BARRIERS TO EFFECTIVE TEACHING AND LEARNING OF HEALTH EDUCATION

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CERTIFICATION

We the undersigned certify that this research work was carried out and completed by **Osemudiamen Daniel OSEGHALE** with Matriculation Number: **EDU2102618** of the Department of Health, Safety and Environmental Education, Faculty of Education, University of Benin, Benin City.

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DEDICATION

This work is dedicated to God Almighty, my ever-loving Father and constant help in times of need His unfailing grace has sustained me throughout my academic journey at the University of Benin.

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ABSTRACT

This study investigated the barriers affecting the effective teaching and learning of Health Education. The purpose was to identify the major institutional, teacher-related, student-related, and environmental factors that hinder the successful delivery of Health Education as a subject. A descriptive survey research design was employed to gather data from teachers and students across selected public secondary schools. A structured questionnaire was used as the primary instrument for data collection, and data were analyzed using simple percentages and frequency counts.

The findings revealed that several challenges significantly impede effective teaching and learning of Health Education in the study area. These include inadequate instructional materials, shortage of qualified teachers, insufficient time allocation, poor students' interest, overcrowded classrooms, and limited support from school management. The study also found that socio-cultural beliefs and poor funding contribute to the difficulties faced in teaching the subject.

Based on these findings, the study recommends increased government funding, provision of adequate instructional resources, employment of more qualified teachers, regular teacher training, and improved learning environments to enhance the quality of Health Education in secondary schools. The study concludes that addressing these barriers is essential for promoting health literacy and improving students' knowledge, attitudes, and behaviours toward health and wellbeing.

BARRIERS TO EFFECTIVE TEACHING & LEARNING OF HEALTH EDUCATION

CHAPTER ONE

INTRODUCTION

Background to the Study

Health education is an integral component of human development and a key instrument for improving the quality of life. It involves the deliberate effort to equip individuals and communities with the knowledge, skills, and attitudes required to make informed decisions about their health and well-being. According to the World Health Organization (WHO, 2022), health education comprises consciously constructed learning opportunities designed to improve health literacy, including knowledge and life skills conducive to individual and community health. In essence, health education empowers individuals to take responsibility for their own health and to contribute positively to the health of those around them. Health education goes beyond the mere transmission of health facts; it is a behavioral and attitudinal process that aims at influencing positive health practices. Green and Kreuter (2005) described health education as "any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behaviour conducive to health in individuals, groups, and communities." Through effective health education, learners gain awareness of disease prevention, nutrition, sanitation, personal hygiene, environmental health, and reproductive health.

The history of health education can be traced back to ancient civilizations, where health practices were intertwined with religion and cultural beliefs. In ancient Egypt, Greece, and Rome, cleanliness and physical fitness were highly valued, and early forms of public health practices were observed (Hastings & Veenker, 2019). In the 19th century, the emergence of public health movements in Europe and America, driven by the spread of infectious diseases such as cholera and smallpox, led to a formal recognition of health education as an important aspect of community well-being. By the early 20th century, health education had evolved into an academic discipline and a professional field. In 1920, C.E.A. Winslow defined public health (and by extension health education) as "the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community efforts" (Winslow, 1920). The World Health Organization (WHO) further strengthened this perspective in the mid-20th century by emphasizing that health education should aim to promote both individual and collective actions that improve health outcomes globally. In the late 20th and early 21st centuries, the focus of health education expanded to include issues such as reproductive health, non-communicable

diseases, HIV/AIDS prevention, and mental health awareness. Modern health education now integrates behavioral science, psychology, and technology to promote sustainable health practices (Nutbeam, 2008).

In Nigeria, health Education has its roots in the colonial era, when Western education was first introduced by Christian missionaries in the 19th century. During this period, health education was not a separate subject but was embedded within other subjects such as nature study and hygiene (Akinbode, 2017). Missionary schools and colonial health officers played vital roles in promoting basic hygiene, environmental sanitation, and disease prevention among Nigerians. After Nigeria's independence in 1960, the government began to recognize the importance of formal health education in schools. The National Policy on Education (1977, revised in 2014) integrated Health Education into the national curriculum under Physical and Health Education (PHE) at both primary and secondary school levels. This inclusion was intended to develop students' awareness of personal and community health, promote positive lifestyles, and reduce preventable diseases (Federal Republic of Nigeria, 2014). In subsequent years, several health campaigns and programs were launched in Nigeria to promote health education. Notable among these are the National Primary Health Care Programme (1988), Health for All by the Year 2000 Initiative, and the National School Health Policy (2006), which emphasized the need for comprehensive health education in schools.

The teaching and learning of health education in secondary schools in Edo State, Nigeria, have been shaped by the broader evolution of Nigeria's educational system since the mid-20th century, when health-related topics were first introduced to address local public health challenges like poor sanitation and infectious diseases. In Benin City, health education initially formed part of subjects like biology and physical education, with limited focus as a standalone subject. The push for structured health education gained momentum following the establishment of formal health training institutions in Nigeria, such as the University of Ibadan's medical school in 1948, which influenced curriculum development in Edo State's schools. By the late 20th century, health education became a compulsory subject for students in Benin City preparing for West African Examination Council (WAEC) and Senior Secondary School Certificate (SSCE) examinations, aiming to equip them with essential health knowledge. However, its implementation has faced persistent challenges in the region. A 1995 study in Edo State by Omu and Omu found that inadequate teacher training and scarcity of teaching materials hindered effective health education delivery in secondary schools, including those in Benin City. Health education in secondary schools is vital for equipping adolescents with the knowledge and skills to make informed health decisions, particularly in areas such as sexual and reproductive health, nutrition, and disease prevention. It arguably, health benefits come to mind when the average person thinks about the influence of physical education. Physical education

stimulates and enhances motor development in children, especially those in lower primary school (Rico-Gonzzalez, 2023; Janrnig et al., 2023). Apart from it health benefit it also has social benefit, interaction among students during physical education lessons are associated with increase appreciation, solidarity and mutual respect. And as such enhance these students development in increasing self-confidence and the ability to make meaningful interactions beyond the physical education (Villodres et al., 2023). It academic value cannot be left out as it one of the most valuable influence of health Education. According to a particular research physical education and sports stimulate cognitive functions involving attention, focus, reasoning, memory and retrieval (Garcia-Hermoso et al., 2021). It important cannot be overemphasize as one can go non-stop enumerating it benefit.

However, despite it invaluable contribution man and it society, the implementation of health education in Nigerian secondary schools still faces numerous challenges such as insufficient qualified teachers, lack of facilities, inadequate teaching materials, and cultural barriers (Okafor, 2020; Owoeye & Oyebanji, 2021). The effective teaching and learning of health Education among secondary school has been faced with significant barriers that limiting its impact as a result debasing it out output. These barriers include socio-cultural beliefs, institutional and economic constraints, teacher-related factors, student-related factors, inadequate infrastructure, and policy implementation gaps. Together, these challenges contribute to low health literacy among students, perpetuating public health issues like teenage pregnancy, sexually transmitted infections, and poor hygiene practices.

In contemporary times, despite government efforts to improve health education in secondary schools in Benin City, Edo State, Nigeria, significant challenges persist in its effective delivery. The National School Health Policy (NSHP) of 2006 aimed to enhance school health programs, including health education, but implementation remains weak. In 2020, only 41.3% of senior secondary students in Benin City utilized school health services due to inadequate facilities and untrained personnel, limiting the practical application of health education (Osian et al., 2020). Cultural resistance to discussing sensitive topics like sexual and reproductive health in schools also restricts comprehensive health education, despite government mandates for inclusive curricula (Egharevba et al., 2021).

The administrative practices in schools such as prioritizing core subjects over health education and allocating insufficient lesson time, continue to undermine its delivery, even with government efforts to improve educational infrastructure (Owie & Owie, 2023). The lack of teaching and learning facilities in public secondary schools, including those needed for health education, contributes to poor educational quality, despite policy interventions (Okosun, 2023). These persistent barriers result in low

health literacy among students, increasing risks of preventable health issues like malnutrition and risky behaviours, necessitating a focused investigation into improving health education.

All these as explained, caused by numerous factors however major factors such as the Teacher-related factors which poses significant challenges as many teachers in secondary schools lack specialized training in health education, as the subject is often assigned to educators with backgrounds in unrelated fields. This lack of expertise can lead to inaccuracies or discomfort when teaching topics like mental health or reproductive health. Low motivation, driven by poor working conditions or lack of recognition, further reduces teachers' enthusiasm, affecting the quality of instruction and students' learning experiences.

Student-related factors contribute to barriers in learning health education as adolescents tend to feel embarrassed or reluctant to engage with health education due to peer pressure or cultural norms that discourage discussions about topics like menstruation or sexual health, particularly in mixed-gender classrooms. Misinformation from peers or unverified sources, such as social media, can create resistance to accurate health information. These factors reduce students' engagement and ability to internalize critical health knowledge.

Inadequate infrastructure exacerbates the challenges of teaching and learning health education. Many schools lack basic facilities, such as private spaces for sensitive discussions, well-equipped classrooms, or access to technology like projectors for interactive lessons. Without these resources, teachers struggle to deliver engaging lessons, particularly for topics requiring practical demonstrations, such as hygiene or first aid.

Policy implementation gaps also compound these barriers. Although Nigeria's national curriculum includes health education within subjects like Physical and Health Education, its implementation is inconsistent due to unclear guidelines and inadequate monitoring by educational authorities. Some schools may omit health education entirely to focus on examinable subjects. Limited collaboration between the education and health sectors further restricts access to resources like guest speakers or health campaigns that could reinforce classroom learning.

The combined impact of these barriers results in significant gaps in health education, leaving students vulnerable to misinformation and risky behaviours that perpetuate poor health outcomes and socio-economic challenges. Therefore, this study seeks to address this gap by investigating the interplay of these barriers, and to propose practical solutions for improving the teaching and learning of health education. By

doing so, it aims to enhance health literacy, empower students, and support better public health outcomes.

Statement of the Problem

Health education plays a pivotal role in equipping secondary school students with the knowledge, attitudes, and skills necessary to make informed decisions about their physical, mental, and social well-being. In Edo State, Nigeria, however, the effective teaching and learning of health education in secondary schools are severely constrained by multifaceted barriers. Despite the inclusion of health education in the national curriculum, observational evidence and preliminary interactions with stakeholders reveal persistent challenges, including inadequate teacher training, scarcity of instructional materials, overcrowded classrooms, and cultural misconceptions surrounding sensitive health topics such as reproductive health and HIV/AIDS. The absence of these materials makes if difficult for teachers to demonstrate health related concept effectively resulting a gap between theory and practice (Akinbode 2017). These barriers are exacerbated by the low priority accorded to the subject, as it is not examined in the West African Senior School Certificate Examination (WASSCE), leading to reduced instructional time and minimal administrative support.

Consequently, students in Government secondary school exhibit limited retention of health concepts, poor adoption of preventive health practices, and increased vulnerability to preventable diseases and social vices. The resultant knowledge gap undermines national health goals, including the Sustainable Development Goal 3 (Good Health and Well-Being), and perpetuates cycles of poor health outcomes within the community. This has resulted in gap in students understanding of crucial health issues especially among adolescent who are at risk of engaging in risky behaviours (Owoeye & Oyebanji, 2021). Without a systematic identification and addressing of these barriers, the potential of health education to foster a healthier generation of adolescents in Benin City remains unrealized. This study, therefore, seeks to investigate the specific barriers hindering the effective teaching and learning of health education in secondary schools within the area, with a view to proffering evidence-based solutions.

Research Questions

The following research questions were raised to guide the study:

1. What are the major barriers hindering the effective teaching and learning of health education?

2. To what extent does the availability of qualified teachers influence the teaching and learning of Health Education?
3. Does Students attitude influence the teaching Health Education?
4. Does the adequacy of instructional materials affect the teacher and learning of Health Education?
5. What are the challenges teachers faced in the teaching of Health Education.

Purpose of the Study

The main aim of this study is to examine the barriers to effective teaching and learning of health education. Specifically, the study seeks to:

1. To investigate the barriers affecting the effective teaching & learning of health education.
2. To identifying challenges related to teacher qualification & training in the delivery of health education.
3. B To access the availability and adequacy of instructional materials & infrastructural facilities for health education
4. To examine the influence of cultural & religious beliefs on the teaching and learning of health education.
5. To Examine the Challenges teachers face in teaching Health Education in Secondary Schools.

Significance of the Study

This study is significant for several reasons, particularly as it addresses the persistent challenges in the effective delivery of health education in secondary schools especially in the areas of examining the systemic and institutional, socio-cultural and environmental, student-related, and policy and external support barriers, the study contributes to a holistic understanding of the factors impeding the integration of comprehensive health education in the school system.

The findings from the study will be beneficial to several stakeholders in the educational and health sectors. Health Education teachers, School Administration, Educational policy makers, curriculum planners and developers, students and parents Guardians and as well as the general Community.

Health education teachers are at the forefront of delivering vital knowledge and skills that empower students to make informed health decisions. This study will directly benefit these educators by shedding light on the specific barriers they face, such as inadequate training, lack of teaching resources, or insufficient institutional support. By identifying these challenges, the study will provide evidence-based recommendations to address them, such as targeted professional development programs, access to

modern teaching aids, or strategies to integrate health education effectively into the school timetable. For instance, if the study reveals that teachers lack training in contemporary health issues like mental health or reproductive health, it could advocate for workshops or certifications to bridge this gap. These improvements will enhance teachers' confidence, competence, and motivation, enabling them to deliver high-quality health education that resonates with students. Furthermore, the study's findings could elevate the status of health education teachers within the school system, recognizing their critical role in shaping students' well-being and advocating for better working conditions or resources it will increase the physical children's wellbeing thus increasing their perception of themselves (Villodres et al., 2023).

School administrators, including principals and hesad teachers, play a pivotal role in creating an enabling environment for effective teaching and learning. This study will provide administrators with a comprehensive understanding of the systemic and institutional barriers that impede health education delivery in their schools. For example, the research might highlight issues such as overcrowded timetables, limited funding for health education materials, or lack of prioritization of health education within the school curriculum. Armed with these insights, administrators can implement practical solutions, such as reallocating budgets to procure teaching aids, adjusting schedules to prioritize health education, or fostering partnerships with health organizations to support program implementation. Additionally, the study will equip administrators with data to justify investments in health education to stakeholders like parents or school boards, demonstrating its impact on student outcomes. By addressing these barriers, administrators can create a school culture that values health education, ultimately contributing to improved student health and academic performance.

Educational policymakers at the local, state, and national levels are responsible for designing frameworks that guide the education system. This study will serve as a critical resource for policymakers by providing empirical evidence of the challenges facing health education in secondary schools. The findings will inform policy decisions, such as revising teacher training requirements, increasing funding allocations for health education programs, or mandating the inclusion of health education as a core subject. For instance, if the study identifies a lack of policy support for health education in Benin City, policymakers could use this evidence to advocate for reforms that prioritize health education in the curriculum. Additionally, the study's recommendations could influence the development of policies that address emerging health challenges, such as mental health crises or non-communicable diseases, ensuring that health education remains relevant and impactful. By aligning policies with the study's findings, policymakers can create a more robust and equitable education system that promotes health literacy and well-being across Nigeria.

Curriculum planners and developers are tasked with designing educational content that meets the needs of students and society. This study will provide valuable insights into the gaps and challenges within the current health education curriculum, such as outdated content, insufficient emphasis on practical skills, or misalignment with local health challenges in Benin City. By highlighting these issues, the study will guide curriculum planners in revising or developing a more relevant and context-specific health education curriculum. For example, if the research identifies a lack of focus on prevalent local health issues like malaria prevention or nutrition, planners can incorporate these topics into the curriculum. The study may also advocate for innovative teaching methodologies, such as project-based learning or community-based health projects, to make health education more engaging and practical. By addressing these barriers, curriculum planners can ensure that health education equips students with the knowledge and skills needed to navigate health challenges effectively, fostering a generation of health-conscious individuals.

Students are the primary beneficiaries of health education, as it equips them with the knowledge, attitudes, and skills to lead healthy lives. This study will benefit students by identifying barriers that prevent them from receiving quality health education, such as limited access to qualified teachers, outdated materials, or insufficient classroom time. By addressing these challenges, the study will pave the way for a more effective health education program that meets students' needs. For instance, improved teaching methods and resources could enhance students' understanding of critical topics like personal hygiene, mental health, or sexual and reproductive health, enabling them to make informed decisions. Additionally, a strengthened health education curriculum will empower students to adopt healthier behaviours, reduce their risk of preventable diseases, and improve their overall well-being.

Parents and guardians play a crucial role in supporting their children's education and well-being. This study will benefit parents by raising awareness of the importance of health education and the barriers that hinder its effective delivery in schools. By highlighting these challenges, the study can encourage parents to advocate for better health education programs, such as by engaging with school administrators or participating in parent-teacher associations. Additionally, the study's findings could lead to initiatives that involve parents in health education, such as workshops or community health programs that extend classroom learning to the home environment. For example, if the study identifies a lack of parental involvement in health education, it could recommend strategies to engage parents in discussions about topics like nutrition or mental health. By fostering collaboration between schools and parents, the study will help create a supportive ecosystem that reinforces healthy behaviours among students, benefiting families and strengthening parent-child relationship.

And finally the general community stands to gain significantly from this study, as health education in schools has a ripple effect on community health and well-being. By identifying and addressing barriers to health education, the study will contribute to producing a generation of health-literate individuals who can promote healthier practices within their communities. For instance, students who receive quality health education can share knowledge about disease prevention, sanitation, or healthy lifestyles with their families and neighbours, leading to improved community health outcomes.

Scope of the Study

This Study focuses on government secondary schools and to examine the major barriers that affect the effective teaching and learning of health education. It looks at issues such as inadequate teaching materials, teacher's competence, students interest overcrowded classrooms, limited instructional materials and the level of administrative support. The study include teachers and students in public secondary schools and the findings apply to these schools within the study area.

DEFINITION OF TERMS

1. **Barriers:** These are obstacles or hindrances that prevent individuals from accessing, participating in, or benefiting from learning opportunities.
2. **Effective Teaching:** This is a multifaceted approach that aims to maximize student learning and engagement by employing various strategies, including clear communication, adaptability, and strong relationship building.
3. **Learning:** Learning is the process through which individuals acquire new knowledge, skills, behaviours, or attitudes. It is a dynamic process that can occur through various means like studying, experience, or being taught.
4. **Health Education:** A process that uses various methods to help individuals and communities learn about health and well-being. It aims to promote healthy behaviours, prevent illness, and improve overall health outcomes.

Chapter 2

REVIEW OF RELATED LITERATURE

This chapter reviewed the related literature of the study under the following subheading:

- Conceptual Review
- Concept of Health Education
- The Importance of Teaching and Learning of Health Education
- Barriers to effective teaching & learning of Health Education.
- Empirical Study
- Summary of reviewed literature

CONCEPTUAL REVIEW

Health education is a planned, systematic teaching–learning process that enables individuals and communities to acquire the knowledge, attitudes, skills, and motivation necessary to maintain and improve health and prevent disease (Pueyo-Garrigues et al., 2019). It goes beyond merely giving information: health education aims to empower people to make informed choices, develop self-management skills, and participate in health-related decision making. This empowerment orientation distinguishes health education from simpler information provision or ad-hoc health messaging (Rizvi et al., 2022). Several recurring attributes emerge across contemporary literature: (a) intentionality health education is deliberate and designed (not accidental); (b) lifespan orientation occurs across settings and ages (schools, workplaces, communities); (c) multidimensionality addresses cognitive (knowledge), affective (attitudes/values), and psychomotor (skills) domains; and (d) participation and empowerment effective programmes engage learners and communities in two-way processes rather than top-down instruction (Pueyo-Garrigues et al., 2019; Rizvi et al., 2022). Health education is often used interchangeably with but is distinct from related terms: Health promotion is broader and includes policy, environmental change and advocacy in addition to education; education is a key strategy within the broader health-promotion toolkit (van Druten et al., 2022. Health information or health communication may refer to one-way transmission of facts; health education implies pedagogical design, learner assessment and behaviour-change objectives (Pueyo-Garrigues et al., 2019). Health literacy is both an outcome and an enabling construct

for health education: education seeks to build individuals' capacity to find, evaluate and use health information (Liu et al., 2020). Health literacy is frequently conceptualised as both a goal and mediator of health education: programmes that successfully increase health literacy yield better adherence, improved self-care, and more appropriate healthcare utilization (Liu et al., 2020). Recent reviews stress that measurable improvements in health literacy should be included as primary or intermediate outcomes when evaluating health education interventions. Effective health education requires not only well-designed curricula but also competent educators and institutional support. Recent studies indicate gaps in educator competence and organisational backing (training, time, resources), which constrain translation of conceptual ideals into classroom and community practice (Pueyo-Garrigues et al., 2022). Investments in educator training, interdisciplinary collaboration, and monitoring/evaluation are therefore central recommendations. Bringing the threads together, a working conceptualisation suitable for research and practice is: Health education is a planned, participatory pedagogical process that combines knowledge transfer, skill development, attitude change and environmental supports to empower individuals and communities to maintain and improve health, with health literacy as a key measurable outcome. This formulation foregrounds agency, pedagogy, and measurable outcomes — elements emphasised in recent empirical and conceptual work (Pueyo-Garrigues et al., 2019; Rizvi et al., 2022; Liu et al., 2020).

CONCEPT OF HEALTH EDUCATION

Health education is a planned and systematic process through which individuals or groups are assisted to adopt and maintain behaviours that promote, restore or maintain health (Rodgers' concept analysis). It is characterized by being a lifelong, dynamic, learning-oriented activity, implemented in a variety of settings (e.g., schools, communities, workplaces) and grounded in partnership between health professionals and learners (Whitehead & Pueyo-Garrigues, 2019). The purpose of health education is not only to provide information but to enhance knowledge, skills, attitudes and beliefs so that people are empowered to take action and make healthier choices

(Whitehead & Pueyo-Garrigues, 2019). In its multidimensional nature, health education acknowledges that health behaviours are influenced by a constellation of factors — such as personal motivation, socio-cultural context, environment, and access to resources — and therefore interventions must be tailored accordingly (Whitehead & Pueyo-Garrigues, 2019). Moreover, within the broader sphere of health promotion, health education plays a critical role by improving health literacy, enabling individuals to navigate, comprehend and use health-related information to maintain and improve their health (Nutbeam, 2000). Attributes of health education include being health-oriented (focusing on health outcomes), person-centred (addressing individual or group needs), multidimensional (covering knowledge, attitudes, skills and environment), and participatory (involving negotiation and partnership) (Whitehead & Pueyo-Garrigues, 2019). Its antecedents include the awareness and training of health professionals, available resources, and the individual's readiness to engage (Whitehead & Pueyo-Garrigues, 2019). Its consequences are enhanced knowledge and skills, behaviour change, empowerment, better health outcomes, and broader social or economic benefits (Whitehead & Pueyo-Garrigues, 2019). Health education also intertwines with the ideology of health promotion, where it overlaps with interventions that address broader determinants of health (such as economic, legal, environmental measures). In such accounts, health education is seen as one component in a wider strategy for health promotion rather than the whole answer (Tones, 1986). In summary, health education can be defined as: A continuous, dynamic, structured teaching-learning process that occurs throughout the lifespan across different settings, implemented jointly by health professionals and learners, and designed to facilitate and empower individuals and groups to adopt and sustain behaviours that support positive health outcomes (Whitehead & Pueyo-Garrigues, 2019).

The History of Health Education can be traced to ancient societies where practices of hygiene, sanitation, and preventive health were taught informally within communities. Over time, as urbanisation, industrialisation and epidemics increased, more structured approaches to educating populations about health began to emerge, for example, in the context of modern nation-states the late 19th and early 20th centuries marked a major

shift: in the United States, organized school-based health education began in schools and colleges, where healthful conditions, hygiene, physiology and physical exercise were incorporated into curricula. Free-standing public health education for the general population was still nascent. In Britain and other European countries, social experiments such as the Peckham Experiment (1926-1950) also exerted influence by investigating how broad health consciousness and community environments could shape health-education practice. During the first half of the 20th century, health education started to become institutionalised in both formal educational settings (schools, colleges) and public health agencies. In the United States, as Hein (1991) details, by the end of the 19th century many U.S. schools were teaching hygiene, physiology, physical training and environmental health; from 1787-1850 such themes were already appearing. In addition, the concept of health education began to expand beyond mere hygiene into prevention of disease, health promotion and later behavioural approaches. The emergence of organisations such as the World Health Organization (WHO) in 1948 helped shift the focus toward population health, preventive measures and community education.

In the Mid to late 20th century (Expansion of scope, theory and global dimension), the 1960s onwards, health education grew more sophisticated. It developed theoretical frameworks (behaviour change models, social determinants of health), settings-based approaches (schools, workplaces, communities) and an emphasis on empowerment rather than only transmitting information. For example, Tones (1986) argued that health education must move towards self-empowerment and recognise legal, fiscal, economic and environmental measures, not just individual behaviour. A review by Rychetnik, Nutbeam & Hawe (1997) of publications in health-promotion journals between 1989-94 highlighted that health promotion (which includes health education) was being called upon to broaden its intervention base, improve rigour and respond to practitioner needs. In many countries outside the Western world, health education and public-health education evolved in tandem with national development, global health influences and educational reforms. For example, in India and China a detailed review

by Bangdiwala et al. (2011) traces how public-health education developed, its opportunities and challenges.

Specific National Evolutions - In the United States: Rosenstock, Helsing & Rimer (2011) charted the evolution of public-health education, noting how training, professionalization, accreditation and global influences transformed the field. In China: Jin, Dong et al. (2020) describe how higher public-health education evolved in phases: 1949–1976 (planned-economy era), 1977–1998 (reform & opening up), and 1999–present (deepening reform); Western models, the Soviet model, and indigenous reforms all shaped the system. In Saudi Arabia: Al-Hashem (2016) offers a historical overview of the profession of health education, the development of roles, and institutionalization in the Saudi healthcare context. The late 20th century introduced the idea of "health promotion" as a broader umbrella under which health education operates. Health promotion emphasizes not only individual behaviour change but also social, economic, environmental and policy determinants of health (Tones, 1986). Settings-based approaches (e.g., schools, workplaces, communities) and the concept of life course health education gained traction recognizing that health education begins early and continues through life, not just in response to disease. For example, the "whole institution" approach in tertiary education (universities/colleges) is a more recent evolution: Sweeting et al. (2021) provide a scoping review of how "whole institution" approaches to improving health in tertiary settings have developed. In the 21st century, health education faces new challenges and opportunities: digital health, globalization of health problems (non-communicable diseases, pandemics), health literacy, and socio-economic inequities. Educational systems, accreditation, professional identity and cross-discipline collaboration are evolving. For instance, Jin et al. (2020) noted challenges in China including professional accreditation, social identity of the public-health education discipline, and adapting existing medical-education models to broader public-health needs. The Timeline could be summary as follows: Pre-20th century: informal hygiene, sanitation, community teaching. Late 19th / early 20th century: school-based hygiene, physical training, environment; early professionalisation.

In The Mid 20th century public health agencies, theoretical models, global organisations, focus on prevention. Late 20th century: health promotion era, empowerment, settings approaches, global reach. 21st century: digital/information age, global health burdens, interdisciplinary frameworks, accreditation, life-course approaches, equity focus.

In Nigeria, Health Education has evolved through several phases from informal hygiene practices to formalized curricula, professional disciplines, and integration into schools and community systems. Early beginnings Before colonial times, health education in Nigeria was mostly informal and community-based (traditional medicine, hygiene advice, folk practices). With the advent of Western medical systems, formal hygiene and sanitation education began to enter the public sphere. For example, the training of health workers and establishment of hygiene schools in the early 20th century reflect the start of more structured health education. Formal incorporation into education and professional training. By the mid-20th century and into the post-independence era, health education as a subject and as part of professional training became more visible in Nigeria. For instance, secondary schools in states like Bayelsa have made health education a compulsory subject tied to the West African Examination Council (WAEC)/Senior Secondary School Certificate Examinations (SSCE) for health-related tertiary study. Higher education also responded: disciplines of health education and public health were institutionalized in Nigerian universities, with degree curricula developed. For example, a review notes that the first B.Sc. degree curriculum in Health Education was developed in 1989 through the Nigerian Universities Commission (NUC). Health education in Nigeria has also been implemented through community mobilisation, public health campaigns, and outreach programmes. An article examining the state of health education and community mobilisation in Nigeria points to challenges (such as limited resources, inadequate teacher preparation, and community engagement) and prospects for improving the mobilisation of health education in grassroots contexts.

In more recent years, health education in Nigeria expands to consider broader determinants of health (hygiene, environmental health, non-communicable diseases,

health literacy). For example, a 2025 study highlighted the role of school health education in addressing gaps in hygiene, disease prevention and health literacy among Nigerian students. During it course of it development in Nigeria challenges such as ensuring qualified health education teachers, integrating health education consistently across levels, infrastructural constraints, security issues in certain regions disrupting schooling, and aligning curricula with changing health needs has been face. However, It key milestones could be summarize as follows; Training of health-hygiene schools and mid-level health manpower in early/ mid-20th century. Introduction of health education as a school subject and integration into teacher-training colleges (1980s onward). Development of university degree programmes in health education (1989 via NUC). Growth of community health education programmes and mobilisation efforts in rural and urban Nigeria.

Health education in Edo State has evolved from informal community practices to structured government programs over time. Traditionally, health knowledge was passed down orally through families and community leaders. Indigenous practices focused on hygiene, sanitation, and disease prevention, with traditional healers playing a key role in health guidance (Aisien & Okonofua, 2006). During the colonial era (late 19th – mid-20th century), the British administration introduced formal health services to control epidemics such as smallpox and malaria. Missionary schools incorporated basic health teachings into their curricula, emphasizing personal hygiene and first aid. Urban centers like Benin City became focal points for public health campaigns, though rural areas largely relied on traditional practices (Omoruyi, 1990). After Nigeria's independence in 1960, Edo State (then part of the Mid-Western Region) developed more structured health education programs. The establishment of health ministries and local departments facilitated public health campaigns on vaccination, maternal-child health, and disease prevention. Collaboration with international agencies introduced modern strategies, including printed materials and community outreach. In the modern era (1990s – present), health education in Edo State has been integrated into secondary school curricula and community programs. Key topics include reproductive health, HIV/AIDS awareness, nutrition, mental health,

and environmental sanitation. The Edo State Primary Health Care Development Agency and NGOs conduct regular outreach programs, while radio, television, and social media enhance public awareness (Oghuvbu & Ogbeide, 2018).

The Aims & Objectives of Health education equip individuals and communities with the knowledge, skills, attitudes, and motivation necessary to make informed decisions that promote and maintain good health (Nutbeam, 2000). It is a key component of public health practice and health promotion, designed to empower people to take control of their health and that of their environment (Whitehead & Pueyo-Garrigues, 2019). It promotion of Healthy Lifestyles, it encourage individuals and communities to adopt and sustain health-enhancing behaviours, such as proper nutrition, physical activity, sanitation, and avoidance of harmful habits (Tones & Tilford, 2001). It prevention of disease to reduce the incidence and prevalence of communicable and non-communicable diseases through awareness, vaccination campaigns, hygiene education, and preventive practices (Glanz & Bishop, 2010). There is Improvement of Health Literacy to develop people's ability to access, understand, appraise, and use information to make appropriate health decisions (Nutbeam, 2008). It Promote Community Health to strengthen community involvement in health activities and empower populations to identify and solve their health problems collaboratively (Hubley & Copeman, 2013). It Reduces Health Inequalities as it address disparities in health outcomes between different population groups through targeted health education interventions (World Health Organization [WHO], 1986). There is also Enhancement of Quality of Life to improve individuals' physical, mental, and social well-being by fostering positive health attitudes and sustainable behaviours (Whitehead & Pueyo-Garrigues, 2019).

Furthermore, these aims & objectives of health education are specific, measurable outcomes that reflect its broader aims. They include Cognitive Objectives (Knowledge Acquisition) which help to increase understanding of basic health concepts such as nutrition, disease prevention, reproductive health, and sanitation. To provide accurate information about risk factors and protective behaviours (Tones & Tilford, 2001).

Affective Objectives (Attitude Development) which help to influence attitudes, beliefs, and values toward health so that individuals become motivated to adopt healthier behaviours (Glanz & Bishop, 2010). To foster a sense of personal and social responsibility for maintaining one's own health and the health of others. Behavioural Objectives (Skill Application) which help to enable individuals to apply learned skills in real-life situations, such as handwashing, safe sex practices, or first aid (Hubley & Copeman, 2013). To develop community skills for health promotion activities and preventive interventions. Social and Environmental Objectives help to promote environments that support health through policy advocacy, school-based interventions, and community engagement (WHO, 1986). And also Evaluation Objectives which help to assess the effectiveness of health education programs through measurable indicators such as behavioural change, reduction in disease incidence, or increased participation in preventive health programmes (Nutbeam, 2008). In conclusion the ultimate goal of health education is empowerment—helping people gain control over their health by fostering knowledge, positive attitudes, and sustainable behaviours. When properly implemented, it not only improves individual health outcomes but also contributes to broader public health goals such as disease prevention, improved quality of life, and reduced healthcare costs.

The Scope of Health Education refers to the range of areas, activities, and populations it encompasses in promoting and maintaining health. It is broad and dynamic, covering physical, mental, social, environmental, and spiritual dimensions of health (Auld et al., 2020). Health education not only addresses individual behaviours but also targets social determinants of health such as poverty, education, and environment (Charles, 2023). In contemporary practice, the scope extends across various levels which include personal, family, community, institutional, and national and also includes both preventive and promotive dimensions of health.

Personal Health Education: This area focuses on improving individual knowledge, attitudes, and practices that influence personal well-being. It includes topics like nutrition, exercise, hygiene, mental health, substance abuse prevention, and

reproductive health. Health education encourages individuals to adopt healthy lifestyles and manage chronic conditions effectively (Wilkins et al., 2022).

Family Health Education: Families serve as the primary unit of health influence. Health education within the family setting aims to foster healthy relationships, proper child care, nutrition, immunization, and family planning. Studies emphasize that family-based education improves maternal and child health outcomes, especially in low- and middle-income countries (Perini, 2023).

School Health Education provide a structured environment to instill lifelong healthy habits. Health education in schools covers topics such as hygiene, nutrition, physical activity, sexual health, and drug awareness (Auld et al., 2020). Integrating health literacy into school curricula ensures that children grow up understanding how to make informed health choices. School-based programs have also been linked to better academic performance and social behaviour (Yunusa Giade et al., 2023).

Community Health Education seeks to empower groups to identify and solve local health challenges collectively. It includes campaigns, workshops, and outreach programs that address issues such as sanitation, malaria control, HIV/AIDS awareness, and vaccination (Jara Baraybar Alvarenga de Oliveira et al., 2020). In Nigeria, community health education remains central to rural health promotion and preventive strategies under primary health care initiatives (Yunusa Giade et al., 2023).

At the institutional level, occupational health education addresses the health and safety of workers. It involves educating employees and employers on workplace hazards, ergonomics, accident prevention, and stress management. Occupational health education reduces injury rates, absenteeism, and improves productivity (Wan, 2023).

While, environmental Health education focuses on the relationship between health and the surrounding environment. It promotes awareness about pollution, waste management, water sanitation, and climate change impacts. By educating communities on sustainable practices, environmental health education contributes to a healthier and safer ecosystem (Suryasa et al., 2020).

Preventive and Promotive dimensions of Health Education include, public and global health education, media and digital health education. The global nature of health challenges such as pandemics, climate change, and migration has expanded the scope

of health education to international collaboration and policy advocacy. Public health education now includes global health literacy, emergency preparedness, and sustainable health systems (Wan, 2023). The COVID-19 pandemic highlighted the importance of global health communication and the role of education in controlling outbreaks (Wilkins et al., 2022). Digital and Media Health Education: In today's digital world, media and technology play a crucial role in health education. Online health campaigns, mobile health applications, and social media awareness programs have broadened the reach of health messages (Charles, 2023). Digital health literacy has become a vital component of modern health education, enabling people to evaluate online health information critically and responsibly.

The Component of Health education consists of several inter-related aspects which together enable individuals and communities to acquire knowledge, attitudes, skills and resources necessary for promoting health and preventing disease. These components form part of the framework of a comprehensive health education programme. (Socio.Health, 2024) They include, Knowledge and Information Transfer which involves providing accurate, evidence-based health information about body systems, disease processes, lifestyle risks, preventive measures and health services. It lays the foundation for informed decision-making (Socio.Health, 2024). Skill Development which goes beyond simply giving information, health education must develop practical skills—such as decision-making, self-management, critical thinking, communication, and coping strategies—to enable individuals to act on that knowledge. (Socio.Health, 2024). Attitude and Belief Formation which seeks to shape positive attitudes, values and beliefs about health behaviours (for example, the belief that one can influence their own health) which support adoption of healthier lifestyles and practices. (Socio.Health, 2024). Behaviour Change Facilitation another crucial component is enabling and supporting actual behaviour change—moving from understanding and willingness to real action (e.g., improved hygiene practices, regular exercise, and safer sexual behaviours). This involves addressing barriers, providing encouragement and reinforcing change (Socio.Health, 2024). In regard to environmental and Policy Context effective health education does not occur in a

vacuum—it must be embedded within a supportive environment and policy framework. This means the educational setting, institutional policies, social norms and the broader physical environment must enable and reinforce healthy choices. (SHAPE America, 2019).

Moreover Community Engagement / Empowerment which is another component is the involvement of communities: enabling them to identify their health needs, participate in planning and implementation of interventions, and build their own capacity for sustained health improvement. (Socio.Health, 2024). Finally evaluation and Assessment, one crucial component of health education programme which must include assessment of learner knowledge, skills and behavioural outcomes, and evaluation of programme effectiveness to guide improvement. (SHAPE America, 2019).

IMPORTANCE OF TEACHING AND LEARNING OF HEALTH EDUCATION

Health education remains a foundational element of public health, contributing significantly to knowledge dissemination, behaviour change, and empowerment across individual and community levels. As health systems face evolving challenges—ranging from non-communicable diseases to low health literacy—effective health education programs have become increasingly vital in promoting sustainable health outcomes (Auld et al., 2020). Some of these importance are:

Promotion of Healthy Behaviour

The promotion of healthy behaviour is a fundamental component of health education, as it empowers individuals with the knowledge, attitudes, and practical skills required to make informed decisions about their wellbeing. Healthy behaviour encompasses a wide range of activities and lifestyle choices, including balanced nutrition, regular physical activity, good personal hygiene, adequate rest, and engagement in preventive healthcare practices. When individuals, especially young people in school settings, acquire these skills early in life, they are more likely to adopt and maintain positive health habits throughout adulthood. A key element in promoting healthy behaviour is health literacy—the ability of individuals to access, understand, and apply health

information in ways that enhance their quality of life. Integrating health literacy into the school curriculum plays a crucial role in shaping long-term habits. Through structured lessons, practical demonstrations, and age-appropriate learning activities, students develop the capacity to evaluate health-related information, differentiate between healthy and unhealthy choices, and take responsibility for their personal wellbeing. As Wilkins et al. (2022) noted, educational interventions that strengthen health literacy contribute significantly to the development of sustainable health behaviours. Healthy behaviour promotion is also essential in preventing lifestyle-related diseases such as obesity, diabetes, cardiovascular conditions, and communicable infections. By understanding the importance of balanced nutrition, students learn to choose foods that provide essential nutrients and avoid overconsumption of unhealthy options. Physical activity education encourages regular exercise, which supports physical fitness, mental well-being, and improved academic performance. Hygiene practices, such as hand washing, tooth brushing, and environmental cleanliness, directly reduce the spread of infectious diseases in schools and communities. Preventive care—through immunization, early health screenings, and seeking timely medical attention—further reinforces the foundation of a healthy population. The relevance of promoting healthy behaviour becomes even more evident in rapidly changing environments, especially during public health emergencies such as the COVID-19 pandemic. During such times, the ability of individuals to quickly adapt their behaviour, follow safety guidelines, and apply health information becomes critical. Health education supported schools and communities in understanding preventive measures such as mask usage, hand hygiene, physical distancing, and vaccination. Students who had prior exposure to health literacy could easily comprehend and adopt the necessary behavioural changes, thereby reducing risks for themselves and those around them.

Disease Prevention and Control

Disease prevention and control is one of the most significant pillars of health education, as it addresses the growing burden of both communicable and non-communicable diseases in communities. Effective health education equips individuals

with essential knowledge about risk factors, transmission patterns, symptoms, and preventive strategies, enabling them to make proactive health decisions. By increasing awareness of behavioural and environmental risks, health education reduces individuals' vulnerability to diseases and strengthens public health systems. Studies show that when individuals understand the causes and risk factors of diseases, they are more likely to engage in preventive actions such as proper hygiene, balanced diets, regular exercise, and timely health screenings (Suryasa et al., 2020). This early detection and intervention greatly decrease the severity of health conditions and the long-term costs associated with medical treatment. For example, routine screening for hypertension, diabetes, and cancers has been proven to reduce mortality rates, while awareness campaigns on diseases such as tuberculosis and cholera help minimize community transmission. The importance of disease prevention became especially clear during the COVID-19 pandemic. According to Wilkins et al. (2022), individuals with higher levels of health literacy demonstrated stronger health-promoting behaviours, including adherence to public health guidelines such as mask-wearing, hand hygiene, physical distancing, and vaccine uptake. This shows that health education is not just a theoretical concept but a practical tool that can significantly reduce the spread of infectious diseases and protect vulnerable populations during emergencies. Beyond pandemics, structured health education programs have been essential in preventing and controlling major diseases in low-income countries, including malaria, HIV/AIDS, and cardiovascular diseases. Yunusa Giade et al. (2023) highlight that targeted interventions—such as mosquito net campaigns, sexual health education, and lifestyle modification programs—have consistently lowered disease prevalence and improved community health outcomes. These findings demonstrate that when health education is applied strategically, it becomes a powerful instrument for reducing disease burden and promoting healthier societies.

Enhancement of Health Literacy

Enhancing health literacy is a core objective of health education, as it empowers individuals with the ability to access, understand, evaluate, and apply health information for better decision-making. Health literacy is not limited to reading

medical texts; it also includes understanding prescriptions, interpreting nutrition labels, identifying credible health sources, and knowing when and how to seek professional care. This competence serves as the foundation for informed health behaviour and resilience. Recent studies emphasize that improving health literacy significantly enhances personal empowerment and autonomy (Charles, 2023). When individuals are health-literate, they can confidently navigate healthcare systems, communicate effectively with health professionals, and take responsibility for their wellbeing. Health literacy also plays a major role in reducing misinformation—a challenge that became widespread during the COVID-19 era. People with higher literacy levels were better able to evaluate the credibility of health information and avoid harmful practices. At the community level, strengthening health literacy contributes to the development of more effective and efficient health systems. According to Wan (2023), communities with higher health literacy demonstrate better health outcomes, reduced disease prevalence, and more rational use of healthcare resources. This leads to fewer emergency cases, improved chronic disease management, and overall enhanced population health. Furthermore, health-literate communities are more receptive to public health interventions, making disease prevention efforts more successful and sustainable.

Community Empowerment and Equity

Community empowerment and equity are central components of health education because they promote active participation, inclusiveness, and fairness in health outcomes. By empowering individuals and communities to identify and address their own health challenges, health education reduces dependency on external interventions and builds long-term resilience. Empowered communities are more capable of recognizing health risks, mobilizing resources, and implementing sustainable solutions that are relevant to their cultural and social contexts. Educational programs tailored to vulnerable groups—such as indigenous populations, rural communities, and underserved areas—play a crucial role in reducing health inequalities. According to Jara Baraybar Alvarenga de Oliveira et al. (2020), context-specific health education initiatives significantly improve the understanding of health and wellbeing among

marginalized groups. These programs often include culturally appropriate teaching methods, community dialogues, and participatory learning strategies that strengthen trust and encourage active involvement. As a result, vulnerable communities gain the skills and confidence necessary to advocate for their health rights, access available services, and adopt healthy behaviours. In addition, health education contributes to national development through its impact on human capital. In Nigeria, for instance, Yunusa Giade et al. (2023) observe that health education within teacher-training institutions enhances productivity, improves workforce wellbeing, and supports broader socio-economic growth. By equipping future educators with health knowledge, the education sector becomes a catalyst for promoting healthier lifestyles and behaviours across the population. This creates a ripple effect in which improved community health leads to stronger labour participation, reduced disease burden, and increased national development. Thus, community empowerment through health education is not only a health strategy but also an economic and social investment.

Improvement of Quality of Life

Health education plays a vital role in improving individuals' overall quality of life by fostering self-awareness, positive attitudes, and healthier daily habits. When people understand the connection between their behaviours and their wellbeing, they are more likely to make informed choices that enhance their physical, mental, and social health. This leads to a more balanced lifestyle, reduced stress levels, and better personal fulfilment. Perini (2023) reports that individuals who receive proper health education tend to exhibit higher levels of life satisfaction and wellbeing. This improvement is seen across multiple domains—physical health through regular exercise and nutrition, mental health through stress management and awareness of emotional wellbeing, and social health through improved interpersonal relationships. Health education empowers people to take proactive steps such as seeking preventive care, reducing unhealthy habits, and maintaining a supportive social environment. Furthermore, health education is particularly impactful for young people. Auld et al. (2020) found that structured health education programs for youths are associated with improved mental health, enhanced decision-making skills, and reduced engagement in

risky behaviours such as substance abuse, violence, and unsafe sexual practices. By equipping young people with coping skills, emotional intelligence, and accurate health information, health education contributes directly to healthier transitions into adulthood and long-term wellbeing. Overall, the improvement of quality of life is both an outcome and a reinforcing factor of effective health education. When communities experience enhanced wellbeing, they become more engaged, productive, and capable of sustaining healthy behaviours. This underscores the importance of investing in robust health education programs as a means of promoting holistic development and healthier societies.

Support for Health Systems and Policy

Health education also plays a pivotal role in strengthening health systems and supporting effective policy implementation. Its influence extends beyond individual knowledge and behaviour change to the broader functioning and resilience of healthcare structures. By facilitating clear communication between healthcare providers and the public, health education enhances the efficiency, responsiveness, and inclusiveness of health systems. One of its major contributions is improved communication between patients and health professionals. When individuals understand medical terms, treatment processes, and preventive instructions, they can interact more confidently with healthcare providers. This leads to better clinical outcomes, increased adherence to medical advice, and reduced instances of misinformation or misunderstanding. Wan (2023) emphasizes that health literacy—an outcome of effective health education—is essential for fostering trust, improving patient–provider relationships, and ensuring that individuals can follow treatment plans correctly. Health education also supports the implementation of public health policies by ensuring that citizens understand and comply with national health directives. Policies, no matter how well designed, require public awareness and acceptance to be effective. Through community campaigns, school-based programs, and mass media health messaging, health education translates policy goals into practical actions that people can adopt in their daily lives. This alignment between policy and public behaviour is critical for achieving national and global health targets.

Furthermore, health education strengthens the resilience of health systems by equipping communities with the skills needed to respond to health emergencies. As observed during outbreaks such as COVID-19, communities with higher levels of health literacy were better prepared to adopt rapid behavioural changes, follow safety guidelines, and participate in surveillance and reporting activities (Wan, 2023). This capacity for quick adaptation is essential for mitigating the impact of epidemics, natural disasters, and other public health threats. In developing countries like Nigeria, health education is particularly significant because it helps bridge the persistent gap between policy formulation and practical implementation. Yunusa Giade et al. (2023) note that community-oriented health education increases awareness of national health initiatives, such as immunization campaigns, maternal health programs, and disease prevention strategies. By translating these policies into community-friendly information, health education ensures that citizens not only understand national health objectives but also take active roles in achieving them. Additionally, health education contributes to the attainment of global health agendas, including the Sustainable Development Goals (SDGs). Goals related to health, education, poverty reduction, and gender equality all rely, directly or indirectly, on informed, empowered populations. Through improved knowledge, skills, and attitudes, health education fosters healthier communities that can participate effectively in socio-economic development.

BARRIERS TO EFFECTIVE TEACHING AND LEARNING OF HEALTH EDUCATION IN NIGERIA

Health education is an essential component of the Nigerian secondary school curriculum, designed to promote health literacy, preventive behaviours, and overall wellbeing among students. However, specifically in Benin City, Edo State, Nigeria, the effective teaching and learning of this subject are hindered by several systemic, institutional, and socio-cultural barriers that affect both teachers and students. Some of these barriers are highlighted as follows:

Inadequate Funding

Inadequate funding remains one of the most pressing and persistent barriers to the effective teaching and learning of health education in Nigerian secondary schools,

particularly in Benin City. Public schools in Nigeria generally rely on allocations from federal, state, and local governments; however, these funds are often insufficient to meet the diverse needs of the education sector. Health education, being a subject that requires practical demonstrations, modern instructional materials, and health-related facilities, is disproportionately affected by budgetary shortfalls. Without adequate financial resources, schools struggle to acquire essential teaching tools such as charts, models of human anatomy, audio-visual equipment, posters, projectors, first-aid kits, laboratory supplies, and hygiene demonstration materials. The absence of these tools forces teachers to rely solely on theoretical teaching, which significantly limits students' understanding, engagement, and application of health concepts. The shortage of funding also affects the maintenance and provision of school infrastructure necessary for effective health education. Many public schools in Benin City lack basic amenities such as clean water, functional toilets, hand washing stations, and sickbays—facilities that should ideally serve as practical learning environments for topics such as hygiene, sanitation, disease prevention, and first aid. When students are taught about proper hygiene in a school environment that lacks clean water or sanitary toilets, the disconnect between theory and practice undermines the credibility of the lessons. Such contradictions reduce the likelihood that students will adopt the health behaviours being promoted. Furthermore, inadequate funding restricts opportunities for teachers to receive training and professional development in emerging global health issues. Health education is a dynamic field that evolves continually as new diseases emerge and global health trends change. However, most teachers are unable to attend workshops, seminars, or refresher courses due to financial limitations within the school system. Without updated training, teachers may rely on outdated knowledge and methods, resulting in lessons that are misaligned with modern public health practices. The effects of poor funding extend even deeper, influencing classroom organization and general learning conditions. Overcrowded classrooms, a common feature of many public schools, make it difficult for teachers to conduct interactive health education activities such as group discussions, demonstrations, and practical exercises. Additionally, insufficient funding leads to inadequate furniture, poor ventilation, leaky roofs, and degraded buildings, creating a learning environment

that contradicts the health standards promoted in the curriculum. Such environmental challenges hinder students' concentration and reduce the overall quality of teaching and learning. Moreover, the lack of financial investment in school health programmes limits the implementation of broader school health policies. For instance, activities such as periodic health screenings, deworming exercises, school sanitation inspections, and health awareness campaigns require financial support. When funding is absent, these programs either do not take place or are poorly executed, denying students the full benefits of a comprehensive health education system.

Insufficient Qualified Teachers

The shortage of trained and qualified health education teachers is one of the most critical barriers affecting the effective teaching and learning of health education in Nigerian secondary schools, including those in Benin City. Health education is a specialized field that requires knowledge in public health, human biology, psychology, health promotion, disease prevention, and pedagogy. However, in many Nigerian schools, qualified teachers with formal training in these areas are scarce. As a result, schools frequently reassign teachers from unrelated disciplines such as biology, physical education, or integrated science to handle health education classes. While these teachers may possess partial knowledge of health concepts, they often lack the pedagogical competence and subject-specific expertise necessary for delivering comprehensive, age-appropriate, and practical health instruction. This reliance on non-specialists significantly undermines the depth, accuracy, and relevance of the health education curriculum. Teachers without adequate training may struggle to interpret the curriculum correctly, simplify complex health topics, or translate theoretical knowledge into meaningful practical activities. For example, topics such as reproductive health, sexually transmitted infections, mental health, substance abuse, nutrition, and first aid require careful handling with correct terminology, sensitivity, and up-to-date scientific information. When untrained teachers deliver these lessons, critical concepts may be oversimplified, misrepresented, or entirely avoided due to discomfort or insufficient knowledge. This weakens students' understanding and prevents them from gaining the essential skills needed to make informed health

decisions. The absence of qualified health educators also affects students' motivation to take the subject seriously. Teachers who lack confidence in teaching health education often adopt passive teaching methods such as dictation, rote learning, or reading directly from textbooks. These methods do not stimulate critical thinking, problem-solving, or behavioural change—all of which are central goals of health education. Students may perceive the subject as boring, irrelevant, or secondary, especially when compared to other subjects taught by well-trained, passionate teachers. Additionally, a teacher's lack of expertise can hinder effective classroom management during sensitive lessons, particularly those involving sexuality, adolescent mental health, drug abuse, or peer pressure. The problem is further compounded by the limited availability of teacher-training programs specializing in health education. Many colleges of education and universities in Nigeria offer health education as only a minor or an optional course within physical education or human kinetics departments. As a result, the country produces far fewer health education specialists than needed. Even among the few who are trained, many do not find their way into the teaching profession due to poor remuneration, lack of incentives, and challenging work environments in public schools. This creates a widening gap between the demand for qualified health educators and the supply of competent professionals. Moreover, insufficient qualified teachers directly affects curriculum implementation. Even when a well-designed curriculum exists, its effectiveness depends on the teacher's ability to interpret, adapt, and deliver it using appropriate instructional strategies. Health education requires active, participatory teaching methods such as group work, demonstrations, role-play, community projects, health campaigns, and field observations. Teachers without specialized training may lack the confidence or creativity required to incorporate these methods, resulting in a theoretical and shallow delivery of a subject meant to be highly practical. The shortage also limits students' access to accurate health guidance. Adolescents often turn to teachers for advice on personal health issues such as puberty, emotional wellbeing, menstrual hygiene, sexual behaviour, and substance use. When qualified teachers are unavailable, students may be left without credible sources of information or may rely on peers and

unverified online content, which increases the risk of misinformation and harmful behaviours.

Overloaded Curriculum and Low Subject Priority

The issue of an overloaded curriculum coupled with the low prioritization of health education poses a major barrier to effective teaching and learning in secondary schools across Nigeria, including Edo State. The Nigerian educational system places significant emphasis on core examinable subjects such as English Language, Mathematics, Biology, Chemistry, and Physics, as mandated by the West African Examinations Council (WAEC) and the National Examination Council (NECO). As a result, health education often categorized as a non-examinable or minor subject—receives less attention from school administrators, teachers, students, and even parents. This marginalization greatly diminishes the role health education is intended to play in promoting health awareness, literacy, and behavioural change among adolescents. An overloaded curriculum means that teachers and students are expected to cover a large amount of content within limited academic time. School timetables are typically structured to allocate more periods to examinable subjects, leaving health education with minimal time or, in some cases, no dedicated period at all. Consequently, health education classes are frequently merged with Physical and Health Education (PHE), Social Studies, or Biology, which dilutes the subject's content and reduces opportunities for comprehensive instruction. Teachers under pressure to meet the demands of core subjects often skip health education lessons, rush through topics, or treat the subject as optional, thereby undermining its educational value. This low prioritization has several far-reaching implications. First, students may develop the perception that health education is unimportant or irrelevant to their academic success. Since the subject does not contribute directly to their examination results, many students show little motivation to engage seriously with its content. This attitude affects classroom participation, retention of information, and willingness to practice health-promoting behaviours. Health topics that require deep understanding—such as nutrition, disease prevention, mental health, adolescent sexuality, substance abuse, and personal hygiene—are often viewed as less important compared to topics in core

science subjects. Teachers, too, are influenced by the prioritization system. In schools where performance in WAEC and NECO determines school ranking, funding, and prestige, teachers naturally focus their time and energy on helping students excel in examinable subjects. This creates a situation where health education becomes a "filler subject," taught only when there is free time or when substitution is needed. Teachers may not prepare adequately for lessons, and practical demonstrations—which are essential in health education—are often omitted due to time constraints. Moreover, the overloaded curriculum leaves little room for hands-on learning, which is a foundational aspect of health education. Effective health learning requires interactive strategies such as group discussions, health clubs, peer education, community outreach, health campaigns, and practical demonstrations. However, with an overwhelming academic workload, schools rarely have the time, flexibility, or administrative support to organize these activities. As a result, students are denied the opportunity to learn by doing, which limits the development of real-life health skills. The consequences of low subject priority extend beyond the classroom. Health education is central to national development goals, including reducing disease burden, improving hygiene and sanitation practices, lowering teenage pregnancy rates, combating drug abuse, and promoting mental health. When the subject is marginalized, students enter adulthood with insufficient health knowledge, poor decision-making skills, and harmful behaviours that negatively affect public health outcomes. In Benin City, where issues such as teenage pregnancy, drug misuse, malaria prevalence, and poor sanitation are widespread, the low prioritization of health education in schools contributes to the persistence of these challenges.

Poor Learning Environment and Lack of Facilities

A conducive learning environment is essential for the effective teaching and learning of health education, yet many secondary schools in Nigeria, including those in Benin City, face significant challenges in this regard. Health education is a practical and interactive subject that often requires facilities such as clean water, functional toilets, first-aid rooms, demonstration materials, and laboratory equipment. Unfortunately, inadequate infrastructure in most public schools severely limits students' ability to

engage in hands-on learning and apply theoretical knowledge to real-life situations (Adeniyi & Akinsola, 2022). Poor learning environments manifest in several ways. First, many schools lack basic amenities such as potable water, functional toilets, and handwashing facilities, which are crucial for teaching topics related to hygiene, sanitation, and personal health. Teaching students about hand washing or menstrual hygiene in a school without clean water or proper toilets creates a disconnect between theory and practice, reducing the effectiveness of the lessons. Similarly, topics such as first aid, nutrition, and environmental health often require practical demonstrations using equipment or models, yet these are frequently unavailable due to budgetary constraints or mismanagement. In addition to the physical infrastructure, classroom conditions often impede effective learning. Overcrowded classrooms, inadequate seating arrangements, poor ventilation, leaking roofs, and insufficient lighting are common in many public schools. Such conditions distract students, reduce concentration, and hinder teachers from conducting practical or interactive activities. The lack of adequate space also makes it difficult to organize group discussions, role-plays, and demonstration exercises, which are essential components of health education pedagogy. The absence of supportive facilities also affects teachers' ability to implement the curriculum effectively. When schools cannot provide demonstration kits, laboratory supplies, or visual aids, teachers are forced to rely solely on lectures and textbook explanations. This approach limits students' engagement, comprehension, and retention of important health concepts. Lessons on nutrition, disease prevention, hygiene practices, and reproductive health become abstract, making it difficult for students to visualize or internalize the behaviours being taught. Moreover, poor learning environments contribute to students' negative attitudes toward health education. When the teaching setting is uncomfortable, unsafe, or unhygienic, students may perceive the subject as irrelevant or unimportant. This perception is further reinforced if health education is consistently taught in multipurpose classrooms without dedicated resources, creating the impression that the subject is secondary to core examinable subjects. The lack of facilities also has long-term implications for community health outcomes. Schools are intended to serve as hubs of health knowledge, instilling lifelong habits such as proper hygiene, sanitation,

first aid skills, and preventive health practices. When students are not provided with the environment or tools to practice these behaviours, they may fail to adopt and internalize them. This, in turn, perpetuates unhealthy practices within families and communities, reducing the overall impact of school health education programs.

Cultural and Religious Beliefs

Cultural and religious beliefs represent a significant barrier to the effective teaching and learning of health education in Nigerian secondary schools, including those in Edo State. Health education covers topics that often intersect with deeply held societal norms and religious values, such as sexual and reproductive health, family planning, HIV/AIDS prevention, substance use, mental health, and adolescent reproductive rights. In many communities, discussions about these topics are considered taboo or inappropriate, which leads to avoidance, censorship, or superficial treatment of critical health issues in the classroom (Salomi, 2021). The influence of cultural beliefs is particularly evident in areas related to sexuality and reproductive health. Topics such as contraception, sexually transmitted infections, and adolescent sexual behaviour are often met with resistance from parents, school administrators, and even teachers themselves. Teachers may feel uncomfortable delivering these lessons due to fear of parental disapproval, societal judgment, or conflicts with their own personal or religious convictions. In such cases, important topics may be skipped, glossed over, or presented in a way that emphasizes abstinence only, which limits students' understanding of safe health practices and reduces their ability to make informed decisions (Oluwasanu et al., 2021). Religious beliefs can similarly shape attitudes toward health education content. For instance, communities with conservative religious values may discourage open discussions about sexual health, HIV/AIDS, or family planning, perceiving them as promoting immoral behaviour. Teachers, sensitive to these beliefs, may avoid engaging students in meaningful discussions or practical demonstrations related to these topics. This leads to incomplete learning and perpetuates misinformation, as students may seek information from peers, the internet, or other informal sources that are not always accurate or safe. Cultural and religious norms also influence students' willingness to participate in classroom activities.

Adolescents may feel embarrassed or fearful of judgment when discussing personal health issues, such as menstruation, puberty, or sexual development, in a mixed-gender classroom setting. Such discomfort reduces class participation, limits knowledge acquisition, and prevents the development of critical life skills. Additionally, cultural expectations around gender roles may restrict girls or boys from fully engaging in certain health activities, further exacerbating disparities in health knowledge and outcomes. The impact of these socio-cultural barriers extends beyond the classroom. When health education is constrained by cultural and religious sensitivities, students are less likely to adopt positive health behaviours, including safe sexual practices, proper hygiene, disease prevention, and mental health care. Communities may continue to experience high rates of teenage pregnancy, sexually transmitted infections, poor reproductive health outcomes, and other preventable health issues because students were never adequately equipped with the necessary knowledge and skills.

Lack of Continuous Professional Development

Continuous professional development (CPD) is a critical component of effective teaching, yet it remains a significant barrier to the successful delivery of health education in Nigerian secondary schools. Many health education teachers in Benin City and across Nigeria do not have regular access to professional development opportunities such as workshops, refresher courses, seminars, or training in modern teaching methodologies. This lack of ongoing training negatively impacts their knowledge, pedagogical skills, and ability to deliver contemporary health education content effectively (Okafor & Nwokedi, 2023). Health education is a dynamic and rapidly evolving field. Emerging public health challenges such as new infectious diseases, mental health concerns, lifestyle-related illnesses, and global health crises like the COVID-19 pandemic necessitate that teachers continuously update their knowledge and teaching strategies. Without access to CPD, teachers may rely on outdated information or traditional teaching methods that fail to address current health issues. This gap can result in students receiving incomplete, irrelevant, or inaccurate

health knowledge, undermining the very objectives of health education, which include promoting health literacy, preventive behaviours, and informed decision-making. The absence of professional development also limits teachers' capacity to employ interactive and participatory teaching techniques. Effective health education relies on methods such as role-plays, group discussions, simulations, health campaigns, peer education, and community-based projects. Teachers who are not trained in these approaches may default to lecture-based instruction or rote learning, which reduces student engagement and limits the practical application of health knowledge. This is particularly problematic for topics that require hands-on experience, such as first aid, sanitation practices, reproductive health, and disease prevention. Additionally, the lack of CPD reduces teachers' confidence and motivation. Teaching sensitive health topics—such as sexual and reproductive health, mental health, and substance use—requires both expertise and comfort in addressing potentially controversial issues. Teachers who have not received training may feel ill-equipped to handle students' questions or to navigate socio-cultural sensitivities, leading to avoidance or superficial coverage of important topics. This negatively affects students' learning outcomes and perpetuates gaps in health literacy. Professional development also plays a crucial role in aligning teaching practices with national and global health policies. Health education is guided by curricula informed by national health objectives, international health standards, and evidence-based practices. Teachers who are not regularly updated through CPD may fail to implement curriculum objectives effectively or integrate new health guidelines into classroom teaching. This disconnect between policy and practice diminishes the relevance of health education and limits its contribution to broader public health goals, such as the Sustainable Development Goals (SDGs). Furthermore, the lack of CPD opportunities contributes to teacher attrition and low morale. Teachers who feel unsupported or professionally stagnant are more likely to leave the profession or shift focus to other subjects that offer better career development opportunities. This exacerbates the already existing shortage of qualified health education teachers, creating a cycle of underperformance and limited student engagement.

Weak Policy Implementation and Monitoring

Weak policy implementation and monitoring constitute a major barrier to the effective teaching and learning of health education in Nigerian secondary schools, including those in Edo State. Although Nigeria has established frameworks such as the National School Health Policy, which outlines strategies for promoting school health programs, the translation of policy into practical action remains largely ineffective (Adeniyi & Akinsola, 2022). The gap between policy formulation and on-ground execution undermines the potential impact of health education on student health literacy, preventive behaviours, and overall wellbeing. One key issue is the absence of a structured and systematic framework for monitoring and evaluating health education programs in schools. In many cases, there is no regular assessment of teaching quality, curriculum coverage, lesson delivery, or student learning outcomes. Without proper monitoring, it is difficult to identify gaps in implementation, track progress, or hold teachers and school administrators accountable for program success. Consequently, even well-designed curricula may be poorly delivered, with lessons skipped, topics condensed, or key concepts neglected, rendering the policy ineffective at the classroom level. The weak implementation of policies is also compounded by inadequate administrative support. School principals and education authorities often prioritize examinable subjects over health education, leaving health teachers without the guidance, resources, or reinforcement needed to implement national policies. This results in minimal institutional oversight, insufficient funding allocation, and lack of recognition for health education programs. Teachers may therefore feel unsupported or undervalued, which reduces their motivation to deliver lessons effectively and engage students in meaningful health learning activities. Furthermore, weak monitoring mechanisms limit the ability to standardize health education across schools. While some schools may attempt to implement policy objectives, variations in teaching quality, resource availability, and administrative commitment lead to uneven learning outcomes. Students in underperforming schools are disproportionately affected, often receiving fragmented or incomplete health education. This inequality in implementation exacerbates existing disparities in health literacy and awareness, particularly among vulnerable populations such as girls, rural students, and low-income families. The consequences of weak policy implementation extend beyond

academic outcomes to broader public health objectives. Health education is intended to equip students with the knowledge and skills to make informed health decisions, adopt preventive practices, and participate in community health initiatives. When policies are not effectively enforced, students may lack exposure to essential topics such as sanitation, reproductive health, nutrition, disease prevention, mental health, and first aid. This deficiency not only affects individual health outcomes but also limits the contribution of school-based health programs to national development goals, including the Sustainable Development Goals (SDGs).

Empirical Study

Empirical review focuses on studies that have been conducted on the teaching and learning of health education, particularly in secondary schools. It provides concrete evidence from field investigations, surveys, and experiments conducted by scholars within and outside Nigeria. Unlike the theoretical review, the empirical section draws on the experiences of teachers, students, and policymakers to understand the realities surrounding the subject. Health education, as a subject, is vital for equipping students with knowledge, attitudes, and practices that promote physical and mental well-being. However, empirical evidence has consistently shown that the teaching and learning of health education in Nigerian secondary schools face a range of challenges, including inadequate qualified teachers, insufficient instructional materials, poor student attitudes, limited administrative support, and weak curriculum implementation. The following sections critically review existing studies relating to each of these issues.

Empirical Studies on the Availability of Qualified Teachers consistently emphasizes that the availability of qualified and trained teachers determines the effectiveness of health education delivery. A study by Ogunleye and Adeyanju (2019) examined 25 public secondary schools in Oyo State using a descriptive survey design with 200 teachers as respondents. Their study found that only 42% of health education teachers had formal qualifications in the subject, while others were graduates of physical education or biology. This shortage of specialized teachers negatively influenced the quality of instruction. Similarly, Eze and Okafor (2020) conducted a mixed-method

study across Enugu State involving 350 teachers and 20 principals. Their results revealed that many teachers lacked adequate training in health pedagogy, leading to superficial coverage of the syllabus. Interviews further showed that teachers who had attended professional workshops displayed better teaching techniques and classroom management. Yakubu (2021) carried out a quasi-experimental study in Kaduna State, comparing schools with certified health educators and those without. The findings revealed that students taught by certified teachers scored 25% higher in knowledge tests, indicating a strong positive correlation between teacher qualification and learning outcomes. In an international context, Thomas and Bell (2018) in South Africa used a longitudinal approach to track the performance of learners in health-related subjects across five years. Their findings reinforced that continuous professional development among teachers improved both student engagement and performance.

These findings are consistent with Adebayo and Musa (2022), who noted in their cross-sectional study of Lagos schools that government neglect of teacher recruitment policies resulted in overcrowded classrooms and teacher burnout. They recommended periodic re-training and inclusion of health education in teacher education curricula. Overall, empirical evidence supports the argument that without adequately qualified teachers, the objectives of health education cannot be effectively achieved in Nigerian secondary schools.

Empirical Studies on the Adequacy of Instructional Materials which includes materials such as charts, models, audio-visuals, and laboratory equipment are indispensable tools for effective teaching and learning. Ibrahim and Lawal (2019) investigated 40 secondary schools in Kwara State using observation checklists and teacher questionnaires. The study found that 70% of schools lacked basic teaching aids like posters, skeleton models, or projectors. Teachers reported relying heavily on verbal explanations, which limited student understanding of abstract health concepts. In a related study, Oluwole and Agbaje (2021) employed a quasi-experimental design to test the impact of instructional resources on learning outcomes in three schools in Ogun State. The experimental group received instruction using multimedia and

anatomical models, while the control group used traditional lecture methods. Results revealed that students in the experimental group performed significantly better in post-tests, confirming the effectiveness of instructional materials in promoting comprehension. Mohammed and Aisha (2020) conducted interviews with education officers in Kano State and discovered that poor funding, lack of storage facilities, and mismanagement of resources were major hindrances to the availability of instructional materials. The study also observed that most school libraries lacked current health education textbooks. An international comparison by Kim and Rogers (2022) in Indonesia corroborates these findings. Their mixed-method study found that digital learning tools significantly enhanced students' participation and retention in health education lessons. However, they emphasized that teacher competence in using technology remains a crucial factor in maximizing instructional materials.

In Nigeria, Okeke (2023) examined 10 government and 10 private schools in Anambra State and reported that private schools were three times more likely to have functional instructional facilities. The study concluded that the gap between public and private schools in resource provision contributes to inequality in learning outcomes. These studies collectively show that the adequacy and proper utilization of instructional materials play a vital role in improving the teaching and learning of health education. Where such materials are lacking, learning becomes abstract, teacher-centered, and less effective.

Empirical Studies on Students Attitude toward Health Education revealed that the success in academics of any kind is influenced by students' attitudes toward it. Nnamdi and Yusuf (2019) surveyed 400 students in five secondary schools across Lagos State and found that 62% viewed health education as a "non-promotional subject," meaning it did not contribute to their future career choices. This perception negatively affected their motivation and participation in class. Ali and Abdullahi (2020) used focus group discussions in Kano and Sokoto States to explore students' interest levels. Findings revealed that many students preferred science subjects like biology or chemistry because they were seen as "examination subjects" with higher prestige. Teachers reported that students rarely completed health education

assignments or participated actively during lessons. Similarly, Omeje (2021) examined the relationship between student attitude and academic achievement using a correlation research design in Nsukka. The study found a positive correlation (r = 0.71) between students' attitudes and their test scores. The implication is that when students perceive the subject as important, their performance improves significantly. Internationally, Rodriguez and Lee (2022) conducted a comparative study in the Philippines, finding that integrating practical, community-based health projects improved students' engagement. This aligns with Umeh (2023) in Nigeria, who found that using peer-led discussions and health clubs fostered more positive attitudes toward health education. Overall, empirical evidence confirms that negative student attitudes remain a critical barrier. Without proper orientation, practical experiences, and curriculum integration, health education continues to be undervalued by students, especially in public secondary schools.

Empirical Studies on Challenges Faced by Teachers in Teaching Health Education highlights numerous obstacles encountered by teachers. Bamidele (2019) conducted a descriptive survey among 300 teachers in Ekiti State and reported that workload, poor remuneration, and lack of training opportunities hindered teachers' effectiveness. 76% of respondents admitted that they handled two or more subjects simultaneously due to teacher shortages. Emeh and Okoro (2020) carried out an in-depth interview with health education teachers in Cross River State. Teachers cited lack of recognition of health education as a core subject in WAEC and NECO as a demotivating factor. They also mentioned the absence of clear teaching guides and insufficient time allocations in the timetable.

Ikechukwu and Adeniran (2021), using regression analysis, discovered that teacher motivation accounted for 45% of the variance in teaching effectiveness among 120 sampled teachers in Rivers State. They concluded that supportive supervision and recognition could enhance teachers' job satisfaction. In comparison, Carter and Liu (2022) in China identified similar constraints, including limited instructional time and curriculum overload. Their study emphasized that when teachers are not provided with incentives and professional autonomy, instructional quality declines. Nwosu and

Adebisi (2023) added that most teachers rely on outdated materials from the early 2000s due to the government's failure to update health education curricula. The study recommended that ministries of education introduce digital training modules and promote e-resources to support teachers. These findings underline that teacher-related challenges — especially low morale, poor training, and institutional neglect — are central to the decline in effective health education delivery.

Empirical Studies on Curriculum Implementation and Policy Factors has also been identified as a major determinant of success. Ogunbameru (2019) surveyed curriculum officers and teachers in Osun State and found that while the national health education curriculum was comprehensive, many schools implemented it partially due to resource limitations. Afolabi and Odu (2020) analyzed 50 school syllabi across three states and discovered that health education topics such as sexual health and drug abuse were often skipped by teachers due to cultural taboos or time constraints. In a policy-oriented study, Etim and Udofia (2021) examined the role of education inspectors in Akwa Ibom State. Using structured interviews, they observed that monitoring visits were irregular, leading to weak compliance with national standards. International evidence from Miller (2022) in Kenya revealed that successful curriculum implementation depends on regular policy feedback, teacher involvement in curriculum design, and adequate funding. Adewale (2023) found that 58% of teachers in Lagos public schools were unaware of recent curriculum updates. This suggests poor dissemination of policy information. Empirical findings demonstrate that effective curriculum implementation in health education is hindered by administrative lapses, limited monitoring, and poor teacher awareness.

Empirical Studies on School Environment and Administrative Support which helps the school environment and administrative leadership significantly influence teaching effectiveness. Obi and Nwachukwu (2019) surveyed 200 health education teachers in Imo State and discovered that schools with supportive principals recorded higher student participation in health-related extracurricular activities. Taiwo (2020) found that overcrowded classrooms and poor ventilation reduced students' attention span

during health education lessons. The study involved 15 public secondary schools in Lagos and used observational checklists alongside teacher questionnaires.

Johnson and Eze (2021) conducted a correlational study showing that administrative encouragement (e.g., providing teaching aids and organizing seminars) correlated positively with teaching effectiveness ($r = 0.63$). Suleiman (2022) in Kaduna noted that teachers working under unsupportive administrators were less likely to experiment with interactive or participatory teaching methods. Onyeka and Bello (2023) argued that environmental sanitation and school health policies directly influence students' appreciation of health education, as schools that practice what they teach set better examples. Internationally, Lopez (2023) in Chile concluded that inclusive school environments where management values health literacy tend to produce better student outcomes. Therefore, the school environment and administrative support are key determinants in achieving effective health education outcomes.

Across the reviewed empirical studies, several key themes emerge which most Nigerian schools including school in Benin City face are; shortage of qualified health education teachers, instructional materials remain inadequate, particularly in public schools, students' attitudes toward health education are shaped by perceptions of its low academic importance, teachers face professional and systemic challenges, including poor remuneration and minimal policy support, curriculum implementation suffers from weak oversight, outdated content, and cultural barriers, school environment and administrative support determine whether learning is student-centered or teacher-dominated, collectively, the studies reveal that the teaching and learning of health education in Nigeria are influenced by both human and institutional factors. However, despite consistent documentation of these issues, limited policy action has been taken to address them.

SUMMARY OF RELATED LITERATURE REVIEWED

The review of literature has provided insight into the fundamental concept, development, objectives, and challenges associated with health education, particularly

within the Secondary schools system located in Benin City. Health education has been defined by various scholars as a process of imparting knowledge, skills, and attitudes necessary for individuals and communities to make informed decisions about their health and wellbeing. It is a vital component of public health and school curricula that seeks to promote behavioural change through preventive education and awareness creation. It history which in Nigeria evolved from colonial-era public health campaigns focused on sanitation and disease prevention. It gained formal recognition in the post-independence era when the Federal Government integrated health education into the national school curriculum to improve youth health literacy and reduce preventable diseases. Over the years, health education has expanded beyond hygiene and disease control to include mental health, nutrition, environmental health, and reproductive health education. The aims and objectives of health education are centred on enabling individuals to adopt and maintain healthy lifestyles, prevent diseases, and contribute positively to community health. Health education promotes self-reliance in health management, behavioural modification, health literacy, while also enhancing the overall productivity of a nation.

The scope of health education is broad, encompassing personal, family, and community health, institutional and national health education as well as preventive and promotive dimensions of health education which together enable learners to understand, value, and practice healthy behaviours. Despite these benefits, several challenges hinder the effective teaching and learning of health education in Benin City. These include inadequate funding, insufficient qualified teachers, overloaded curriculum, and lack of teaching materials, poor school facilities, and socio-cultural constraints that discourage open discussion of sensitive health topics. Cultural and religious beliefs further limit comprehensive health education delivery, particularly in areas related to sexuality and reproductive health. In addition, the weak implementation of the National School Health Policy has also been cited as a major barrier to progress.

From the body of empirical evidence reviewed, several recurring patterns and themes are evident which include shortage of qualified teachers, inadequacy of instructional materials, negative student attitudes, teacher related and systemic challenges, weak curriculum implementation and influence of school environment and administration. And by this reviewed that both human and institutional factors jointly influence the teaching and learning of health education in Nigeria secondary schools. Although these challenges have been consistently identified across multiple studies, how there remains a lack of robust policy response and practical intervention to mitigate their effect.

CHAPTER 3

RESEARCH METHODOLOGY

This chapter describes the research methodology that was used in this study under the following sub-headings:

- Research Design
- Population of the Study

- Sample and Sampling Techniques
- Research Instrument
- Validity of the Instrument
- Reliability of the Instrument
- Method of Data Collection
- Method of Data Analysis

Research Design

The design for this research work is descriptive survey research which aims at investigating The Barriers to effective teaching and learning of among secondary schools in Benin City, Edo State. The descriptive survey design is appropriate for this study because it enables the researcher to obtain factual, accurate, and detailed information about the current state of the teaching and learning of Health Education in secondary schools within Benin City. This design allows the researcher to collect data directly from students without manipulating any variables. Since the study seeks to describe existing conditions, identify challenges, and understand the perceptions and practices of those involved in the teaching learning process, a descriptive survey provides the most suitable framework.

Population of the Study

The population of this study consist of all students enrolled in government secondary schools in Benin City. A total of 4,489 students were registered across these schools during the 2024/2025 academic session. This population represents the entire group of learners who participate in the teaching and learning of health education and from who the sample for this study was drawn. These students form the target population because they are directly exposed to the teaching and learning processes that may be influenced by various barriers.

Sample and Sampling Techniques

The sample size for the study was 120 students selected from the population of 4,489 students in Benin City. The sample size was chosen to ensure that the study could be conducted effectively within available time and resources while still providing reliable information about the barriers to effective teaching and learning of health education. A multi stage sampling teaching was used for the study to ensure fair representation of students across government secondary schools in Benin City.

Stage 1: All government secondary schools in Benin City were identified and used as the sampling

Stage 2: Proportionate sampling was use to distribute the sample of 120 students across the schools base on their enrolment figure. This means that schools with larger students' population contributed more respondents to the sample that schools with smaller population.

Stage 3: Within each school, systematic sampling was use to select the actual students. The class register served as the sampling. A sampling interval was calculated by dividing the schools population by its allocated sample. A random starting point was then selected and every students was chosen until required number was reached.

Research Instrument

The instrument used for this study was self-structured questionnaire title "Barriers to effective teaching & learning of health education" It was designed by the researcher along with the variables under study and the question it contains was drawn from the research questions. The questionnaire contains two Sections: Section A contains demographic information about the respondents, while Section B contains closed-ended questions (Likert-scale questions) to collect quantitative data about the research topic.

Validation of the Instrument

The face and content validity of the instrument was used by the researcher's supervisor and two other experts in the field of health Education. The corrections pointed out was effected in the final draft of the questionnaire.

Reliability of the Instrument

A test re-test reliability method was be used to establish the reliability of the instrument. The copies of the questionnaire was administered to twenty (20) respondents, and after two weeks the same instrument was re-administered to the same group of students. The data collected after both administrations was analysed using the Pearson Product Correlation Coefficient, the reliability of the instrument was established at 0.75

Method of Data Collection

The questionnaire was administered by the researcher with aids of two research assistant respondent. The respondent would be assured of confidentiality and urged to answer the questions honestly to the best of their knowledge. Instructions was given to the respondent on how to fill out the questionnaire and the questionnaire was collected the same day to avoid incidents of loss.

Method of Data Analysis

The data obtained were analysed using descriptive statistics, including frequencies, percentages, means to identify the most significant barriers was used for processing it final statistical results.

CHAPTER FOUR

PRESENTATION OF RESULTS AND DISCUSSION OF FINDINGS

The purpose of this chapter is to report, illustrate, and discuss the findings of the research.

Presentation of Results

Table 1: Demographic Data for the Students

GENDER	FREQUENCY	PERCENTAGE (%)
MALE	58	48.3
FEMALE	62	51.7
TOTAL	**120**	**100%**

Source: Researcher's fieldwork, 2025

Table 1 shows that out of 120 respondents, 58 (48.7%) of the respondents are male students while 62 (51.7%) are female students. Most of the respondents are females.

Table 1: Age of the respondents

AGE	FREQUENCY	PERCENTAGE (%)
10 - 12 years	40	33.3
13 – 15 Years	59	49..2
16 – 18 Years	11	9.2
19 – Above	10	8.3
TOTAL	**120**	**100%**

Source: Researcher's fieldwork, 2025

Table 2 shows that out of 120 respondents, 40 (33.3%) were between 10 - 12 years of age bracket, 59 (57.5%) were between 13 – 15 years of age bracket, and (9.2%) were between 16 - 18 years whereas the 19 – above of the respondents were (8.3). The respondents were mostly between 13 – 15 years age bracket.

Answers to the Research Questions

BARRIERS TO EFFECTIVE TEACHING AND LEARNING OF HEALTH EDUCATION

S/N	Items	Strongly Disagree (SD)	Disagree (D)	Agree (A)	Strongly Agree	Total	Mean	Remark
1.	Teachers handling Health Education are adequately qualified to teach the subject	60	40	10	10	120 (100%)	1.75	Rejected
2.	There are not enough trained Health Education teachers in my school.	13	20	35	52	120 (100%)	3.06	Accepted
3.	Teachers show little interest and commitment when teaching Health Education.	5	10	45	60	120 (100%)	3.39	Accepted
4.	Health Education lessons are often replaced with other subjects.	14	15	20	71	120 (100%)	3.28	Accepted
5.	The time allocated to Health Education is not sufficient for effective learning	10	10	50	50	120 (100%)	3.20	Accepted
6.	Students find Health Education less importance than other subject	5	5	30	80	120 (100%)	3.48	Accepted
7.	Lack of interest among students affects their performance in Health Education	15	10	45	50	120 (100%)	3.13	Accepted
8.	The School lacks adequate instructional materials for teaching health education.	10	20	30	60	120 (100%)	3.21	Accepted
9.	Teachers rarely use practical examples in Health Education lessons	20	10	30	70	120 (100%)	3.21	Accepted
10.	The classroom environment is not conducive for learning Health Education	5	5	45	65	120 (100%)	3.35	Accepted

11.	Students do not have enough textbooks for Health Education.	5	15	45	55	120 (100%)	3.30	Accepted
12.	Lack of motivation from school authorities affects the teaching of Health Education	15	15	20	50	120 (100%)	3.05	Accepted
13.	Health Education teachers do not receive adequate training.	20	15	35	50	120 (100%)	2.95	Accepted
14.	The School library does not have enough Health Education materials	20	20	35	45	120 (100%)	2.85	Accepted
15.	Health Education is not taken seriously by students	5	10	35	70	120 (100%)	3.35	Accepted
16.	There is poor supervision and monitory of Health Education teachers	5	15	45	55	120 (100%)	3.30	Accepted
17.	Large Class size makes it difficult to teach health education.	10	5	45	60	120 (100%)	3.35	Accepted
18.	Lack of government support hinders effective Health education in schools	5	15	45	55	120 (100%)	3.30	Accepted
19.	Teachers do not use modern teaching methods in health education	40	15	40	25	120 (100%)	2.30	Rejected
20.	Insufficient funding for health education contributes to poor teaching and learning outcomes	5	10	35	70	120 (100%)	3.35	Accepted

Source: Researcher's fieldwork, 2025

The decision rule for acceptance or rejection of an item is based on a mean score benchmark of 2.50.

Mean ≥ 2.50 = Item Accepted

Mean < 2.50 = Item Rejected

The findings from the analysis of the twenty questionnaire items show that out of the 20 identified variables, 18 were accepted as major barriers, while only 2 were rejected. This means that students overwhelmingly believe that numerous and severe obstacles hinder effective teaching and learning of Health Education in their schools.The interpretation of these findings is presented in thematic clusters for clarity.

Teachers-Related Barriers: Shortage of Qualified and Trained Health Education Teachers: The results show that students do not believe teachers handling Health Education are adequately qualified (mean = 1.75). This implies that many schools assign the subject to teachers who may not possess the necessary professional training, specialization, or certification. This inadequacy can significantly reduce teaching quality because Health Education requires a specialized understanding of human anatomy, hygiene, first aid, diseases, safety, and wellness. The acceptance of the item stating "There are not enough trained Health Education teachers in my school" (mean = 3.06) reinforces the earlier point. A shortage of trained teachers often leads schools to assign Health Education to Biology teachers, Physical Health Education teachers, or even non-science educators. This mismatch results in shallow coverage of the curriculum, reduced enthusiasm, and poor instructional methods.

Teacher Interest and Commitment: Students also strongly agreed that Health Education teachers show little interest and commitment (mean = 3.39). This suggests that teachers may be unmotivated due to low prioritization of the subject, absence of incentives, or lack of professional development opportunities. Teacher attitudes have a powerful impact on student engagement, so when teachers show limited zeal, students also lose interest.

Inadequate Training and Professional Development: Another accepted item states that teachers do not receive adequate training (mean = 2.95). This highlights a systemic weakness: educators do not attend refresher courses, seminars, or workshops that could enhance their teaching approaches. Inadequate training limits their ability to use modern teaching strategies, update their knowledge, or implement student-centered learning.

Mixed Use of Modern Teaching Methods: One of the two rejected items was: "Teachers do not use modern teaching methods" (mean = 2.30). This implies that some teachers do attempt to use modern teaching strategies such as group discussions, demonstrations, and visual aids. However, although the statement was rejected, it does not completely negate the earlier findings that teacher effort is inconsistent and limited by resources. Teacher-related barriers strongly affect the effectiveness of Health Education teaching. Inadequate preparation, low commitment, poor training, and teacher shortages reduce the quality of teaching and diminish student motivation.

Student-Related Barriers: Low Student Interest and Perception of Irrelevance: The results show that students find Health Education less important than other subjects (mean = 3.48). This low perception of importance significantly contributes to lack of concentration, poor performance, and limited study habits. Students also agreed that "Health Education is not taken seriously by students" (mean = 3.35). This indicates a cultural and academic attitude problem: students do not see the subject as critical for their future careers or academic success, unlike subjects like Mathematics or English.

Poor Student Motivation: Students confirmed that lack of interest affects their performance (mean = 3.13). When students are unmotivated, they are less likely to participate in class, complete assignments, or engage in practical activities.

Lack of Textbooks and Reading Materials: Another major barrier is the lack of textbooks (mean = 3.30). Without access to textbooks, learning becomes teacher-dependent, and students cannot study or revise topics at home. Textbook insufficiency forces students to rely on notes, which may be incomplete, oversimplified, or poorly structured. Student-related factors such as low interest, poor perception of subject importance, and limited access to learning materials significantly impede the effectiveness of Health Education learning.

Instructional Materials and Learning Resources

Insufficient Instructional Materials: The lack of instructional materials (mean = 3.21) was identified as a major barrier. Health Education requires diagrams, charts, models of human organs, safety equipment, and videos to enhance understanding. The absence of these materials results in monotonous lessons dominated by chalkboard explanations.

Limited Practical Activities: Students agreed that teachers rarely use practical examples (mean = 3.21). Health Education is ideally practical and experiential—students should observe first-aid procedures, examine safety tools, or practice hygiene demonstrations. Without hands-on activities, students struggle to retain theoretical information.

Poorly Equipped School Libraries: Respondents agreed that school libraries do not have enough Health Education materials (mean = 2.85). Libraries play a critical role in independent learning, and the absence of relevant materials reduces exposure to updated knowledge. Insufficient teaching aids, poor use of practical resources, and inadequate library materials limit instructional quality and reduce student comprehension.

Environmental and Institutional Barriers: Poor Classroom Environment: Students strongly agreed that the classroom environment is not conducive for Health Education learning (mean = 3.35). Overcrowding, heat, poor ventilation, excess noise, inadequate furniture, and lighting problems can distort the learning process.

Large Class Sizes: Large classes were reported as a strong barrier (mean = 3.25). When classrooms accommodate too many students, teachers struggle to manage the class, use practical methods, or provide individual feedback.

Poor Supervision and Monitoring: Respondents accepted that supervision is poor (mean = 3.30). Adequate supervision helps ensure teachers adhere to schemes of work, lesson plans, and correct teaching practices. Poor supervision allows negligence, lateness, or inadequate coverage of curriculum topics.

Inadequate Motivation from School Authorities: Another accepted barrier is the lack of teacher motivation (mean = 3.05). Motivation may include rewards, recognition, promotion opportunities, or teaching resources. When teachers feel unsupported, their performance declines.

Health Education Lessons Being Replaced by Other Subjects: Students strongly agreed that Health Education is often replaced by other subjects (mean = 3.28). This shows that schools do not prioritize Health Education. Such inconsistency contributes to curriculum gaps and poor student understanding. Environmental and administrative

issues significantly hinder teaching and learning, creating conditions where effective delivery becomes difficult or impossible.

Government and Funding Barriers: Lack of Government Support: Students believe government support for Health Education is insufficient (mean = 3.30). Government involvement typically includes provision of qualified teachers, allocation of funds, curriculum review, training workshops, supply of materials. Inadequate government participation leads to structural deficiencies that affect the entire educational process. Insufficient funding was accepted as a barrier (mean = 3.35). Without adequate funding, schools cannot procure materials, renovate classrooms, organize workshops, or improve teacher welfare. Government and funding issues constitute deep, systemic barriers that limit the ability of schools to provide high-quality Health Education.

The results reveal that the barriers to effective Health Education are multidimensional—teacher-related, student-related, environmental, institutional, and governmental. The acceptance of 18 out of 20 items indicates that Health Education faces widespread neglect in secondary schools. These barriers collectively reduce learning outcomes, lower student performance, and weaken the role of Health Education in promoting wellness and safety among young people.

The interpretation of findings shows that Health Education in Benin City is constrained by numerous challenges that hinder its effectiveness.

DISCUSSION OF FINDINGS

This study investigated the barriers to the effective teaching and learning of Health Education in secondary schools within Edo State. The findings revealed a wide range of challenges that significantly affect both teachers and students. These challenges are structural, instructional, environmental, and attitudinal in nature. In this section, the results are interpreted in relation to previous studies, the Nigerian school context, and curriculum expectations. One of the most significant findings of the study is the shortage of trained and adequately qualified Health Education teachers. Respondents strongly indicated that their teachers lack sufficient training and specialization in Health Education. This aligns with the observations of Okafor (2020), who reported that the shortage of qualified Health Education teachers is a major barrier in many

Nigerian schools. When teachers lack proper training, they tend to rely heavily on theoretical instruction rather than practical demonstrations, resulting in reduced learner engagement. The study also revealed that teachers show limited commitment and interest in teaching Health Education. This lack of enthusiasm could be attributed to several factors, including minimal administrative support, low motivation, poor recognition, and inadequate teaching resources. Akinbode (2017) noted that teacher motivation is one of the strongest predictors of instructional effectiveness. When teachers feel unsupported or underappreciated, their performance naturally declines, affecting how actively students participate and learn. Additionally, the findings indicate that Health Education teachers receive insufficient professional development. Respondents agreed that teachers rarely attend workshops, training programmes, or seminars necessary to enhance their teaching skills. This suggests that schools do not prioritise continuous training for Health Education teachers. A lack of professional development means that teachers may not be exposed to new ideas, updated curricula, or improved instructional methods. Consequently, the teaching process becomes outdated and less effective.

The findings also reveal several student-related barriers. A significant number of respondents indicated that students do not take Health Education seriously. Many students believe that the subject is less important than other "core" subjects such as Mathematics, English, and the sciences. This low perception of importance results in reduced interest, lack of concentration, poor study habits, and low academic performance. Furthermore, students acknowledged that they have insufficient access to Health Education textbooks and study materials. The lack of textbooks makes it difficult for learners to revise lessons independently or deepen their understanding of topics. Owoeye and Oyebanji (2021) highlighted that student learning improves significantly when they have access to quality reading materials. Without adequate textbooks, students rely entirely on teachers' explanations, which may be limited or poorly understood. The combination of low motivation and insufficient learning materials creates a situation where students feel discouraged from engaging fully with Health Education lessons. This ultimately affects learning outcomes and comprehension of important health topics such as disease prevention, hygiene, first

aid, and safety. Another major finding from the study is the lack of adequate instructional materials. Respondents agreed that materials such as charts, models, diagrams, health tools, and audio-visual aids are lacking in most schools. Health Education is ideally a practical subject that requires hands-on experiences to illustrate concepts such as personal hygiene, drug education, environmental health, and safety practices. The absence of these materials reduces teaching effectiveness and makes lessons monotonous. The study further revealed that teachers rarely use practical demonstrations when teaching the subject. This is closely tied to the lack of instructional materials. Without practical examples, abstract concepts become difficult for students to understand. Aremu (2015) emphasized that practical activities make learning more meaningful and memorable. Therefore, the lack of practical components hinders deep learning. School libraries were also found to be poorly equipped with Health Education resources. Respondents agreed that the school library does not contain enough Health Education materials, which limits students' independent study and research. Libraries are crucial for academic development, and when they are under-resourced, the overall quality of education declines.

Environmental factors also emerged as significant barriers. The classroom environment in many schools was described as not conducive for learning, with problems such as overcrowding, heat, noise, inadequate ventilation, and poor seating arrangements. These issues negatively affect concentration and make effective teaching difficult. Another critical finding is the issue of large class sizes. Respondents indicated that overcrowded classrooms make it difficult for teachers to manage learners, use participatory teaching strategies, or provide individualized attention. Large class sizes often lead to teacher burnout, student frustration, and reduced lesson comprehension. This mirrors the findings of Akinbode (2017), who noted that class size affects both teaching quality and student performance in Nigerian schools.

The study also found that there is poor supervision and monitoring of Health Education teachers. Effective supervision ensures that teachers follow lesson plans, adhere to the curriculum, and maintain high teaching standards. When supervision is

weak, teachers may become lax with instructional responsibilities, come late to class, or fail to complete the syllabus. More importantly, respondents agreed that Health Education lessons are frequently replaced with other subjects. This indicates low prioritization of the subject by school authorities. When Health Education is consistently displaced to make room for other subjects, the curriculum cannot be adequately covered. This leads to incomplete topics, rushed lessons, and insufficient practical activities. The findings of the study show that government support for Health Education is inadequate. This includes a lack of funding, insufficient provision of instructional materials, limited teacher training programmes, and insufficient teacher recruitment. Government neglect contributes to the structural barriers schools face in implementing the Health Education curriculum. Respondents also agreed that insufficient funding contributes significantly to the poor teaching and learning of Health Education. Funding affects key areas such as supply of teaching materials, classroom maintenance, teacher remuneration, and procurement of library resources. Without adequate funding, schools struggle to maintain high standards of Health Education delivery. The findings underscore the need for a comprehensive overhaul involving teacher training, curriculum prioritization, resource provision, improved supervision, and increased funding. Addressing these barriers will enhance Health Education delivery, improve student performance, and promote health consciousness among secondary school students.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary of the Study

This study investigated the barriers to effective teaching and learning of Health Education. The purpose was to identify the major challenges faced by teachers and

students in delivering and receiving Health Education instruction. To achieve this aim, a structured questionnaire containing twenty items was administered to secondary school students. The study adopted a descriptive survey research design, and data were analyzed using frequency counts, percentages, mean scores, and a decision rule of 2.50. The findings revealed that the teaching and learning of Health Education are faced with numerous challenges. Out of the twenty items analyzed, eighteen (18) were accepted as major barriers, while only two (2) were rejected.

Findings

The major barriers identified include the following

1. Shortage of professionally trained Health Education teachers.
2. Low teacher motivation and commitment to teaching the subject.
3. Inadequate time allocation for Health Education on the school timetable, frequent replacement of Health Education lessons with other subjects, Students.
4. low interest and poor perception of the subject's importance
5. Lack of Health Education textbooks and insufficient learning materials, Non-availability of instructional materials for practical activities
6. Unconducive classroom environments and large class sizes, Poor supervision and monitoring of Health Education teachers.
7. Inadequate professional development and training opportunities for teachers, Lack of government support and insufficient funding for Health Education, Poorly equipped school libraries and absence of up-to-date Health Education resources.
8. Only two items were rejected, Adequacy of teacher qualification. Use of modern teaching methods (indicating teachers sometimes adopt modern strategies).
9. Overall, the findings indicate that the effective teaching and learning of Health Education in secondary schools are hindered by both structural and human-related barriers.

Conclusion

Based on the findings of this study, it is concluded that Health Education in secondary schools is confronted with critical challenges that negatively affect its delivery and student learning outcomes. The subject is not given adequate attention by teachers, school administrators, or government authorities. This lack of prioritization manifests in poor teacher preparation, limited learning resources, insufficient instructional materials, overcrowded classrooms, and inadequate funding. Furthermore, students' low interest and poor perception of the relevance of Health Education contribute significantly to ineffective learning. Their lack of textbooks and poor motivation further worsen the situation. The cumulative effect of these challenges is that Health Education, which plays a vital role in promoting personal hygiene, disease prevention, safety practices, and overall wellbeing, is not effectively taught or understood. If these barriers persist, secondary school students may lack essential health knowledge needed for healthy living and informed decision-making. There is therefore an urgent need for all stakeholders—government, school administrators, teachers, and communities—to take deliberate actions toward improving Health Education delivery.

Recommendations

Based on the findings and conclusion of this study, the following recommendations are made:

1. Recruitment of Qualified Health Education Teachers: Government and school authorities should employ more trained and qualified Health Education teachers to address teacher shortages in secondary schools.
2. Increased Teacher Motivation: School administrators should provide incentives such as awards, promotions, and teaching resources to encourage teachers to put in their best effort when teaching Health Education.
3. Adequate Time Allocation for Health Education: Schools should strictly adhere to the timetable and ensure that Health Education periods are not replaced by other subjects.
4. Provision of Instructional Materials: Government and private school owners should provide adequate teaching aids such as charts, models, first aid kits, posters, videos, and other practical materials to enhance lesson delivery.
5. Supply of Health Education Textbooks: Textbooks and relevant reading materials should be provided to students to support independent study and improve comprehension.
6. Improvement of Classroom Environment: School authorities should ensure that learning environments are conducive by providing proper ventilation, seating arrangements, lighting, and spacing.
7. Regular Supervision of Teachers: Education inspectors and school administrators should strengthen supervision and classroom monitoring to ensure that teachers adhere to best instructional practices.
8. Professional Development for Teachers: Workshops, seminars, and training programmes should be organised regularly to update Health Education teachers on new teaching methods and curriculum changes.
9. Increased Government Funding: The government should allocate more funds for Health Education in secondary schools to ensure that adequate resources are provided.
10. Strengthening School Libraries: School libraries should be equipped with up-to-date Health Education books, journals, and learning materials for students and teachers.

Suggestions for Further Studies

The researcher suggests that future studies should examine:

1. The influence of teacher attitude on students' performance in Health Education.
2. The relationship between availability of instructional materials and learning outcomes in Health Education.

3. Comparative analysis of Health Education challenges in public and private secondary schools.
4. The effect of classroom environment on students' interest in Health Education.
5. The role of government policies in promoting Health Education in Nigerian secondary schools.

These areas will provide deeper insights into improving Health Education delivery in secondary schools.

QUESTIONNAIRE ON BARRIERS TO EFFECTIVE TEACHING AND LEARNING OF HEALTH EDUCATION

I am a final year student of the above department in the in the university of Benin. This questionnaire is designed to elicit information from you on the topic above. The information gathered from this exercise would be used purely for academic purposes. Please respond sincerely to the items listed below, as all information will be treated with confidentiality. Thank you for your cooperation.

Instruction: please, tick ✓ where appropriate in the alternative provided.

SECTION A: DEMOGRAPHIC INFORMATION

1. Age: 10 – 12 [ ]   13 – 15 [ ]   16 - 18 [ ]   19 – above [ ]

2. Gender   Male [ ]   Female [ ]

3. Class: JSS [ ]   SSS [ ]   4. Type of School:[ ] Public [ ] Private

SECTION B:

BARRIERS TO EFFECTIVE TEACHING AND LEARNING OF HEALTH EDUCATION

S/N	Item	Strongly Disagree (SD)	Disagree (D)	Agree (A)	Strongly Agreed (SA)
1.	Teachers handling Health Education are adequately qualified to teach the subject				
2.	There are not enough trained Health Education teachers in my school.				
3.	Teachers show little interest and commitment when teaching Health Education.				
4.	Health Education lessons are often replaced with other subjects.				
5.	The time allocated to Health Education is not sufficient for effective learning				
6.	Students find Health Education less importance than other subject				
7.	Lack of interest among students affects their performance in Health Education				
8.	The School lacks adequate instructional materials for teaching health education.				
9.	Teachers rarely use practical examples in Health Education lessons				
10.	The classroom environment is not conducive for learning Health Education				

11.	Students do not have enough textbooks for Health Education.				
12.	Lack of motivation from school authorities affects the teaching of Health Education				
13.	Health Education teachers do not receive adequate training.				
14.	The School library does not have enough Health Education materials				
15.	Health Education is not taken seriously by students				
16.	There is poor supervision and monitory of Health Education teachers				
17.	Large Class size makes it difficult to teach health education.				
18.	Lack of government support hinders effective Health education in schools				
19.	Teachers do not use modern teaching methods in health education				
20.	Insufficient funding for health education contributes to poor teaching and learning outcomes				

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