it does appear that high school children are left to receive medical care at the available facilities such as health centres, spiritual Healing Homes, patent medicine stores, hospital, etc.

This study therefore affords an opportunity to review what health facilities are available in the high schools in Uyo Local Government Area, to determine exactly how the students' health problems are solved, the factors which influence their decisions and what decisions are finally taken.

## THE NATURE AND EXTENT OF THE PROBLEM

What do Secondary School Students view as their major health concerns? How do they seek health care?

Most people generally have felt concerned about health problems presented by secondary school students, for example, smoking, drug abuse and alcoholism. They are also concerned with the means of dealing with these problems. But very little consideration has been given to their general health concerns, health behaviour and attitudes and their medical care needs.

Particularly lacking, is information about how secondary school students seek health care or how they take decisions to meet their health needs in the Nigerian community where many still live in abject poverty and where medical facilities are in many cases non-existent.

Yet Nigeria continues to witness a steady rise in the population of its secondary school students. For example, the projected students population in the Nigerian Secondary Schools for 1983 was 0.45 million (Federal Ministry of Economic Planning, 1975). The projected figure for the 1975-80 plan period was 1.6 millions. For the 1980-81 period, the Cross River State had a total enrolment of 113,991 students in

its secondary institutions. Because no previous systematic study has been carried out in this area of how secondary school students seek health care, this study is conducted to gain an insight into how the students' health problems are solved.

The study was conducted in Uyo Local Government Area of the Cross River State. Uyo Local Government Area is unique for this survey because apart from being the second most developed urban area, it has the highest number of post-primary institutions in the Cross River State. Other reasons which contributed to the choice of this setting include:

(a) Boarding Facilities - The Cross River State still operates Boarding schools in its post-primary institutions. Thus, the researcher felt that a study of this type might elicit more interesting responses from these Boarding schools.

(b) Day Schools - Even the Day Schools which are operational in Uyo in the Cross River State are such, that a great number of the day students in the Cross River State come from distant villages and towns to live with guardians or fellow students or alone in rented accommodations near the school compound.

Some students however, come to school directly from their homes.

(c) Uyo possesses no Government hospital which could cater adequately for the students' health problems.

(d) Free Treatment - There is no free treatment of any kind for the high school students in the Cross River State as at the period of study. The State Government used to pay for the students' treatment at the two existing Mission Hospitals in Uyo Local Government Area. But according to the Principal of one of the secondary schools, "this privilege was withdrawn three years ago," probably because of austerity!

## .4 THE SETTING

The Cross River State lies wholly within the Cross River Basin, between latitudes 7°.15' 9°.30' East. (Ministry of Information, Calabar, 1973).

The State has an area of 28,900 sq. kg. and shares common boundaries with Cameroon Republic on the East, Benue and Plateau States on the North, Imo and Rivers States on the West, and the Bight of Biafra to the South.

### 3.4.1. Climate

The climate is mostly tropical except on the Obudu Plateau (152,395 m. above sea level) where, due to altitude, it is temperate throughout the year.

The coastal areas have an annual rainfall of approximately 140 inches while in the hinterland, it ranges from 1,520mm - 2,432mm. There are two seasons: the rainy season which begins in May and ends in October, and the dry season lasting from November to April.

3.4.2. It's people

The people of the Cross River State were among the first people to imigrate from East and Central Africa, to this country country.

There are three major othnic groups - Efik/Ibibio/Annang - to the South of the State, the Ejagham and the Ekoi to the North.

3.4.3. Population

The population of the State according to the 1963 Census figures, is 3,633,593. More than 90% of this population live in the rural areas as farmers, fishermen and craftsment. According to the 1963 census, Calabar had a population of 243,105 and Uyo had 296,822.

3.4.4. Divisions

The Cross River State after its creation in 1973, was divided into fourteen divisions each of which was headed by a Senior Divisional Officer. With the emergence of Local Government, 17 Local Government Areas were created in 1979 (See Map on Appendix C)

3.4.5. Education

The State has a total of nineteen (19) Nursery and International Primary School with an enrolment of over 6,005 pupils (Education Statistics, 1980-81). The existing 1,656 Primary Schools have a total enrolment of 808,825 pupils with 23,264 teachers. There are 291 secondary educational institutions with a total enrolment of 113,991 students (Education Statitics, 1980-81).

Uyo, which is one of the seventeen (17) Local Government areas with seven (7) sub-divisions, has a total enrolment of 11,679 students in its thirty-five (35) secondary institutions.

3.4.6. Health

There are about thirty-five (35) General and Mission Hospitals in the Cross River State with at least one located in each of the former 17 Local Government areas. There is one Teaching Hospital situated in Calabar, the State Capital. Most of the rural areas are served by Dispensaries, Maternity Homes, Patent Medicine Stores and a few health centres now becoming operational in some areas. In the urban areas, there are quite a number of private hospitals and clinics, pharmacies and patent medicine store in addition to the existing hospitals. There are also prayer houses (spiritual healing

homes) and herbalists to supplement the modern medical facilities.

Uyo town - the headquarters of the administrative division of Uyo, is situated about 49 kilometers from Oron on the Oron - Aba Road. Uyo division has boundaries with Etinan and Oron on the South, Abak on the West, Itu on the North and Cross River on the East (Ministry of Information Bulletin, Cross River State Appendix 3).

Samples selected for this study are fairly representative of the Secondary Schools scattered throughout the Uyo Local Government area of the Cross River State. The variables - which have been randomly selected and examined - attempted to provide an analytical frame-work for a reasonable explanation of the problem.

It is hoped that the findings, conclusions and recommendations of this research will serve as a source of reference to the schools and health authorities on this issue investigated.

Lastly, while the findings of this study cannot be regarded as being conclusive on this very important issue, it is hoped that the exploratory study will stimulate further research into the area of secondary school students' health care seeking behaviour not only in the Cross River State but in Nigeria as a whole.

## Organization of the Study

Chapter one of this study deals with historical perspective, the setting and the nature and extent of the problem. Chapter two is on the review of related literature on the theory of adolescence, concept of health, self-care, secondary school students' decision making, adolescent health and health problems, drug abuse and school health services. Chapter three focuses on the study - the objectives, methodology and limitations of the study. Chapter four dwells on the results, chapter five focuses on discussion while chapter six deals with the conclusion of the study and recommendations.

## 1.3 Problem

One quickly becomes aware of the multitude of health related topics and problems by reading through the daily newspapers, listening to the radio, watching the television or even discussion with friends. Every day a major portion of the news deals directly or indirectly with health issues. The headlines toll of a secondary school boy killed in a ghastly motor acoident; school girl, 18, attempts suicide; doctors appeal to the government for an abortion law; drug overdose kills a young woman; question and answer columns about physical, mental and social health appear regularly on the newspapers and magazines. Television and radio programmes which deal with such topics as obesity and venereal diseases have large audience. Yet

there has been little evidence of interest in the question of how secondary school students seek health care. The prevailing impression appears to be that these students take their health for granted or that the school health services do in fact meet the health needs of the students. Perhaps this impression reflects adult views (e.g. high school authorities take decisions and provide solutions to students health problems), more than it does the views of the students (Brody 1968; Gallagher, 1966; Masterson, 1963). This study intends to determine whether in a sample of secondary school students, the findings will support the notion that these students are contented with the available means for meeting their health needs or the fact that the school authorities provide all the necessary health care services.

Most of the health studies which have focused on this particular age-span have dealt with specific issues such as mental illness, drug use, suicide, accidents, pregnancy and veneral disease. For example, the works of Oviasu (1976); Lambo (1965); Akindele (1974); Anumonye (1975) on students and drug abuse and its problems in Nigeria. Also there are studies done by Asuni (1964) on the "Socio-psychiatry problems of cannabis in Nigeria," and Boroffka (1966) on "Mental Illness and Indian Hemp in Lagos."

The study of how secondary school students seek health care in the Cross River State has not been documented in literature. How do they make decisions concerning solutions to their health problems? What factors influence these decisions? What do they finally decide to do? What implications do these decisions have for health planners? The above questions relate to how, when and why students seek care. The subject matter of this study.

## 1.4 Statement of Problem

To determine perceived health concerns and care seeking behaviour of school students in Uyo Local Government area of the Cross River State.

### Sub-Problems

1. What do secondary school students view as their major health concerns?
2. What are the health facilities available within the school?
3. To what extent do the students utilize the available facilities to solve their health problems.
4. How do they make decisions concerning seeking health care among the various options?
5. What are the consequences of such decisons?

### Rationale for Choice of Secondary School Students (Ages 13 - 18 years)

The students fall into the group of persons who are neither children nor adults. They are expected to make independent decisions.

They have special health concerns and needs.

Traditionally, paediatric care and school health services (at home and in the hospitals) drop at about age 12 with entry into the secondary schools when pupils presumably pass into whatever health services are available for adults, and it is assumed that they make independent decisions concerning their health. In Nigeria, the School Health Programme does not in most cases, provide adequately for the health of this group. Since they are not yet adults and present numerous health problems because of their ambiguous social status, for example, psychiatric problems, veneral diseases, pregnancies, accidents, suicide, smoking, drug-abuse - there is need to look into the means by which these problems are solved by the secondary school students themselves - that is, need for a comprehensive assessment rather than the fragmentary problem related ones. This could lead to providing the secondary school students with special health services or counselling.

The need for this type of research is underscored by the report of the World Health Organization Expert Committee on Health Problems of Adolescence which states:

> "The illness of members of this age-group has received considerable medical attention for many years in many countries but physicians as a whole have not given adolescents the care that they have given to children and adults.
>
> Medical students have been taught less about adolescents than other age-groups, less research has been carried

> out on their disorders and fewer facilities have been provided for their care. Yet the future effectiveness of these young people depends in no small part on the care given them during the formative years of adolescence" (World Health Organization, 1965).

As yet, health services for secondary school students in the Cross River State, as in most parts of Nigeria, are fragmented and reach only a very few of these age-group.

## 1.6 Statement of Purpose

To assess the health needs of the secondary school students ages 13-18 years in Uyo Local Government Area of the Cross River State with a view to making recommendations to the health authorities.

## 1.7 Scope of the Study

The study involves an exploration of the ways in which secondary school students in Forms three, four and five of ten (10) secondary schools seek health care. Other areas investigated include, how do the students view their health generally, what common health problems the students complain of and their causes, what facilities exist in the schools for the solution of these health problems, what alternative places exist outside the schools to complement or supplement the schools' efforts; how do the students make decisions concerning seeking health care, who influences such decisions and what

do they actually do finally?

## 1.8 Definition of Terms

The following terms will be used in this study:

Health - that quality of physical, emotional, and social well-being that enable on to live effectively and enjoyably.

Secondary School - An institution of learning to which the student is admitted after he has gone through the elementary school. For the purpose of this study, the term "high school" is synonymous with secondary school.

Adolescence - The state of life which starts with puberty and ends when the individual has achieved a reasonable degree of maturity and independence from his parents.

For the purpose of this study, this period commences at about the age of 13 years and ends at about 18 years.

Puberty - The period of time beginning when the child is about 13 years and involving the development and maturation of the reproductive, endocrine and structural system.

Secondary School Students - Students who are currently studying in the secondary schools and are within ages 13 to 18 years.

Transition - The period of life which for this study is 13 to 16 years of age marked by a variety of psycho-social changes and involves some very obvious physiologic changes.

Self-Care - The practice of activities that individuals personally initiated and perform on their own behalf for the maintenance, restoration, or promotion of health.

Substance Abuse - Taking into the body of any substance to modify one or more of its functions without medical or professional advice or direction. This includes not only medications but also some other pharmacologically active substances like tobacco, alcohol and Indian hemp.

Health Concern - A behavioural disorder in the physical, emotional and social activity or life inappropriate to the situation in which the student finds himself or herself. In order words, the term refers to a pressing health problem.

Perceived Health Concern - Health problem from the students' perspective.

Perceived General Health Concerns - General health problems observed by secondary school students among other students of their age group.

Care Seeking Behaviour - How the students seek health care.

## REVIEW OF LITERATURE AND CONCEPTUAL FRAME-WORK

During the review of literature, it was discovered that no study has been done in the area of how the Nigerian secondary school student seeks health care. However, literature on theories of adolescence, the concept of health, self-care, decision-making, adolescent health problems, drug/substance abuse and school health services is available and could help throw some light into the present study.

1. Theory of adolescence: This attempts to define adolescent and offered some explanation to the concept of adolescent transition considering the physiological and psychological development and needs.

2. Self-Care: This dealt with self care concepts, types of self-care and the factors which tend to influence self-care pattern.

3. Secondary School students' decision-making process for seeking care reviewed are the attempts made to explain students' actions in a choice-making situations in seeking health care.

4. Adolescent Health Problems: Focus was on the various studies carried out in the area of adolescent health concerns, their specific health problems and general

health need.

5. Drug Abuse among Secondary School Students': This briefly examines the pattern of drug use among adolescents all over the world as well as in Nigeria.

6. School Health Services: The review of school health services focussed on the aspect which dealt with Guidance and Counselling.

## THEORY OF ADOLESCENCE

The term "adolescence comes from the Latin word "adolescere" which means "to grow into maturity" (Chambers, 1981). According to Michael and Sewall (1980), adolescence has often been called a phenomenon of the twentieth century. It is a time of close examination, investigation and exploration of attitudes and beliefs of one's culture. The extent to which adolescents are able to recognize their abilities is closely related to environmental influences.

These authors maintained that the adolescence is in a period of transition - neither a child nor an adult - and is often subjected to conflicting messages from adults who also serve as role models. This confusion has been observed in the developed countries and even here in Nigeria.

The tired phrase, "do as I say, not as I do," merely adds to the confusion of the adolescent. Michael and Sewall also mentioned that

the physiologic changes now occur at an earlier age in the individual's development because of numerous advances in health care and nutrition. Thus individuals are faced with emotional inconsistencies and physical changes at a much younger age than before and are unable to deal with them cognitively.

Chinn (1974) defines adolescence as a psychosocial process that is initiated by puberty and involves some very obvious but basic physiologic changes. According to Chinn, adolescence begins just before or concurrent with the changes of puberty but lasts for an extended period after puberty has been completed. The author further remarked that the period of adolescence, like other developmental stages is not possible to define in exact chronological terms. While it is often thought of as beginning with the onset of puberty and ending with the achievement of a certain level of maturity, these landmarks are not easy to identify, and they do not seem adequate in describing the many complex factors which comprise adolescence.

Chinn believes that adolescence may most appropriately be conceptualized as the period of life during which emancipation from the primary family unit is the central task of the individual, while the term "puberty" is used to denote the period of time that involves the development and maturity of the reproductive, endocrine and structural systems.

Gunn (1970) describes adolescence as an artificial state where physically mature individuals are too often denied the responsibility and economic security but are, at the same time still expected to behave as adults.

According to the author, in some developing countries, such as some parts of Africa, the 'stage' of adolescence is virtually non-existent; there is only pre-puberty, puberty and adulthood, with the rubicon form one to the other being passed as soon as either - male or female - reaches the mature stage of being able to procreate.

In the developed society it is all, however, prolonged by the demands of education, and is characterized by a stage where the individual is neither a child nor an adult, and is recognized as neither by all other members of the society who are older or younger. Chinn, (1974) supports this fact when he stated as follows: "In the African cultures and societies, where immediate or rapid entry into adult living is possible, adolescence as a state of behavioural development does not occur, hence adolescence has become an important and difficult stage of development unlike any that precedes or follows it."

Nigeria probably fits in somewhere between the developing and the developed world as far as adolescence transition is concerned, although there is no documentary evidence as yet from which generalizations could be made. For example, in some parts of the

Cross River State, the female is given up for marriage before or as soon as reaches puberty - that is when menstruation is established - and procreation is expected to commence immediately thereafter. So it is still common to find an adolescent of 15 years of age who is already a mother of three children. The males also tow a similar line - procreating from about the age of 15 years or even earlier than that in recent years. With this group of people, education is still not their central task as they are occupied mainly with farming, fishing or petty-trading. But this not the case with secondary school students. They tend to follow the pattern established in developed countries. Offer and Offer (1972) described adolescence as the "in-between stage," when the boy is not quite a man and the girl still has many childish qualities. These authors maintain that adolescence should be viewed as a unique period of disruption and change.

The adolescent stage is given a name often based in the mode of dress adopted by those who are in this somewhat unfortunate group - the teenager 'teddy-boys,' 'Rockers', 'hippies,' or 'youth'.

In the Cross River State, they are given such names as 'Nkaiferi' for adolescent girls and 'Nkparawa' for adolescent boys - both indicating their mode of dressing and group. The interesting point is that in medical terms it is impossible to define adolescence, even in psychological terms, attempts at

definition become epigrammatic rather than precise. Some authors have said for example, that an adolescent is "someone who when treated as an adult, behaves as a child." But sometimes, it is the other way round. Other authors have said that adolescence is a process of adaptation to puberty, but in the long run any classification must be sociological, not medical or psychological, for the group's characteristics vary from culture to culture.

## THE CONCEPT OF TRANSITION

Why is the concept of transition used to characterize what is going on in adolescence? According to Jessor (1982), the concept is reserved for changes of such magnitude, comprehensiveness and coherence that there has been a transformation of the person and the status the person occupies. It is change that is considered to be lasting, developmental, directional and irreversible. Jessor maintains that developmental transitions are obviously associated with age and major transitions do occur between age-defined statuses as, for example, the shift from adolescent to young adult or from middle-life to old age. Also, there are major biological changes which seem to be associated with age, for example, the onset of puberty in relation not only to age but to a diversity of other factors as well. While chronology and biology are clearly relevant, Jessor observes that neither is able to capture enough of what is intended by the concept

of transition. In the final analysis, a full understanding of transition requires a psychosocial perspective.

From a psychosocial perspective, adolescent transitions involve changes in social-and self-definition, new patterns of interpersonal relationships, access to new kinds of personal and social experience, and an expanded repertoire of personal and social skills, membership in different social groups, admission to new social statuses, increased opportunities to gain certain rewards and to pursue certain goals and the acquisition of new behaviours. In essence, a psychosocial perspective of transition emphasizes changes in personal and social identity - how a secondary school student defines himself or herself and how he or she is defined by significant others. Jessor further mentions that what makes the concept of transition even more complex is the fact that these developmental changes can occur at different levels of analysis and at different points in time.

## PHYSICAL CHARACTERISTICS AND NEEDS OF SECONDARY SCHOOL STUDENTS

In terms of physical development, the adolescent is a growing organism (Cunan, 1973). According to Willgoose (1972), growth is rapid and uneven; arms and legs grow rapidly. The lateral types (mesomorphs) mature earlier than the linear type (ectomorphs). Muscular development is rapid and frequently results in relatively poor co-ordination and the appearance of awkwardness.

Willgoose stresses that health examinations and screening tests should be given routinely. In some cases, acne may appear, causing an interest in skin conditions and the use of cosmetics. In this period there appears to be an unlimited source of energy, sometimes accompanied by great exuberance and boisterousness. There is need for a discussion of physical capacity, human energy, chronic fatigue, sleep and instruction on how to relax.

Boys have voice changes and pubic hair at about 13.5 years of age; sexual maturity and nocturnal emissions are reached in most cases. They need to understand what these growth characteristics mean now and in the future.

Girls are about 1½ years ahead of boys in maturation. Height increases rapidly as secondary sex characteristics develop. The menstrual cycle is irregular initially. They have a great concern for personal appearance and they need to be given a chance to discuss growth variations and talk about one's figure and general appearance.

Other health needs indicated by Willgoose for the senior high school students (older adolescents) include: interesting nutrition instruction in relation to use of food, food fads, and weight control; need to relate out of school activities to food, exercise, rest and medical advice; need to understand their own feelings and sexual drives which have become strong at this period.

Also, Brunswick (1969) in a Washington Heights Study of what adolescents see as personal health care needs reported the following health concerns which were most frequently mentioned:

(a) not getting enough exercise (35%);

(b) not eating the right kind of food (28%); the right amount of food (12%), and not eating regularly (1[illegible]%);

(c) smoking or smoking too much (2[illegible]%);

(d) not getting enough sleep (20%);

(e) eating too many sweets - often referring to its effects on the teeth (16%).

PSYCHO-SOCIAL DEVELOPMENT

Willgoose (1972) observed that there is a desire for independence from 'old-fashioned' adults and school authorities. They have great loyalty to group leaders. There is need and want for friendship, and to measure themselves with friends through class projects, contests and achievements. They are interested in impressing the opposite sex.

He identified the need for smoking and drug education, also need for self-appraisal through a number of activities. They need opportunity to develop social poise and confidence. They need also to understnad why health ducation is important now.

Boys are sometimes self-conscious about their physical inadequacies; they frequently think that physical prowess is all-important. Here, Willgoose, stresses the need for sympathetic

guidance from parents, teachers, and other adults; also need to know how to groom themselves and appear proper to peers. As consumers both sexes need consumer health understandings.

The older adolescents, according to Willgoose, have a tendency to be intensely emotional and complex so they need to see value in accepting both failure and success. They need to appreciate some limitations during early years of life. Both sexes are more predictable, more cheerful, friendly and out going than in earlier years. They gain status essentially through social activities.

Other needs identified by Willgoose include opportunities to work with peers for common goals, to appreciate the need for some rules for living and the way to relieve tensions since boys have mild to strong female interests, there is need to understand sexual moves in their culture and their own inhibitions and finally need to discover how to adjust to a busy world of persons and things.

## ENVIRONMENTAL INFLUENCE AND THE STUDENT'S HEALTH

Perry and Murray (1982), identified four structures of influence that affect health behaviour within the environment. These structures affect specific choices a student may make by creating opportunities, constructing barriers, and by providing motivation and reinforcement. Jessor (1977) in their problem-behaviour theory, uphold a similar view when they observed that

certain structures within the environment are more or less proximal to the actual behaviours of concern. According to Perry and Murray, these factors most proximal to the behaviour and to the person are most likely to exert the greatnat influence on behaviour, and at the same time, they are the most appropriate targets for health promotion activities.

The authors identified the most proximal environmental influence on health behaviour as the model structure, which include the actual behaviour of significant others. In further explanation of the model, the authors sail that people acquire and are prompted to engage in behaviours as a function of observing others (Bandura, 1977). Thus, the secondary school student might consider parents and siblings, best friends, teachers, sometimes television, movie or rock music celebrates as models. Parents demonstrate what constitutes adult behaviour by their life style and by the way they communicate their values, norms and beliefs. For example, secondary school students with parents who smoke are likely to begin smoking themselves (Evans et al, 1982).. For selections, exercise habits, ways of coping with stress and alcohol use are other lifestyle patterns modeled by parents. Perry and Murray agree that peers also serve as health behaviour models; for example in smoking and drug use. (A report of the Surgeon General, Washington D.C.; 1979).

For example, the single reason most often cited by adolescents for experimenting with smoking is the use of cigarettes by a close friend (Newman, 1970).

The network structure is the next most proximal environmental influence (Perry and Murray, 1982). Networks according to the authors are loosely organized groups of people who interact with each other regularly such as peer groups, neighbourhoods and families. The influence of the network on health behaviour is evident in families where behaviours such as overeating, salt consumption and exercise patterns are shared (Litman, 1974). Peer groups become increasingly important during adolescence and with them come particular patterns of behaviour.

The third and the next most distal factor environmental influence on adolescent health behaviour are the social system which include the rules, constraints and health messages of formal groups such as school, church or work place. The school is the most critical organization for most secondary school students, since it regulates their options and choice for a large portion of each day.

According to Perry and Murray, the most distal of the behaviours themselves are community and demographic characteristics. The community message structure offers general messages about health through government regulations, mass media and private health

organizations. For example, in Nigeria, advertising, food availability and health facilities will all affect how the secondary school students perceives the environment.

In summary, four structures have been identified which could affect the health behaviour of secondary school students in the environment. They include, the actual behaviour of significant others such as parents, best friends and siblings, teachers and at times mass media. This group is said to be the most important or most proximal environmental influence.

Perry and Murray also identified the next closest factors like peer groups, neighbours and families, the most important of which is peer group in students' health behaviour.

Other distant factors in the environment identified are rules, constraints, health messages from school, church or work place as well as community and demographic characteristics. The school as the most critical organization for most secondary school students, since it regulates their choices and options for a greater part of the day.

## THE CONCEPT OF HEALTH

Such publications as Wilson and Junger's monograph on "Principles and Practice of Screening for Diseases" for the World Health Organization, (1968) and the volume, "Chronic Illness" in the United States include in their discussions "non-physical" problems as mental illness. Nevertheless, the fact that the vocabulary of definitions includes

such terms as "disease," "defect," or "body organs" clearly reflects an anachroniatic view of health which neglects the context in which a child lives (Lessler 1972). Such an orientation toward health also lend validity to those who would believe that the school authorities provides all solutions to and perhaps decides on how the secondary school students health problems might be solved on the grounds that there is a low yield of gross pathological conditions since "school age is the healthiest period in a child's life" (Meyerstein, 1969). Meyerstein's review indicates that two percent of first grade children were found to have unknown pathological conditions even after extensive health examinations. Most frequently found were the acute conditions such as otitis media acuta, tonsilitis and upper respiratory infections. Bower (1969) comments that where living is equated with and therefore measured by degrees of illness rather than health, one can easily perceive the world as a giant hospital peopled by patients whose only health lies in discovering how sick people are."

Thus, it would seem pertinent if not imperative to broaden the orientation of the concept of health from disease and defect to include psychological, and socio-cultural as well as biological elements. Richmond and Weinberger (1970) state that we must include elements of the entire social mielieu in which children develop - the educational system, the social system and the physical and emotional

environment itself in any consideration of health care.
Ademuwagun (1984) supported this view when he stated that the health of the school health child is considered in the context of health as a complete physical, emotional and social well-being, and not merely the absence of disease or infirmity. Gendel (1969), in a consultative report for the Guilford Country (N.C.) Comprehensive Health Study, defined children's health services as "preventive, therapeutic and rehabilitative in nature - focused on the child and hie environment.

Once a broader concept of health is accepted, attention must be directed toward how health problems are solved by secondary school students. Children in school have different problems confronting them than to adults. It seems logical to suggest that the difficulties to be identified should be those related to the child's life tasks (Lessler 1972). Richmond and Weinnberger (1970) supported this view when they stated that "since the primary task of the school aged child is learning, the focus of comprehensive health services in this age group should be directed at fostering and maintaining optimum intellectual capacity and function. Also Ademuwagun (1969) stated that the future of the health of a nation is to promote, improve, and preserve the health of the youngsters in its colleges. Acoording to the author, a school health education programme is aimed at helping the school age child to achieve a

complete physical, mental and social well-being.

Gendell (1969) suggests that "the common characteristics of school attendance mandate concern for health needs - for the learning process, for protection of the common good and for full potential in emotional, social and physical development."

SELF-CARE

Orem (1971) defines self-care as the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health and wellbeing. Essentially, self-care is a person's continuous contribution to his or her own health (Lynda, 1980).

Levin (1979) defines self-care as "a process whereby a lay person functions on his/her own behalf in health promotion and prevention and in disease detection and treatment. Fry identifies the following four roles of self-care: health maintenance; disease prevention; self-diagnosis; self-medication and self-treatment; and patient participation in health care services.

According to Lynda (1980) self-care is founded on the following premises:

1. Self-care is based on voluntary actions which humans are capable of undertaking.
2. Self-care is based on deliberate and thoughful judgement that leads to appropriate action.

The individual becomes the principal agent in guiding, directing, and regulating his or her own behaviour.

3. Self-care is a requirement of every person and is a universal requisite for meeting basic human needs.

Self-care requires the use of specified sets of actions or techniques in order to benefit health.

Although self-care has often been discussed in adult literua literature, it is seldom mentioned in paediatric readings. Yet a young child can engage in some activities of self-care (Faoteau 1980). Clinical experience demonstrates that children will engage in some aspect of self-care depending on their developmental level, cultural and familiar influences and age.

## SECONDARY SCHOOL STUDENTS' DECISION-MAKING PROCESS FOR SEEKING CARE

Decision making consists of making a choice between two or more available options after an evaluation of the outcome (Fetens, 1983).

In many cases, the decision making process involves uncertainty about future events or actions of others. Some of the decisions involves simple well-understood parameters such as money.

In other decision making process, it is not easy to find a simple quantitative parameters with which to measure progress toward the fulfilment of objectives (Radford, 1978). For example, Ademuwagun (1977) in a study of the determinants of pattern and degree of utilization of health services in Western State, Nigeria found that the choice of a particular service was based on a complex of factors such as age, educational status, type of occupation, place of work, medical cost, the individual's perception of and attitudes, towards services or dispensers of service, and the quality of and location of services.

A combination of events or unforeseen conditions and action of others may result in a decision that has been considered a logical basis having less desirable outcome than had been forecast. In all cases the lessening of uncertainty about the future is a major objective of the decision maker (Humpton; 1979, Pong, 1981).

In discussing the importance of providing a positive experience for the patient, Smith and Bass (1979) state as follows: "perhaps a crucial test of people's attitudes is their satisfaction with the actual medical care they have been getting. Patient satisfaction is important since the ultimate valicator of the quality of care is its effectiveness in achieving health and satisfaction. Fiedler(1981)

observed that literature on patient satisfaction is characterized by two different approaches:

a) The first views satisfaction as a dependent variable of either preconceived notions of care, or as is more often the case, a function of utilization. The use of satisfaction data assumes that it is a proxy for the effectiveness or quality of care.

b) The second approach employs satisfaction as an independent variable, capable of predicting health and illness behaviour by assuming that difference in satisfaction influence access and utilization behaviour.

It is, however, important to assure that the secondary school students consider seeking solution to their health problems as a result of an interplay of cultural and health care organizational influence. Secondary school students when evaluating the meaning and consequences of an illness and making decisions about its solutions, are guided by knowledge possessed as participants in a particular cultural tradition. At the same time, their decision to seek aid must take into account the characteristics of the available options especially since they are students from backgrounds with some control over the manner in which these options are presented to them.

## PROCESS AND STAGES OF DECISION IN SEEKING MEDICAL CARE

A few attempts have been made to specify the various detailed process - stages of decision making in seeking medical care. For example, Radford (1978) has described the decision process as consisting of three major activities - search for information, analysis of available options, and choice between options.

Any given illness has certain characteristics more or less perceptive to the sick person and to significant others in his social milieu (Mechanic, 1980). These characteristics include:

a) The frequency with which the illness occurs in a given population - its commonality;

b) The relative familiarity with the symptoms of members of the group;

c) The relative predictability of the outcome of the illness; and

d) The amount of threat and loss that is likely to result from the illness.

The first two dimensions refer to the problem of "illness organization," the last two, to the problem of "illness danger" when a particular symptomatology is both easily reconizable and relatively devoid of probable danger. It is routine illness when it occurs more infrequently in the population: making identification

more difficult, and with increasing perceived danger. There is likely to be a greater sense of concern.

Becker (1974) focussed on four elements of illness behaviour in relation to decisions to act; the decisions include those made for oneself and others (e.g. children dependent on the decision-maker). The key elements include:

a) Health motivations aroused by system experience, representing differences in the degree of concern for health matters;

b) The threat posed by symptoms, including physical harm and influence on functioning;

c) The benefits, efficacy or value of action to reduce the threat;

d) Barriers or costs of the action.

According to Radford (1978) in his classical treatments of decision making, decisions are said to be made under three conditions:

1. Decision-making under certainty
2. Decision-making under risk
3. Decision-making under uncertainty

The decision maker's choice between options is seen as being influenced by his/her appreciation of which of these conditions applied to the problem at hand. The choice of criteria for selection between available options depends on the condition seen as prevailing.

## 1. DECISION-MAKING UNDER CERTAINTY

Decision-making under certainty implies complete information regarding which decision has to be made. The assumptions, are that the decision-maker is able to enumerate and list all possible strategies or causes of action, knows the requirements to carry them out, and can project their respective consequencies with complete certainty (Lovely and Loomba, 1978).

Radford (1978) also observed that decisions are regarded as being made under conditions of certainty when there is seen to be only one consequence or outcome of each of the options available to the decision-maker. This means that the effect of choosing any option is known in advance with certainty.

## 2. DECISION-MAKING UNDER RISK

Decisions are said to be taken under risk when there is more than one possible pay off resulting from selection of an option and the decision maker is assumed to know the probability of occurrence of each of these pay off. The variation of pay off can be considered to be the result of factors occuring outside the control of the decision-maker. Assuming that a number of these factors can occur and that the probabilities of occurrence are known, the chance of various combination of these factors, sometimes called states of nature can be calculated (Radford 1978).

According to Levey and Loomba (1978) the optional strategy in decision making under risk is identified by calculating the expected value of each strategy which has the highest (if it is profit type objective) or the lowest (if it is a cost type objective) value.

## 3. DECISION-MAKING UNDER UNCERTAINTY

Decisions are said to be made under uncertainty when neither the number of possible future states of nature nor their probabilities or occurrence are known to the decision-maker. The decision maker's ignorance under the condition called uncertainty may be partial. Also, it may be possible for him to obtain further information at a cost in time and money. This suggests that it may be advantageous to postpone the decision, or at least part of it until more information may be gathered (Fotenc, 1982).

The information collected may be used as the basis for defining more comprehensively the possible future states of nature and their probabilities of occurrence, as well as the options available to the decision maker. Thus information gathering may cause the condition under which the decision is considered to move from what has been described as uncertainty nearer to state defined as risk.

The three methodological approaches mentioned earlier will now be considered and how each approach contributes to an understanding of decision-making on the secondary school students' health care choice.

## 1. CORRELATION APPROACHES

In these approaches, studies have sought to explain differential utilization by reference to phenomena that may be demonstrated co-vary with specific health care choices. These studies may be classified according to whether they emphasized:

a) Characteristics of illness tending to be taken to each treatment alternatives (e.g. local distinctions between "doctor-curable" and "folk-curable" illness, or more general etiological distinctions.

b) Characteristics of the people tending to use each alternative (e.g. acculturative status).

c) Characteristics of the health-care providers, or various combinations of these factors.

The common feature of these approaches is the discovery or assertion of some characteristics of the illness or clientele that tends to co-ovary with the use of different treatment alternatives, and then attribute to such characteristics a determinative significance in the actor's decision making.

## 2. THICK DESCRIPTIVE APPROACHES

This approach exemplified in Janzen's (1973) study of therapeutic choice making among the Bakongo of Lower Zaria, analyzes a small number of especially complex illnesses in the belief that such cases would best classify the multiple relationship between alternative

treatments and systems of therapy and the ways in which actors view their options. In this study, Janzen followed cases through times and interpreted the resulting therapeutic choices on the basis of information's post hoc rationalizations' combined with his knowledge of the particular social position and personal history of the patient. In Janzen's approach, the cases most amenable to to analysis are usually complex and prolonged ones.

3. EXPLICIT DECISION MAKING APPROACHES

Here the primary concern is not with the articulation of alternative medical systems per se, nor with the aggregate patterns of choices and their discernible regularities, rather the focus is in explicity upon the individual actor and the considerations involved in their choices of treatment. The approach centres upon the discovery of what information the actor considers when faced with an illness treatment decision, how the available treatment alternatives are evaluated and what relevant constraint are operative.

Fetene (1983), in his recent study in the Lagun Community at Ibadan identified the predisposing, enabling and reinforcing factors from the individual's perceived needs and from the dependent variables measuring use of health services. The predisposing factors included the climatic and sanitary condition of the area, life-style of the people and belief about disease causation and treatment. The enabling factors were availability of drugs,

service hours, time delay, comprehensiveness of the services and availability of essential items, perceived skill and ability of the providers, and co-ordination among services. The reinforcing factors included the provider - provider relationship, group influence, seriousness and types of diseases.

Generally, the study indicated that accessibility of services, social pressure, seriousness of the illness and the types of diseases were the four influential forces in making decision regarding use of health services in the community. According to the author these factors are interrelated and one cannot easily determine the causal sequences.

## I. THE HEALTH BELIEF MODEL

The health belief model uses the socio-psychological variables to explain preventive health behaviour. It explains an individual's motivation to act as a function of the expectancy of goal attainment in health behaviour. The model, which is concerned with the subjective world of the acting individual considers the following:

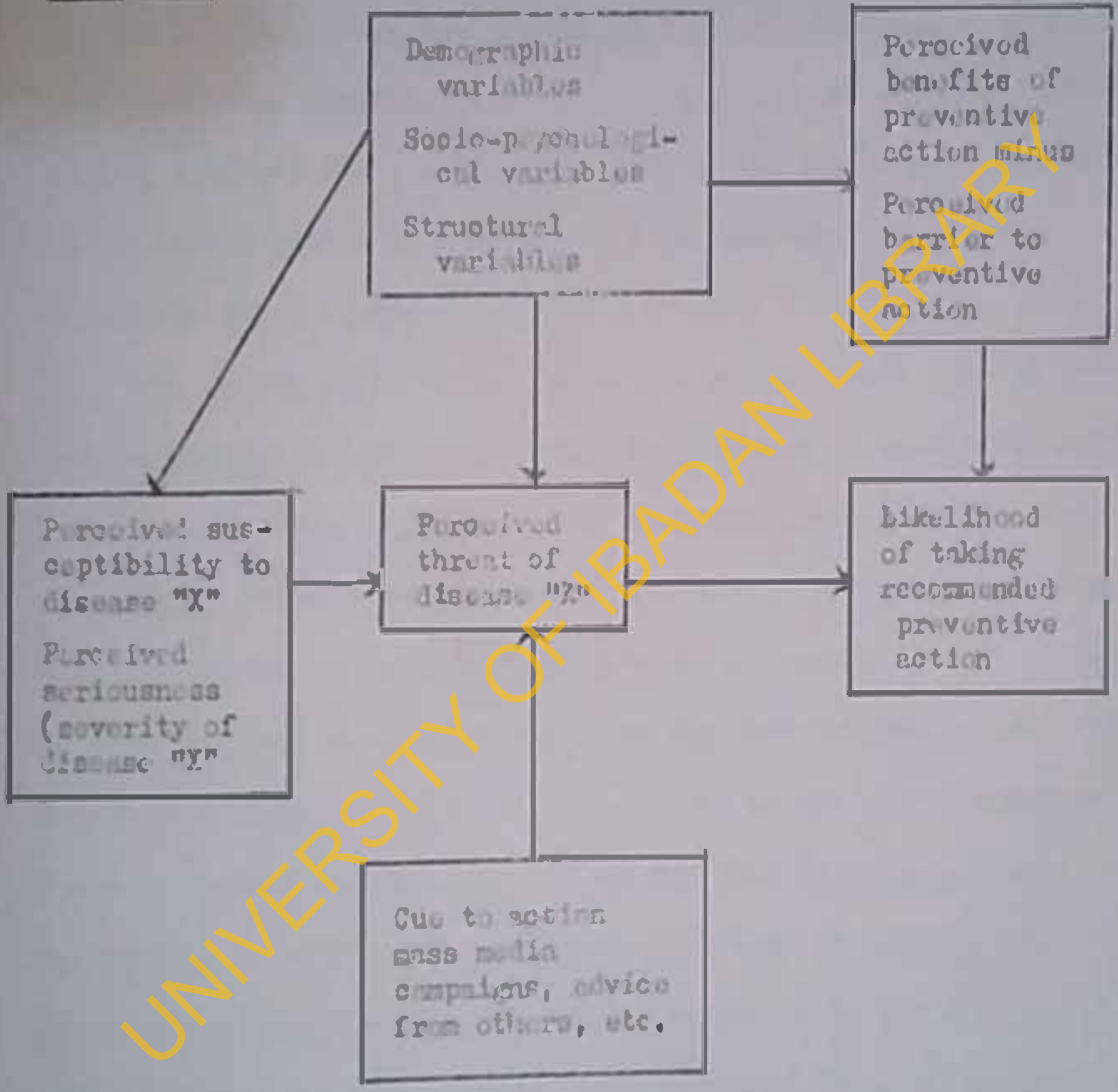
1) The individual's psychological "readiness to take action" relative to a particular health condition is determined by a person's perceived "susceptibility" or vulnerability to the particular condition, and by his perceptions of "severity" of the consequences of contracting the condition; and

2) The individual's evaluation of the advocated health action in terms of feasibility and efficaciousness (i.e. his estimate of action's potential "benefits" in reducing actual (or perceived) susceptibility and/or severity weighed against his perceptions of psychological and other "barrier" or "costs" of the proposed action including the "work" involved in taking the action.

3) Finally a "stimulus" (e.g. interpersonal interactions, mass media communications, personal knowledge of persons affected by the condition) must occur to trigger the appropriate health behaviour. This is termed the "cue to action." The "cue to action" appears to make the individual consciously aware of his feelings, thus enabling him to bring them to bear on the particular problem.

Figure I

## THE HEALTH BELIEF MODEL




The "health belief model" as predictor of preventive health behaviour taken from Becker, M.H., the health belief model and personal health behaviour, Charles B. Slack, Inc., Thorofare, 1974, p. 7.

This expectancy approach to health behaviour thus views the action that an individual will take as related to the subjective desire to "lower" susceptibility and severity, and to an estimation of benefits minus costs. The expectancy variable may be conceived of as a quantitatively varying belief that some particular action in a particular situation will lead to a goal. The perceived likelihood of successfully attaining the goal or the expectancy of success of the health action is a function of the perceived benefits of taking the health action.

The health belief model, which has recently been revised to include general health motivation, distinguishes illness behaviour and sick role behaviour from health behaviour (Ross and Mico 1980). According to these authors, health behaviour is any activity undertaken by persons who believe themselves to be healthy for the purpose of detecting and preventing disease in any asymptomatic stage. Illness behaviour on the other hand is defined as any activity undertaken by persons who feel ill to discover what is wrong and what can be done about it, while sick-role behaviour is any activity undertaken by persons who consider themselves to be ill for the purpose of getting well. Young (1950) reported that, if an individual is to take action to obtain a medical diagnosis then follow through with a prescribed treatment requirement, he must adopt an appropriate or "sick" role. The author states that "human beings, even when

concerned with symptoms, act under the influence of a variety of norms, values, fears, and expected rewards and punishments - that is, in terms of the costs and rewards offered by the social role of the sick person."

In conclusion, these combination of factors are believed to determine the likelihood of seeking health care. Thus, the health belief model can generally be used to examine the factors affecting the secondary school students decision-making regarding seeking solutions to their health problems.

## II. THE PRECEDE FRAMEWORK

The PRECEDE framework focuses on the "predisposing, reinforcing, and enabling factors" in educational diagnosis and evaluation. It draws our attention to the need to identify what behaviour precedes each health benefit, what are the causes of such health behaviour and the importance of considering those factors in health education planning.

The precede framework for planning is based on four disciplines: epidemiology, social/behavioural sciences, administration and education. Each discipline stands as a primary support to a specific phase of the PRECEDE.

Green's PRECEDE framework (1980) identified seven phases of health educational planning.

Figure 2

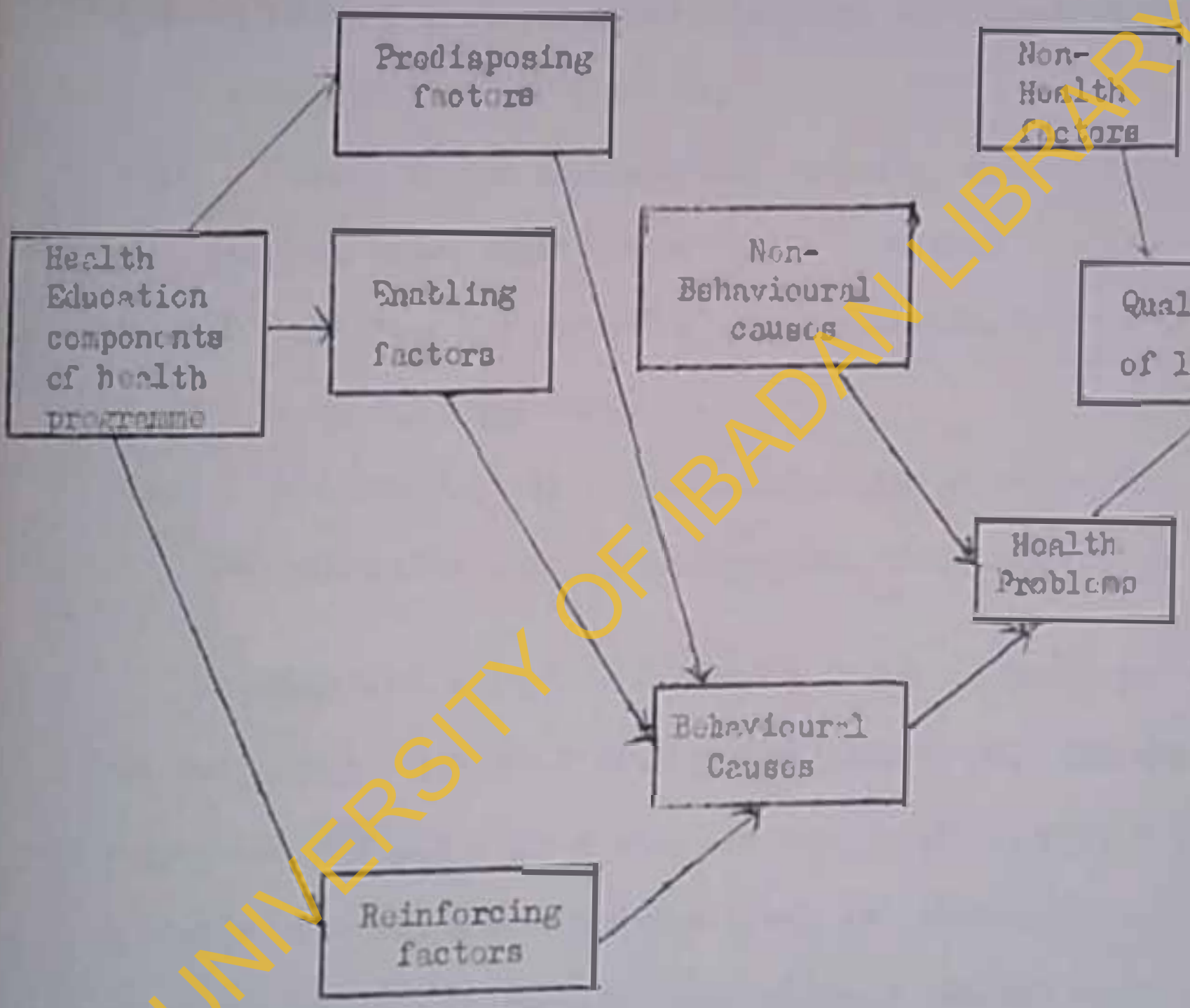
## THE PRECEDE FRAMEWORK

Phase 6
Administrative

Phase 4-5
Educational
Diagnosis

Phase 3
Behavioural
Diagnosis

Phase 1-2
Epidemiology and
social diagnosis




Source: Adapted from Green et al, Health Education Planning: A Diagnostic Approach (Palo Alto, Calif: Mayfield Publishing Co., 1980), page 3.

Phase 1 assess the quality of life by focusing on the general social problems of concern to individuals.

Phase 2 identifies specific health problems and non-health factors that seem to be contributing to these social problems, mentioned in Phase 1.

Phase 3 identifies the specific behaviours that appear to be connected with the problems.

Phase 4 focuses on the predisposing, enabling, and reinforcing factors which could affect health behaviour.

Phase 5 identifies the focus for health education intervention.

Phase 6 is on implementation and,

Phase 7 (not illustrated) includes evaluation as an integral and continuing part of the programme planning.

Successful completion of Phase 1, 2 and 3 depends greatly on the use of epidemiological methods and information. Successful completion of Phase 3 and 4 requires some familiarity with the social/behavioural theory and concepts. And finally, designing and implementing a health education programme demands knowledge of educational and administrative theory and experience.

The PRECEDE model emphasizes two basic propositions:

1) health and health behaviour are caused by multiple factors; and

2) because of this health education efforts must be multi-

dimensional if it is to affect behaviour (Green 1980).

Thus, the PRECEDE framework could be adopted to guide, in identification of important social and health problems in the group under study. It could also help in assessing their needs and for planning educational intervention.

## ADOLESCENT HEALTH AND HEALTH PROBLEMS

Research bearing directly or indirectly on adolescent health and health care needs fall into different categories. One body of work deals with what adolescents themselves think about their health (Brunswick, 1972). For example, a study conducted by Deisher and Mills (1963) in the U.S. in which high school students were asked if they had any health problems. One hundred and eighty three, or nearly 27 percent of the 690 who replied said they did. The report of the study indicated that more girls (30 percent) than boys (22 percent) had health problems.

A second source consists of data from health examination survey. Another body of research deals with adolescent patients and what health professionals had observed in special populations of adolescents. For instance, research studies have indicated that many young men reaching draft age presenting long-standing health problems (Tuthill, 1972). Many of these problems have been identified, but not improved during the school years. Another school study indicated that the best

predictor of a pupil's future absence record in his past year's absence record (Roberts et al, 1969; Rogers and Reese, 1965).

This study therefore suggested that a high absence record would seem an indicator of pupils with health problems. Still another kind of research has addressed itself to specific health problems of youth, such as mental illness, drug use, suicide, accident, pregnancy and venereal diseases. (Brunswick, 1972). Some work has been done on the health care facilities which are or should be available to adolescents in other countries.

There are also studies of class and ethnic differences in health status, health behaviour, utilization of health services, and the delivery of medical care.

There have been a few sample surveys in which adolescents themselves were asked to report on their own health. For example, the reports issued by U.S. National Centre for Health Statistics from its Health Interview Survey (with respondents who were at least 17 years of age) present data separately for 5-14 and 15-24 years age groups, thus combining children and younger adolescents in one group and older adolescents and young adults in another (National Centre for Health Statistics, 1970a, 1971a).

Other studies in the field of adolescent health have also been based either on observations of youngsters receiving treatment from physicians or in hospitals (Deisher and Mills, 1963; Gallagher, 1966;

Carell, 1965; Nolte, 1965; Pediatrics Clinics of North America, 1960; Schmidt, 1962; Sklar and Downs 1966). This of course leaves out the presumably larger numbers who have not been treated. Such studies have been unrepresentative in other ways with regard to the populations studied - for example, reports on the health status of young men found medically unqualified for military service which of course, excludes young women (Adolf, 1964; President's Task Force on Manpower Conservation, 1964); Vandou et al., 1967). Also studies dealing with high school students (Rogers and Reese, 1964); or reports on the health status of youth in job-training programs who are not likely to be representative of their communities (Eisner et al., 1966; Salisbury and Berg, 1969).

Regarding specific health problems of adolescents and youth, there is a considerable epidemiological literature on the incidence and prevalence of such problems as suicides, drug abuse, psychiatric disorders, venereal disease, out-of-wedlock pregnancies, accidents, etc. However, the methods of data collection and the age groups studies vary so widely that it is difficult, if not impossible to generalize from them. For example it is widely believed that drug abuse is a major health problem of youngsters in many parts of the world. Yet so far, there are no reliable data available on the prevalence of drug abuse in any one such community, let alone the nation as a whole.

In Nigeria, the absence of country-wide registration of deaths and other vital events have it impossible to obtain accurate statistics of the major causes of morbidity and mortality in this age group on a national scale (Oduntan, 1973). However, a picture of the health problems of these children can be discerned from the reports of the few school health programmes, from hospital records, from data, from other medical institutions, and from special epidemiological surveys in selected areas (Oduntan, 1973). According to Oduntan, records from the hospitals, outpatient clinics and other institutions show that children of school age constitute a very high proportion of patients seen at these institutions indicating high morbidity rate in these age groups. Also, the findings of epidemiological surveys have shown an alarmingly high prevalence of ill-health in apparently well children (Oduntan, 1972).

These sources also indicate that the major health problems of Nigerian school children are related to malnutrition, multiple infections and trauma (Oduntan, 1973). The state of health of these children and the pattern of disease are apparently determined by social and environmental factors and show a strong correlation with the educational and economic status of the parents, the cultural practices in the home including diet, the standard of public sanitation and personal hygiene in the community, the use of specific chemo-prophylaxis and the availability of health services. There is a clear evidence

factor in the educational progress of many Nigerian children (Odunlan, 1973).

Some attempts have been made to survey the health facilities which are present in the U.S. (Simons and Downs, 1968; Carroll, 1965), but these studies did not anticipate the changing legal status of young people seeking medical care or certain innovations in the delivery of that care which have taken place in recent years.

This study has addressed itself to determining how secondary school students solve their health problems in a single state in Nigeria. Relevant to this research are studies deling with the health status of youths and the medical care available to them. What is known) The initial assumption was that young people in the secondary schools present many unmet health care needs.

Data is lacking - national or local - on the health of youngsters in the 13-18 year age group in Nigeria which would make it possible to compare the health status of and medical care received in different socio-economic an ethnic groups.

Do poor people in general tend to under-utilize health care services? A number of investigators have argued that this is the case and that such behaviour is related to a "culture" of poverty (and lack of future-orientation) which is incompatible with modern medicine or with preventive health behaviour (Rosenstock, 1969).

This evidence does not by any means suggest that poor students in our society are more negligent in this respect than the affluent.

No less important is the structure of ghetto medicine, i.e. the mismatch between the needs of poor secondary school students and the health services available to them in their communities and the attitudes of health authorities toward the students (Norman, 1969). But what is known about health care in the Cross River State has little to do directly with secondary school students.

In short, although there is growing interest in adolescent health and health care, there is as yet little information available on a representative basis regarding this age group to which this study adressed itself. Nor is much known about the most effective ways of delivering needed health care to the secondary school youths - i.e. should it be segregated as the movement for adolescent medicine in the U.S. suggests, or integrated with comprehensive care for whole families? The study reported here in therefore unique in focusing on how a wide-section of secondary school students seek health care in urban and rural communities of the Cross River State. It is also unusual in addressing itself to the problem of how counselling might help the students in solving their perceived health problems.

## DRUG ABUSE AMONG SECONDARY SCHOOL STUDENTS

There can be no adequate description of the secondary school student drug abuser. Each youngster comes from a cultural, economic

group, a family, and a location, and each of these factors influences his reasons for drug-taking, his patterns of drug use, and choice of drug (Schooler, 1973). Until recently, the black and under-priviloged adolescents from ghetto areas were more involved with alcohol, babiturates, and heroin then with the hallucinogens or amphetamines, which their white middle-class counterparts use more heavily (Schoolar, 1973).

Nevertheless, drug abuse is a problem which cuts across international boundaries. For instance, the United State of America has been labelled as the industrial area with the worst drug problems (Adeyanju, 1978). Also officials in Portugal admit that drug abuse is reaching the 'magnitude of a national calamity.' The nation is said to have one of the highest per person narcotics consumption rate in Europe. Neither is the situation less serious in Africa. The United Nations Commission on Narcotic Drugs recently called the drug situation south of the Sahara 'grave' (Awake, 1977).

The involvement of Nigerian youths in drug abuse has been a major concern of the Nigerian Government. This is evidenced in the day-to-day outcry by the Federal and State Governments. At the Federal level, Col. Ibn Suleiman - the then Federal Commissioner for Health (1975), in his opening address at the Third National Health Education Seminar held at Enugu in 1975 said:

I wish to talk briefly about two programmes which will shortly require further attention; of Health Education Practitioners. The first is the control of drug abuse and misuse as well as addiction ... the Federal Military Government intends to launch both curative and preventive programmes for combating this menace ...

(Third National Health Education Seminar Report, 1975).

Also the Chief Federal Health Education Officer - J.A. Laoye (1975) when discussing "Health Education in the life of a school child" said:

> Today drug abuse and misuse are becoming rampant in our society ... Children of the well-do-do, families have been caught with the misuse ... of such dangerous drugs that the Federal Military Government felt that a solution should be sought for this social, health problem.

At the State level, the Sokoto State's acting Military Governor, Col. Harrison Eghagha (1977) decried of drug addiction among youths. Also the Imo State Commissioner for Health Dr. Howland Asobie (1977) blamed the prevalence of crime wave in the country on drug abuse.

## SCHOOL HEALTH SERVICES

The need for health services for the school children is well documented in literature. The health status of children during the high school years is of critical importance to their future physical and psychosocial development. Furthermore early learning of good health habits which reduce the risk of illness and the need

According to Turner (1971), the school health services is made up of six areas: Guidance and Counselling, Health appraisal, First aid care and Emergency treatment, Control of communicable diseases, school meals programme and follow-up services of the handicapped children. Turner emphasizes that the school health services should aim at helping the child attain his maximum health, to be able to engage actively and meaningfully in gainful learning experiences provided in and around the school. Oberteuffer et all (1966) expressed a similar view when they affirmed that the school health services aim at helping each pupil attain and maintain the highest possible level of health. A good school health services programme they affirmed, must not only ensure that the pupil is in good health, but also serve as a means of enriching the pupils education. This is achieved by providing educational experiences aimed at the development of sound attitudes towards health, fostering understanding and practices that will help those people become self-reliant in maintaining and improving their own health and the health of others and promoting healthy safe environment.

Several authors have stressed the importance of health counselling in the school health services. One of such authors is Robert Neal (1981), who stressed the need for inclusion of health counselling in undergraduate programme for health educators.

He defined health counselling as that dimension of counselling which attempts to make individuals aware of the underlying psychosocial aspects of health behaviour. According to him, health counselling stresses the importance of viewing health problems from a holistic point of view. Gapinski, (1979), states that a student's concern for a physical weight problem must be viewed for possible mental, emotional, social and spiritual (value) problems as well. Gapinski further argues that health counselling skills focus on universal communicative and facilitative skills, rather than being directed at a specific health problem.

Pollock and Obertouffer (1962) define health counselling as the procedures by which nurses, teachers, physicians, guidance personnel, and others interpret to pupils and parents the nature and significance of a health problem and aid them in formulating a plan of action which leads to solution of the problem.

Pollock et al. (1974) further explained that during health counselling, the teacher or nurse helps the pupil to understand the problems, suggest ways that he and his parents might obtain information needed to solve it, discuss with them the tentative solutions and helps them decide upon the one that appears more feasible for them.

Bucher (1967) reviews the objectives of health counselling as stated by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

They are:

1. To give students as much information about their health status, as revealed by appraisal, as they can use to a good advantage.
2. To interpret to parents the significance of health conditions and to encourage them to obtain needed care for their children.
3. To motivate pupils and their parents so that they will want and accept the needed treatment and to accept desirable modifications of their school programmes.
4. To promote each student's acceptance of responsibility for his own health in keeping with his stage of maturity.
5. To encourage students and their parents to utilize available resources for medical and dental care to best possible advantage.
6. To encourage, if necessary, the establishment or enlargement of treatment facilities for students from needy families.
7. To contribute to the health education of students and parents.
8. To obtain for exceptional students educational programmes adapted to their individual needs and abilities.

In his report on the "Survey of Child Health and School" presented at the 1960 Annual Assembly of the World Conferation of Organization of the Teaching Profession, Troeter (1960) reported that everywhere more and more children go to school these days and that children who live outside the city have fewer services available to them than the city children. He also reminded the school authorities of their responsibility to teach the basic health habits since health of the children is important to their success in learning.

Nwagwu (1977) in his article on School Health Services within the Universal Primary Education Scheme emphasized the need for the established of school health services. He emphasised the fact that the population of the school children from all levels of socio-economic status are admitted with their different peculiar health problems.

Nwagwu regretted that the school health services was not given the attention it desires in Nigeria, unlike in advanced and modernized countries like Britain where although the standard of living is high, there are free medical facilities around for all citizens but the government made provisions for the school health services mandatory as far back as 1907. He therefore urged the Nigerian government to establish health services in the schools for the following reasons:

1. Nigeria is not well provided with health facilities and medical personnel and so school children cannot depend on the inadequate and sometimes non-existent public health services.
2. The children will suddenly turn up in the school in millions and we are inescapably going to face over-crowding with its health and epidemic hazards.
3. Many poorly cared for children will come to school with varying standards of health and all sorts of diseases, some of them communicable.
4. The immediate health of the fast growing children are specific and these cannot be taken lightly.
5. School health services and health education help to prepare the children for adult life.
6. Any unhealthy child cannot benefit fully from the schools instructional programme.

# CHAPTER THREE

## THE STUDY

Research methods were designed to meet the requirements of this study:

(a) to collect information on the Secondary School Students perception of their health and how their health needs are met; and

(b) to do this in a cross-section of Secondary School Students.

To meet these requirements with due consideration for reliability and validity of the measurement, a combination of techniques was employed: a personal interview and observation.

### 3.1 Objectives of the Study

For the purpose of this study, the following objectives were formulated:

3.1.1. To find the perceived general health problems of the students in ten secondary schools in Uyo Local Government area of the Cross River State.

3.1.2. To identify and assess the health facilities available in these schools.

3.1.3. To identify factors influencing the secondary school students' decision in providing solutions to their health problems.

3.1.4. To determine the ways in which they actually solve these health problems.

3.1.5. To make recommendations concerning students health counselling/health education and improvement of the health care delivery for youngsters in the secondary schools.

HYPOTHESES

The following null hypotheses were formulated:

1. There is no significant difference in the type of perceived general health problems reported at secondary school students in: (a) in male and female students;
   (b) urban and rural institutions; and
   (c) in boarders and day students.
2. There is no significant difference in the factors affecting secondary school students decision making in solving their health problems (a) in male and female students; (b) in urban and rural institutions; and (c) in boarders and day students.
3. There is no significant difference in those who influence secondary students to seek health care (a) in male and female students; (in urban and rural institutions; and (c) in boarders and day students.
4. There is no significant difference in the places where secondary school students seek health care (a) in male and female students; (b) in urban and rural institutions; and (c) in boarders and day students.

3.1.5. To make recommendations concerning students health counselling/health education and improvement of the health care delivery for youngsters in the secondary schools.

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4. There is no significant difference in the places where secondary school students seek health care (a) in male and female students; (b) in urban and rural institutions; and (c) in boardors and day students.

## 3.5 THE RESEARCH DESIGN

The aim of the study is to determine perceived health problems of secondary school students and how they solve them. So, this is basically an explorative, descriptive study as there is no clear information on the state of the students health. This study hopes to provide data on which interventions can be designed.

As an exploratory, non-experimental study, no attempt was made to control the variables, but every effort was made to sample situations and study subjects which are representative.

The important stages in the data collection are highlighted as follows:

Delinsation of the target population

3.5.1. Selection of the sample

3.5.2. Instrument construction and strategy for analysis

3.5.3. Results

3.5.4. Discussion on findings

Although, this study was principally directed to Uyo in the Cross River State, some aspects of the study may have a universal application. I chose this State for convenience and particularly looked for those areas which are manngeable in size for a study of this nature. Uyo Local Government areas satisfied this criteria.

Forms III, IV, V secondary school students were chosen based on the probable fact that they were mature enough to give the responses

required in this study and they also spent most of their time away from home and parental control. Since by their status in the school system they are conceivably mature enough to make some independent decisions, it was hypothesized that they also hold beliefs and attitudes towards finding solutions to their health problems, based on their past life experiences, learnings, values, and biases.

The Target Population (Universe)

The target population comprised all Forms III, IV and V secondary school students in the thirty-five (35) secondary schools in Uyo Local Government Area numbering about 5,263 students in all.

It will be recalled that there are 35 secondary schools in Uyo Local Government Area. How secondary schools below Form III were excluded because the students would not be relatively mature enough to give the responses required for this study.

3.5.1. The Sample

Ten secondary schools from the existing 35 schools were selected from Uyo Local Government Area by stratified random sampling as follows:

First, the schools were arranged into two homogenous groups:

a) Urban Schools - 12

b) Rural Schools - 23

The 12 Urban Schools were further grouped as:

i) Boarding Schools - 5

ii) Day School - 7

Then two Boarding School were randomly selected (through secret ballot), and two day schools were also randomly selected. This gave a ratio of 2:2. There were therefore a total of 4 urban schools.

2:2 This stratification of the urban schools allow for not only the boarders and day students to be included in the sample but also the Girls' Schools.

Total - Four (4) Urban Schools.

A sample of the six (6) Rural Secondary Schools were selected as follows:

First, the school were grouped according to their six-sub-divisions in Uyo Local Government Area.

Then, one school was randomly selected from each of the six sub-divisions of Uyo Local Government area. This type of stratification allows for sufficient spread of the school. Since the Boarding Schools are more typical of the older schools and are found crowded in two or three local sub-divisions, this

method of selection avoids selecting too many boarding schools from the same division.

Total - Six (6) Rural Schools (3 Boarding and 3 Day Schools)

Ration of Urban to Rural Schools = 4:6

Total - Number of schools selected = 10.

(5 Boarding 5 Day Schools).

Selection of Subjects

The subjects were selected using the stratified random sampling as follows:

First, the Forms III, IV,, and V students in each school were grouped into male and female groups according to class.

Then,

15 male students and 15 female students were randomly selected from Form III. Total = 30 Form III students from each school.

15 male and 15 female students were randomly selected from Form IV. Total = 30 Form IV students from each school.

15 male and 15 female students were randomly selected from Form V. Total = 30 Form V students from each school.

= 90 students were selected from each of the 10 schools.

A total of 900 respondents in all which is 17.1% of the target population (450 males and 450 females).

However, errors brought the number to 600 (274 males, 326 females).

In addition:

5 teachers were interviewed in each of the schools - this gave a total of 50 teachers in all the ten schools.

The criteria for selection of this sample size were:

1. Time factor
2. Limitation of funds
3. Manageability of the survey community.

3.5.2. Preliminary Instrument

The review of related literature revealed that no study had ever been conducted in this area of how the secondary schools students seek health care and so there was need for the development of a valid and reliable instrument for the assessment of how secondary school students seek health care. In order to ascertain that pertinent content were included in the instrument, health textbooks, research studies and health journals were thoroughly reviewed. Also advice was obtained from the Project Supervisors and from experts in the fields of health education.

Instrument Construction and Strategy for Analysis

Since the study is an exploratory survey, it was felt that the use of observation and interviews would be best in eliciting the data required on how secondary school students seek health care in the Cross River State.

3.5.2. Observation

Observation was adopted as a supportive method to obtain an on-the-spot information which could be used to verify and strengthen the data gathered by interview technique.

All the study subjects were observed generally by the researcher once in a fortnight for a period of six months (September 1983 to March, 1984). This meant that with ten (10) schools in the Sample, the researcher could only do a thorough observation by taking one school a day and spending most of the day in each school. During this period, the students were observed in the classrooms, dormitories and during extra-curricular activities.

The observation method was used for collecting specific data on the following:

1. Availability of health facilities in the schools e.g. the School Dispensary, the First Aid cupboard, etc.
2. The extent of utilization of those facilities by the students.
3. Health needs of the students.
4. Drug abuse:- What drugs they take, dose and when.
   Alternative sources of Health Care e.g. Prayer Houses.

### 3.5.3. Interviews

Open-ended questions were used in attempt to elicit more accurate responses from the selected students. In order to ensure adequate comprehension of the questions by the interviewees, the questions were interpreted in Ibibio language where necessary by the trained interviewers.

Interviews were conducted by the researcher and the research assistants in each of the ten (10) selected secondary schools at the time scheduled by the schools and the researcher. This method was used for collecting data such as:

1. Students
1. Assessment of secondary school students general health status - What health problems do they say they have.
2. Which are the common problems and their causes?
3. The health facilities available in the schools.
   What are the alternative health facilities outside the schools.
4. Which of these facilities do they use and why?
   What influences them in deciding where to go or what to do when they are sick?
5. What do they finally decide to do?

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5. What do they finally decide to do?

### 3.6.1 Training Research Assistants and Pilot Study

To be sure that the tool was reliable, sensitive and meaningful and to familiarize the research assistants with the working conditions of the various instutions, interviews were conducted (pre-tested) in two units immediately after training the assistants. The Pilot study utilized 60 Forms III and IV Students (in two secondary schools) who are considered homogenous and as close to the study population as possible. All the necessary amendments were made on the interview guide before commencing the study.

### 3.6.2 Permission

Letters requesting for permission to conduct the study were delivered personally to the authorities of the schools concerned by the researcher.

Conferences were held with the students in the schools where they were briefed on the purpose of the study. They were informed that the study was not intended to discriminate or criticize them in any way, but to obtain information on how young people solve their health problems. Lastly, they were assured of the confidentiality of all information and that nobody would be identified by name.

The Principal and four school teachers in each of the two schools were also interviewed particularly the Hall Masters and Mistresses responsible for sick students (where these were available).

Data collected from Principal, Teachers/Hall Masters/ Mistresses included:

1. What facilities are available?
2. What is the school's policy on sick students generally?
3. What are some health problems commonly reported by the students or observed by the teachers.
4. Health needs of the students.

3.6 Data Collection Strntegy

Five Third Year students of the Department of Physical and Health Education were invited to assist in the data collection. They were briefed on the purpose of the study and were given two days of training on how to interview the respondents. They were briefed on the category of personnel to be studied, and accuracy and reliability in recording was stressed.

These five assistants and the researcher assumed responsibility for the data collection in each of the ten (10) units.

The data collected was brought back to the base at the end of each day by the research assistants. Conferences were held at the end of each date collecting session with the research assistants to discuss the problems encountered during the session and make adequate preparations for the next day.

### 3.6.3 Analysis of Data

Data was analysed using descriptive and inferential statistics. These included the simple percentage and the chi-square techniques. The null hypotheses were tested at .05 level of significance.

## 3.7 Limitations of the Study and Problems Encountered

### 3.7.1. Non-payment of Teachers' Salaries

The study was conducted at a time when all civil servants including the researcher were on their fifth month (June to September) without salaries in the Cross River State. The consequence of this situation was grave as there was low morale and lack of cooperation on the part of most teachers and students. Students were commonly seen loitering around the streets and roads as they were either unable to pay their school fees and be admitted into the schools, or the tutors refused to teach them.

Most teachers on their part did not even report at school as they complained of lack of money for feeding, paying their children's school fees or even for transportation to places of work. The researcher therefore had to really appeal and in some cases promised some incentives to win the teachers co-operation. Even, the principal of one Rural school bluntly refused to grant his permission for the study on the grounds that it would be impossible to get

his teachers to co-operate with the researcher.

In another school, after the Principal had given consent, a day was fixed for orientation with the teachers. This orientation did not take place as most of the teachers who were seen standing around and discussing in groups said they would only be willing to meet the researcher if she came to discuss the salary issues.

Three other scheduled visits were made to the same school in vain within a period of three weeks. One of their teachers later advised me to wait for another one month to let tempers cool. The timely intervention by my Supervisor, who kindly wrote a letter of appeal to each of the schools later envoked the situation. Most Principals were, however, willing to consent without much ado.

3.7.2 Transfers

The year, 1983 happened to be a year of mass transfers of teachers in the Secondary Schools. All categories of teachers were involved in the posting exercise. This resulted in the researcher having obtain permission twice in more than three schools after the first principal who had granted his permission would have left to a new station. In some cases where the new Principal failed to arrive at the new station or refused transfer, such a school would be left without a Principal and the researcher had to make repeated visits before permission could be obtained.

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3.7.3 Finance

The researcher had to borrow money for petrol to get to these schools!

In the light of the afore-mentioned problems, it was thought that delivering the letters of consent personally by the researchor to the school authorities would be best and faster than if these letters were delivered by mail.

3.7.4. Students

In two of the schools, the Form V students refused to participate in the study unless the researcher gave them some financial benefit. This could be attributed to the situation of poverty resulting from the non-payment of salaries to their parents and guardians most of whom are civil servants.

However, after intervention by the Principal, Vice-Principal and some teachers, they reluctantly accepted to participate.

There was also indiscipline generally among the students in these schools as they were not controlled by their teachers. Those students therefore did not take their participation in the study seriously even when they volunteered to take part. Some students absconded from their schools, other did not bother to report since there would be no lectures.

### 3.7.5. Time Constraint

Time was another limiting factor. The 1983 Elections with its associated tension in the Cross River State limited people's movement for some time thereby disturbing the progress of the survey and wasting time.

### 3.7.6. Sample Size

The large sample size of 600 respondents contributed to the problem. This is because interview with open-ended questions adopted for this study was time consuming, as also was the hand processing method of data analysis.

### 3.7.8. Masquerade

The period of July to January (the period of the study) is the season for the Ekpe (Juju) masquerade in almost all the villages in Uyo Local Government Area and Ibibio land as a whole.

During this period, women's movement are restricted. They must not go out in four days of a week unless accompanied by a man who is a member of the society. In fact, the researcher was nearly lynched by a group of masquerades while driving alone to one of the schools. Report on the back page of the "daily times" newspaper indicated the next day that two people were killed at that very encounter.

3.7.8 End Roads

Another problem encountered was the terribly poor condition of roads in the Cross River State. Occasionally, this situation kept the researcher at the Mechanic's workshops for several hours repairing the car for use the next day.

In summary, time constraint and finance were the major limiting factors which could have affected the study as the researcher could have wished to drew up a larger sample size from all the schools in the Cross River State. The problems encountered included the large sample size of 600 respondents with the open-ended questions adopted for interviews, mass transfer of teachers and the general uncooperative attitude of some teachers, poor condition of roads, limitation of women's movement by Ekpo Masquerades and lack of cooperation and indiscipline among some students.

In spite of these numerous problems, it is hoped that the study has made some useful contributions toward health in the Cross River State.

# CHAPTER FOUR

## RESULTS

In this Chapter, the results obtained from students, and from observation are presented. The chapter deals with different topics relating to the objectives of the study: the perceived general health problems reported by the secondary school students in the Cross River State; availability of health facilities in the secondary schools; factors affecting the secondary school students' decision to seek health care and where students really seek health care.

Background information was obtained on the students including parents' occupation, place of residence and an idea of their belief about their present health status. Out of 600 students, 34.3% indicated that their parents were businessmen and women, 26.0% were in the teaching profession, 14.3% were civil servants, 5.7% were farmers, 9.0% and 4.3% were private employees and medical paramedical workers respectively. Lastly, 2.4% represented unclassified occupations such as palm-wine tappers, poachers, armed forces.

The students were then asked with whom they were living if they were not in the boarding school. The responses were mainly of two categories: Parents/Guardian 55.6%, Alone: 36.3% and others 8.1% which included living with friends, teachers, priests and pastors.

The next question was to test the student's responses as to their present health condition. The responses were grouped into 'Good,' 'Fair,' 'Poor,' and 'Don't know,' depending on the students', perception. Before accepting the student's response, the question 'Why' was asked and a further explanation received from the respondents to confirm that he or she really knew what he or she was talking about. For instance, most of the respondents who graded their health condition as 'fair' or 'poor' did attribute that condition to some illness like malaria, abdominal pains, headaches or any other illness. The responses received were as follows: 'Good' 38.3%, 'Fair' 46.2%,' Poor' 12.8% and 'Don't know 2.7%.

In order to confirm their present health condition, the students were further asked when last they were ill. The responses were: Less than a week ago 1.0%, about a month ago 31.2% about three months ago, 18.2%, about six months ago 23.5% and more than a year ago 14.2%. Some respondents (11.9%) said they did not remember when they were last ill.

## 4.1 Reported Perceived General Health Problems

The perceived general health problems reported by students of ten (10) secondary schools in Uyo Local Government Area of the Cross River State are presented here.

Through a pirate sets of questions in indepth interviews, information was obtained from 600 secondary school students on their

major health problems. Malaria related problems were by far the most frequently reported of all health problems in this sample (43.8%). The problems in this category include fever, headache, body pains, joint pins, internal heat, dizziness and fainting.

In order of frequency, the following are the other health problems: abdominal pains: 15.1% Eye Problems 12.2%, Respiratory Tract Infections 6.7%, Venereal Diseases 6.7%, Smoking and Drinking 6.7%, Drug Use 5.0%. Other unclassified health problems like rashes, injuries and accidents, leg pain, earache, emotional problems, chest pain and pregnancies were reported by 2.6% of the respondents, while 1.8% had no health problems.

A breakdown of the respondents by sex showed the following results:

Male Respondents: Malaria related problems 49.6%, Abdominal pain 13.2%, Respiratory Tract Infections 5.8% Eye problems 10.6%, Drug use 6.9%, Smoking and Drinking 6.6%, Venereal Disease 5.1%, other health problems mentioned above: 0.7%, 1.6% gave no health problems.

Female Respondents: Malaria related problems were also most frequently mentioned (38.9%) of the respondents, followed by Abdominal pains reported by 16.9%, other health problems included Eye defects 13.5%, Venereal Diseases 7.9%

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Respiratory Tract Infections 7.4%, Smoking and Drinking 6.7%, Drug use 3.4%, while 2.0 reported other health problems already mentioned above such as rashes, injuries and accidents, leg pain, ear ache, depression and chest pain and pregnancies, sleeping sickness, dislocation, 1.8% mentioned no health problems at all.

Table 1 shows that there is a significant difference in the type of perceived general health problems reported in the secondary schools among male and female students ($X^2$ = 16.007, df = 7, p < 0.05). This is probably due to the fact that more boys than girls reported malaria related problems (49.6% versus 38.9%) and drug use (6.9% versus 3.4%), whereas more girls reported abdominal pains and venereal diseases than boys as indicated in the Table 1.

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TABLE 1

Most Reported Health Concerns of Secondary School Students by Sex

N = 600

| Health Concerns | SEX | | | | | |
|---|---|---|---|---|---|---|
| | Male(n = 274) | | Female(n=326) | | Total | |
| | n | % | n | % | n | % |
| Malaria Related | 136 | 49.6 | 127 | 38.9 | 263 | 43.8 |
| Abdominal Pains | 36 | 13.2 | 55 | 16.9 | 91 | 15.1 |
| Eye Problems | 29 | 10.6 | 44 | 13.5 | 73 | 12.2 |
| Drug Use | 19 | 6.9 | 11 | 3.4 | 30 | 5.0 |
| Smoking and Drinking | 18 | 6.6 | 22 | 6.7 | 40 | 6.7 |
| Respiratory Tract Infections | 16 | 5.8 | 24 | 7.4 | 40 | 6.7 |
| Venereal Diseases | 14 | 5.1 | 26 | 8.0 | 40 | 6.7 |
| *Others | 2 | 0.7 | 10 | 3.0 | 12 | 2.0 |
| No Health Problems | 4 | 1.4 | 7 | 2.2 | 11 | 1.8 |
| Total | 274 | 100.0 | 326 | 100.0 | 600 | 100.0 |

$\chi^2$ = 16.007, df = 7, P < 0.05

*Others include rashes, injuries and accidents, chest pain, leg pain, earache, depression, pregnancies, sleeping sickness, dislocation.

TABLE 2

Most Reported Health Concerns of Secondary School Students according to Location of Schools

N = 600

| Health Concerns | Location | | | | | |
|---|---|---|---|---|---|---|
| | Urban(n = 240) | | Rural(n = 360) | | Total | |
| | n | % | n | % | n | % |
| Malaria Related | 110 | 45.8 | 153 | 42.5 | 263 | 43.8 |
| Abdominal Pains | 39 | 16.3 | 52 | 14.4 | 91 | 15.1 |
| Eye Problems | 24 | 10.0 | 49 | 13.6 | 73 | 12.2 |
| Venereal Diseases | 19 | 7.9 | 21 | 5.8 | 40 | 6.7 |
| Respiratory Tract Infections | 16 | 6.7 | 24 | 6.7 | 40 | 6.7 |
| Drug Use | 12 | 5.0 | 18 | 5.0 | 30 | 5.0 |
| Smoking and Drinking | 11 | 4.6 | 29 | 8.1 | 40 | 6.7 |
| *Others | 6 | 2.5 | 9 | 2.5 | 15 | 2.5 |
| No Health Problems | 3 | 1.2 | 5 | 1.3 | 8 | 1.3 |
| Total | 240 | 100.0 | 360 | 100.0 | 600 | 100.0 |

$\chi^2 = 5.768$, df = 7, $P > 0.05$

*Others include rashes, injuries and accidents, chest pain, leg pain, earache, depression, pregnancies, dislocation, sleeping sickness.

A further categorization of the respondents into urban and rural schools showed the following results:

~~In urban schools~~: Malaria related problems were reported by 45.6%, abdominal pains by 16.3%, eye problems by 10%, venereal diseases by 7.9%, respiratory tract infections by 6.7%, drug use by 5.0% and other unclassified health problems mentioned above by 2.5%, no health problems were reported by 1.2% of the respondents.

In the rural schools; the responses obtained were as follows: 42.5% for malaria related problems, 14.4% for abdominal pains, 13.6% for eye problems, 8.1% for smoking and drinking, 6.7% for respiratory tract infections, 5.8% for venereal diseases, 5.0% for drug use, 2.5% for other health problems and 1.2% for no health problems (Table 2).

Table 3 shows the pattern of responses when the schools were grouped into boarding and day types of schools.

The results for the boarders showed the following: Malaria related problems 12.0%, abdominal pains 17.0%, eye problems 12.00%, respiratory tract infections 7.3%, venereal diseases 7.3%, smoking and drinking 5.3%, drug use 4.3 while other health problems were reported by 3.3% of the respondents, while 1.3% have no health problems.

For the day students, 45.7% of the respondents indicated malaria related problems, 13.3% complained of abdominal pains, 12.3% mentioned eye problems, 8.0% reported smoking and drinking, 6.0% gave respiratory tract infections, 6.0% indicated venereal diseases, 5.7% drug use, other health problems scored 2.6%, while no health problems were indicated by 1.2% of the respondents.

Direct observation as well as chi-square test show that there is no significant differences in the type of health problems reported between urban and rural students ($x^2$ = 5.768, df = 7, P 0.05) and between boarders and day students ($x^2$ = 5.824, df = 7, P 0.05).

Also 55.4% of the 47 teachers interviewed reported malaria related problems as being the commonest health problems observed or reported by the students. This was followed by respiratory tract infections reported by 25.5% of the population. Eye problems was mentioned by 10.6% of the sample; 6.4% indicated abdominal pains while 2.1% reported other health problems including minor accidents pregnancy, skin diseases.

TABLE 3

Most Reported Health Concerns of Secondary School Students According to Type of School

N = 600

| Health Concerns | Boarding School (n = 300) | | Day School (n = 300) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Malaria Related | 126 | 42.0 | 137 | 45.7 | 263 | 43.8 |
| Abdominal Pains | 51 | 17.0 | 40 | 13.3 | 91 | 15.1 |
| Eye Problems | 36 | 12.0 | 37 | 12.3 | 73 | 12.2 |
| Respiratory Tract Infections | 22 | 7.3 | 18 | 6.0 | 40 | 6.7 |
| Venereal Diseases | 22 | 7.3 | 18 | 6.0 | 40 | 6.7 |
| Smoking and Drinking | 16 | 5.3 | 24 | 8.0 | 40 | 6.7 |
| Drug Use | 13 | 4.3 | 17 | 5.7 | 30 | 5.0 |
| *Others | 10 | 3.3 | 6 | 2.0 | 16 | 2.6 |
| No Health Problems | 4 | 1.3 | 3 | 1.0 | 7 | 1.2 |
| Total | 300 | 100.0 | 300 | 100.0 | 600 | 100.0 |

$\chi^2$ = 5.824, df = 7, P > 0.05

*Others include rashes, injuries and accidents, chest pain, leg pain, earache, depression, pregnancies, sleeping sickness, dislocation.

## 4.2. Assessment of Health Facilities Available in the Secondary Schools

From observation, only three of the ten (10) schools sampled possessed empty first aid boxes and two other schools had non-functional dispensaries. Five schools had neither dispensaries or first aid boxes. So generally speaking, there were no available health facilities in the schools.

The students were then asked about what alternative health facilities existed outside the school for the treatment of sick students. The responses were as follows: 53.3% mentioned hospital/private clinics, 26.7% indicated Dispensary /Health Centre, 22.7% reported Traditional Healers, 20.8% mentioned Chemists/Patent Medicine Stores, 14.3% indicated traditional healers and 1.3% said there were no facilities outside the school.

## 4.3 Factors Affecting Students' Decision to Seek Solutions to their Health Problems

The respondents were asked what factors they consider when taking decisions concerning solutions to their health problems.

Overall, more than one-third of the respondents (35.2%) said they considered finance as the most important factor, 19.1% considered distance between the school and place of treatment, 12.0% indicated quick treatment, 10.2% mentioned type of illness, 9.4% indicated perceived seriousness of illness, 4.1% listed other factors such as

parents' wish, enduring the illness as much as possible, fear of injection or doing nothing at all.

When the respondents were categorized according to sex, the results showed the following pattern: For the male respondents: 46.7% reported considering finance as the first factor, 12.7% considered distance to the places of treatment, 12.8% reported considering quick treatment, 8.8% mentioned perceived seriousness of illness, 5.9% considered type of illness and 5.1% indicated other factors mentioned above.

For the female respondents, the results were: 43.9% for finance, 18.7% for distance to the place of treatment, 12.9% for type of illness, 11.3% for quick treatment, 9.8% for perceived seriousness of illness while 3.4% reported other unidentified factors. Table 4 shows that there is no significant difference in the factors affecting the secondary school students' decision in seeking health care between male and female students ($X^2 = 7.794$, df = 5, $P > 0.05$).

When the respondents were grouped as urban and rural schools, the responses showed the following: 52.1% of the urban respondents mentioned finance as against 40.6% of the rural respondents. A higher percentage of the rural respondents (24.2%) reported distance as against 11.7% of the urban dwellers. Similarly, 14.1% of the rural respondents mentioned quick treatment as against

TABLE 4

Factors Affecting Students' Decision to Seek Solutions to their Health Problems by Sex

N = 600

| Factors | Male (n = 274) | | Female(n = 326) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Finance | 128 | 46.7 | 143 | 43.9 | 271 | 45.2 |
| Distance to place of treatment | 54 | 19.7 | 61 | 18.7 | 115 | 19.2 |
| Quick treatment | 35 | 12.8 | 37 | 11.3 | 72 | 12.0 |
| Perceived seriousness of illness | 24 | 8.8 | 32 | 9.8 | 56 | 9.3 |
| Type of illness | 19 | 5.9 | 42 | 12.9 | 61 | 10.2 |
| *Others | 14 | 5.1 | 11 | 3.4 | 25 | 4.1 |
| Total | 274 | 100.0 | 326 | 100.0 | 600 | 100.0 |

$X^2 = 7.094$, df = 5, $P > 0.05$

*Others include parents' wish, enduring the illness as such as possible, fear of injection, doing nothing at all or no response.

## TABLE 4

### Factors Affecting Students' Decision to Seek Solutions to their Health Problems by Sex

N = 600

| Factors | Male (n = 274) | | Female (n = 326) | | Total | |
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N = 600

| Factors | Male (n = 274) | | Female(n = 326) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Finance | 128 | 46.7 | 143 | 43.9 | 271 | 45.2 |
| Distance to place of treatment | 54 | 19.7 | 61 | 18.7 | 115 | 19.2 |
| Quick treatment | 35 | 12.8 | 37 | 11.3 | 72 | 12.0 |
| Perceived seriousness of illness | 24 | 8.8 | 32 | 9.8 | 56 | 9.3 |
| Type of illness | 16 | 5.9 | 42 | 12.9 | 61 | 10.2 |
| *Others | 14 | 5.1 | 11 | 3.4 | 25 | 4.1 |
| Total | 274 | 100.0 | 326 | 100.0 | 600 | 100.0 |

$x^2 = 17.094$, df = 5, $P > 0.05$

*Others include parents' wish, enduring the illness as much as possible, fear of injection, doing nothing at all or no response.

## TABLE 5

### Factors Affecting Students' Decision to Seek Solutions to their Health Problems According to Location of Schools

| Factors | Urban (n = 240) | | Rural (n = 360) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Finance | 125 | 52.1 | 146 | 40.6 | 271 | 45.2 |
| Distance to place of treatment | 28 | 11.7 | 87 | 24.2 | 115 | 19.2 |
| Type of illness | 28 | 11.7 | 33 | 9.2 | 61 | 10.1 |
| Perceived seriousness of illness | 27 | 11.2 | 29 | 8.0 | 56 | 9.3 |
| Quick treatment | 20 | 8.3 | 52 | 14.4 | 72 | 12.0 |
| *Others | 12 | 5.0 | 13 | 3.6 | 25 | 4.2 |
| Total | 240 | 100.0 | 360 | 100.0 | 600 | 100.0 |

$\chi^2$ = 23.582, df = 5, P < 0.05.

8.3% of the urban respondents. Another factor was type of illness. Nearly 12% (11.7%) of the urban respondents and 9.2% of the rural dwellers gave this as a factor. This was followed by perceived seriousness of illness mentioned by 11.2% of the urban and 8.0% of the rural respondents. Other factors such as parents' wish, enduring the illness as much as possible, doing nothing at all or fear of injection were mentioned by 5.0% of the urban and 3.6% of the rural respondents (Table 5).

A further test confirmed that there is a highly significant difference in these factors between urban and rural students ($X^2$ = 23.582, df = 5, $P < 0.05$). This is because finance as a single factor affected more urban than rural students, whereas the rural students considered distance as being more important than the urban students did (Table 5).

Table 6 shows the respondents categorized into boarding and day schools. The results of the sample showed that 50.3% of the day schools and 40.0% of the boarders respectively indicated finance. Also a higher percentage of the day students (20.7% than boarders (17.7%) reported distance. Other factors included quick treatment mentioned by 16.6% of the boarders and 8.0% of the day students. Type of illness was mentioned by 12.3% of the boarders and 8.0% of the day students and perceived seriousness of illness was mentioned by 10.3% of the boarders and 9.3% of the day students. For other

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## Table 6

### Factors Affecting Students' Decision to Seek Solutions to their Health Problems According to Type of School

N = 600

| Factors | Boarding School (n = 300) | | Day School (n=300) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Finance | 120 | 40.0 | 151 | 50.3 | 271 | 45.2 |
| Distance to place of treatment | 53 | 17.7 | 62 | 20.7 | 115 | 19.2 |
| Quick treatment | 48 | 16.0 | 24 | 8.0 | 72 | 12.0 |
| Type of illness | 37 | 12.3 | 24 | 8.0 | 61 | 10.7 |
| Perceived seriousness of illness | 31 | 10.3 | 25 | 8.3 | 56 | 9.3 |
| *Others | 11 | 3.7 | 14 | 4.7 | 25 | 4.1 |
| Total | 300 | 100.0 | 300 | 100.0 | 600 | 100.0 |

$\chi^2$ = 16.022, df = 5, $P < 0.05$.

*Others include leaving the solution of health problems entirely to the discretion of their parents, enduring the illness.

unclassified factors already mentioned above, the percentages were 4.7% for day students and 3.7% for boarders.

A further test showed a significant difference in the factors affecting secondary school students' decision making in seeking solutions to their health problems between boarders and day students ($\chi^2 = 16.022$, df = 5, $P < 0.05$), (Table 6). Thus the hypotheses that there is no significant difference in the factors affecting secondary school students' decision making in seeking solutions to their health problems between urban and rural schools and between boarders and day students were rejected.

## 4.4 Who Influences the Secondary School Students' Decision to Seek Healthcare?

The next question was to find out how the secondary school students make decisions concerning solutions to their health problems, in other words, to find who influences their decision making.

Of the 600 students interviewed, 49.7% indicated that such decision were usually taken on their behalf by parents and guardians. Other findings were as follows: Self: 23.5%, medical/paramedical personnel 9.8%, teachers: 8.7%, friends: 4.3% and finally others such as preachers, school prefects, colleagues, family friends, neighbours, were mentioned by 3.8% of the respondents.

The above findings were further analyzed by sex. For the male students, the findings were as follows: Parents/Guardians 46.7%, self 20.5%, medical/paramedical personnel: 15.0%, teachers: 7.3%, friends, 5.8% and others 4.7%. For the female respondents, the findings were: Parents/Guardian: 52.1%, self 26.1%, teachers 9.7%, medical/paramedical 5.5%, friends 3.4% and others 3.1% (Table 7).

A further analysis of the respondents into urban and rural schools showed a similar pattern to the table already indicated above. Top on the list were were parents/guardians with 52.1% for the urban and 48.0% for the rural respondents. Self was recorded next with 24.2% for the rural and 22.5% for the urban respondents. For the medical and paramedical personnel, it was 11.7% for the urban and 8.6% for the rural dwellers. This was followed by teachers with 10.0% and 7.8% for the urban and rural respondents respectively. For the rural dwellers, the least percentage was recorded for friends (5.6%) whereas for the urban dwellers, the least was recorded for others such as school mates, colleagues, preachers, family friends, nuns (Table 8).

When the respondents were grouped into boarding and day schools, it was discovered that parents still have considerable influence on their children and wards when it comes to decision making on medical care, whether they are boarders or day students. For the respondents

## TABLE 7

### Secondary School Students' Responses on Who Influences them to Seek Health Care by Sex

N = 600

| Persons | Male(n = 274) | | Female(n = 326) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Parents/Guardian | 128 | 46.7 | 170 | 52.1 | 290 | 49.7 |
| Self | 56 | 20.5 | 85 | 26.1 | 141 | 23.5 |
| Medical/Paramedical Personnel | 41 | 15.0 | 18 | 5.5 | 59 | 9.8 |
| Teachers | 20 | 7.3 | 32 | 9.8 | 52 | 8.7 |
| Friends | 16 | 5.8 | 11 | 3.4 | 27 | 4.5 |
| Others | 13 | 4.7 | 10 | 3.1 | 23 | 3.8 |
| Total | 274 | 100.0 | 326 | 100.0 | 600 | 100.0 |

$\chi^2$ = 20.096, df = 5, P < 0.05

*Others include School Prefects, Priest and Pastors, Neighbours and Siblings.

TABLE 8

Secondary School Students' Response on Who Influences them to Seek Health Care According to Location of Schools

N = 600

| Persons | Urban (n = 240) | | Rural(n = 360) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Parents/Guardians | 125 | 52.1 | 173 | 48.0 | 298 | 49.7 |
| Self | 54 | 22.5 | 87 | 24.2 | 141 | 23.5 |
| Medical/Paramedical | 28 | 11.7 | 31 | 8.6 | 59 | 9.8 |
| Teachers | 24 | 10.0 | 28 | 7.8 | 52 | 8.7 |
| Friends | 7 | 2.9 | 20 | 5.6 | 27 | 4.5 |
| *Others | 2 | 0.8 | 21 | 5.8 | 23 | 3.8 |
| Total | 240 | 100.0 | 360 | 100.0 | 600 | 100.0 |

$X^2$ = 14.047, df = 5, $P < 0.05$

*Others include leaving the solution of health problems entirely to the discretion of their parents, enduring the illness as much as possible.

in boarding schools, the results were as follows: Parents 45.7%, self 26.3%, teachers 14.0%, friends 7.0%, others 3.7% and finally medical/paramedical personnel 3.3%

For the day students, the findings (also in order of magnitude) were: Parents/Guardians 53.7%, self 20.7%, medical/paramedical personnel 16.3%, teachers 3.3%, friends 2.0% and others 4.0% (Table 9).

In summary, Tables 7, 8 and 9 show that there is a significant difference in those who influence secondary school students to seek health care between male and female students, urban and rural students and between boarders and day students ($X^2$ = 20.096, df = 5, $P < 0.05$), ($X^2$ = 14.447, df = 5, $P < 0.05$) and ($X^2$ = 57.332, df = 5, $P < 0.05$) respectively. Some of the factors which account for these differences are, that more girls than boys are influenced by medical and paramedical personnel than boarders (3.3%).

## 4.5 Where Secondary School Students Seek Health Care

Consideration will now be given to where the secondary school youngsters seek health care in the Cross River State.

Turning to the findings from interviews, 29.5% of the 600 students interviewed admitted using hospitals and private clinics, 23.3% said they use self-medication, 15.5% consult the chemists and patent medicine stores, 5.7% reported doing nothing, 2.0% take

## TABLE 9

### Secondary School Students' Response on Who Influences them to Seek Health Care According to Type of School

N = 600

| Persons | Boarding School (n = 300) | | Day School (n = 300) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Parents/Guardian | 137 | 45.1 | 161 | 53.7 | 298 | 49.7 |
| Self | 79 | 26.3 | 62 | 20.7 | 141 | 23.5 |
| Teachers | 42 | 14.0 | 10 | 3.3 | 52 | 8.7 |
| Friends | 21 | 7.0 | 6 | 2.0 | 27 | 4.5 |
| Medical/Paramedical | 10 | 3.3 | 49 | 16.3 | 59 | 9.8 |
| *Others | 11 | 3.7 | 12 | 4.0 | 23 | 3.8 |
| Total | 300 | 100.0 | 300 | 100.0 | 600 | 100.0 |

$\chi^2$ = 57.832, df = 5, $P < 0.05$

*Others include leaving the solution of health problems entirely to the discretion of their parents, enduring the illness.

remedies from the first aid box, while 3.0% gave other ways such as leaving the solution of health problems entirely to the discretion of their parents, enduring the illness as much as possible.

A breakdown of the respondents by sex showed that 30.1 of the females and 28.8% of the males use hospitals and private clinics to solve their health problems. Other results are as follows: For the male respondents: 23.0% administer self medication, 13.9% use the spiritual healing homes, 12.0% visit the traditional healers, 9.1% consult the chemist/patent medicine stores, 8.4: reported doing nothing, 2.6% take remedies from First Aid Box, while 2.2% gave other responses mentioned above. For the female respondents: 23.6% use self-medication, 16.2% visit the spiritual healing homes, 11.7% consult the chemists/patent medicine stores, 9.8% consult the traditional healers, 3.4% said they do nothing, 1.5% use remedies from first aid box, and 3.7% mentioned other responses (Table 10).

Table 11 shows a further breakdown of the respondents by location of schools. For the urban schools, the responses were: Hospitals/private clinic 32.1%, self medication 18.3%, spiritual healing homes 16.7%, traditional healers 11.7%, chemists/patent medicine stores 11.3%, nothing 5.4%, first aid box 1.6%, and others 2.9%.

## TABLE 10

### Where Secondary School Students Really Seek Health Care by Sex

N = 600

| Places | Male(n=274) | | Female(n=326) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Hospital/Private Clinics | 79 | 28.8 | 98 | 30.1 | 177 | 29.5 |
| Self-medication | 63 | 23.0 | 77 | 23.6 | 140 | 23.3 |
| Spiritual healing home | 38 | 13.9 | 53 | 16.2 | 91 | 15.2 |
| Traditional healer | 33 | 12.0 | 32 | 9.8 | 65 | 10.8 |
| Chemist/Patent Medicine Store | 25 | 9.1 | 38 | 11.7 | 63 | 10.5 |
| Do nothing | 23 | 8.4 | 11 | 3.4 | 34 | 5.7 |
| First Aid Box | 7 | 2.6 | 5 | 1.5 | 12 | 2.0 |
| *Others | 6 | 2.2 | 12 | 3.7 | 18 | 3.0 |
| Total | 274 | 100.0 | 326 | 100.0 | 600 | 100.0 |

$\chi^2$ = 11.5, df = 7, $P > 0.05$

*Others include leaving the solution of health problems entirely to the discretion of their parents, during the illness.

## TABLE 11

### Where Secondary School Students Really Seek Health Care According to Location of Schools

N = 600

| Places | Urban(n = 240) | | Rural(n = 360) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Hospital/Private Clinics | 77 | 32.1 | 100 | 27.7 | 177 | 29.5 |
| Self-medication | 44 | 18.3 | 96 | 26.7 | 140 | 23.3 |
| Spiritual health home | 40 | 16.7 | 51 | 11.2 | 91 | 15.2 |
| Traditional Healer | 28 | 11.7 | 37 | 10.3 | 65 | 10.8 |
| Chemist/Patent Medicine Store | 27 | 11.3 | 36 | 10.0 | 63 | 10.5 |
| Do nothing | 13 | 5.4 | 21 | 5.8 | 34 | 5.7 |
| First Aid Box | 4 | 1.6 | 8 | 2.2 | 12 | 2.0 |
| *Others | 7 | 2.9 | 11 | 3.1 | 18 | 3.0 |
| Total | 240 | 100.0 | 360 | 100.0 | 600 | 100.0 |

$X^2$ = 11.91, df = 7, P > 0.05

*See Table 10.

Similarly for the six (6) rural schools, the results showed that 27.7% reported using hospitals and private clinics, 26.7% reported using hospitals and private clinics, 26.7% reported using self medication, 14.2% go to spiritual healing homes, 10.3% visit the traditionnl healers, 10.0% consult the chemists/patent medicine stores, 5.8% do nothing, 2.2% use first aid box, and 3.1% gave other responses.

In Table 12, the respondents were grouped by the type of school. The following results were obtained in respect of boarders: 30.0% for hospitals, 24.3% for self-medication, 13.7% for chemists/ patent medicine stores, 12.0% for spiritual healing homes, 10.0% for traditional healers, 5% for doing nothing, 2.3% take drugs from first aid box, 2.7% for other responses such as leaving the solution of health problems to their parent's discretion or trying to endure the illness.

Similarly, 29.0% of the day students use hospitals/private clinics, 22.3% administer self-medication, 18.4% consult the spiritual healing homes, 11.7% visit the traditional healers, 7.3% consult the chemists/patent medicine stores, 6.3% do nothing and 3.3% gave other responses.

## TABLE 12

### Where Secondary School Students Really Seek Health Care According to Type of Schools

N = 600

| Places | Boarding School (n = 300) | | Day School (n = 300) | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Hospital/Private Clinics | 90 | 30.0 | 87 | 29.0 | 177 | 29.5 |
| Self-medication | 73 | 24.3 | 67 | 22.3 | 140 | 23.3 |
| Chemist/Patent Medicine Store | 41 | 13.7 | 22 | 7.3 | 63 | 10.5 |
| Spiritual healing home | 36 | 13.0 | 55 | 18.4 | 91 | 15.2 |
| Traditional healer | 30 | 10.0 | 35 | 11.7 | 65 | 10.8 |
| Do nothing | 15 | 5.0 | 19 | 6.3 | 34 | 5.7 |
| First Aid Box | 7 | 2.3 | 5 | 1.7 | 12 | 2.0 |
| Others | 8 | 2.7 | 10 | 3.3 | 18 | 2.0 |
| Total | 300 | 100.0 | 300 | 100.0 | 600 | 100.0 |

$\chi^2 = 11.5$, df = 7, $P > 0.05$

See Table 10.

The results of the statistical test carried out showed that there is no significant difference in the places where secondary school students seek health care between male and female students ($X^2 = 11.5$, $df = 7$, $P > 0.05$), between urban and rural students ($X^2 = 11.91$, $df = 7$, $P > 0.05$), and between boarders and day students ($X^2 = 11.4$, $df = 7$, $P > 0.05$). (Tables 10, 11, and 12 respectively).

# CHAPTER FIVE

## DISCUSSION ON FINDINGS

### REPORTED HEALTH PROBLEMS

In considering the implications of this cross-section survey of secondary school students in Uyo Local Government Area of the Cross River State, perhaps the first fact to note is the amount of concern about health evidenced here.

The findings from personal interviews have tapped the kinds and frequency of students perceived health problems. As in the presentation of data already discussed (Chapter four), the main focus is on secondary school students, and 13 to 18 years who were presented in sufficient numbers and for whom observations were made over six months of the study.

For convenience, the information gathered was grouped into eight main categories: malaria related problems; abdominal pains; respiratory tract infections, eye problems; venereal diseases, smoking and drinking, drug abuse and other unclassified problems (which included rashes, injuries and accidents, leg pain, earache, chest pain and pregnancies).

wire-gauze. In the boarding schools, only relatively few students were seen to possess mosquito nets on their beds. Further discussion with the students indicated that majority of them were not provided with malaria prophylactic drugs by the school or from home. The general effect of the non-availability of these preventive devices is the exposure of the students to frequent mosquito bites and malaria attacks.

## ABDOMINAL PAINS

Abdominal pains came next with the percentage of 15.2%. This category include abdominal related complaints, such as stomach ache and diarrhoea, vomiting, lower abdominal pain, menstrual pain, appendicitis and abdominal pains. When asked about the causes, most respondents gave such answers as poor source of drinking water (61.5%), poor feeding (51.6%) and poor environmental sanitation (39.6%), unripe fruits (17.6%). In effect, none of the rural schools observed by the researcher possessed any pipe-borne water.

A breakdown of the respondents by sex showed that more females (16.9%) reported abdominal problems than males (13.2%). This high percentage among the females may be related to their frequent complaint of menstrual pains during the study.

EYE PROBLEMS

The next frequently reported group was eye problems which scored 12.2%. A closer look at the analysis reveals that the highest percentage of the eye trouble was scored in the rural schools 13.6% as against 10% recorded for the urban schools. The respondents were asked what they though were the causes. Although some respondents gave such responses as bad air, lack of medical check up, too much working in the sun, the majority (71.3%) were of the consensus that "eye straining especially with bad light (bush lamp)" was a major cause or "too much reading and assignments with bad light," as they put it. From observations, all the urbans schools are supplies with electricity from the National Electric Power Authority (NEPA) while most of the rural schools have electricity generating plants. However, three of the rural day schools are yet to be supplied with electricity. Most of the respondents who complained of eye problems confessed of reading with bush lamp, torch lights or candles when there are power failures from NEPA or family generators or after "Lights out" at 10 p.m. in the boarding schools.

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However, the abundance of palm oil in the Cross River State with its rich content of Vitamin A could be helping the situation.

## RESPIRATORY TRACT INFECTIONS

This category of infections included such reports as cough, chest pain, colds and catarrh, throat infection as was given by 4.7 of the respondents. A breakdown of the respondents showed more females (7.4%) than males (5.8%) and more boarders (7.3%) than day students reporting this as a problem.

## VENEREAL DISEASE (GONORRHOEA)

Gonorrhoea was reported by 6.7% of the respondents. A breakdown of the result indicated that more females (8.0%) than males (5.1%) perceived this as a problem among the secondary school students. A further analysis of the results by class showed the following: 6.0% for Form III, 7.5% for Form IV and 6.5% for Form V. The slight difference in the results for Forms III, IV and V may be due to more awareness for this problem on the part of the older students.

## SMOKING AND DRINKING

About 6.8% of the respondents reported smoking and drinking as their perceived health problems. A close observation of the results shows slightly more girls (6.7%) than boys (6.6%) more than (8.1%) than urban students and more day students (8.0%) than

boarders (5.3%). The high percentage recorded for the rural students may be associated with the abundance of palmwine in the area of study.

DRUG ABUSE

This ranked lowest among the reported health problems with a percentage of 5.0% and more males (6.9%) perceiving it as a problem than females (3.4%). This could be due to greater adult social stigma attached to drug use and therefore reluctance to report it.

Some of the drugs reported to be used commonly include the sleeping pills such as Librax, "Valium 5" (Valium), analgesics, or antibiotics. This findings is in conformity with the findings of Akeredolu (1978) who found that the greater proportion of drug users (92.3%) were below 25 years of age in his study of "The Use and Misuse of Drugs among Post-Primary Students in Abeokuta. It also supported the findings of Ahmed and Akindele (1974); Oyinsa (1976); Lucas (1965); who all noted that the problem of drug abuse is more common among younger generation of under 25 years.

Other unclassified health problems in this group include accidental injuries, pregnancy, sleeping sickness, ear noise, depression, worries, bad dreams, dislocation, malnutrition, rashes or no health problem at all. On the whole, a percentage of 14% was recorded for this category.

The health problems reported here seemed to support the findings of Meisher and Mills (1963) in his study of "The Adolescent Looks at his Health and Medical Care". The students were asked if they had any health problems. One hundred and eighty three (183), or nearly 27% of the 690 who replied said they did. There were more girls (30%) than boys (22%) who had health problems. When questioned regarding the nature of these problems, the largest group was concerned with growth and weight. This accounted for almost 20% of the positive answers.

Also, the findings of Oduntan (1972) in an epidemiological survey indicated that the major health problems of the Nigerian school children are related to malnutrition, multiple infections and trauma.

## AVAILABILITY OF HEALTH FACILITIES IN THE SCHOOLS

From discussion with some teachers, only two principals confirmed having what was described as "an empty dispensary" in their schools - one rural and one urban school. Both principals explained that they inherited the empty room each with a man called a "Dispensary attendant" from their predecessors. But since the attendants have not got even cotton wool or any equipment to work with, they did not hesitate to deploy them to other departments of the school. Another important reason given by the principals is that the attendants had absolutely no training of any kind and they

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wondered how they were deployed by the Ministry of Education for such a delicate post.

Asked what was the fate of ill students in the various schools, many teachers were unanimous in their schools policy of referring all sick students to the nearest hospitals or their homes if such students consult the schools authorities. But according to the teachers, not all the ill students report to the school authorities before seeking health care. Some go ahead with their private arrangement and others even abscond from schools in the event of ill health.

The referral pattern is mostly practiced in the boarding schools. Further investigations also revealed that the students' referral pattern has nothing to do with the cost of such medical care as this is said to be the responsibility of the students and parents or guardians. The principals said that the Cross River State Government used to sponsor the secondary school students' medical treatment in the hospitals but this privilege had since been withdrawn for reasons not explained to them.

In the day schools, the teachers said they could not account for a great number of ill students since they only remain with the students for a few hours, that is 8 a.m. to 2 p.m. A sick student could only be sorted out from the register of absentees while taking the roll calls, if the student gives sickness as a cause of his absence. All attempts to obtain an accurate record of sick

students for the past one year failed as most schools said they kept no such records.

Three schools had empty first aid boxes which were shown to the researcher. The principal of one school and two health teachers of another school said they have had to get first aid materials from their houses or buy them on humanitarian bases to treat students with minor accidents before sending them to the hospital.

## FACTORS AFFECTING SCHOOL STUDENTS' DECISION TO SEEK SOLUTIONS TO THEIR HEALTH PROBLEMS

In this area, the study identified the predisposing, enabling and reinforcing factors affecting the students' decision to seek health care. The predisposing factors comprise the sanitary and climatic conditions of the area belief about disease causation and treatment, and attitude towards the health care provider.

The enabling factors are finance, distance between the school and place of treatment and the perceived skill and ability of the providers.

The reinforcing factors included type and seriousness of the illness, pressure from parents, friends, teachers, medical and paramedical personnel.

These factors which could be summarized as finance, distance (accessibility of health services), social pressure, type and perceived seriousness of illness - all tend to exert some influence

of the secondary school students when making decisions regarding solution to their health problems. These factors are interrelated one cannot easily determine causal sequences. This finding have supported the findings of Fetene (1983) who in hie study in the Lagun community at Ibadan identified the predisposing, enabling and reinforcing factors from the individual's perooived needs and from the dependent variables measuring the use of health services. Generally, the study identified that accessibility of services, social pressure, seriousness of illness and type of diseases were the four influential forces in making decision regarding the use of health services in the community.

As already mentioned, 45.2% of the respondents considered finance to be the most important factor in the solution of their health problem. The reason for this high percentage may not be unconnected with the fact that it is the students and their parents who bear the cost of medical treatment. Under normal circumstances, one would have thought that the type and or the seriousness of illness should have ranked highest on the list. But on the contrary, it is finance which is an indication of the indigent background of most students. With the present situation of exhorbitant fees for curative treatment especially in the private clinics, this also indicates the need for some form of preventive medicine and health counselling.

Distance to the place of treatment is the next factor mentioned in order of frequency by 19.1% of the respondents. Further investigations with the students and teachers revealed that the students are also responsible for their transport arrangements to and from their places of treatments, except in very serious cases, where such students may be conveyed with the school van or a staff's vehicle. Also, the non-availability of the local transport system and the very high cost of the few existent in Uyo Local Government Area further complicates the picture.

Obtaining quick treatment was mentioned by 12.0% of the respondents. When asked further as to the reasons behind considering quick treatment an important factor, most respondents said "they feared missing lectures," or "fear that illness might get worse," or that "they get fed up waiting in the hospital to see a doctor." A good number of the respondents gave quick treatment as a reason for consulting the private clinics and hospitals rather than the available mission hospitals where treatment might be cheaper.

Type of illness was mentioned by 10.2% of the respondents as an important factor. Further discussion with the respondents revealed that the type of illness is closely associated with the perceived beliefs about disease causation and treatment rather than the usual medical classifications. According to these, generally

When individual is ill, there is a preliminary self-speculation or in consultation with significant others as to the possible type of such illness. If people believe the illness to be of a supernatural type, then they are more likely to consult the traditional healers and spiritual healing homes which are considered more potent in such cases than the orthodox medicine. Examples of such types of illnesses given include mental illness, heavy menstrual bleeding among girls, repeated headaches, chest pain or almost any illness depending on the interpretation. "Even accidental injuries could be of a supernatural origin," said one of the respondents.

However, people tend to use the orthodox medicine (hospital, private clinics for more obvious and frequently occuring illnesses like, malaria, measles, pneumonia, accidents than for the less commonly occuring types of cases.

Seriousness of illness was the last factor reported by 9.4% of the respondents. Here, perceived seriousness acts as a reinforcing factor not only for using the health services but also selecting the type of health services and course of action to be adopted according to the level of seriousness of the illness.

For instance, some respondents said they would try to endure the illness if less serious rather than miss their lessons while attending the hospitals. Others reported that trying self-medication

first and if it works, then no need for further medical consultation. This suggests that many secondary school students may not take actions in the solution of their health problems, unless the illness is considered to be of a serious nature.

4.1% of the respondents gave other uncategorised factors such as fear of injections, doing nothing at all because of finance, enduring the illness as much as possible or no response.

## WHO INFLUENCES THE SECONDARY SCHOOL STUDENTS' TO SEEK HEALTH CARE

On who influences the secondary school student's decision to seek health care, nearly fifty percent (49.7%) of the responders said that parents and guardians took such decisions. This high percentage probably stresses the importance of the family institution in decision making in the Cross River State and in Nigeria generally. It also supports the statement by Abasiekong (1981) when he rightly referred to this importance during discussion on the role of the family in Nigeria. He stated: "Traditionally in Nigeria, especially in the rural areas, the family was always played a very important if not a dominat role in the day-to-day decisions that people make about present and futher plans."

The data also suggested that although the Nigerian secondary school student like his counterparts else where in the present day society strives for independence, the family still holds a vital

locus in some important decision making processes. Also, the fact that it is the parents who must pay for medical treatment in the Cross River State adds to the necessity of involving them in such a decision making process.

Finally, the information pointed to the need for any planned health intervention programme to focus on not only the secondary school student but also the family as a unit if it is to achieve any success.

Another important finding in decision making is the self - which scored 23.5%. The relatively high figure here suggested the fact that secondary school students really make some independent decisions. A breakdown of the figure shows that more females, 26.1% than males 20.9% take independent decisions concerning solutions to their health problems. Perhaps, this also accounts for why quite a number of students practice self-care.

Surprisingly, teachers were mentioned by only 8.7% of the respondents in spite of the schools' policy of referring all ill students to the hospital. This confirmed the teachers' explanation that even with rigid discipline of students would still sneak out of the school for their private treatment rather than go through the school authorities (more observed in the boarding schools than day schools).

Nearly four percent (3.8%) of the respondents gave other influential groups such as siblings, pastors, and priests, neighbours, school prefects.

Medical and paramedical personnel were mentioned by 9.8% of the group. Further discussion with some respondents indicated that previous experience, previous contact and the students background contributed to this percentage. Quite a number of the respondents mentioned having medical paramedical persons either as parents, relatives or friends.

Friends ranked lowest with 4.5% of the total scores. This might explain the fact that although the secondary school adolescent is trying to socialize within his group by way of behaving and reasoning, he is not completely dependent on his group on all matters of decision making.

Thus, parents and guardian ranked highest in the students decision making concerning seeking solution to their health problems. As mentioned earlier, this stresses the importance of this institution in the day-to-day decision making in Nigeria. A breakdown of the figure shows more females (52.1%) than males (46.7%) who are influenced by parents/guardian. The difference observed for both sexes indicates the fact that females are more dependent on their parents/guardian for decision making than the males. This finding supported some studies by (Bichler, 1976) Crandell-Robson,

1960; Deutsch, 1967) which have reported that females are more dependant.

The next interesting finding on self care (23.5%) stresses the fact that secondary school students are capable of independent decision making.

Medical and paramedical personnel were mentioned by 9.8% of the respondents for reasons such as previous experience, previous contact and students' background.

Other influential groups included teachers, friends and others such as neighbours, siblings, priests and pastors, school prefects.

These groups of persons tend to act as reinforcing factors in providing support and influencing the secondary school students' decision to seek solutions to their health problems.

The finding here has also supported Perry and Murray (1982) who in their study identified parents, best friends and siblings, teachers, peer group and neighbours as the closest structures which could affect the health behaviour of secondary school students in the environment.

Where Secondary School Students Seek Health Care

HOSPITAL/PRIVATE CLINICS

Although finance was considered a major factor when taking decision to solve their health problems, 29.5% of the respondents indicated using hospitals and private clinics. As mentioned earlier, this fairly high percentage could be associated with the schools' policy of referring sick students to the hospitals. It could also be attributed to the fact that most decisions to seek health care are taken by parents. It is possible that many parents might be reasoning quite differently as to how and where their children should be treated when in danger of ill health. A breakdown of the respondents show that more females, (30.1%) use the hospitals than males (28.8%). The slight difference also could be due to the fact that more females tend to be dependent on their parents during decision making than males.

On the other hand, the percentage of only 29.5% could be regarded as being rather low and contrary to expectation in spite of the abundance of hospitals and private clinics in the Cross River State, as well as the referral system by these high schools. So finance could be accepted as the major limiting factor here as most students had already indicated. Since access to the available health services in the Cross River State is largely shaped by the

resources of the students and family, it is possible that many indigent students are without available resources to seek care from these institutions. This information also raises the need for some forms of preventive health care in view of the expensive cost of curative medicine.

Self-Medication and Drug Abuse

A clear distinction must be between self-medication and drug abuse. Self medication implies the use and over-use of drugs on ourself to relieve pain and discomfort whereas in drug abuse, drugs are used for non-medical purposes, but to meet emotional needs in response to internal or environmental stress.

Self-medication was reported by 23.3% of the respondents. Vaging reasons for self-medication, some respondents explained that they would administer self-medication if they or their parents could not afford for the high fees charged by the hospitals or other health institutions. Others said self-medication was faster and would save time, thus avoid missive lectures. Quite a number of the students interviewed, however, said they would only use self medication if they considered the illness to be of a less serious type.

Further discussion with the teachers revealed that some schools really encouraged self-medication. The principals and teachers of two boarding schools admitted including some anti-malaria and pain relieving drugs in the students' prospectus, "because of the present situation of things," as they put it. But then, the students possess more drugs than is their schools' intention. Discussion with some students, confirmed that the students took drugs such as Codeine, Aspirin, Panadol, Nive-

quine, Camoquine, Cough Syrup, Butazolidine, Librum, Valium, Ophtalgin, Antibiotics such as Ampicilin; Teramycin, Tetracycline Capsules, Septrin and native herbs when last they were ill.

Apart from the home remedies given by parents, many students said they bought the drugs themselves from the pharmacies or patient medicine stores, some got them from friends while other were from hospitals or their different consultants.

Observation in some students hostels and discussion with their matrons and health sisters confirmed the student possession of those drugs, some of which had no labels and could therefore not be identified by the researcher. Various types of herbs were also discovered, the commonest of which was a bottle of illicit gin (ufofop) to which certain leaves are dissolved. This is said to be for the treatment of malaria. The drug was mostly found among the older boys although it was said to be for both sexes. Some students especially the boys who had admitted possessing drugs were, however, unwilling to show them to the researcher in spite of all reassurance, for possible fear of victimization.

## DRUG ABUSE

The problem identified here with the self-care practiced by the secondary school students is not so much with finance, or finding the drugs but with the dosage. For example, some respondents reported taking two or three capsules of Ampicillin or

tetracyclines for self diagnosed illnesses, or one or more tablets of Fivaquine than necessary for the treatment of malaria. The self-prescribed inadequate treatment especially with antibiotics could create resistant strains in the body thereby making it difficult to treat subsequent infections. On the other hand, over dosage of drugs could result in drug poisoning. There were still others who administered inappropriate medications for self diagnosed illnesses such as Ampicillin for malaria symptoms or antimalaria drugs for respiratory or abdominal symptoms.

Thus, self-care from the students' perspective could be said to have advantages and disadvantages. The advantages include saving finance, transportation problems and time already discussed. The disadvantages would be that of resistent strains, drug poisoning or worsening the illness through inappropriate medication or drug abuse.

Other ways of solving their health problems included:

a) Traditional Healers: The use of traditional healers was mentioned by 10.8% of the respondents. A breakdown of the figure shows slightly more males (12.5%) than females (9.8%) using this source. As mentioned earlier, the respondents associated the use of traditional healers with certain types of health problems for which hospital treatment is considered ineffective. Such health complaints reported included [illegible] pains, malaria, menstrual

irregularity among women, dizziness and fainting, some accidental injuries especially fractures and dislocations, worries and depression. Therefore, perceived skill and ability of the providers, (traditional healers) here is considered a predisposing factor for the use of their services. This finding has supported the findings of Fetene (1983) in his study of Lagun community at Ibadan. According to the results, people prefer the traditional medical services especially when the illness is related to supernatural phenomenon. Thus, 94.3% of the 360 adults sampled expressed that only traditional medical services can cure such diseases. Other factors given by the respondents include unlimited service hours which makes it suitable for the student to receive treatment without necessarily missing lectures and quick service. A few respondents also mentioned cheap service depending on the illness. In some cases, however, traditional treatment is said to be much more expensive than the orthodox medicine.

b) Spiritual Healing Homes: 15.2% of the sample indicated this as their place of treatment, for reasons quite similar to those advanced for the traditional healers. In spiritual healing, no fee is charged, no herbs are administered, healing being effected mainly through efficacy of prayers.

[illegible] and rubbing or drinking holy oils and water. Reported health problems in this group include emotional problems like depression, worries, bad dreams, emaciation. Others include those types of health problems listed above for traditional healing depending on the interpretation of the illness by the students and/or his significant others. Thus cheap services could be a contributory factor in the use of this service.

## CONSULTING THE PATENT MEDICINE STORE/CHEMIST

This was the next place of treatment mentioned by the students in order of frequency with a percentage of 10.5%. Investigations by the researcher reveals that in this case, there is some form of consultation between the student and chemist or the patent medicine dealer who would diagnose or confirm the students' diagnosis of his illness. He then recommends or prescribes drugs to be purchased from his store/chemist. No fee is charged for the diagnosis and prescription. One could have expected a higher percentage than this for the consultation of this source, in view of the high cost of medical fees in the hospitals and private clinics reported by the students, the abundance of patent medicine stores and chemists in the Local Government Area and the high percentage of respondents who had indicated taking self-medication. But a closer observation of these drugs stores by the researcher have shown that with the present

conomic situation in the country and the world-wide inflation, rugs have not only become scarce these days, but also sold at exhitant prices which most indigent students may not afford. his may explain why some students indicated borrowing drugs for elf medication.

NURSE

Five percent of the respondents reported doing nothing when ill. Most of the reasons given were related to finance. Some said heir parents and guardians could not afford for treatment. Others ere no response. The consequence of this is the wastage of students' ime and lecture periods while trying to endure an illness. Also, a imple illness might in fact progress to a very serious type before ny health care is sought by the student. In extreme cases, the tudent may even die depending on the type of illness.

USE REMEDIES FROM THE FIRST AID BOX

This was reported by only 2.0% of the respondents. Some of these cases were for accidental injuries. However, as already mentioned, some teachers had reported treating such cases from their private kit since most schools did not possess first aid equipment or drugs.

Three percent (3.0%) of the respondents gave other response as leaving the solution of their health problems entirely to the discretion of their parents, and enduring the illness as much as possible.

In summary, the availability of a competent source and the accessibility of services generally influence the secondary school students decision on whether or not to seek health care from those institutions. As mentioned earlier, more adolescents tend to use the General/Private clinics depending on the types of illness, and the students' background. However, finance and lack of quick services have been identified as the major limiting factors to the use of this care by many students although most of those decisions are taken by their parents and guardians.

Some people still prefer to consult the traditional healers. This shows that despite the existence of Western Health Services in the Cross River State, traditional medicine does not seem to be losing its influence. Thus, the secondary school students still seek its services especially when the illness is interpreted to be related to a supernatural cause for example, witchcraft. This information therefore indicates the need for some form of integration of the traditional and orthodox medicine if people are to benefit from these health services. However, as mentioned earlier, the decision taken and the course of action adopted for solving the secondary school students' health problems will depend on the type

# CHAPTER SIX

## SUMMARY, CONCLUSION AND RECOMMENDATIONS

### SUMMARY AND CONCLUSION

This research was intended to contribute to the improvement of health care for secondary school students in the Cross River State.

The study has looked at the student's perceived health need, the facilities available to them and the health care seeking behaviour of the secondary school students.

A total of 600 students were interviewed in ten (10) secondary schools randomly selected from a list of 35 secondary schools in Uyo Local Government Area. The respondents were in Form three, four and five.

Interviews and discussions were also conducted with some selected teachers of the schools to obtain additional data as to the health care seeking behaviour of their students.

Analysis of data showed that the students reported numerous health problems, there was a general lack of health facilities in their vicinities which could be used to meet the students' health needs. Therefore, most students reported seeking health care from the alternative health facilities which are available outside their schools. These facilities include hospitals and private clinics, chemist shops/patent medicine stores, traditional healers, spiritual healing homes and self care.

Finance, distance, quick services, type and perceived seriousness of illness were identified as the major factors which influence secondary school students' decision to seek health care. The perceived seriousness and type of illness seemed to influence the student in selecting the type of service and whether or not to seek health care.

The role of social influence from parents, friends, teachers, medical and paramedical personnel and siblings have also been considered to act reinforcing and limiting factors in the decision to seek health care. Although the secondary school students spend a greater part of his/her day at school, parents still served as the most influential persons when making decisions affecting his health.

While many of the secondary school students seek health care in the hospitals and private clinics, the study has shown that all the care the secondary school student need cannot be provided in these hospitals. Other sources such as mentioned above are also consulted by the students. Finance has been identified as the major limiting factor affecting the use of hospital care. This is because the expensive cost of medical treatment in the hospitals which many students cannot afford.

## 6.2 RECOMMENDATIONS

Some of the findings of this study suggest at least some of the measures that should be taken in planning the delivery of health care for the secondary school students.

Therefore, the following recommendations are made:

### 6.2.1. FIRST AID BOX

As indicated in the study, only very few schools possessed First Aid Boxes. This therefore stresses an urgent need for the Ministry of Education to make it mantatory for all secondary schools to possess first aid boxes and equipment. There should also be a trained personnel, preferrably a staff or Form IV student to manage the equipment and administer first aid.

### 6.2.2. SCHOOL DISPENSARY

Ideally, there should be a School Dispensary with trained personnel in every school to cater for the students' health needs. But the study has indicated that this is not the case within the sampled area of study. From observation, only two out of ten (10) schools had what was termed 'empty dispensary' since it may not be feasible with the present economic situation in the country to make it mandatory for every school to have a dispensary, it is suggested that where possible, the Government should

endeavour to provide central medical centres for a combination of schools.

The principals could involve the Parents/Teachers Association in the establishment of such centres.

6.2.3. HOSPITALS/CLINICS

The result of the study has revealed that many students boycott the hospitals because of the exorbitant medical fees which they cannot afford since the Government withdrew its sponsorship from the schools.

As already mentioned in this write-up, there was an earlier policy whereby the Cross River State Government paid for all the secondary school students' treatment at the hospitals. The reversal of this policy in 1980 has brought untold hardship to the students in the Cross River State. It is therefore suggested that the schools Principals should be urged to liaise with the Ministry of Education with the view to bringing back free medical treatment to all h secondary schools in the Cross River State.

6.2.4. TRADITIONAL HEALERS

The study has shown that the traditional healers as health care providers are quite accessible to the secondary school students. In fact, traditional medicine still flourishes in the Cross River State and could be said to

be competing with the government health care delivery system. Their role cannot therefore be ignored. Since both traditional and Western medicine have their limitations and benefits, integration of both systems would be useful to the people.

Thus, it is suggested that:

(1) The role of the traditional healers should be recognized by the government.

(2) The government should encourage and promote research in the area of traditional medicine.

This is in conformity with the recommendation of Fotene (1983) in his study of the Lagun Community at Ibadan. This author recommended the recognition of the role and importance of traditional medicine as health care delivery system and acceptance of its integration with Western medical system.

This integration of the traditional medicine into the existing health care delivery could give the individuals freedom to choose and use the services freely. This is because quite a large number of the secondary school students use their services and therefore to ignore them would mean leaving the lives of those students in danger.

## 6.2.5. THE SCHOOL HEALTH SERVICES UNIT

Although the School Health Services Unit is in existence in Uyo Local Government area, investigation has revealed that it is non functional. Discussions with the Health Sister Incharge of the Unit indicated that the Unit is short of vehicles, equipment and personnel and even funds.

The Ministry of Health which is responsible for the functioning of the unit should be called upon to revitalize it so as to enable its impact be felt in the schools. It would be recalled that the duties of those Unit cover a wide spectrum in health care delivery which includes health visiting of schools. The importance of such a Unit in the Preventive health care delivery therefore need to be overemphasised.

## 6.2.6. PREVENTIVE MEASURES

The prevention of diseases in the secondary school students should be the concern of all branches of health services in Nigeria but the State and Federal Government should make special arrangements, under a decree to safeguard the health of students at school. The Cross River State Ministry of Health must organise a comprehensive range of integrated health services for the secondary school

students including a school health service run in conjunction with the State Ministry of Education. The school health service should have a school clinic which provides simple treatment for minor ailments, and also some form of periodic medical examination of the secondary school students. At present such services are available for elementary school children only in some parts of Nigeria. Mostly, the services are given by nurses under the supervision of medical officer of health (Odunlan 1973).

5.2.7. DRUG ABUSE

There should be effective legal control on the distribution, sale and dispensation of drugs especially antibiotics and other dangerous drugs so as to reduce their availability.

Serious consideration must be given by the Federal and State Governments to the indiscriminate sale of drugs in our open markets by drug peddlers, chemist shops and patent medicine stores. This is in conformity with the recommendations of Adeyanju (1978) who in his study recommended effective legal control of the sale and dispensation of drugs by the State and Federal Governments.

Drug legislation must be carefully adapted to our local needs, priorities, political and socio-economic conditions taking into account the feasibility of enforcing it.

6.2.8. HEALTH EDUCATION

Health education programmes for the secondary school students must be comprehensive it it is to influence their health knowledge, attitude and behaviour in finding solutions to their health problems. Such education programmes should be designed to focus on the already identified factors of the study. Parents must be actively involved.

The health education of the policy-makers especially those in education field is also of prime importance. They should be made to see the rationale behind incorporating health education courses into our educational system. A National Education Policy with emphasis on health education should be formulated. Pre and In-service training of health education teachers and other health personnel in preventive medicine is very essential.

6.2.9. HEALTH EDUCATION CURRICULUM

Some aspects of anatomy and physiology are justifiably taught in health education; but cursory reviews of the current school health textbooks and curriculum guides still reveal a substantial emphasis on these topics. It is suggested these two topics be extracted from the traditional health education curricular and transferred to other related courses such as biology, physical education, etc. Such a

transfer of health content could create more opportunities to focus health instructions on topics more closely related to the pressing needs and real interests of today's students. The necessary information to develop such a curriculum could be obtained through students, teachers, parents, community leaders especially those at the decision making level and experts in the field of health education. This would help to ensure a relevant content and economize necessary curriculum time.

4.2.10. ENVIRONMENTAL MODIFICATION

Malaria related problems ranked highest among the numerous health concerns reported by secondary school students. Although no medical examination was conducted to confirm these health problems, yet some positive measures must be required by the school and the health authorities to eliminate those environmental factors presumed to be related to the students reported health problems.

A good number of the students mentioned frequent bites of mosquitoes as the major cause of malaria. It is therefore suggested that:

(1) Each Boarding School should make it compulsory for the students to possess mosquito nets in their dormitories.

(2) Wher-ever possible, all students' dormitories and classrooms should be wire-gauzed. The parents - teachers Association could be invited to assist in the provision of wire gauze if the principal finds it difficult to obtain funds from the Ministry of Education. But it might be better and less expensive for the Ministry of Education to include wire-notting in the contract agreement for any contractor building a dormitory or classroom block from now on.

(3) In addition, the schools' environment must be inspected by the teachers to ensure environmental sanitation - no stagnant water around and all grass and the surrounding bush kept really low. From observation, this was not the case in many schools (especially the rural schools.).

So a lot more needs be done by the teachers. The students' co-operation would be won if they were health educated on the causes and prevention of malaria and then get them involved in the above preventive measures. This could go a long way to reducing mosquito bites and checking possible incidents of malaria among secondary school youths.

Abdominal related complaints were the next frequently reported group, the causes of which were said to be related to poor source of water supply, poor environmental sanitation and dirty foods.

It is suggested that health education be included as a matter of urgency if these complaints are to be checked. Also measures should be adopted to improve environmental sanitation in the schools. Such health education programmes should focus on the areas of students concern mentioned above rather than on irrelevancies.

## 2.11. HEALTH SUPERVISION IN THE SECONDARY SCHOOLS

Communicable diseases were among those health problems reported by the students and they pose a special problem in schools because of opportunities for spread; examples are dysentery, infective hepatitis, scabies, streptococcal infections. Many of these diseases are best prevented by environmental improvement. Control is only possible by early identification by alert teachers and health staff and by having available facilities for further early case finding, isolation and treatment.

Many schools are troubled by excessive absenteeism from diseases which require a visit to a distant hospital for some quite simple remedy. In such cases it is suggested that the

teachers be equiped with some small school drug supply. However, unless there is a school nurse, this school medicine box should be kept to the simplest remedies; otherwise ill-students might be incorrectly treated by the teachers. In all school first aid boxes, dressings should be kept.

12.12. REFERRALS

It is suggested that every school should have some method of referral of sick students to a dispensary or hospital, but preferrably, this should be done through the parents.

Whereever possible, a special time should be arranged with the medical authorities for seeing the secondary school students.

12.13. SPECIAL SCHOOL SITUATIONS

(a) BOARDING SCHOOLS

As many of the secondary school students come from great distances, the parents cannot arrange transport for an ill-child so that this becomes the responsibility of the school. It is suggested that a small sick bay with a resident nurse be provided for every boarding school and there should be a visiting doctor on call from the nearest hospitals. The diets of these boarding schools should be reviewed periodically because it is very easy for some vital item to be omitted with

subsequent development of deficiency diseases in the students. This is necessary because the majority of the sampled boarders and even their teachers complained of poor feeding of the students.

(b) THE URBAN SECONDARY AND DAY SCHOOLS

In the urban schools in Uyo Local Government Area, a special problem has arisen with students coming from the rural areas and distant places to attend a secondary school in town. Many of them have to find their own accommodation, often in unsuitable surroundings where they are exposed to diseases such as tuberculosis and also the social situations likely to lead to venereal diseases.

Awareness of this problem could lead to solutions by:

(i) home visiting by the school nurse where available or nurses of the school health services unit at Uyo.

(ii) establishment of hostels outside the schools by the government and the schools' authorities for such affected students.

(iii) the principals could make arrangement for the schools to remain open at night to provide a haven for studying.

## SPIRITUAL HEALING HOMES

Quite a number of the respondents indicated using this source for the solution of their health problems. As mentioned in an earlier chapter, the source consulted depends on the various beliefs concerning the disease causation and treatment. Most people tend to consult the spiritual healing homes when they consider the diseases to be caused witches, or any other supernatural means which the efficacy of prayers only can overcome. Such self-diagnosis of diseases have often resulted in the delay of seeking appropriate medical care, at times it even results in death. It is also common to see some patients commuting between the spiritual healer and the hospital.

Some of those erroneous beliefs about disease causation might be changed if the secondary school student is educated through an appropriate health education programme about disease causation, treatment and prevention related to the commonly occuring diseases in the area. The parents and the community members must also be health educated.

In conclusion, the secondary school students in the Cross River State are in dire need for health care in providing solutions to their numerous health problems. Some of the ways of meeting those health needs have been considered. It is not necessarily recommended here that

all secondary school students be given extensive health education programmes or extensive medical examination as this would be too expensive. But in the Cross River State, neither in the school nor in the Community are there adequate resources which to deal effectively with the students health problems.

2.15. HEALTH EDUCATION PROGRAMME

The high rate of participation of secondary school students in the interviews during the study reflect their concern regarding health matters. This means that there is a considerable motivation on the part of the youngsters themselves to obtain some form of health care. The variety of health problems presented by the secondary school students and the various ways with which these problems are solved point to the advantage for preventive education.

The role of the schools in health education and health care needs be considered here. Schools could be doing more than at present to provide students with the knowledge and information they need about growth and development, and about the services available for the solution of their health problems. In this case, the teaching of health as a course in the curriculum should be made compulsory for all schools at the elementary and secondary school levels. As at now, only

the Teacher Training Institutions offer health education as a compulsory subject, and even here, it is offered in combination with physical education. Only two of the ten secondary schools sampled offered health science as a course. The reason is that this course is not made compulsory, rather, it is offered as an alternative to Biology.

But there is a familinr maxim which states that "health is wealth" therefore, the principals should be called upon to make the students realized the importance of this subject and its usefulness to their persons. The Government should make the subject compulsory in the secondary schools so that the course may act as Practical health care delivery system. This means that the students could practice what they learn.

The need to review the present health education content of the schools' curriculum should not be over-emphasized. Such a reviewed content must reflect the secondary school students, needs rather than place an undue emphasis on Anatomy and Physiology, as in the case now. The following areas of Health concerns should be stressed: Nutrition education in relation to the locally available foods, exercise, rest, relaxation and sleep; smoking and drug education, self care, personal hygiene and environmental sanitation, sex education and emotional

health. Also to be emphasized are areas of first aid, recognition of the commonly occuring diseases and disabilities, their causes and prevention. They include malaria, diarrhoea and dysentery, helminthic worms, filariasis, respiratory tract infections, accidental injuries and a host of others. Those areas have unfortunately been ignored by most teachers probably because of their inadequacies in health instruction. This is because most of the teachers who handle health science in the schools are teachers of Biology rather than health education. No wonder the emphasis on Anatomy and Physiology!

The results of the study indicates that the students need a lot more than that. A very large number of the students interviewed had poor knowledge of their reported health problems and their causes.

For example, malaria was said to be caused by unripe fruits, hot weather, flies or anything. Therefore compulsory health instruction for the secondary school students could go a long way to improving their knowledge and contributing to the proper solution of their health problems.

Since the study has revealed that secondary school students in fact, do make bad dependent decisions, the

principle of involvement should be adopted that is, efforts should be made to involve them in the planning of their health education programme. Also to be involved in the planning are health education experts from Institutions of higher learning, the State Ministries of Education and Health, community leaders, nurses, doctors, and of course, parents who have been identified as important figures in the students, decision making to seek health care. Parent and guardian could be reached through the Parents/Teachers Association, School Health Committees or special seminars and conferences organized for them.

In teaching the school health education, guest lecturers and health education experts could be invited at least once in a while from the two existing universities and polytechnic in the Cross River State or they could be drawn from the Ministry of Health and hospitals to augment the present acute shortage of manpower in this field.

Meanwhile periodic seminars and workshops should be organized by the State Ministry of Education in conjunction with the Ministry of Health to update the Teachers' knowledge in health education. The University of Cross River State could assist by organising short induction courses for the teachers of Health. - -

The present proposal by the Department of Health and Physical Education of the State University to organize a similar programme for the gomos-masters and mistresses during the coming long vacation is a step in the right direction. But previous experience has shown that although these gomosmasters and mistresses are in most cases the teachers of health education in their respective schools, the health instruction aspect is almost completely forgotten, the only area included in their induction course being First Aid. This perhaps indicates the need to divorce Physical Education and Health Education which had hitherto been married so as to give each programme the attention it deserves.

**SCREENING**

Schools are in addition, a logical place to screen for the educationally disabling conditions, such as vision impairment and refer such cases to the hospitals for appropriate care. Ken Lassiter (1972) in his study had stated that 10 percent of all children have problems which can seriously interfere with their learning or adjustment. Consequently, he recommended that "comprehensive screening to detect a wide variety of handicaps is needed so that all children who might benefit from an individualized or special program will be recognised."

The researcher's investigation revealed that not one out of the ten schools sampled ever conducted any form of screening. The sick students are identified and referred to the hospital only when they report ill. Equally important, the schools can follow up on the youngsters they refer for care.

Only one principal of the Girls' school admitted ever following up some sick students after referral by the school.

5.2.17. NEED FOR COUNSELLING

Health counselling of students would fit well into the plans for organising health care in such a way as to keep many students out of hospitals. The importance of health counselling in the school health services has already been discussed in the literature review. According to Pollock and Oberteuffer (1966), during health counselling, the teacher or nurse helps the pupils to understand the problems, suggest ways that he and his parents might obtain the information needed to solve it, discuss with them the tentative solutions and helps them decide upon the one that appears more feasible for them. This study conducted has indicated the need for counselling.

Through counselling, secondary school students could be helped to understand their growth characteristics.

physical capacity and sexual maturity which are reached at this period. They are also given a chance to discuss their problems and general appearance which are of great concern to them, how to groom themselves and appear proper to peers as well as need to avoid fatique through exercise, rest relaxation and sleep or other recreational activities.

The students interviewed in this study have presented with numerous health problems but many showed poor knowledge of their causes, health counselling could assist such students in identifying the causes of those problems and suggesting their possible solutions or treatment.

5.3.18. SELF CARE AND DRUG ABUSE

A high percentage of the respondents (23.3%) indicated using self-care, therefore to ignore them would be fatal. Through health counselling and school health education, the students could be educated about the dangers of self-diagnosis and the prevention on those common ailments. The counsellor who already possesses knowledge of the emotional and social problems that the secondary school youths are likely to have assist in the ways and means of identifying such Problems in the individual children under their care. This is necessary so that he makes the students aware of

need to adjust to life situations and the need to meet the demands of life and face new challenging situations without resorting to indiscriminate use of drugs; in this case, the influence of friends in the students' decision to administer self care needs be considered.

For example, quite a number of the students interviewed mentioned friends and colleagues as important reinforcing factors in their decision to seek care. They also indicated borrowing medications from the same sources. It is therefore pertinent that any health education or counselling activities be directed to their peers as well, since the student often enjoys their confidence more than that of the adults.

Involvement is a basic concept in health education. Therefore, involvement of the consumers of a programme (in this case, youths) will help the planners in providing many opportunities for educating and influencing the people on the problem of drug abuse. Furthermore, active involvement of the teachers, parents, policy makers and the community in general is important towards preventive measures aimed at drug abuse.

The protection of students from drug abuse should commence from the pre-school years. They should be encouraged by their parents to develop normal ways of coping with the

stress of life. If this habit is firmly established early in life, then many students will be less likely to seek escape from real problems through the illusions that drugs can offer.

Drug abuse should be considered not only a legal problem but also a health and social problem in Nigeria which requires a planned strategy by all concerned.

Certainly, prevention is better than cure. So in order to bring a positive change in the self care and drug abuse of secondary school youths, health education with its counselling aspect is the tool.

But like any other health problem, the educational activities for preventing drug abuse must consider the dynamic ecologic transactions of the planner/policy maker, health worker, health consumer, and situational-environmental factors (Adamuwagun, 1975).

## IMPLICATIONS FOR RESEARCH

It is recognized that secondary school students have attributes and problems different from both younger children and adults. Because a major portion of the secondary school students health care is provided in the hospitals and other available place outside the school, further

research is needed in the area of secondary school students health care. Answers to research questions will provide a strong basis to guide the planning in the delivery of secondary school students' health care. Such studies should engage the attention of various disciplines with the cooperation of Local, State or Federal health authorities.

Some of the areas which needed be studied are as follows:

1. What is the appropriate Government involvement in the health care of secondary school students?
2. Health problems of secondary school students in Nigeria.
3. What health facilities are present in the secondary schools on a nation wide basis for the solution of students health problems?
4. Do students who assume responsibility for their own health are exhibit different health care behaviours than students who are taken care of by parents?
5. Are there any significant differences over time in health status between students who take independent health decisions versus students

requiring parental consent?

6. Patterns of substance use and misuse among secondary school students.
7. What kind of services are needed for high school students - preventive and curative?
8. How best may such services be provided in Nigeria?
9. Extension of this study on how secondary school students solve their health problems on a nation wide basis.
10. Patterns of utilisation of the medical services by secondary school students.
11. What is perceived as threatening to health?
12. What do students do to maintain their health?
13. Health knowledge of secondary school students.

Answer to these and other questions will improve the understanding of the developmental uniqueness of adolescents and provide a sounder basis of health education. These answers can also provide a base for health education to use in promoting and supporting policies that are sensitive to to the health and developmental needs of secondary school students.

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# APPENDIX A

## LIST OF SCHOOLS SELECTED FOR THE STUDY

### UYO URBAN

1. Lutheran High School, Obot Idim, Uyo.
2. Community Secondary School, Aka Offot.
3. Adiaha Obong Secondary Commercial School, Oniong.
4. Government Technical School, Uyo.

Total - 4 Urban Schools selected.

### RURAL SCHOOLS

1. Government Technical College, Etono Ukim.
2. Secondary School, Nsoi.
3. Community Secondary Comprehensive, Ukubo Andua Etong.
4. Ikono Ibom Comprehensive School, Iket Ayua Ikono.
5. Community Secondary School, Mbiaya.
6. Ibeblkpo Secondary Commercial School, Nung Udoe.

APPENDIX A-1

SELECTION OF RURAL SCHOOLS ACCORDING TO DIVISION AND TYPE OF SCHOOLS

| DIVISION | Number of Schools | Boarding | Day | SELECTED | |
|---|---|---|---|---|---|
| | | (1) | (2) | (1) | (2) |
| 1. Southern Uruan | 4 | 1 | - | 1 | - |
| 2. North/Central Uruan | 4 | 1 | 3 | - | 1 |
| 3. Etoi/Offot | 4 | - | 4 | - | 1 |
| 4. Ikono Poku | 4 | 3 | 1 | 1 | - |
| 5. Ibesikpo/Asutan Ekpo | 3 | 3 | - | 1 | - |
| 6. Eastern Arit | 4 | 1 | 3 | - | 1 |
| Total | 23 | 12 | 11 | 3 | 3 |

Number of Rural Schools Selected = 6.

Total - 10 Schools.

# APPENDIX B

## INTERVIEW SCHEDULE FOR STUDENTS

1. Name of School .....
2. Age: ..... years
3. Sex: .....
4. Where do your parents live? .....
5. Parents' Occupation .....
6. Are you a boarder or day Student? .....
7. With whom are you living if you are not a boarder?

   .....
8. How do you feel about your present health condition? .....

   .....
9. What are some of the health problems you have? .....

   .....
10. What common health problems would you say young people like yourself have? .....

    .....

    .....
11. What are the causes? .....

    .....

    .....

12. What are the health facilities available in your school for treating the sick students? .....
..... .....
.....

13. Which are the alternative places for treatment around here?
.....
.....
.....
.....

14. Which of these places do students use when they are ill?
.....
.....
Why? .....
.....
.....

15. When were you ill last? .....

16. What was the nature of your sickness: .....
.....

17. What type of care did you seek? .....
.....
How did you find the services? .....

Why? Give Two reasons .....

.....

18. How did you decide to seek health care? .....

.....

.....

19. Who usually influences your decisions concerning solution to your health problems? .....

.....

20. What factors do you consider most important when seeking solution to your health problems?.....

.....

What do you finally decide to do .....

.....

21. What are some of the health needs that you have? .....

.....

.....

.....

22. What suggestions would you like to make concerning health care delivery to high school students? .....

.....

.....

.....

## APPENDIX C

## INTERVIEW SCHEDULE FOR TEACHERS

1. Name of School: .....

2. Sex: .....

3. What health problems do your students commonly complain of?

.....

.....

4. What are the causes? .....

.....

.....

5. What health services are available in the school for the students? .....

.....

.....

6. Which are the alternative health facilities around here?

.....

.....

.....

7. Which of these facilities do the students use? .....

.....

.....

8. What is the school's policy concerning sick students? .....

.....

.....

.....

9. What are the health needs of the school? .....

.....

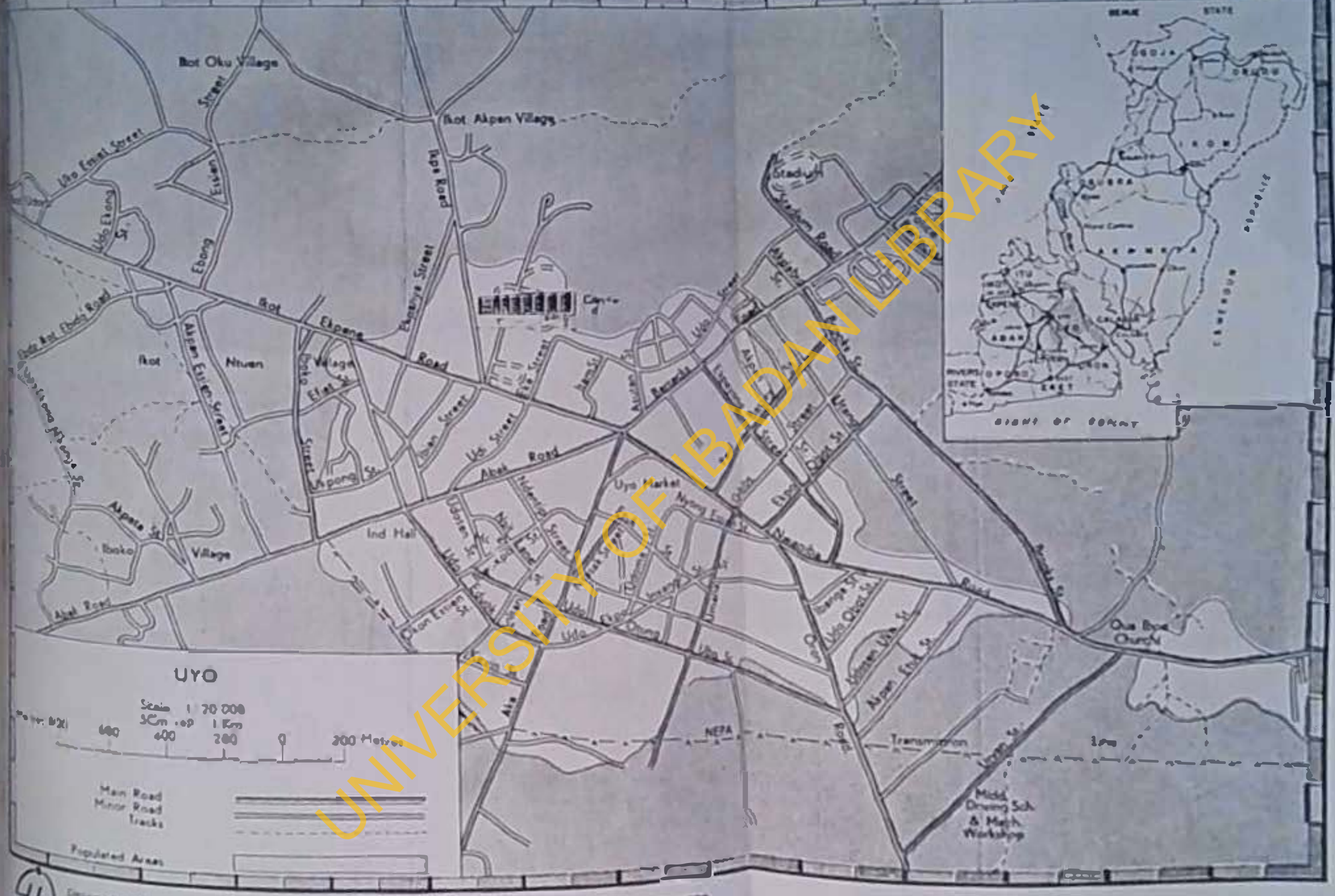
.....

APPENDIX D

FIGURE 2.1 CROSS RIVER STATE: LOCATION & LOCAL GOVERNMENT REGIONS


MAP BY D. G. WILDMAN

Benue State
OGOJA
OBUDU
IKOM
DIVISION
Anambra State
CROSS
RIVER
Republic
OBUBRA
Imo State
NORTHERN
AKAMKPA
IKONO
IKOT EKPENE
ITU
ODUKPANI
Cameroon
CALABAR
ODUKPANI
ABAK
UYO
DIVISION
UKANAFUN
ETINAN
ORON
Rivers State
MAINLAND
IKOT ABASI
ESET
BIGHT OF BONNY
N
Kilometres 10 0 10 20 30 40
Miles 10 0 10 20 30



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