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Enhancing emotional resilience and community cohesion in Nigerian primary schools: the role of child-friendly school initiative

IKOGHO, Doris Eseoghene *

Department of Health and Safety Education, Faculty of Education, Delta State University, Abraka. Delta State, Nigeria.

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Abstract

The Nigerian educational system faces persistent challenges, including inadequate infrastructure, socio-economic disparities, and cultural barriers, which impede holistic child development. The Child-Friendly School Initiative (CFSI), championed by UNICEF, offers a transformative approach emphasizing inclusivity, safety, health literacy, and participatory governance. This study evaluates the effectiveness of CFSI in Delta State, Nigeria, by comparing CFSI and non-CFSI schools across three dimensions: emotional health, health literacy, and community cohesion.

Using a descriptive survey design, data were collected from 1,229 participants, including pupils, teachers, and community leaders. Instruments were adapted from UNICEF's evaluation framework, achieving reliability scores of 0.77 to 0.87. Statistical analyses, including Chi-square and ANOVA, were conducted at a significance level of 0.05. Results revealed that CFSI schools significantly outperformed non-CFSI schools in promoting emotional resilience ($p < 0.01$), implementing health education curricula ($p < 0.01$), and fostering community cohesion ($p < 0.01$).

The findings underscore the critical role of CFSI in addressing health disparities, reducing absenteeism, and enhancing social integration. Barriers such as resource limitations, cultural resistance, and insufficient teacher training were identified as constraints to scaling up CFSI. Recommendations include targeted interventions to expand CFSI across Nigeria, addressing funding gaps, promoting community ownership, and integrating health literacy into educational frameworks. This study contributes to the discourse on sustainable educational reforms, aligning with the Sustainable Development Goals (SDGs) on quality education, health, and reduced inequalities.

Keywords: Child-Friendly School Initiative; Health Literacy; Emotional Resilience; Community Cohesion; Sustainable Development Goals

1. Introduction

The Nigerian educational system is faced with persistent challenges stemming from inadequate infrastructure, socio-economic disparities and cultural barriers, which limits the ability of schools to provide a holistic support for children. Primary school pupils are often victim of this system, contending with social exclusion, emotional stress and the absence of a supportive learning environment. These issues not only impede academic performance but also impact students' emotional resilience and social integration (UNICEF,2016).

The Child-Friendly School Initiative (CFSI), championed by UNICEF, ensures that a transformative approach to addressing these challenges is provided. By emphasizing inclusivity, safety, and participatory governance, the initiative's main objective is to create environments that nurture pupils' emotional well-being and foster positive relationships within school communities. This approach is particularly relevant in Nigeria, where ethnic diversity and

* Corresponding author: IKOGHO Doris Eseoghene

cultural differences present both a unique opportunity and a complex challenge for promoting community cohesion (American Institute for Research (AIR). (2008; UNICEF,2008;Baker & Schall, 2016).

Emotional resilience on the other hand, provides the capacity to recover from adversity and thrive in challenging educational circumstances. This is essential for children's mental health and academic success (Fauziati, 2016). When institution prioritize emotional well-being alongside academic achievement, they lay a foundation for pupils to navigate life's challenges with confidence and optimism. Moreover, schools with a focus on fostering respect, inclusivity, and collaboration can have far-reaching implications for community cohesion (Freeman,2014).

Central to the success of CFSI is its emphasis on health literacy, empowers children with the knowledge and skills to make informed decisions about their physical, emotional, and social well-being. When integrated into child-friendly education models, health literacy not only enhances individual outcomes but also strengthens the collective capacity of communities to support children's development. However, this aspect is often-overlooked (Jill,2012). Evidence from Nigerian schools highlighted the importance of integrating health literacy into primary education. For example, Oyinlade et al. (2021) demonstrated that health education programs in child-friendly schools led to improved hygiene practices and reduced absenteeism due to preventable illnesses. Despite these successes, challenges such as inadequate resources, teacher training, and cultural resistance hinder the widespread adoption of health literacy initiatives. (Edwita, Hasanah & Marini, 2025). The participatory governance aspect of CFSI, includes parental involvement and community partnerships, were seen as a key driver of cohesion. Studies in Nigeria have suggested that engaging community stakeholders in school management build trust and accountability (Ogunyemi, 2017). For instance, in Bauchi State, community-driven interventions improved resource mobilization and reduced ethnic tensions within schools (Oyinlade, etal., 2021). On the contrary, challenges such as poor funding,entrenched cultural biases and insufficient policy support frustrate the full realization of community cohesion. Despite the free and compulsory education offered by the federal government under the Universal Basic Education (UBE) Act, infrastructural deficits exist (Akinyemi et al. (2022). Furthermore, the absence of inclusive policies for children with disabilities exacerbates inequities (Okonkwo & Oladipo, 2019).

Globally, countries with robust CFSI frameworks demonstrated great improvements in pupils well-being. In Thailand, for example, a multi-stakeholder approach involving government agencies, NGOs, and local communities has led to increased enrollment and reduced bullying (Karon, et al., 2017). Similarly, Rwanda's investment in infrastructure and the integration of gender-sensitive teaching styles enhanced school attendance and emotional well-being among pupils (Muhidin, Sudarmo & Desiderius, 2019;*Ikogho & Esewe, 2012).*

These success stories therefore points to the need to scale up CFSI in Nigeria, with the aim of addressing funding gaps, fostering community ownership and promoting health. This paper was developed to explores the critical role of the Child-Friendly School Initiative in enhancing emotional resilience and community cohesion in Nigerian primary schools. By examining global and local perspectives, it x-rayed the potentials of CFSI to transform education in Nigeria with a focus on scaling up, so that its benefits can reach the most marginalized communities.

1.1. Statement of Problem

Despite progress in primary education, uneven implementation of the Child-Friendly School Initiative (CFSI) in Nigeria exacerbates disparities in emotional health, health literacy, and community cohesion. Non-CFSI schools, particularly in Delta State, often lack child-friendly environments, including health education, safe spaces, and community support. These gaps contribute to high absenteeism, poor academic outcomes, and vulnerability to preventable diseases, perpetuating cycles of poverty and limited educational attainment.

The absence of structured health literacy programs leaves children in non-CFSI schools unable to adopt basic hygiene practices, increasing their exposure to infectious diseases. Improved handwashing alone could reduce disease incidence by up to 50% (UN-Global Handwashing Day, 2020; Ikogho & Igbudu, 2013; Levels & Trends in Child Mortality Report. (2022), yet this potential remains unrealized. Additionally, insufficient teacher training and support to address psychosocial challenges, such as bullying and emotional neglect, hinder the development of resilient learners. Cultural resistance, resource limitations, and fragmented community engagement further impede CFSI implementation. Schools facing these barriers struggle to provide inclusive environments essential for academic, emotional, and social development. Without targeted interventions, these challenges undermine progress toward Sustainable Development Goals (SDGs) related to quality education, health, and reduced inequalities.

This study evaluates the effectiveness of CFSI schools in Delta State by comparing them with non-CFSI schools across three dimensions: emotional health through health literacy, community cohesion, and barriers to scaling. Addressing these gaps is critical for fostering an equitable, sustainable educational system that supports holistic child development.

1.2. Research Questions

The following research questions were raised to guide the study:

- To what extent have the schools promoted the emotional health of school pupils?
- What is the level of implementation of health literacy in school curriculum?
- To what extent have the schools promoted community cohesion?

1.3. Purpose of the Study

The purpose of the study is to examine the extent of implementation of CFSI in Delta state. Specifically, the objectives of the study are:

- The extent to which pupils experienced a climate of emotional safety
- Provision of health literacy
- The extent to which schools promoted community cohesion

1.4. Significance of the Study

We hope that sharing the study's results will show how well CFSI is being used in Delta State. This information can help expand CFSI to the entire Niger Delta region and allof Nigeria, supporting the health and education goals for 2030. It will also raise awareness about how Tunwashed hands can spread infections and diseases.

2. Literature Review

2.1. The Social-Ecological Model (SEM)

The Social-Ecological Model (SEM), introduced by Bronfenbrenner in 1979, provides a robust theoretical foundation for understanding the role of the Child-Friendly School Initiative (CFSI) in promoting emotional resilience, health literacy, and community cohesion. SEM highlighted

Bronfenbrenner's theory suggested that an individual's development is influenced by several interconnected environmental systems, ranging from the immediate surroundings to broad societal structures. These interconnectedness shape health and educational outcomes. Applied to the context of Nigerian primary schools, the model emphasized the need to equip students with health literacy at the individual level, fostering supportive relationships between teachers and peers at the interpersonal level, and engaging communities to mobilize resources and ensure cultural alignment. At the organizational level, it stresses the importance of implementing policies and infrastructure that reflect CFSI principles, while at the societal level, it underscores the critical role of national policies, funding, and cultural norms in scaling up the initiative. By addressing these multi-level factors, SEM offers a scientific framework for analyzing the comprehensive impact of CFSI and identifying actionable strategies for sustainable implementation and widespread adoption.

2.2. The Value of health literacy in Primary Schools

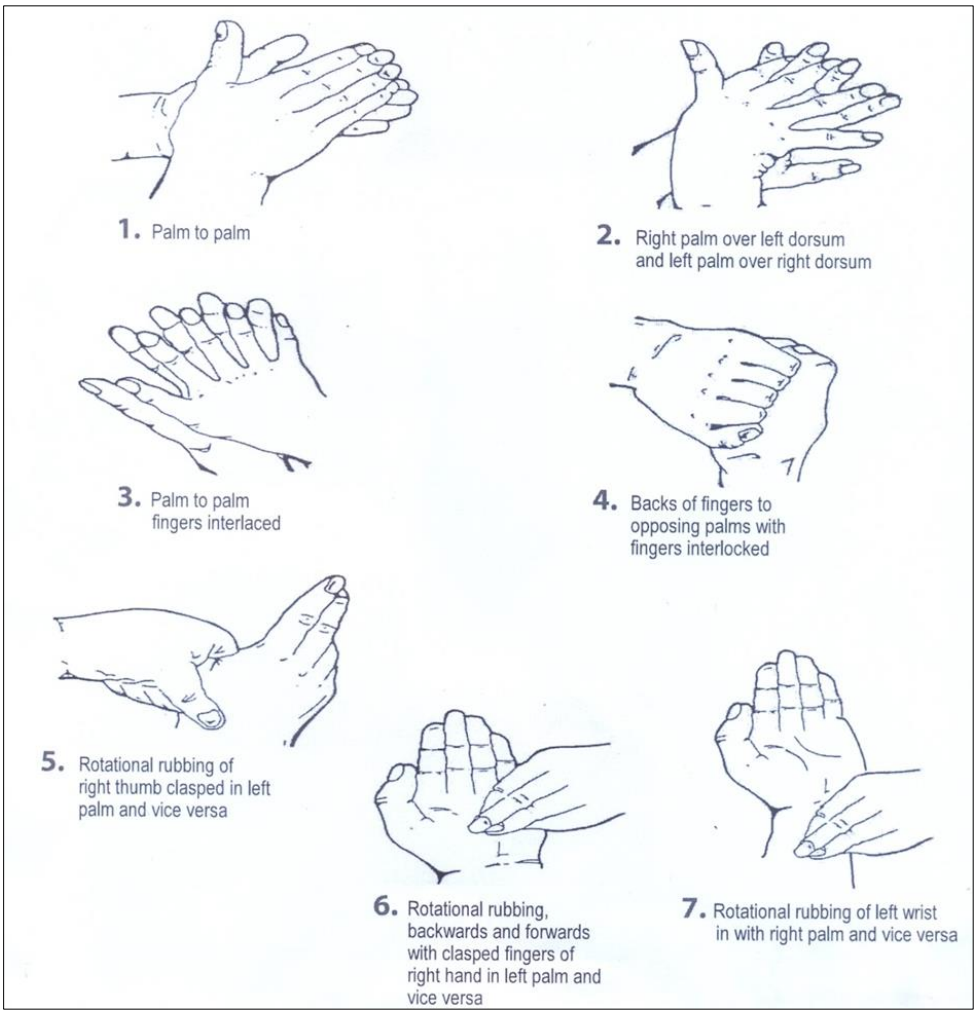
Health literacy is the ability of an individual to access and process basic health information to make informed decisions. The World Health Organization (WHO) in 2021, described health literacy as the ability to read, understand such health related information and the capacity to apply that knowledge to promote health. Health literacy lays the foundation for future learning. Research established that children with high health literacy are also likely to seek information as they grow older. This by extension, translate into reduced rates of diseases.They are also able to differenciate between reliable and and unreliable sources of health information (Esewe & Ikogho,2011).

Health literacy in primary schools is a critical intervention that fosters lasting behavioral change, improves health outcomes, enhances academic performance, and strengthens community engagement. By targeting children, health literacy may help to cultivates lifelong skills, positioning them as agents of change within their families and communities. For example, initiatives like the UN Global Handwashing Day demonstrate the far-reaching influence of a single child educated on proper hygiene practices (UNICEF, 2016; Curtis et al., 2020). Health literacy geared towards

bullying can reduce childrens' fear of being bullied. Bullying according to Onyilibe and Ikediugwu (2020), may deter children from attending school, negatively impacting their mental well-being. The promotion og psychological well-being and teaching coping mechanisms are central to the CFSI framework. Muhidin (2019), Onuemu and Ojo (2014) in their separate studies emphasized that health literacy can empower children with knowledge to prevent illnesses. In the same vein, school children with limited knowledge about personal hygiene will lack the skills to prevent or recover from diseases. Hence in schools where such health curriculum implementation is lacking, presents a missed opportunity to enhance pupils' understanding of hygiene practices. Proper hygiene practices have proven to be potent in reducing incidences of diseases such as diarrhea or respiratory infections by 50% (UNICEF, 2016). By extension, improvement in academic performances of pupils (Freeman et al., 2014).

Furthermore, health literacy focused on hygiene cannot be effective without the provision of adequate hygiene facilities such as clean toilets, handwashing facilities and running water has a direct influence on pupils' ability to imbibe proper hygiene practices (Ikogho &Igbudu,2013).

Research indicates that health education with a focus on hygiene practices promotes healthier learning environments, particularly where access to hygiene facilities are unrestricted (UNESCO, 2020; Karon et al., 2017). Additionally, good hygiene habits at school are likely carried into adulthood(WHO,2021). This can foster a culture of wellness among pupils and the wider school community. This collective approach according to World Health Organisation (WHO) in 2021 aligns with Sustainable Development Goal 6 (clean water and sanitation). This was probably why UNICEF (2008) proposed easily found items in local community for hand washing such as clean mud, ash or lime and described easy steps for effective usage as seen in figure 1:



Source: Adapted from WHO (2008) Guidelines on Hand hygiene in health care.

Figure 1 Basic steps of proper hand washing

2.3. Promoting Community Cohesion

Community cohesion strengthens social bonds, trust, and participation, essential for well-being and educational outcomes. It mitigates challenges like financial constraints and transportation issues (Freeman et al., 2014) while reducing bullying and isolation, fostering a supportive school environment (Onyilibe & Ikediugwu, 2020). By bridging gaps between families and schools, it promotes collaboration in education and enhances parental involvement, improving attendance rates (Ofojebe & Enzugoh, 2019). Inclusive practices that uphold children's rights and engagement further reinforce cohesion (Ikogho & Esewe,2012; Endang, 2016; Baker & Schall, 2016).

In Kenya, WASH programs demonstrated how community involvement enhances sustainability, improves attendance and academic outcomes (McAlister, n.d.). Policies such as the UK's *Education and Inspection Act* promote shared values, human rights education, and family-community engagement (Department for Education and Skills, 2007). Globally, initiatives like Healthy People 2030 leverage community institutions to advance health and education (CORE Group, 2014; U.S. Department of Education, 2023). Cohesive communities also ensure safer environments, encouraging school attendance without fear of violence (Onyilibe & Ikediugwu, 2020).

2.4. The Concept of Scaling Up

Scaling up refers to expanding effective interventions or programs from a localized context to broader settings to achieve significant societal benefits. The process may require enhanced scope and resources, thus replicating a successful intervention into an existing systems. The is to make a proven programme accessible to a larger setting (Yadav, 2022). The value of Scaling Up CFSI included ; to transform schools and extend to their communities, address disparities in access to quality education, benefit vulnerable groups. Evidence revealed CFSI has the capacity to increase pupils motivation to learn among others (CORE Group, 2014). It involves a structured process encompassing proof of concept, contextual adaptation, stakeholder engagement, resource mobilization, and ongoing evaluation (CORE Group, 2014; Yadav,2022). These steps ensure the intervention remains effective while addressing the unique demands of new contexts.

Success stories were found about such initiatives in Indian (Yadav, 2022).

3. Methodology

This study employed a descriptive survey research design, focusing on primary 6 pupils aged 8–10 years, along with their headteachers, teachers, and community leaders. The population comprised 1,229 participants from both CFS and non-CFS schools in Delta State, including Amawhe Primary School (Ozoro), Abuano Primary School (Ogwashiukwu), Ovierie Primary School (Ethiope East), and Ovu Primary School (Ovu). A stratified sampling technique, followed by systematic random sampling, ensured representative participant selection. Data collection utilized validated tools, including a questionnaire, focus group discussions, and an observation checklist adapted from UNICEF's 2008 evaluation framework for CFSI in Nigeria. The reliability of these instruments, confirmed with scores ranging from 0.77 to 0.87, underscores their robustness. Data analysis involved descriptive statistics, Chi-square tests and ANOVA to evaluate relationships at a significance level of 0.05. For pupils, permission of parents were sorted while all other participants gave informed consent to participate in the study.

3.1 Results

3.1.1. ***Research Question 1:*** *To what extent have the schools promoted the emotional health of school pupils?*

Table 1 Chi square Test on the extent schools promoted physical and mental health of pupils

Extent schools promoted emotional health of pupils		**Not True**	**Very True**	**Total**	X^2	**Df**	**p-Value**
CFS Schools	N	18	26	44	8.438	1	0.004
	%	*40.9*	*59.1*	*100.0*			
Non- CFS School	N	16	4	20			
	%	*80.0*	*20.0*	*100.0*			
Total	N	34	30	64			
	%	*53.1*	*46.9*	*100.0*			

P<0.01-Highly Significant
The table 1 revealed that all CFS schools promoted physical and mental health of pupils. This is indicated by 59.1% as against the non- CFSI school(30.0%) (p<0.01)

3.1.2. ***Research question 2:*** *What is the extent of Implementation of health instruction/ Education Curriculum?*

Table 2 Chi square analysis on the extent of implementation of health instruction/ education curriculum

Extent of Implementation of health instruction/ Education Curriculum		**Not True**	**Very True**	**Total**	***X²***	**Df**	**p-Value**
CFSI School	N	39	5	44	16.319	1	0.0001
	%	*88.6*	*11.4*	*100.0*			
Non CFSI School	N	20	0	20			
	%	*100.0*	*0.0*	*100.0*			
Total	N	59	5	64			
	%	*92.2*	*7.8*	*100.0*			

P<0.01-Highly Significant

The table 2 revealed that all CFS implemented health instruction/education. This was indicated by11.4% while in the non- CFSI school is 0.0%. (p<0.01)

3.1.3. ***Research question 3:*** *To what extent have the schools promoted community cohesion?*

Table 3 Chi square analysis on the Extent Schools promoted community cohesion

Extent Schools promoted community cohesion		**Not True**	**Very True**	**Total**	***X²***	**Df**	**p-Value**
CFSI School	N	11	33	44	23.444	1	0.0001
	%	*25.0*	*75.0*	*100.0*			
Non CFSI School	N	18	2	20			
	%	*90.0*	*10.0*	*100.0*			
Total	N	29	35	64			
	%	*45.3*	*54.7*	*100.0*			

P<0.01-Highly Significant

Table 3 revealed that CFS promoted community cohesion as indicated by 75% than in the non- CFSI school (10.0) (p<0.01).

The table showed that the Chi-square value (X^2 = 23.444, df = 1, p = 0.0001) indicated that the observed difference in community cohesion between CFSI and non-CFSI schools is highly significant (p < 0.01). This implied that the implementation of CFSI programs plays a pivotal role in fostering community cohesion in schools. The significant association between CFSI schools and community cohesion suggests that these schools are better equipped to promote inclusive and participatory practices that strengthen relationships among students, teachers, and the community.

Table 4 Analysis of Variance (ANOVA) test of significance among the schools

	School 1 Mean ±SD ***(Min, Max)***	**School 2 Mean ±SD** ***(Min, Max)***	**School 3 Mean ±SD** ***(Min, Max)***	**School 4 Mean ±SD** ***(Min, Max)***	**P-Value**
Extent schools implemented CFSI curriculum	13. 6[a]±2 6 (9 0, 19)	13. 6 [a] ±2 6 (9 0,18)	12. 2 [a] ±2 5 (9, 16)	8. 4 [b]±3 4 (3, 16)	**P<0 001
Extent Schools encouraged healthy behavioral practices	14. 0 [a] ±3 1 (8, 19)	12. 9 [a] ±2 4 (9, 17)	14. 0 [a] ±2 0 (9, 16)	8. 3 [b]±2 0 (4, 12)	**P<0 001
Extent Schools Encouraged hand washing etc	12. 9 [a] ±2 7 (7, 16)	13. 4 [a] ±2 3 (10, 17)	10. 7 [a]±2 0 (8, 14)	9. 4 [b]±1 8 (6, 12)	**P<0 001
Extent of Implementation of health instruction Education Curriculum	10. 3 ±3 9 (4 ,19)	1.0±1 4 (8,13)	9. 2±1 8 (6, 12)	8. 5±1 7 (6, 12)	P>0 05
Extent Schools promoted community cohesion	13 .6 [a] ±2 3 (10, 18)	14 .6 [a] ±2 1 (11, 18)	13 .9 [a] ±3 1 (9, 18)	10. 1 [a] ±2 0 (6, 14)	**P<0 001

NOTE: **P<0 001= Highly Significant mP>0 05= Not Significant

The data analyses showed that schools 1, 2, and 3 (CFSI schools) have higher and comparable mean scores (13.6 ± 2.6, 13.6 ± 2.6, and 12.2 ± 2.5, respectively), indicating effective curriculum implementation. School 4 (non-CFSI) has a significantly lower score (8.4 ± 3.4), demonstrating weaker implementation (**$p < 0.001$**). Similar trends are observed, with CFSI schools (mean scores: 14.0 ± 3.1, 12.9 ± 2.4, and 14.0 ± 2.0) significantly outperforming the non-CFSI school (8.3 ± 2.0; **$p < 0.001$**). CFSI schools also excel in promoting hygiene practices with mean scores between 10.7 ± 2.0 and 13.4 ± 2.3, while the non-CFSI school lags behind (9.4 ± 1.8; **$p < 0.001$**). No significant differences are found ($p > 0.05$), suggesting uniformity in basic curriculum implementation across schools. Consistent with Table 5, CFSI schools show significantly higher mean scores (13.6 ± 2.3, 14.6 ± 2.1, and 13.9 ± 3.1) compared to the non-CFSI school (10.1 ± 2.0; **$p < 0.001$**). The ANOVA results confirm that CFSI schools consistently outperform non-CFSI schools in most dimensions of child-friendly and health-promoting practices. However, the lack of significant differences in health instruction education curriculum suggests that non-CFSI schools may have comparable but less integrated approaches.

4. Discussion of Findings

The findings of this study underscored the transformative impact of the Child-Friendly School Initiative (CFSI) in the following ways;

The study revealed that CFSI schools significantly outperformed non-CFSI schools in promoting the emotional health of pupils. A larger proportion of pupils in CFSI schools (59.1%) reported experiencing emotional safety compared to their counterparts in non-CFSI schools (20.0%), with a highly significant difference ($p < 0.01$). This finding aligns with existing literature that emphasizes the role of supportive and inclusive learning environments in enhancing students' psychological well-being (Freeman, 2014; UNICEF, 2016). Emotional safety is pivotal for fostering resilience, as it provides children with the confidence to navigate adversities and excel academically. The study highlighted substantial disparities in the implementation of health education curricula between CFSI and non-CFSI schools. In CFSI schools, 11.4% of participants confirmed the inclusion of health instruction compared to 0.0% in non-CFSI schools ($p < 0.01$). This underscores the critical role of health literacy in equipping pupils with the knowledge and skills necessary for adopting preventive health behaviors, as noted in previous research (Ikogho & Igbudu, 2013; WHO, 2021). Furthermore, inadequate health education in non-CFSI schools represents a missed opportunity to mitigate preventable diseases such as diarrhea and respiratory infections, which disproportionately affect vulnerable populations. Community cohesion was significantly higher in CFSI schools, with 75.0% of pupils reporting inclusivity and participatory practices compared to 10.0% in non-CFSI schools ($p < 0.01$). This finding corroborates earlier studies demonstrating that schools fostering parental involvement and community partnerships enhance trust and reduce social tensions (Ogunyemi, 2017; Oyinlade et al., 2021). The participatory governance framework integral to CFSI strengthens social bonds, promotes accountability, and reduces ethnic and cultural divisions, thereby creating safer and more collaborative learning environments.

4.1. Barriers and Challenges

Despite the successes of CFSI, several challenges impede its scalability. Infrastructural deficits, cultural resistance, and limited teacher training hinder the full realization of its potential. For instance, the absence of adequate hygiene facilities in non-CFSI schools perpetuates poor health outcomes, as reflected in prior studies (UNICEF, 2016; Ikogho & Igbudu, 2013). Additionally, fragmented policy support and inconsistent funding limit the broader implementation of child-friendly practices.

5. Conclusion

The study demonstrates the effectiveness of CFS schools in promoting emotional health and community engagement, while also identifying areas for improvement, such as addressing bullying and enhancing health education. By addressing these gaps, policymakers and educators can ensure that all schools, whether CFS or non-CFS, provide environments conducive to the holistic development and well-being of children.

Recommendations

- Government Legislators and Policymakers should enforce policies that integrate hygiene education into primary school curricula. Ensure alignment with curriculum standards and monitor implementation.
- Government and Education Authorities should ensure a stronger involvement of stakeholders in Education. School Management Committees (SMCs) and Parent-Teacher Associations (PTAs) should provide adequate information to relevant authorities, community leaders, parents on the need to commit time and financial support to make school more friendly to children.
- Education authorities should encourage scale up CFSI programs to non-CFSI schools to address observed gaps by Providing targeted support to improve areas where non-CFSI schools lag behind, particularly in curriculum integration and community engagement be scaled up to meet SDGs.

Research Limitations

The study is limited by its focus on a specific age group (8-10 years) and a select number of schools, which may not fully capture the broader impact of CFSI across different age groups and regions. Additionally, the study relied heavily on self-reported data and observations, which could introduce biases. Future research should consider a more diverse sample and employ longitudinal designs to assess the long-term effects of CFSI.

Compliance with ethical standards

Disclosure of conflict of interest

The author declares that there are no conflict of interest.

Statement of informed consent

Informed consent was obtained from all individuals who took part in the study.

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