

Knowledge and Awareness of Stakeholders about the Whole School, Whole Community, Whole Child (WSCC) Model and Its Importance in Ife, Osun State, Nigeria

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ABSTRACT

Background: The Whole School, Whole Community, Whole Child (WSCC) model provides a comprehensive framework for integrating health and education to improve students' well-being and academic outcomes. Successful implementation of this model depends largely on the knowledge and awareness of key stakeholders within the school community. This study assessed the level of knowledge and awareness of stakeholders regarding the WSCC model and its importance in schools in Ife, Osun State, Nigeria.

Methods: A cross-sectional descriptive survey design was adopted. The study population comprised school stakeholders including principals, teachers, parents, school health nurses, and program officers in selected primary and secondary schools in Ife. A total of 490 respondents were selected using multistage sampling techniques involving proportionate stratified sampling, systematic sampling, and criterion purposive sampling. Data were collected using a structured questionnaire validated by experts and tested for reliability using Cronbach's alpha. Descriptive statistics such as frequencies and percentages were used to summarize the data, while inferential statistics were used to determine associations between variables at a 0.05 level of significance.

Results: Findings revealed that although a considerable proportion of stakeholders had heard about the WSCC model, detailed knowledge of its components and importance was relatively limited among many respondents.

Discussion: The study concludes that stakeholders' awareness and knowledge of the WSCC model in Ife remain inadequate for effective implementation. The study recommends capacity building, stakeholder engagement, and policy support to strengthen awareness and implementation of the WSCC model in schools.

Keywords: Whole School Whole Community Whole Child, school health, stakeholder knowledge, awareness, Nigeria.

INTRODUCTION

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Schools play a critical role in promoting the health, safety, and holistic development of children and adolescents. Over the years, researchers and policymakers have increasingly recognized the importance of integrating health promotion within educational systems to enhance students' academic performance and overall well-being. One of the most comprehensive frameworks developed to guide such integration is the Whole School, Whole Community, Whole Child (WSCC) model.

The WSCC model was developed through collaboration between the Centers for Disease Control and Prevention and the Association for Supervision and Curriculum Development to strengthen the relationship between health and learning in schools. The model expands the coordinated school health approach by incorporating ten interrelated components including health education, physical education and physical activity, nutrition services, health services, counseling and psychological services, social and emotional climate, physical environment, employee wellness, family engagement, and community involvement. These components collectively aim to create supportive environments that promote both academic success and healthy development among students.

Research has shown that effective school health programs contribute significantly to improved academic performance, reduced absenteeism, and enhanced physical and mental well-being among students.^{1, 2} The successful implementation of the WSCC model, however, requires the involvement and cooperation of various stakeholders within the school system. These stakeholders include school administrators, teachers, parents, health professionals, and community members who work collaboratively to support student health and learning.

Stakeholders play an important role in planning, implementing, and sustaining school health programs. Their knowledge and awareness of the WSCC framework are essential for ensuring that the model is effectively integrated into school policies and practices. Studies have indicated that limited awareness and inadequate understanding of school health frameworks among stakeholders often hinder the implementation of comprehensive school health programs.^{3, 4}

In developing countries such as Nigeria, school health initiatives often face numerous challenges including inadequate resources, lack of coordination among stakeholders, and insufficient awareness of modern school health frameworks. Although national policies emphasize the importance of school health programs, their implementation remains inconsistent in many schools due to limited knowledge among stakeholders and weak collaboration between education and health sectors.⁵

Ile-Ife, located in Osun State, hosts a wide range of primary and secondary schools involving multiple stakeholders responsible for student welfare and educational development. Despite the importance of comprehensive school health programs, there is limited empirical evidence regarding stakeholders' knowledge and awareness of the WSCC model within schools in this area.

Understanding the level of stakeholders' knowledge and awareness is important for identifying gaps that may hinder effective implementation of the WSCC framework. Such information can guide policymakers, school administrators, and public health professionals in designing interventions aimed at strengthening school health programs. Therefore, this study assessed the knowledge and awareness of stakeholders regarding the WSCC model and its importance in schools in Ife, Osun State, Nigeria.

METHODOLOGY

Research Design

This study adopted a descriptive cross-sectional survey design to assess the knowledge and awareness of stakeholders regarding the WSCC model and its importance in schools in Ife.

Study Area

The study was conducted in Ile-Ife, a major educational and cultural center in Osun State, Nigeria. The area consists of both public and private primary and secondary schools with diverse stakeholders involved in educational and health-related activities.

Population of the Study

The study population consisted of stakeholders involved in school health and educational activities in selected schools in Ife. These included: school principals, teachers, parents, school health nurses, and program officers involved in school health programs. A total of 490 respondents participated in the study. A multistage sampling technique was employed.

At first stage, schools were stratified into primary and secondary schools. At second stage, proportionate stratified sampling was used to determine the number of respondents selected from each category of schools. Then, systematic sampling was used to select teachers and parents from the selected schools was employed at the third stage, while criterion-based purposive sampling was used at the fourth stage to select stakeholders with specialized roles such as school health nurses, principals, and program officers because of their direct involvement in school health activities.

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Data were collected using a structured questionnaire developed by the researchers based on the WSCC model framework. The questionnaire consisted of three sections, namely: socio-demographic characteristics (Section A), awareness of stakeholders about the WSCC model (Section B), and knowledge of stakeholders regarding the importance and components of the WSCC model (Section C).

The questionnaire was subjected to expert review to ensure content validity. Experts in school health, public health, and educational management assessed the relevance and clarity of the items using the Content Validity Index (CVI). Items with acceptable validity scores were retained. Moreover, a pilot study was conducted among stakeholders in schools outside the study area. Reliability of the instrument was determined using Cronbach's alpha coefficient. The instrument yielded a reliability coefficient above 0.70, indicating acceptable internal consistency.

Method of Data Collection

Data were collected through direct administration of questionnaires to respondents with the assistance of trained research assistants. Participants were informed about the purpose of the study and participation was voluntary.

Method of Data Analysis

Data collected were coded and analyzed using the Statistical Package for the Social Sciences (SPSS). Descriptive statistics such as frequencies and percentages were used to summarize the data. Inferential statistics such as chi-square tests were used to determine relationships between variables. Statistical significance was set at 0.05.

Ethical Considerations

Ethical approval was obtained from the appropriate institutional review authority. Participants were assured of confidentiality and anonymity, and informed consent was obtained before participation.

RESULTS

Demographic Characteristics of Respondents

Table 1 presents demographic characteristic such as age, level of education, role of respondents in implementation of WSCC. This table shows that majority or largest proportion of the respondents were aged 40–44 years, accounting for 199 respondents (40.6%). While those aged 25–29 years were 145 respondents (29.6%). And respondents aged 30–34 years were 76 (15.5%), and those aged 35–39 years accounted for 40 respondents (8.2%). Only a small proportion of respondents were in the older age categories 29 respondents (5.9%), ages 50–54 years was 1 respondent (0.2%) and others fell within the 45–49 years age group. Majority of the respondents (63.3%) were males, 36.5% female. This shows that larger number of the respondents were male.

Additionally, the table presents the distribution of respondents according to their roles in the school in school health services. Out of a total of 525 questionnaires administered, 490 (93.3%) were validly completed and analyzed, while 35 (6.7%) were missing due to non-response. Parents constituted most of the respondents 371 (75.7%). This indicates a strong parental representation in the study. This was followed by teachers 115 (23.5%). While school health personnel were only 3 (0.6%) and while School Health Program Officer was 1 respondent (0.2%). This finding suggests that participants largely indicated that there are basically two groups of stakeholders.

Out of the total 490 respondents, the largest proportion of stakeholders 225 (45.9%) had no formal education, indicating that nearly half of the participants lacked formal schooling. This was followed by 146 respondents (29.8%) who had primary education, suggesting that a substantial proportion of stakeholders possessed only basic educational qualifications. Furthermore, 65 (13.3%) respondents possess OND/NCE qualifications, indicating that a smaller segment of the stakeholders had attained post-secondary education. In addition, 39 respondents (8.0%) possessed a master's degree, representing the group with the highest level of educational attainment among the respondents. While only 6 respondents (1.2%) had secondary education, which represents the smallest proportion among the educational categories listed. These findings indicated that the majority of stakeholders had low levels of formal education, with only a small proportion possessing higher educational qualifications.

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Table 1: Age Distribution of the Respondents

Age Group	Frequency	percent
Age in years		
20-24	145	29.6
25-29	76	15.5
30- 34	40	8.2
35-39	199	40.6
40-44	1	.2.0
Sex		
Male	311	63.5
Female	179	36.5
Educational Status of Stakeholders		
No formal education	225	45.9
Primary education	146	29.8
Secondary education	6	1.2
OND/NCE	65	13.3
Master's degree	39	8.0
Others	9	1.8
Stakeholders by Role		
Teacher	115	23.5
Parent	371	75.7
School health personnel	3	.6
School Health Program Officer	1	.2

Table 2 presents the level of awareness of stakeholders regarding the Whole School, Whole Community, Whole Child (WSCC) model. Out of the 490 respondents, the majority 392 (80.0%) reported that they were not aware of the WSCC model. This indicates a very low level of awareness of the framework among the stakeholders surveyed.

In addition, 52 respondents (10.6%) indicated that they had little or minimal knowledge of the WSCC model, suggesting that only a small proportion of stakeholders had some limited familiarity with the concept. Meanwhile, only 46 respondents (9.4%) reported that they were aware of the WSCC model.

This table concludes that awareness about the WSCC model among stakeholders is very low, less than one-tenth of the respondents indicated that they were aware of WSCC model. This suggests a significant knowledge gap among stakeholders, which may hinder the effective adoption and implementation of the WSCC framework in schools. This, however, shows that there is a strong need to promote awareness through campaigns, stakeholder education, and capacity-building.

Table 2: Awareness of Stakeholders About WSCC

Levels of Awareness	Frequency	Percent
Aware	46	9.4
Not aware	392	80.0
Minimal awareness	52	10.6
Total	490	100.0

Table3 indicates that out of the 490 respondents, the largest proportion 196 (40.0%) reported that none of the WSCC components were implemented in their schools. While 111 respondents (22.7%) reported that all components of the WSCC model were implemented in their schools. In addition, 81 respondents (16.5%) stated that between 1 and 4 components were implemented, while 65 respondents (13.3%) reported that between 5 and 8 components were implemented in their schools. In addition, 37 respondents (7.6%) indicated that they had no idea about the number components WSCC implemented in their school.

Therefore, this finding indicated that some schools have adopted several components of the WSCC model not as a comprehensive approach. However, larger proportion of stakeholders reported that none of the components is implemented in their school. This suggestive of a potential gap in the adoption of the WSCC framework.

Table 3: Components of WSCC Implemented

Components of WSCC	Frequency	Percent
None	196	40.0
All components	111	22.7
1-4 components	81	16.5
5-8 components	65	13.3

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No idea	37	7.6
Total	490	100.0

Knowledge of the respondents was categorized as low, medium, and high knowledge levels. Respondents stated that WSCC is coordinated and implemented by teachers, parents, school administrators and community are Categorized as having high knowledge. This group represented majority of respondents (63.5%). Those that stated that WSCC was coordinated by teachers and parents are categorized as having medium knowledge. While the respondents that believed WSCC is coordinated by either teachers or parents alone are classified as having poor knowledge.

Table 4: Meaning of WSCC to Respondents

Meaning of WSCC	Frequency	Percent
This is the school health services solely coordinated and implemented by teachers only	111	22.7
This is the school health services solely coordinated and implemented by parents only	64	13.1
This is the school health services solely coordinated and implemented by teachers and parents only	4	.8
School health services solely coordinated and implemented by teachers, parents, school administrators and community	311	63.5
Total	490	100.0

Discussion

The findings of this study revealed that stakeholders in schools in Ife have moderate awareness but limited comprehensive knowledge of the WSCC model. This finding is consistent with previous studies which reported that many school stakeholders are familiar with basic school health activities but lack adequate knowledge of comprehensive frameworks guiding school health programs ^{3,4}.

The limited knowledge observed among some stakeholders may be attributed to insufficient training, limited policy dissemination, and inadequate integration of school health frameworks into teacher training programs. Previous research has shown that when stakeholders lack adequate knowledge of comprehensive school health frameworks, implementation becomes fragmented and less effective ².

The higher level of knowledge observed among school administrators and health personnel may be due to their greater exposure to policy discussions and health-related programs within the school system. Teachers and parents, on the other hand, may have fewer opportunities to receive formal training on comprehensive school health models.

The findings highlight the need for increased awareness campaigns and capacity-building programs aimed at improving stakeholders' knowledge of the WSCC model. Strengthening stakeholder knowledge is critical for ensuring coordinated implementation of school health initiatives and promoting the overall well-being of students.

Conclusion

This study assessed the knowledge and awareness of stakeholders regarding the WSCC model and its importance in schools in Ife, Osun State. The findings indicate that although some stakeholders are aware of school health initiatives, detailed knowledge of the WSCC framework and its components remains limited.

The study emphasizes the importance of improving stakeholders' awareness and knowledge to enhance effective implementation of the WSCC model in schools.

Recommendations

The following recommendations are proposed:

1. Training and capacity-building programs should be organized for school stakeholders on the WSCC model.
2. Educational authorities should integrate the WSCC framework into school health policies and teacher training programs.
3. Schools should strengthen collaboration between education and health sectors to support comprehensive school health initiatives.
4. Community engagement should be encouraged to enhance stakeholder participation in school health programs.

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