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COM 403

HEALTH EDUCATION AND HEALTH ADVOCACY

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Course code: COM 403

Course title: Health Education and Health Advocacy

Course credit load: 1 Unit

Series 1: Principles of Health Education

- **Part 1.1: Definition and Scope of Health Education**
    - Sub Part 1.1.1: Definition of health education
    - Sub Part 1.1.2: Aims and objectives of health education
    - Sub Part 1.1.3: Health education, health promotion, and health advocacy
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Introduction

Health education is among the oldest and most fundamental activities of public health. Long before vaccines, antibiotics, or surgical theatres, human communities transmitted knowledge about clean water, safe food handling, and the isolation of the sick through informal instruction

and cultural practice. Modern health education formalises this ancient human activity into a discipline with defined principles, evidence-based methods, and measurable outcomes, aimed at enabling individuals, families, and communities to take greater control over the determinants of their health.

The aim of this Series is to define health education, establish its aims and its relationship to health promotion and health advocacy, examine the principles that guide its practice, explore the theoretical models that explain health behaviour change, and situate health education within the specific social, cultural, and institutional context of Nigeria.

We shall commence by defining health education and distinguishing it from related concepts. Next, we will examine the principles governing health education practice and the models used to understand health behaviour. Finally, we will close by examining health education within the Nigerian public health context, including the socio-cultural factors and institutional challenges that shape its practice.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 1.1** define health education and describe its aims and objectives,
- **SLO 1.2** distinguish health education from health promotion and health advocacy,
- **SLO 1.3** explain the core principles that govern health education practice,
- **SLO 1.4** describe the major determinants of health behaviour,
- **SLO 1.5** describe the principal behavioural change models relevant to health education, and
- **SLO 1.6** assess the role, socio-cultural context, and challenges of health education in Nigeria.

1.1 Definition and Scope of Health Education

1.1.1 Definition of health education

Health education is any combination of learning experiences designed to help individuals, families, and communities acquire the information and skills they need to make and act on decisions that positively affect their health. The WHO defines health education as comprising **"consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health."** Two elements are central to all credible definitions: that health education is **intentional** (deliberately designed to achieve health outcomes, not merely incidental information transfer) and that it aims to produce **informed voluntary behaviour change** (influencing choices through education and empowerment, rather than coercion, fear, or regulation).

Health education is distinguished from simple health information by its engagement with **skills and motivation** alongside knowledge: telling people that tobacco causes cancer (information) is not health education unless it is accompanied by support for building the motivation, skills, and self-efficacy needed to avoid or quit tobacco use. The product of effective health education is not merely an informed individual but a **health-literate** one: a person capable of accessing, understanding, evaluating, and acting on health information across a range of contexts, including navigating health services, understanding risk, and participating in community-level health decisions. Health literacy, in this sense, is both the proximate outcome of health education and a prerequisite for meaningful community participation in the PHC system examined in related courses.

Fill in the blank: Health education aims to produce informed voluntary _____ change, influencing individual and community health choices through education and empowerment rather than coercion or regulation.

1.1.2 Aims and objectives of health education

The broad **aims** of health education are threefold: to **inform** individuals and communities about health risks, protective behaviours, and available services; to **motivate** them to adopt healthy behaviours and to seek care when needed; and to **empower** them with the skills, confidence, and social support needed to translate healthy intentions into sustained action. These three aims correspond roughly to the cognitive, affective, and psychomotor learning domains, recognising that health education must address what people know, what they feel and value, and what they are able to do, not merely what they intellectually understand.

At a more operational level, health education objectives specify the **knowledge** to be gained (e.g. knowing the symptoms of malaria and the importance of prompt treatment-seeking), the **attitudes** to be shaped (e.g. reduced stigma toward seeking care for tuberculosis or HIV), and the **practices** to be adopted or changed (e.g. consistently sleeping under an insecticide-treated bed net, exclusively breastfeeding for the first six months of life). This **KAP framework** (knowledge, attitudes, practices) has been widely used in Nigerian public health to design and evaluate health education programmes, though it is now recognised that knowledge and attitude change do not automatically translate into behaviour change, requiring more sophisticated behavioural models, examined in Part 1.2.3, to understand the gap between knowing and doing.

Fill in the blank: The KAP framework structures health education objectives around _____ (what people know), attitudes (what they value and feel), and practices (what they actually do), recognising that knowledge alone does not guarantee behaviour change.

1.1.3 Health education, health promotion, and health advocacy

Health education, health promotion, and health advocacy are related but distinct concepts that are frequently conflated. **Health education** (as defined in Part 1.1.1) focuses specifically on learning experiences that build individual and community knowledge, skills, and motivation for health. **Health promotion**, the broader concept, encompasses health education but extends to environmental, policy, and organisational changes that make it easier for people to act on health knowledge; the Ottawa Charter for Health Promotion (1986) defined health promotion as "the

process of enabling people to increase control over, and to improve, their health," with action areas spanning public policy, supportive environments, community action, personal skills, and health services reorientation, not only individual education.

Health advocacy involves using influence, communication, and evidence to change policies, systems, and social norms in ways that improve population health, on behalf of or in partnership with affected communities. Health advocacy operates at the political and systemic level rather than primarily at the individual or community level: advocating for tobacco control legislation, increased PHC funding, or improved sanitation infrastructure in a specific community are all examples of health advocacy. The relationship between the three is hierarchical: health education supports individual and community capacity to act; health promotion creates enabling environments for that action; and health advocacy addresses the upstream policies and social determinants that shape those environments.

Fill in the blank: _____ promotes the broader enabling conditions for health, extending beyond education to include environmental, policy, and organisational changes, while health advocacy operates at the political and systemic level to change policies and social norms.

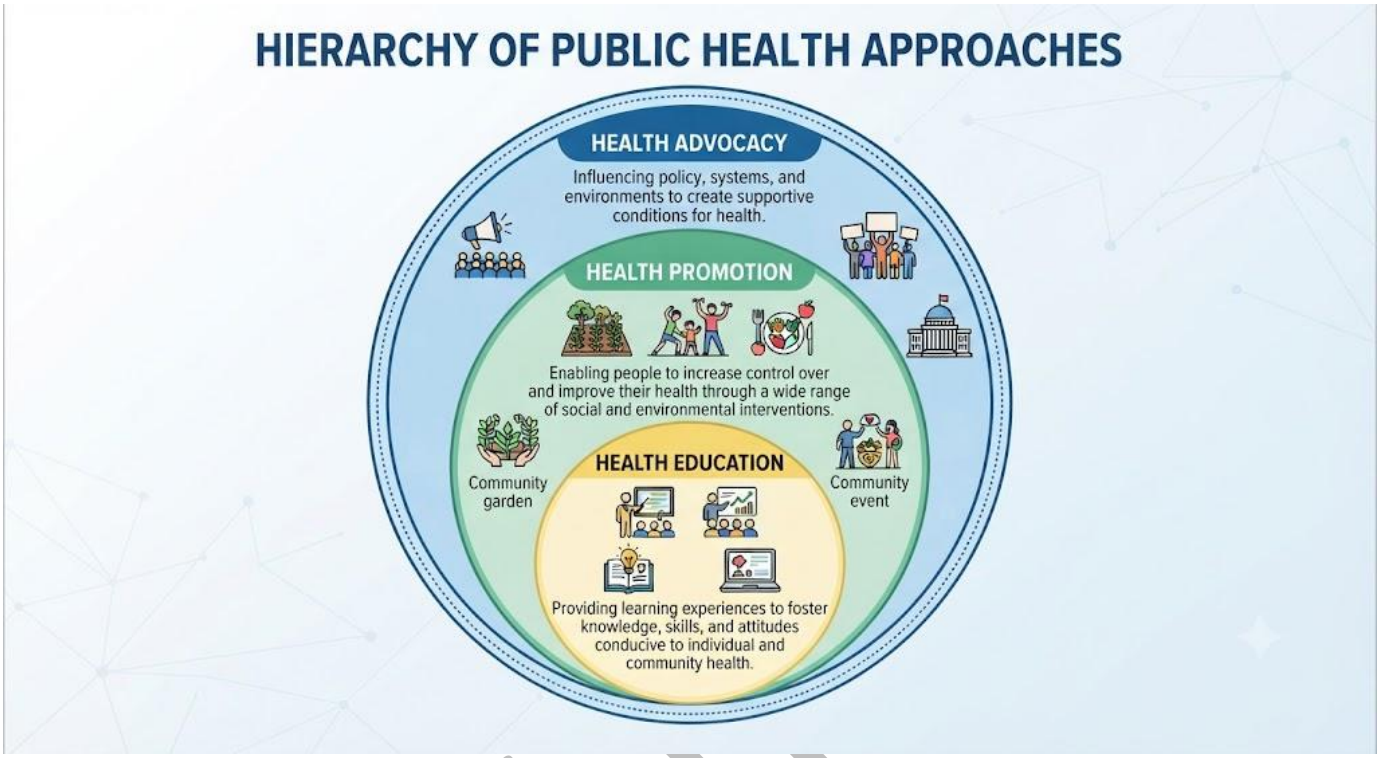

Figure 1.1: Health education, health promotion, and health advocacy: a nested relationship

Pilot questions 1.1

1. Define health education in your own words.
2. What two elements are central to all credible definitions of health education?
3. Name the three broad aims of health education.
4. Distinguish health education from health promotion.
5. Give one example of health advocacy relevant to Nigeria.

1.2 Principles Governing Health Education Practice

1.2.1 Core principles of health education

Health education practice is guided by a set of principles that distinguish effective from ineffective and ethical from unethical approaches. **Credibility**: health education messages must be based on accurate, scientifically sound information and must come from sources perceived as

trustworthy by the target audience; misinformation, even when well-intentioned, undermines both the immediate message and the longer-term credibility of the health educator. **Interest**: educational content must be relevant to the felt needs and interests of the intended audience, starting where people are rather than where the educator assumes they should be, since people are only motivated to engage with information they perceive as relevant to their lives.

Participation: the most effective health education actively involves the community in identifying their own needs, designing interventions, and evaluating outcomes, rather than delivering pre-packaged messages from outside; this participatory principle connects directly to the community participation tenet of PHC. **Comprehensiveness**: effective health education addresses the full range of factors influencing the target behaviour, not merely knowledge, recognising the role of attitudes, social norms, skills, self-efficacy, and environmental enabling conditions. **Reinforcement**: health education messages must be repeated and reinforced across multiple channels, occasions, and settings over time, since single-exposure educational events rarely produce lasting behaviour change. And **facilitation**: health education should reduce the barriers to healthy behaviour (cost, access, social acceptability) rather than simply advocating behaviour change while leaving barriers in place.

Fill in the blank: The principle of _____ requires that health education actively involves the community in identifying needs, designing interventions, and evaluating outcomes, rather than delivering pre-packaged messages from outside.

1.2.2 Determinants of health behaviour

Health behaviour, defined as any activity undertaken for the purpose of preventing disease, detecting it early, or managing it once it occurs, is shaped by a complex, interacting set of determinants. **Predisposing factors** are the individual characteristics that facilitate or hinder health behaviour: knowledge, beliefs, attitudes, values, and perceptions of susceptibility and severity. **Enabling factors** are environmental and skill-based factors that make healthy behaviour possible or easier: access to health services, availability of essential commodities (such as condoms or bed nets), and the practical skills required to perform the behaviour. **Reinforcing factors** are the social consequences of a behaviour, including the attitudes and

behaviour of peers, family members, teachers, and health workers, which either reward or punish adoption of the behaviour.

This **PRECEDE framework** (Predisposing, Reinforcing, and Enabling Causes in Educational Diagnosis and Evaluation) classification of health behaviour determinants, developed by Lawrence Green, remains one of the most practically useful frameworks for planning health education interventions, because it directs attention to the full range of factors that must be addressed for sustainable behaviour change rather than focusing narrowly on knowledge alone. In the Nigerian context, enabling factors, particularly access to essential commodities, affordable health services, and clean water, often represent the binding constraint that renders even excellent health education ineffective in isolation: a mother who knows the importance of oral rehydration therapy but cannot access ORS sachets in her community cannot act on that knowledge regardless of how well she has been educated.

Fill in the blank: The PRECEDE framework classifies health behaviour determinants as predisposing factors (individual beliefs and attitudes), _____ factors (skills and environmental access), and reinforcing factors (social consequences of behaviour).

1.2.3 Behavioural change models in health education

Several theoretical models guide the design of health education interventions by explaining why and how people change health-related behaviours. The **Health Belief Model** (HBM) proposes that an individual is most likely to take a health action when they perceive themselves as susceptible to a health threat, believe the threat is serious, believe the proposed action will reduce the threat, and believe the benefits of action outweigh the barriers, with a **cue to action** (such as a health education message) triggering the decision to act when the other conditions are met. The HBM has been widely applied to preventive behaviours such as vaccination uptake, HIV testing, and malaria prevention in Nigeria.

The **Transtheoretical Model (Stages of Change)** recognises that behaviour change is a process rather than a single event, progressing through stages: precontemplation (not intending to change), contemplation (considering change), preparation (intending to change soon), action (actively changing), and maintenance (sustaining the change). This model is particularly valuable

in health education because it directs interventions to the specific needs of individuals at each stage, rather than applying a single "raise awareness" approach regardless of where the individual already stands in relation to the behaviour. The **Social Cognitive Theory** (Bandura) adds the concept of **self-efficacy** (the individual belief in their own capability to perform the required action) as a critical determinant of behaviour change, suggesting that health education must build practical skill and confidence, not only provide information and motivation.

Fill in the blank: The Transtheoretical Model recognises that behaviour change is a _____ rather than a single event, progressing through stages from precontemplation through contemplation, preparation, action, and maintenance.

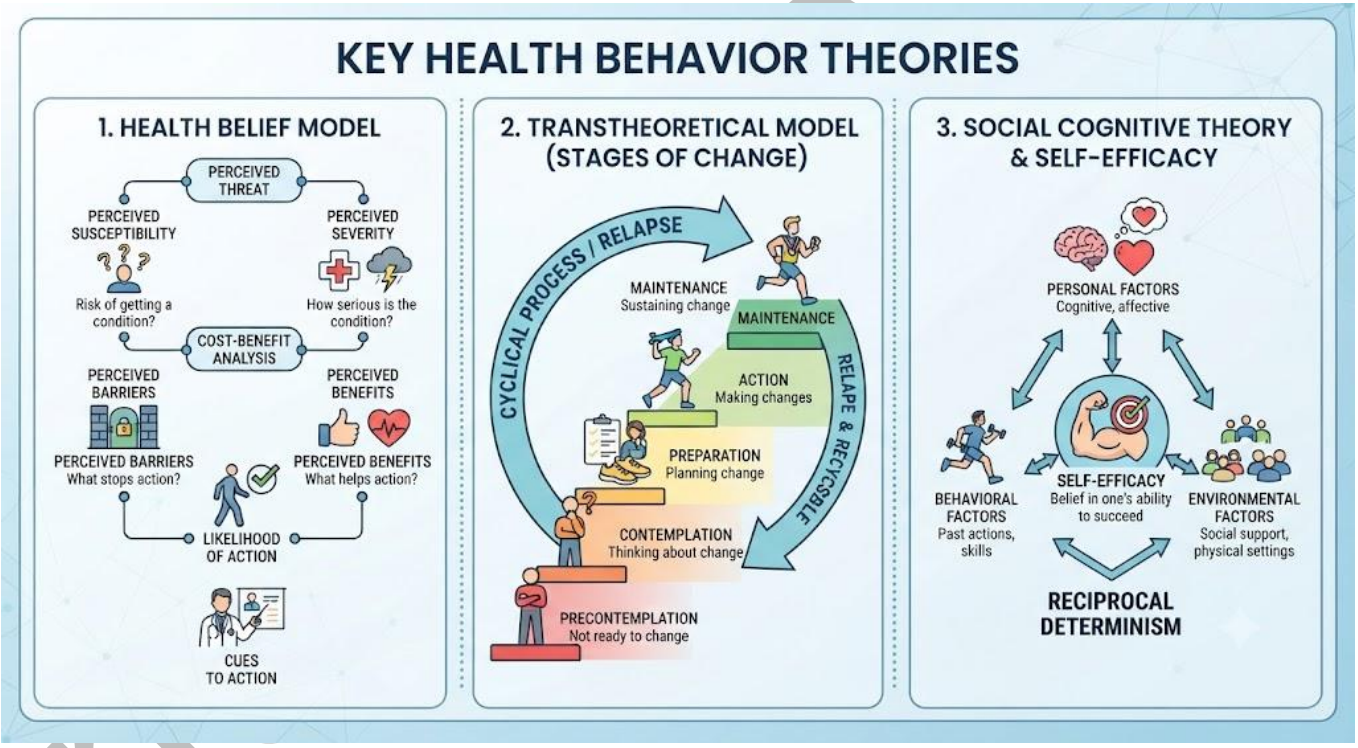

Figure 1.2: Behavioural change models in health education

Pilot questions 1.2

1. Name four core principles of health education.
2. Why might excellent health education be ineffective in isolation in some Nigerian communities?
3. Name the three categories of health behaviour determinants in the PRECEDE framework.
4. Describe the Health Belief Model and its application to malaria prevention.

5. What does the concept of self-efficacy add to health education theory?

1.3 Health Education in the Nigerian Context

1.3.1 The role of health education in Nigeria public health system

Health education is formally embedded within the Nigerian PHC system as one of the eight essential components of PHC specified in the Alma-Ata Declaration (examined in the related PHC course) and is a core function of community health extension workers (CHEWs), who constitute the frontline health education workforce in Nigerian PHC facilities. CHEWs are trained to deliver individual and group health education on topics including family planning, nutrition, maternal and child health, malaria prevention, immunisation, water and sanitation, and HIV prevention, using the interpersonal communication and community mobilisation skills that constitute much of the practical content of this course.

At the national level, the **Health Education Division** of the Federal Ministry of Health coordinates policy on health education and health promotion, and the **National Health Education Council (NHEC)** serves as the professional regulatory body for health education practice in Nigeria. Health education is further delivered through schools (the **School Health Programme** integrating health education into the national curriculum), workplaces, religious institutions, and mass media campaigns, as well as through the PHC facility network. The **Behavioural Change Communication (BCC)** component of national disease control programmes, including the National Malaria Elimination Programme and the National AIDS and STI Control Programme, constitutes the most systematic and heavily funded health education activity in Nigeria, though its outputs have been mixed in translating awareness gains into sustained behaviour change.

Fill in the blank: _____ Health Extension Workers (CHEWs) constitute the frontline health education workforce in Nigerian PHC facilities, trained to deliver individual and group education on topics including family planning, nutrition, and malaria prevention.

1.3.2 Socio-cultural factors influencing health education in Nigeria

Nigeria extreme cultural and linguistic diversity, with over 500 ethnic groups and three dominant language groupings (Hausa-Fulani, Yoruba, and Igbo) alongside hundreds of minority languages, presents both challenges and opportunities for health education. Messages developed in English or in one major language may not reach communities whose primary language of health communication is a local dialect or minority language; culturally inappropriate examples, images, or assumptions built into health education materials produced centrally can alienate audiences whose cultural context differs from that assumed by the material developers. Effective health education in Nigeria must be substantially **localised** to the specific cultural, linguistic, and geographic context of the target community, rather than delivered as a uniform national message.

Traditional beliefs and practices regarding disease causation, appropriate health-seeking behaviour, and the role of traditional healers are powerful determinants of health behaviour in many Nigerian communities, and health education that ignores or dismisses these beliefs is likely to be ineffective or counterproductive. An approach that **engages respectfully** with existing community beliefs, identifying points of alignment with biomedical recommendations and negotiating change from within the community cultural framework rather than against it, is far more likely to produce genuine and sustained behaviour change. **Gender norms** also significantly shape health education dynamics in Nigeria: women, who bear the primary responsibility for child health and household nutrition, may face structural barriers (mobility restrictions, limited decision-making authority, lower literacy) that constrain their ability to act on health education, even when effectively reached by educational messages.

Fill in the blank: Health education that engages _____ with existing community beliefs, identifying points of alignment with biomedical recommendations and negotiating change from within the cultural framework, is more likely to produce genuine behaviour change than education that dismisses traditional beliefs.

1.3.3 Challenges and opportunities for health education in Nigeria

Health education in Nigeria faces significant structural challenges. **Workforce gaps**: despite the central role of CHEWs in health education delivery, many PHC facilities are understaffed, and CHEWs often face excessive clinical workloads that leave insufficient time for the group education and community outreach activities that are nominally part of their mandate. **Resource constraints**: health education materials, audio-visual equipment, and community outreach transportation are chronically underfunded in most LGA PHC budgets, limiting the scope and quality of health education activities. **Literacy barriers**: despite improvements, adult literacy rates remain below 70% in Nigeria, and significant gender and regional disparities exist, meaning that text-based health education materials are inaccessible to large segments of the intended audience, particularly in rural northern states.

Against these challenges, several significant **opportunities** exist. Nigeria large and growing **mobile phone penetration** (with over 180 million active mobile subscriptions as of recent estimates) creates unprecedented reach for digital health education content, particularly through voice calls, SMS, and increasingly WhatsApp and social media platforms accessible even in communities without reliable electricity or internet infrastructure. **Religious institutions** (both Islamic and Christian, which are trusted community anchors across Nigeria diverse regions) represent underutilised channels for health education delivery, with documented examples of religious leaders successfully promoting vaccination uptake, family planning acceptance, and HIV testing when engaged as health education partners. And the **community health volunteer** networks established through various national programmes offer a scalable, low-cost model for extending health education reach to the household level, if adequately trained, supported, and supervised.

Fill in the blank: Nigeria large and growing _____ phone penetration creates unprecedented reach for digital health education content, particularly through SMS, voice calls, and social media platforms accessible even in communities with limited infrastructure.

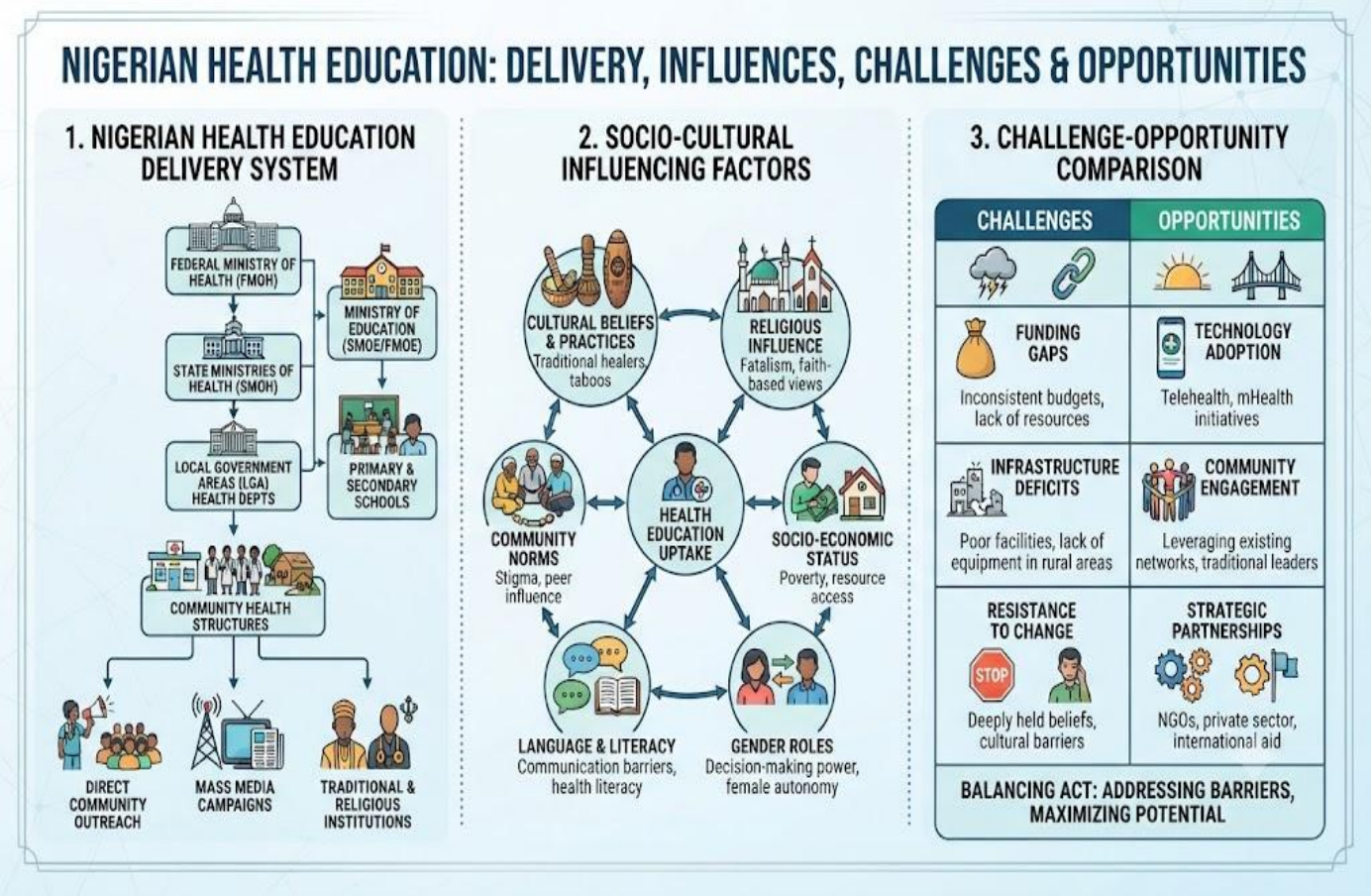

Figure 1.3: Health education in the Nigerian context: actors, factors, and challenges

Pilot questions 1.3

1. Name two national-level institutional actors responsible for health education in Nigeria.
2. Why must health education materials in Nigeria be localised rather than uniformly applied?
3. Name three structural challenges affecting health education delivery in Nigeria.
4. Name two opportunities for expanding health education reach in Nigeria.
5. Why might health education be ineffective when women face gender-based barriers to action?

Series Summary

This Series established the foundations of health education as a discipline. Health education was defined as intentional, learning-experience-based activity aimed at producing informed voluntary behaviour change through the development of health literacy. Its aims were described across the inform-motivate-empower triad and operationalised through the KAP framework of knowledge, attitudes, and practices. The distinction between health education, health promotion, and health advocacy was established as a nested hierarchy, from individual learning (education) to enabling environmental conditions (promotion) to upstream policy and systemic change (advocacy).

The core principles governing health education practice, including credibility, interest, participation, comprehensiveness, reinforcement, and facilitation, were examined alongside the PRECEDE framework for understanding health behaviour determinants. Three major behavioural change models, the Health Belief Model, the Transtheoretical Model, and Social Cognitive Theory, were introduced and their relevance to health education practice explained. The Series concluded by situating health education within the Nigerian public health system, examining the roles of CHEWs, the NHEC, and BCC programmes, and the socio-cultural factors and structural challenges that shape health education practice in Nigeria (SLOs 1.1 to 1.6).

Glossary of Terms

- **Behavioural Change Communication (BCC):** a health education approach using communication to influence individual and collective health behaviours, widely applied in Nigerian disease control programmes.
- **CHEW:** Community Health Extension Worker; the frontline health education workforce in Nigerian PHC facilities.
- **Health advocacy:** the use of influence, communication, and evidence to change policies, systems, and social norms in ways that improve population health.
- **Health Belief Model:** a behavioural change theory proposing that health action is determined by perceived susceptibility, severity, benefits, and barriers, triggered by a cue to action.
- **Health education:** consciously constructed learning experiences designed to improve health literacy and support informed voluntary behaviour change.

- **Health literacy:** the capacity to access, understand, evaluate, and act on health information across a range of contexts.
- **Health promotion:** the broader process of enabling people to increase control over and improve their health, encompassing education, policy, environmental, and community action.
- **KAP framework:** a framework structuring health education objectives around knowledge, attitudes, and practices.
- **PRECEDE framework:** a health behaviour analysis framework identifying predisposing, reinforcing, and enabling causes of health behaviour.
- **Self-efficacy:** an individual belief in their own capability to perform a required health action; a central concept in Social Cognitive Theory.
- **Transtheoretical Model:** a behavioural change theory describing behaviour change as a staged process from precontemplation through contemplation, preparation, action, and maintenance.

Concept Check Questions [Series 1]

Objective questions

1. Health education aims to produce informed voluntary _____ change, influencing choices through education and empowerment rather than coercion. (Linked to SLO 1.1)
2. _____ is the broader concept that encompasses health education but extends to environmental, policy, and organisational change to enable health. (Linked to SLO 1.2)
3. The principle of _____ requires health education to actively involve the community in identifying needs, designing interventions, and evaluating outcomes. (Linked to SLO 1.3)
4. The PRECEDE framework classifies health behaviour determinants as predisposing, _____ , and reinforcing factors. (Linked to SLO 1.4)
5. The Transtheoretical Model describes behaviour change as a _____ rather than a single event, progressing through defined stages. (Linked to SLO 1.5)
6. _____ Health Extension Workers constitute the frontline health education workforce in Nigerian PHC facilities. (Linked to SLO 1.6)

Short-answer questions

7. Explain the KAP framework and its limitation as a guide to health education programme design. (Linked to SLOs 1.1–1.2)
8. Describe the PRECEDE framework and give a Nigerian example illustrating each category of health behaviour determinant. (Linked to SLO 1.4)

Long-answer questions

9. Discuss the major behavioural change models relevant to health education and explain how they guide the design of health education interventions. (Linked to SLOs 1.4–1.5)
10. Evaluate the role, socio-cultural context, and challenges of health education in Nigeria, and identify opportunities for expanding its reach and effectiveness. (Linked to SLO 1.6)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Behaviour.
2. Health promotion.
3. Participation.
4. Enabling.
5. Process.
6. Community.

Short-answer questions

7. The KAP framework structures health education objectives around knowledge (what people know), attitudes (what they feel and value), and practices (what they actually do). Its limitation is the assumption that improving knowledge and attitudes will automatically translate into behaviour change; in reality, numerous enabling and reinforcing factors can prevent behaviour change even when knowledge and attitude objectives are fully met, requiring more comprehensive behavioural models that address the full range of determinants.
8. Predisposing factors: individual knowledge, beliefs, and attitudes facilitating or hindering behaviour; Nigerian example: a mother knowing the WHO recommended exclusive breastfeeding period. Enabling factors: access and skills making behaviour possible; Nigerian example: availability and affordability of ORS sachets in a rural market. Reinforcing factors: social consequences shaping behaviour; Nigerian example: a community health worker praising a mother for completing her child immunisation schedule, reinforcing future health-seeking behaviour.

Long-answer questions

9. **Basic response:** Health Belief Model: perceived susceptibility, severity, benefits, barriers, and cue to action determine health action; applied to malaria prevention by addressing perceived susceptibility to malaria and barriers to bed net use. Transtheoretical Model: stages of change (precontemplation, contemplation, preparation, action, maintenance); directs interventions to stage-specific needs rather than one-size awareness campaigns. Social Cognitive Theory: self-efficacy as central determinant; health education must build practical skill and confidence alongside knowledge and motivation.

   Value-added response: The three models are complementary rather than competing: the Health Belief Model explains what motivates initial consideration of a health action; the Transtheoretical

Model maps where an individual currently stands in the change process and what type of support they need; Social Cognitive Theory explains why individuals who are motivated and at the preparation stage may still not act, due to low self-efficacy. Effective health education programmes use all three insights: assessing barriers and perceived severity (HBM), meeting people at their current stage (TTM), and building practical skill alongside motivation (SCT).

10. **Basic response:** Role: health education embedded in PHC as one of eight essential components; delivered by CHEWs at facility and community level; coordinated nationally by NHEC and Health Education Division; implemented through BCC in disease control programmes. Socio-cultural context: 500+ ethnic groups and linguistic diversity require localisation; traditional health beliefs must be engaged rather than dismissed; gender norms restrict women ability to act even when educated. Challenges: workforce gaps, resource constraints, literacy barriers. Opportunities: mobile phone penetration, trusted religious institutions, community health volunteer networks.

Value-added response: The persistent gap between health education investment and sustained behaviour change in Nigeria reflects a systemic mismatch between the delivery model and the binding constraints on behaviour. Most investment goes into information delivery (BCC campaigns, CHEW training) while enabling factors (ORS availability, bed net supply, affordable health services) that determine whether educated individuals can actually act on what they know remain underfunded. Health education policy in Nigeria needs to address this mismatch explicitly, recognising that education without access is empowerment without tools.

Answers to Pilot Questions [Series 1]

Part 1.1

1. Health education is any combination of learning experiences intentionally designed to help individuals, families, and communities acquire the information and skills needed to make decisions that positively affect their health, aiming for informed voluntary behaviour change.
2. That it is intentional (deliberately designed to achieve health outcomes) and that it aims for informed voluntary behaviour change (through education and empowerment, not coercion).
3. To inform, to motivate, and to empower.
4. Health education focuses specifically on learning experiences building knowledge, skills, and motivation for health. Health promotion is broader, encompassing health education but extending

to environmental, policy, and organisational changes that make it easier for people to adopt healthy behaviours.

5. Any one of: advocating for tobacco control legislation, campaigning for increased PHC funding, lobbying for improved sanitation infrastructure in a community.

Part 1.2

1. Any four of: credibility, interest, participation, comprehensiveness, reinforcement, facilitation.
2. Because enabling factors, particularly access to essential commodities, affordable services, and clean water, may be the binding constraint; even perfectly educated individuals cannot act on health knowledge if the resources or environment needed to do so are unavailable.
3. Predisposing factors, enabling factors, and reinforcing factors.
4. The Health Belief Model proposes that a person will take a health action when they perceive themselves as susceptible to a health threat, believe it is serious, believe the action will reduce the threat, and believe benefits outweigh barriers, triggered by a cue to action. Applied to malaria: a community education session that increases perceived susceptibility to malaria, emphasises severity, demonstrates the benefits of bed net use, and removes cost barriers could function as the cue to action needed for net adoption.
5. Self-efficacy adds the recognition that even motivated individuals who know what action to take may not act if they lack confidence in their ability to perform it; health education must therefore build practical skill and confidence alongside knowledge and motivation.

Part 1.3

1. Any two of: the Health Education Division of the Federal Ministry of Health, the National Health Education Council (NHEC), the NPHCDA (coordinating health education through PHC).
2. Because Nigeria has over 500 ethnic groups and hundreds of languages; messages in English or a major language may not reach communities whose primary health communication language is a local dialect, and culturally inappropriate assumptions in centrally produced materials can alienate audiences with different cultural contexts.

3. Any three of: CHEWs being understaffed and over-burdened with clinical work; chronic underfunding of health education materials and outreach transportation; adult literacy barriers making text-based materials inaccessible in some communities.
4. Any two of: mobile phone penetration (SMS, voice calls, social media); trusted religious institutions as health education delivery channels; community health volunteer networks for household-level outreach.
5. Because health education builds knowledge and motivation, but if women face structural barriers such as mobility restrictions, limited decision-making authority, or lower literacy, they are unable to act on what they have learned, making even effective educational messages ineffective in changing health outcomes for this group.

References and Attributions [Series 1]

Textual references

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- Green, L. W., & Kreuter, M. W. (2005). Health program planning: An educational and ecological approach (4th ed.). McGraw-Hill.
- Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2015). Health behavior: Theory, research, and practice (5th ed.). Jossey-Bass.
- National Open University of Nigeria (NOUN). (2023). Health education and health advocacy course material. NOUN Press.

Figures, Plates, Tables, and Boxes

- Figure 1.1: Health education, health promotion, and health advocacy: a nested relationship
  Attribution: AI generated using prompt "Generate a nested circle diagram showing health advocacy, health promotion, and health education as progressively innermost circles with descriptions." Suggested OER search string: "health education health promotion health advocacy nested relationship Ottawa Charter OER"

- Figure 1.2: Behavioural change models in health education Attribution: AI generated using prompt "Generate a three-panel diagram showing the Health Belief Model, the Transtheoretical Model stages of change staircase, and Social Cognitive Theory with self-efficacy." Suggested OER search string: "Health Belief Model Transtheoretical Model stages of change Social Cognitive Theory self-efficacy health education OER"
- Figure 1.3: Health education in the Nigerian context: actors, factors, and challenges Attribution: AI generated using prompt "Generate a three-panel diagram showing the Nigerian health education delivery system, socio-cultural influencing factors, and a challenge-opportunity comparison." Suggested OER search string: "Nigeria health education CHEW PHC cultural factors challenges opportunities digital health BCC OER"

Course code: COM 403

Course title: Health Education and Health Advocacy

Course credit load: 1 Unit

Series 2: Roles in Health Education

- **Part 2.1: The Health Educator and Core Roles**
  - Sub Part 2.1.1: Who is a health educator?
  - Sub Part 2.1.2: Core competencies of the health educator
  - Sub Part 2.1.3: Professional and ethical responsibilities
- **Part 2.2: Roles of Key Actors in Health Education Delivery**
  - Sub Part 2.2.1: The role of community health extension workers
  - Sub Part 2.2.2: The role of health facility staff and other health professionals
  - Sub Part 2.2.3: The role of community leaders, volunteers, and the media
- **Part 2.3: Interpersonal Communication Skills in Health Education**
  - Sub Part 2.3.1: The communication process in health education
  - Sub Part 2.3.2: Active listening, questioning, and rapport-building
  - Sub Part 2.3.3: Barriers to communication and how to overcome them

Introduction

Health education does not happen by itself. Behind every community outreach session, every bedside counselling conversation, and every radio health programme is a person who has chosen

to play a health educator role, bringing knowledge, skill, and ethical commitment to the task of enabling others to improve their health. Understanding who fills these roles, what competencies they require, and how they communicate effectively is as essential to health education practice as understanding the theoretical models examined in Series 1.

The aim of this Series is to define the health educator role, describe the competencies and ethical responsibilities it demands, examine the specific roles of the key actors who deliver health education in the Nigerian context, and develop the interpersonal communication skills that are the practical foundation of all face-to-face health education encounters.

We shall commence by examining who qualifies as a health educator and the core competencies and ethical responsibilities the role demands. Next, we will examine the specific health education roles of CHEWs, other health professionals, community leaders, volunteers, and the media. Finally, we will close by examining the communication process in health education, with particular attention to the interpersonal skills of active listening, questioning, and rapport-building, and to overcoming barriers to effective communication.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 2.1** define the health educator role and describe the core competencies it requires,
- **SLO 2.2** explain the professional and ethical responsibilities of the health educator,
- **SLO 2.3** describe the health education roles of CHEWs, other health professionals, community leaders, volunteers, and the media,
- **SLO 2.4** explain the communication process as it applies to health education,
- **SLO 2.5** demonstrate active listening, questioning, and rapport-building skills in a health education context, and
- **SLO 2.6** identify barriers to effective health education communication and describe strategies for overcoming them.

2.1 The Health Educator and Core Roles

2.1.1 Who is a health educator?

A **health educator** is any individual who intentionally facilitates learning experiences designed to improve the health knowledge, attitudes, and practices of individuals, groups, or communities. In the formal sense, this includes trained and accredited professionals, such as community health educators, public health officers, and health promotion specialists, who hold recognised qualifications in health education and whose primary professional function is to design and deliver health education programmes. In the broader, functional sense, health education is delivered by a much wider range of actors whose primary role is not specifically health education but who carry significant health education responsibilities as part of their professional function: doctors and nurses during patient consultations, teachers delivering the school health curriculum, CHEWs conducting community outreach, and religious leaders incorporating health messages into sermons.

In Nigeria, the **National Health Education Council (NHEC)** is the professional regulatory body responsible for setting and enforcing standards for health education practice, registering qualified health educators, and accrediting health education training programmes. Professionally, a registered health educator in Nigeria holds at minimum a diploma or degree in health education or a closely related field and has fulfilled the NHEC registration requirements. However, the reality of Nigerian health education delivery means that the broadest and most consistent health education contact with communities occurs not through NHEC-registered specialists but through the much larger cadre of CHEWs, community health officers, and community health volunteers who are trained and supervised to deliver defined health education content as part of their broader community health mandate.

Fill in the blank: The National _____ Education Council (NHEC) is the professional regulatory body responsible for setting standards for health education practice and registering qualified health educators in Nigeria.

2.1.2 Core competencies of the health educator

Health education competencies span several domains. **Needs assessment**: the ability to systematically identify the health education needs of a target population, through community diagnosis methods, KAP surveys, and participatory needs assessment processes, ensuring that educational interventions address real and felt needs rather than assumed priorities. **Programme planning**: the ability to design health education programmes with clear, measurable objectives, appropriate educational methods, suitable resources, and a realistic implementation timeline (examined in depth in Series 4). **Implementation**: the ability to deliver health education using a range of methods and media (Series 3) appropriately matched to the target audience, the educational objectives, and the available resources.

Evaluation: the ability to assess whether health education activities have achieved their intended knowledge, attitude, and behaviour change objectives, using appropriate data collection tools and methods (Series 5). **Communication**: the ability to convey health information clearly and persuasively to diverse audiences, adapting message, language, and style to the specific cultural, educational, and health literacy characteristics of each group (examined in detail in Part 2.3). **Advocacy**: the ability to represent community health needs to decision-makers and to mobilise social, political, and resource support for health education interventions. And **coordination**: the ability to work effectively with other health professionals, community organisations, and government agencies to integrate health education into broader health and development programmes, avoiding the fragmented, isolated health education events that produce limited sustained impact.

Fill in the blank: _____ assessment is the health education competency that involves systematically identifying the health education needs of a target population to ensure interventions address real and felt needs rather than assumed priorities.

2.1.3 Professional and ethical responsibilities

Health educators carry a distinctive set of ethical responsibilities arising from the power asymmetry inherent in the educator-learner relationship. The principle of **autonomy** requires that health educators respect the individual right to make their own health decisions, even when those

decisions differ from biomedical recommendations; the goal of health education is to enable informed decision-making, not to coerce compliance through fear, shame, or social pressure. **Beneficence** requires that health education programmes genuinely benefit the populations they serve, including the obligation to avoid programmes that raise anxiety without providing actionable guidance, or that promise benefits the programme cannot realistically deliver.

Non-maleficence extends to avoiding stigmatisation of individuals or communities through health education messages that, however unintentionally, attribute blame for disease to personal failings or cultural practices, a particular risk in health education about HIV, tuberculosis, and mental health in the Nigerian context. **Confidentiality** is essential in individual health education encounters (counselling sessions, patient education), where personal health information disclosed in the learning context must be protected. **Cultural competence** is an ethical as well as a practical requirement: health educators have an obligation to deliver services that are sensitive to and respectful of the cultural values of the communities they serve, rather than imposing an externally derived, culturally alien framework on health knowledge and practice. **Accountability** requires health educators to be answerable for the quality and outcomes of their work, including reporting honestly about programme limitations and failures as well as successes.

Fill in the blank: The principle of _____ requires that health educators respect the individual right to make their own health decisions, even when those decisions differ from biomedical recommendations, since health education aims to enable informed choice, not coerce compliance.

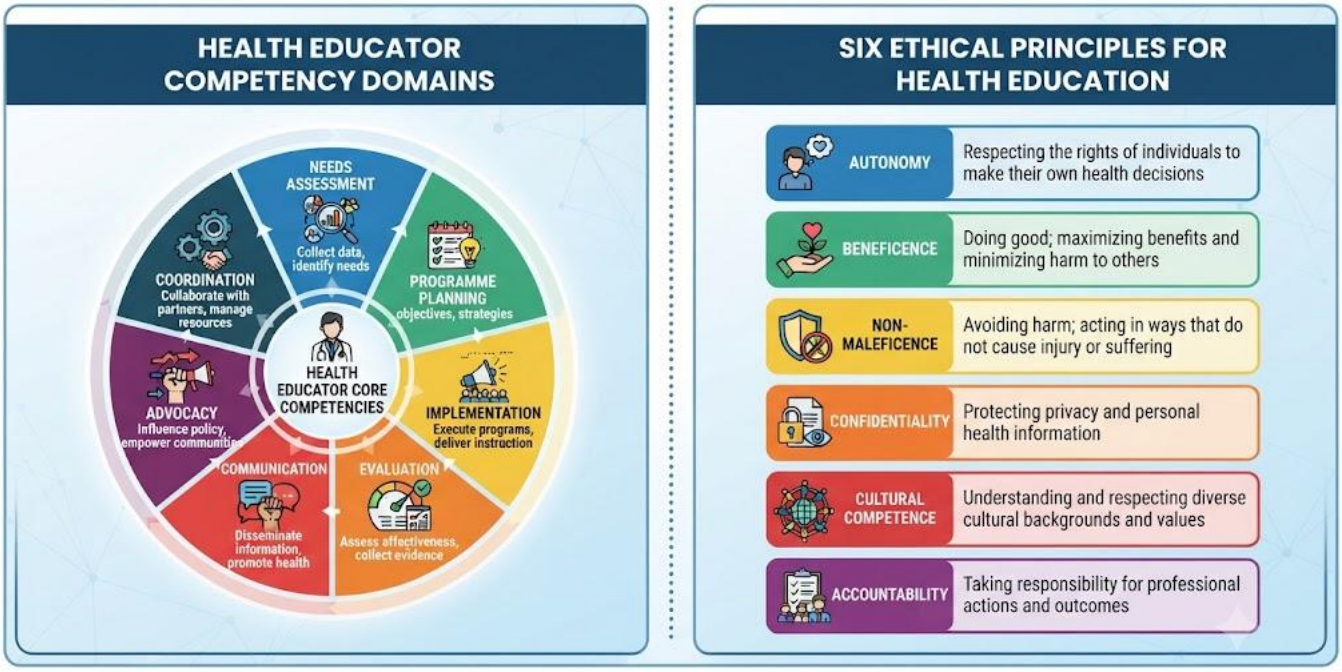

Figure 2.1: Health educator competencies and ethical principles

Figure 2.1: Health educator competencies and ethical principles

Pilot questions 2.1

1. Distinguish between a health educator in the formal and the functional sense.
2. What is the role of the NHEC in Nigeria?
3. Name five core competency domains of the health educator.
4. What does the principle of autonomy require of a health educator?
5. Why is non-maleficence a particularly important ethical principle in Nigerian health education?

2.2 Roles of Key Actors in Health Education Delivery

2.2.1 The role of community health extension workers

Community Health Extension Workers (CHEWs) are the backbone of health education delivery in the Nigerian PHC system. Trained at the School of Health Technology level over a three-year programme, CHEWs are specifically equipped to deliver the health education and community mobilisation functions that constitute a major component of their professional mandate. Their health education roles include: **individual and family counselling** during facility contacts (antenatal visits, immunisation sessions, growth monitoring) on topics including nutrition, breastfeeding, family planning, malaria prevention, and HIV; **group health education** conducted at facility health education sessions, community gatherings, schools, and women groups using a range of facilitation techniques; and **community mobilisation** (examined further in the PHC course) to stimulate community awareness and action on priority health issues, including immunisation campaigns, sanitation drives, and maternal health promotion.

CHEWs also carry **supervisory responsibilities** for Community Health Influencers, Promoters, and Services (CHIPS) agents and other community health volunteers, providing training, material support, and quality oversight for the community-level health education delivered by these lay volunteers. Junior Community Health Extension Workers (JCHEWs) work under CHEW supervision and carry a narrower but complementary health education role, particularly in reaching households and sub-ward communities that the CHEW does not cover directly. The CHEW cadre, despite its central role, faces significant capacity constraints: heavy clinical workloads, limited refresher training opportunities, and insufficient supply of up-to-date health education materials frequently undermine the quality and quantity of health education that CHEWs can deliver in practice.

Fill in the blank: CHEWs are trained at the School of _____ Technology level and are specifically equipped to deliver health education and community mobilisation as a major component of their professional mandate.

2.2.2 The role of health facility staff and other health professionals

Beyond CHEWs, every member of the health care team carries health education responsibilities, even if health education is not their primary professional function. **Nurses and midwives** deliver bedside and group health education on medication adherence, wound care, maternal nutrition, exclusive breastfeeding, and neonatal care; the nursing model of patient education is among the most consistently delivered health education in the Nigerian health system, occurring at every inpatient and many outpatient contacts. **Doctors and clinical officers** provide patient education during consultations, including explaining diagnoses, treatment options, and behavioural recommendations, and their authority lends significant credibility to health education messages even when delivery time is brief.

Pharmacists provide essential medication counselling and adherence support, extending health education to the point of drug dispensing. **Laboratory scientists** explain the purpose and results of diagnostic tests, contributing to patient understanding of their health status. **Dietitians and nutritionists** provide specialised dietary counselling. **Environmental health officers** deliver health education on sanitation, food safety, and environmental hazards in the community setting. The integration of health education across all these professional roles requires shared awareness of health education principles and a culture that values educational encounters rather than treating them as lower-priority tasks to be compressed or skipped under time pressure, a cultural shift that leadership at facility level must actively promote rather than assume will occur spontaneously.

Fill in the blank: _____ and midwives deliver bedside and group health education on topics including medication adherence, maternal nutrition, and exclusive breastfeeding, representing among the most consistently delivered health education in the Nigerian health system.

2.2.3 The role of community leaders, volunteers, and the media

Community leaders (traditional rulers, religious leaders, women group leaders, and local elected officials) serve as powerful health education actors in their own right. Their endorsement of health messages lends cultural and social legitimacy that external health workers often cannot replicate; their access to community members through regular religious services, community

meetings, and traditional gatherings provides frequent, trusted channels for health communication. Engaging community leaders as active health education partners, rather than simply as gatekeepers to be negotiated with during programme entry, is a hallmark of effective community-based health education in Nigeria, demonstrated clearly in successful immunisation and family planning programmes where religious and traditional leader involvement has produced measurable uptake gains.

Community health volunteers (including CHIPS agents, village health workers, and a variety of programme-specific volunteer cadres established by national disease control programmes) extend health education reach to the household and individual level, providing the consistent, sustained, interpersonal contact that changes health behaviour more reliably than single-exposure mass communication. **The media** (including national and community radio, television, print media, and increasingly social and digital media platforms) plays a complementary role in health education, reaching large audiences simultaneously and reinforcing messages from interpersonal health education encounters. Radio is particularly important in Nigeria, given its widespread reach including in communities with limited literacy and electricity, and community radio stations have demonstrated the capacity to deliver locally relevant, culturally appropriate health education content in minority languages that national media cannot serve.

Fill in the blank: Community _____ volunteers extend health education reach to the household and individual level, providing the consistent, sustained, interpersonal contact that changes health behaviour more reliably than single-exposure mass communication.

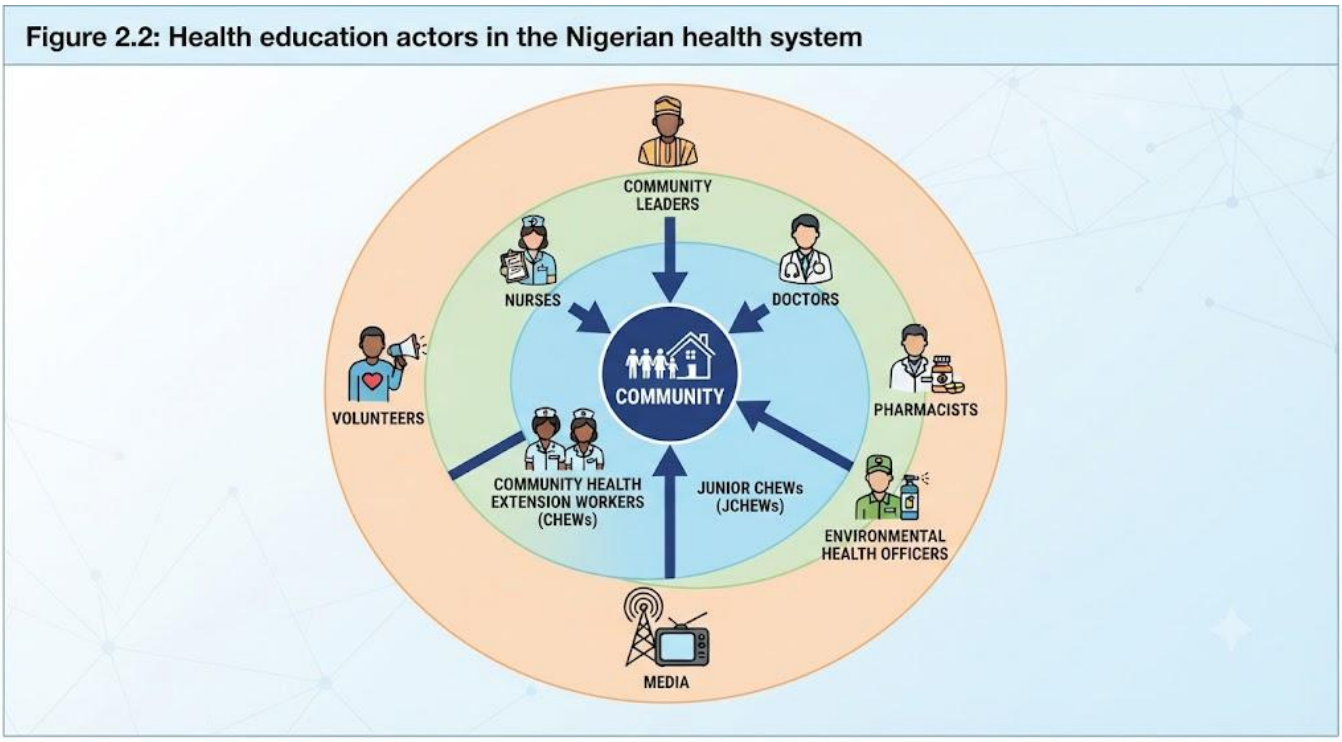

Figure 2.2: Health education actors in the Nigerian health system

Pilot questions 2.2

1. Name three specific health education activities that CHEWs carry out.
2. What supervisory health education role do CHEWs play in relation to community health volunteers?
3. Name four categories of health professionals who carry health education responsibilities beyond CHEWs.
4. Why are community leaders particularly powerful health education actors in Nigeria?
5. Why is radio especially important as a health education medium in Nigeria?

2.3 Interpersonal Communication Skills in Health Education

2.3.1 The communication process in health education

Communication is the foundation of all face-to-face health education. The **communication process** in health education involves a **sender** (the health educator, with a message to convey), a **message** (the health information, skills, or motivation to be transmitted), a **channel** (the medium through which the message is conveyed: face-to-face speech, written material, visual aid, radio, etc.), a **receiver** (the individual, group, or community being educated), and **feedback** (the response of the receiver that tells the sender whether the message was received and understood as intended). In health education, the communication process is bidirectional and iterative: a skilled health educator continuously monitors receiver responses and adjusts message, channel, and style accordingly, rather than delivering a pre-fixed message regardless of how the audience is receiving it.

Noise in communication theory refers to any factor that distorts or disrupts message transmission or reception: physical noise (a loud environment making speech inaudible), semantic noise (technical jargon unfamiliar to the receiver), cultural noise (assumptions embedded in the message that do not align with the receiver cultural context), and psychological noise (receiver anxiety, distrust, or pre-existing beliefs that interfere with accurate message reception). Understanding and minimising noise in the health education communication process is a core practical skill, since health education settings, particularly community group sessions conducted in noisy market spaces or health facility waiting rooms, routinely present multiple simultaneous noise sources that the skilled educator must recognise and manage.

Fill in the blank: _____ in communication theory refers to any factor that distorts or disrupts message transmission or reception, including physical, semantic, cultural, and psychological sources.

2.3.2 Active listening, questioning, and rapport-building

Active listening is one of the most important and most undervalued skills in health education practice. Active listening involves giving the learner full, focused attention; demonstrating

understanding through verbal acknowledgements and non-verbal cues (nodding, appropriate eye contact, body posture oriented toward the speaker); **reflecting** the content or feeling of what has been said back to the speaker to confirm understanding ("It sounds like you are worried that the vaccine might have side effects; can you tell me more?"); and **withholding judgement** while listening, resisting the impulse to correct, dismiss, or counter the learner perspective before fully understanding it. Active listening is particularly important in health education because community members frequently hold beliefs about disease and health that differ from biomedical perspectives; dismissing these beliefs without first fully hearing and understanding them is both ethically problematic and practically counterproductive, as demonstrated by the principle of engagement established in Series 1.

Questioning is the primary tool for assessing understanding, identifying misconceptions, tailoring educational content, and encouraging reflection. **Open questions** (beginning with what, how, why, tell me about) invite extended responses and reveal the learner knowledge, beliefs, and concerns in their own words; they are the primary questioning tool for needs assessment and for understanding the learner perspective before educational content is delivered. **Closed questions** (answerable with yes, no, or a brief factual response) are useful for confirming specific facts or checking comprehension of specific points. **Rapport-building** is the process of establishing a relationship of trust and mutual respect that makes the learner feel safe enough to disclose real concerns, ask apparently "foolish" questions, and engage honestly with educational content, rather than performing expected answers for the authority figure that the health educator represents.

Fill in the blank: _____ questions, beginning with what, how, why, or "tell me about," invite extended responses that reveal the learner knowledge, beliefs, and concerns in their own words, making them the primary tool for needs assessment in health education encounters.

2.3.3 Barriers to communication and how to overcome them

Effective health education communication is undermined by a range of barriers that a skilled health educator must anticipate and actively manage. **Language barriers** (the educator and learner do not share a common language of comfort) require the use of trained interpreters or co-

facilitators from the community, and the development of health education materials in local languages; hasty, inaccurate translation or the use of English-language materials in communities where English is not a language of daily communication can produce serious misunderstanding of health information with direct clinical consequences. **Literacy barriers** require the use of visual, oral, and demonstration-based educational methods rather than reliance on written materials, a particularly important adaptation in the Nigerian rural and northern context where adult literacy rates may be substantially below the national average.

Cultural barriers (the health message conflicts with existing cultural beliefs or practices) require the engagement, bridge-building, and negotiation approach described in Part 1.3.2 of Series 1, rather than simple repetition of a culturally alien message. **Status and authority barriers** arise when learners perceive the health educator as socially superior and therefore feel unable to ask questions or disclose real concerns, particularly problematic in health facility settings where patients may withhold information from clinicians they perceive as authority figures; warm, non-judgmental communication style, active listening, and the deliberate equalisation of the encounter (seating arrangements, welcoming questions, expressing respect for the learner knowledge) can substantially reduce this barrier. **Emotional barriers** (fear, denial, shame, or grief) require the health educator to acknowledge and validate the emotional response before delivering educational content, since emotionally overwhelmed learners cannot effectively process new information.

Fill in the blank: _____ barriers arise when learners perceive the health educator as socially superior and feel unable to ask questions or disclose real concerns, requiring a warm, non-judgmental communication style and deliberate equalisation of the encounter.

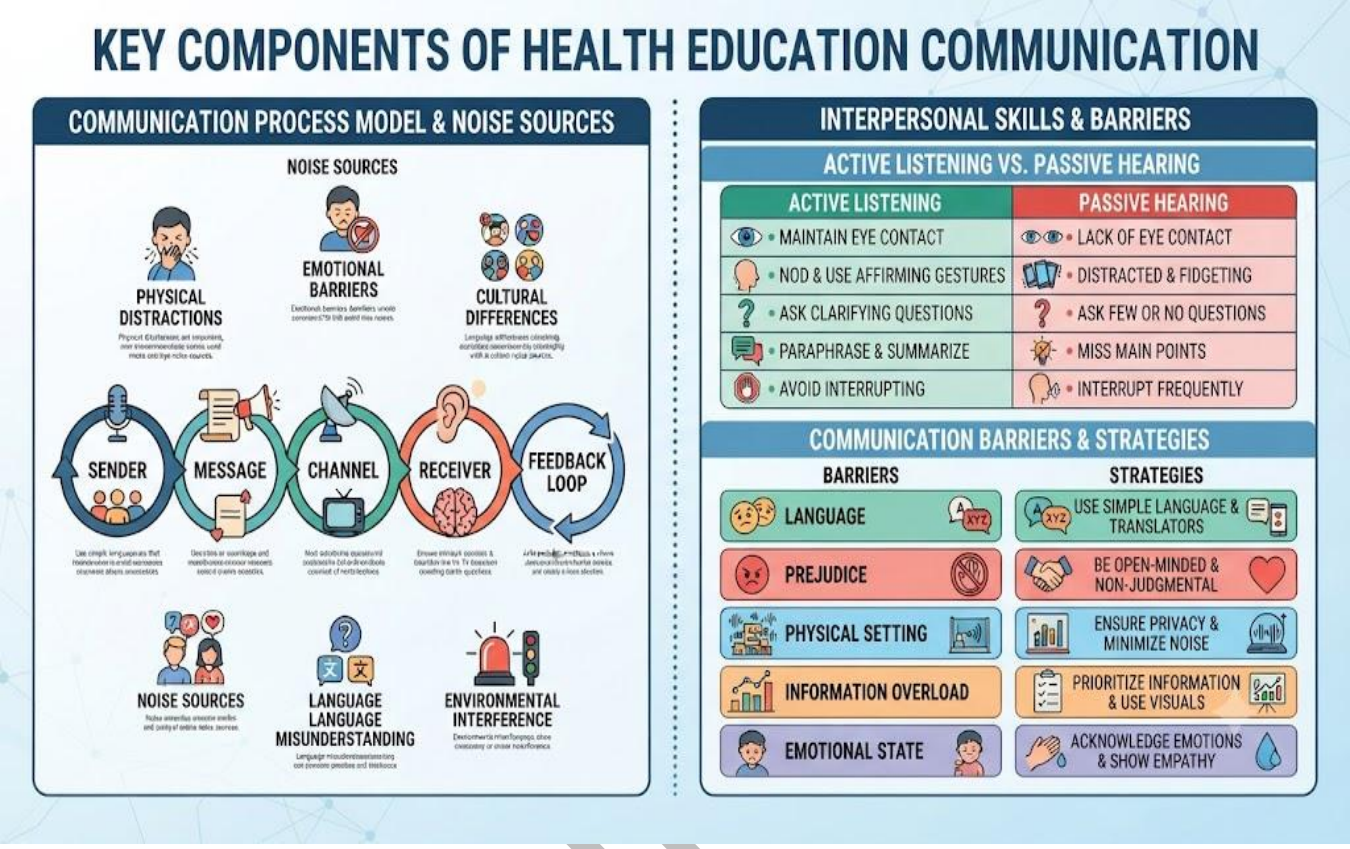

Figure 2.3: The health education communication process and interpersonal skills

Pilot questions 2.3

1. Name the five elements of the communication process in health education.
2. What is "noise" in the communication process and name three types.
3. Describe three behaviours that characterise active listening.
4. Distinguish between open and closed questions in health education encounters.
5. Name three types of communication barrier and one strategy for overcoming each.

Series Summary

This Series examined the roles and communication skills central to health education practice. The health educator role was defined in both formal (professionally accredited) and functional (any actor delivering health education) senses, with the NHEC established as the Nigerian professional regulatory body. Seven core competency domains, from needs assessment through advocacy and coordination, and six ethical principles, from autonomy to accountability, were examined as the professional and ethical framework governing health education practice. The specific health education roles of CHEWs, nurses, doctors, pharmacists, community leaders, volunteers, and the media were described within the Nigerian health system context.

The communication process in health education was examined through its five elements (sender, message, channel, receiver, feedback) and the sources of noise that disrupt effective transmission. Active listening, open and closed questioning, and rapport-building were established as the core interpersonal communication skills of face-to-face health education, and the major communication barriers of language, literacy, culture, status, and emotion were examined alongside specific strategies for overcoming each. Together, the principles of Series 1 and the roles and skills of this Series provide the conceptual and practical foundation for the methods, planning, and evaluation content examined in the remaining Series of this course (SLOs 2.1 to 2.6).

Glossary of Terms

1. **Active listening:** a communication skill involving focused attention, verbal and non-verbal acknowledgement, reflection, and withholding of judgement while the learner speaks.
2. **Autonomy:** the ethical principle requiring health educators to respect an individual right to make their own informed health decisions.

3. **CHIPS agent:** Community Health Influencer, Promoter, and Service agent; a lay community health volunteer supervised by CHEWs to extend health education to households.

4. **Cultural competence:** the ethical and practical obligation to deliver health education that is sensitive to and respectful of the cultural values of the communities served.

5. **Health educator:** any individual who intentionally facilitates learning experiences designed to improve health knowledge, attitudes, and practices of individuals, groups, or communities.

6. **NHEC:** National Health Education Council; the professional regulatory body for health education practice in Nigeria.

7. **Noise:** any factor that distorts or disrupts message transmission or reception in the communication process, including physical, semantic, cultural, and psychological sources.

8. **Open question:** a question beginning with what, how, why, or "tell me about," inviting extended responses that reveal the learner knowledge and concerns.

9. **Rapport-building:** the process of establishing a relationship of trust and mutual respect that enables honest, engaged participation in a health education encounter.

10. **Status barrier:** a communication barrier arising when learners perceive the health educator as socially superior and feel unable to ask questions or disclose real concerns.

Concept Check Questions [Series 2]

Objective questions

- The National _____ Education Council (NHEC) is the professional regulatory body for health education practice in Nigeria. (Linked to SLO 2.1)
- _____ assessment is the health educator competency involving systematic identification of a target population health education needs. (Linked to SLO 2.1)
- The principle of _____ requires health educators to respect the individual right to make their own health decisions. (Linked to SLO 2.2)
- CHEWs are trained at the School of _____ Technology level and deliver individual, group, and community health education. (Linked to SLO 2.3)
- _____ questions, beginning with what, how, or why, invite extended responses revealing the learner knowledge and concerns. (Linked to SLO 2.5)
- _____ barriers arise when learners perceive the health educator as socially superior and feel unable to ask questions or disclose real concerns. (Linked to SLO 2.6)

Short-answer questions

- Describe five core competency domains of the health educator and explain why coordination is important. (Linked to SLO 2.1)
- Explain the communication process in health education and describe the impact of noise on health education delivery. (Linked to SLO 2.4)

Long-answer questions

- Discuss the roles of the various actors in health education delivery in Nigeria, explaining how they complement each other. (Linked to SLO 2.3)
- Evaluate the interpersonal communication skills required for effective health education, covering active listening, questioning, rapport-building, and overcoming communication barriers. (Linked to SLOs 2.5–2.6)

Answers to Concept Check Questions [Series 2]

Objective questions

1. Health.
2. Needs.
3. Autonomy.
4. Health.
5. Open.
6. Status.

Short-answer questions

7. Needs assessment (identifying population health education needs), programme planning (designing interventions with clear objectives), implementation (delivering using appropriate methods), evaluation (assessing outcomes), communication (conveying information to diverse audiences), advocacy (representing community health needs), coordination (working with other actors). Coordination is important because isolated, fragmented health education events produce limited sustained impact; integration with broader health and development programmes multiplies reach and reinforces messages across multiple channels and occasions.
8. The communication process involves a sender (health educator), message (health information to convey), channel (medium of transmission), receiver (individual or community being educated), and feedback (receiver response confirming receipt and understanding). Noise is any factor distorting transmission: physical noise (a loud environment), semantic noise (technical jargon), cultural noise (culturally misaligned assumptions), and psychological noise (receiver anxiety or pre-existing beliefs). Noise can prevent the intended message from being accurately received and understood, and a skilled health educator must recognise and actively manage noise sources.

Long-answer questions

9. **Basic response:** CHEWs: backbone of PHC health education delivery; individual counselling, group sessions, community mobilisation, supervision of CHIPS agents. Nurses and midwives: bedside and group education at every patient contact (medication adherence, maternal health). Doctors: patient education during consultations, lend authority to messages. Pharmacists: medication counselling and adherence. Environmental health officers: sanitation and food safety education. Community leaders: cultural legitimacy, trusted channels through religious services and community gatherings. Community health volunteers: household-level interpersonal contact for sustained behaviour change. Media (especially radio): mass reach, reinforcement of interpersonal messages, local language delivery.

Value-added response: These actors form a complementary system rather than substitutes for each other. Mass media (radio) can raise awareness and set agendas across large populations simultaneously, but cannot achieve the interpersonal engagement that produces lasting behaviour change; community leaders can open doors and lend legitimacy, but cannot replace the technical knowledge that CHEWs and clinical staff bring; CHEWs can deliver consistent health education to facility attendees, but cannot reach the households that never attend the facility without community volunteers. Effective health education programmes explicitly map which actor reaches which segment of the population and ensure the combined system leaves no significant gap.

10. **Basic response:** Active listening: full attention, verbal and non-verbal acknowledgement, reflecting content and feeling, withholding judgement; enables the health educator to understand the learner real concerns and existing beliefs before delivering educational content. Open questions: reveal learner knowledge and concerns in own words, essential for needs assessment in individual encounters. Closed questions: confirm specific facts or comprehension of key points. Rapport-building: establishes trust and safety for honest disclosure. Barriers and strategies: language (use trained interpreters, local language materials), literacy (visual and demonstration-based methods), cultural (respectful engagement, bridge-building), status (warm non-judgmental style, equalise encounter), emotional (acknowledge and validate before education).

Value-added response: The most common health education communication failure in Nigerian practice is not lack of technical knowledge but failure of interpersonal process: health educators who lecture rather than converse, who fail to assess what the learner already knows and believes before delivering pre-packaged content, who use language and literacy-level inappropriate materials, and who do not create sufficient safety for honest disclosure, are delivering information rather than health education. Developing genuine interpersonal communication skill requires practice, reflection, and supervision, not only theoretical knowledge of the principles described here.

Answers to Pilot Questions [Series 2]

Part 2.1

6. In the formal sense, a health educator is a trained, accredited professional whose primary function is health education. In the functional sense, health education is delivered by a much wider range of actors (nurses, CHEWs, community leaders) who carry health education responsibilities as part of a broader professional or community role.
7. The NHEC sets and enforces standards for health education practice, registers qualified health educators, and accredits health education training programmes in Nigeria.
8. Any five of: needs assessment, programme planning, implementation, evaluation, communication, advocacy, coordination.
9. Autonomy requires that the health educator respect the individual right to make their own health decisions even when those decisions differ from biomedical recommendations, aiming to enable informed voluntary choice rather than coercing compliance.
10. Because health education messages about HIV, tuberculosis, and mental health carry particular risks of stigmatising individuals or communities by attributing disease to personal failings or cultural practices, and such stigmatisation causes direct harm to the individuals affected while undermining trust in health services.

Part 2.2

11. Any three of: individual and family counselling during facility contacts, group health education sessions, community mobilisation activities, supervision of CHIPS agents and community health volunteers.
12. CHEWs provide training, material support, and quality oversight for the community-level health education delivered by CHIPS agents and other community health volunteers working below the facility level.
13. Any four of: nurses and midwives, doctors and clinical officers, pharmacists, laboratory scientists, dietitians and nutritionists, environmental health officers.

14. Because their endorsement of health messages lends cultural and social legitimacy that external health workers often cannot replicate, and their regular access to community members through religious services, community meetings, and traditional gatherings provides frequent, trusted channels for health communication.
15. Because radio has widespread reach including in communities with limited literacy and electricity, community radio can deliver locally relevant and culturally appropriate content in minority languages, and it reinforces messages from interpersonal health education encounters across large populations simultaneously.

Part 2.3

1. Sender, message, channel, receiver, and feedback.
2. Noise is any factor that distorts or disrupts message transmission or reception. Three types: physical noise (environmental sounds making speech inaudible), semantic noise (technical jargon unfamiliar to the receiver), cultural noise (culturally misaligned assumptions embedded in the message).
3. Any three of: giving the learner full, focused attention; demonstrating understanding through verbal acknowledgements and appropriate non-verbal cues; reflecting the content or feeling of what has been said back to the speaker; withholding judgement while listening.
4. Open questions (beginning with what, how, why, or tell me about) invite extended responses revealing the learner knowledge, beliefs, and concerns. Closed questions (answerable with yes, no, or a brief factual response) confirm specific facts or check comprehension of particular points.
5. Language barrier (strategy: trained interpreters, local language materials); literacy barrier (strategy: visual, oral, and demonstration-based methods); status barrier (strategy: warm non-judgmental style, deliberate equalisation of the encounter).

References and Attributions [Series 2]

Textual references

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7. Ewles, L., & Simnett, I. (2003). Promoting health: A practical guide (5th ed.). Bailliere Tindall.
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9. National Open University of Nigeria (NOUN). (2023). Health education and health advocacy course material. NOUN Press.

Figures, Plates, Tables, and Boxes

11. Figure 2.1: Health educator competencies and ethical principles Attribution: AI generated using prompt "Generate a two-panel diagram showing health educator competency domains in a wheel and six ethical principles with brief definitions." Suggested OER search string: "health educator competencies needs assessment planning evaluation ethics autonomy cultural competence OER"
12. Figure 2.2: Health education actors in the Nigerian health system Attribution: AI generated using prompt "Generate a tiered diagram of health education actors in the Nigerian health system with the community at the centre and three surrounding tiers." Suggested OER search string: "health education actors Nigeria CHEW nurses community leaders volunteers media tiers PHC OER"
13. Figure 2.3: The health education communication process and interpersonal skills Attribution: AI generated using prompt "Generate a two-panel diagram showing the health education communication process with noise sources and a comparison of active listening versus passive hearing with barrier-strategy pairs." Suggested OER search string: "health education communication process active listening questioning barriers noise sender receiver OER"

Course code: COM 403

Course title: Health Education and Health Advocacy

Course credit load: 1 Unit

Series 3: Methods and Media in Health Education

- **Part 3.1: Classification of Health Education Methods**
  - Sub Part 3.1.1: Individual methods
  - Sub Part 3.1.2: Group methods
  - Sub Part 3.1.3: Mass methods
- **Part 3.2: Selection and Use of Health Education Media**
  - Sub Part 3.2.1: Classification of health education media
  - Sub Part 3.2.2: Criteria for selecting appropriate media
  - Sub Part 3.2.3: Developing and pretesting health education materials
- **Part 3.3: Applying Methods and Media in the Nigerian Context**
  - Sub Part 3.3.1: Combining methods and media for maximum effect
  - Sub Part 3.3.2: Traditional and digital media in Nigerian health education
  - Sub Part 3.3.3: Selecting methods and media for specific Nigerian audiences

Introduction

Knowing what to teach and who should teach it, established in the preceding two Series, is only part of health education practice. The third critical question is how to teach it: which combination of methods and media will most effectively convey the intended message to the specific audience, within the practical constraints of the setting. A health education session delivered using inappropriate methods, however well-prepared its content, will produce far less behaviour change than one in which method and media are carefully matched to the audience, the learning objectives, and the cultural and resource context.

The aim of this Series is to describe the major methods of health education, classify the media available to support health education delivery, examine the criteria for selecting appropriate methods and media, and apply this knowledge to the specific audiences, settings, and resource contexts encountered in Nigerian health education practice.

We shall commence by classifying health education methods into individual, group, and mass approaches, examining the strengths and limitations of each. Next, we will classify health education media and examine the criteria and process for selecting and developing appropriate materials. Finally, we will close by examining how methods and media are combined and adapted for specific audiences and contexts in Nigeria.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 3.1** classify health education methods into individual, group, and mass approaches and describe examples of each,
- **SLO 3.2** explain the strengths and limitations of individual, group, and mass health education methods,
- **SLO 3.3** classify health education media and explain the criteria for selecting appropriate media,

- **SLO 3.4** describe the process of developing and pretesting health education materials,
- **SLO 3.5** explain the principles of combining methods and media for maximum health education impact, and
- **SLO 3.6** select appropriate methods and media for specific audiences and settings in the Nigerian context.

3.1 Classification of Health Education Methods

3.1.1 Individual methods

Individual health education methods involve one-to-one interaction between the health educator and a single learner or client. The primary individual method is **health counselling**: a structured, client-centred conversation designed to help the individual understand their health situation, explore their concerns and motivations, and reach their own informed decision about a health action. Counselling is distinguished from health advice-giving by its participatory nature: the counsellor listens, reflects, and guides rather than lecturing, embodying the active listening and questioning skills examined in Series 2. Counselling is the method of choice for sensitive topics where privacy is essential (HIV testing and counselling, family planning, mental health) and for tailoring health education to the specific knowledge gaps, beliefs, and circumstances of the individual.

Home visits extend individual health education to the client own environment, allowing the health educator to assess actual living conditions, observe health practices directly (rather than relying on self-report), and provide education that is directly relevant to the specific context of the household. Home visits are particularly effective for antenatal follow-up, postnatal care support, defaulter tracing for tuberculosis or immunisation, and nutrition counselling for children with growth faltering. **Bedside teaching** in health facilities provides individualised education to inpatients, timed to moments of high receptivity (the teachable moment during recovery from an illness episode) when the individual motivation to understand and change their health behaviour may be at its peak. All individual methods share the advantages of high interpersonal

engagement, tailored content, and immediate feedback, but are resource-intensive, reaching only one person at a time.

Fill in the blank: Health counselling is distinguished from health advice-giving by its _____ nature: the counsellor listens, reflects, and guides rather than lecturing, making it the method of choice for sensitive topics requiring privacy and personalised engagement.

3.1.2 Group methods

Group health education methods reach multiple learners simultaneously through shared experiences that leverage the educational potential of group dynamics: peer learning, social comparison, and the motivational power of group commitment to behaviour change. The **health talk (group health education session)** is the most widely used group method in the Nigerian PHC system: a facilitated presentation and discussion on a defined health topic delivered to a group of ten to thirty community members, facility attendees, or school pupils, typically lasting twenty to thirty minutes and incorporating question-and-answer interaction. The health talk combines efficiency (reaching multiple individuals in one session) with the interpersonal engagement and immediate feedback that distinguishes it from mass media communication.

Demonstration is a group method particularly effective for teaching practical health skills: showing a group how to prepare oral rehydration solution correctly, how to apply a condom, or how to examine a child for signs of severe acute malnutrition, allows learners to observe the skill before practising it themselves (**return demonstration**), which is essential for building psychomotor competence rather than merely cognitive understanding. **Group discussion** and **focus group** techniques engage learners in structured conversation that surfaces existing knowledge and beliefs, allows peer sharing of experience, and builds collective understanding and motivation. **Role play** and **drama** enable learners to rehearse health-related communication scenarios (such as negotiating condom use with a partner or discussing illness symptoms with a health worker) in a safe, supported group setting, building the interpersonal skill and self-efficacy identified in Series 1 as essential for sustained behaviour change.

Fill in the blank: _____ is a group health education method that enables learners to rehearse health-related communication scenarios in a safe, supported setting, building interpersonal skill and self-efficacy essential for sustained behaviour change.

3.1.3 Mass methods

Mass health education methods reach large numbers of people simultaneously through broadcast or distributed media, without the interactive, personalised quality of individual or group approaches. **Radio** is the single most important mass health education medium in Nigeria, combining near-universal reach with the capacity to deliver in multiple local languages, to reach non-literate audiences, and to convey information, motivation, and emotional engagement through the human voice. **Television** adds visual content to the radio advantages, though with more limited reach in rural and low-electricity settings. **Print media** (newspapers, posters, leaflets, and flip charts) provide visual reference that audiences can retain and revisit, but require literacy and rely on active, rather than passive, audience exposure.

Community announcements (town criers, public address systems at markets and mosques, mobile megaphone vehicles) represent an important, distinctively Nigerian mass method, combining geographical targeting with vernacular language delivery and relatively low cost. **Social and digital media** (WhatsApp, Facebook, Twitter, TikTok, and YouTube) are increasingly important mass channels in Nigeria, particularly among urban, younger, and more educated audiences, combining the scale of mass media with the interactivity and shareability of social communication. Mass methods are characterised by high reach and relatively low cost per person reached, but low interactivity and therefore limited ability to address individual questions, concerns, and misconceptions; they are most effective as awareness-raising tools that create conditions for subsequent individual or group-level educational engagement, rather than as standalone behaviour change interventions.

Fill in the blank: Mass health education methods are most effective as _____ -raising tools that create conditions for subsequent individual or group-level educational engagement, rather than as standalone behaviour change interventions.

Figure 3.1: Classification of health education methods and their characteristics

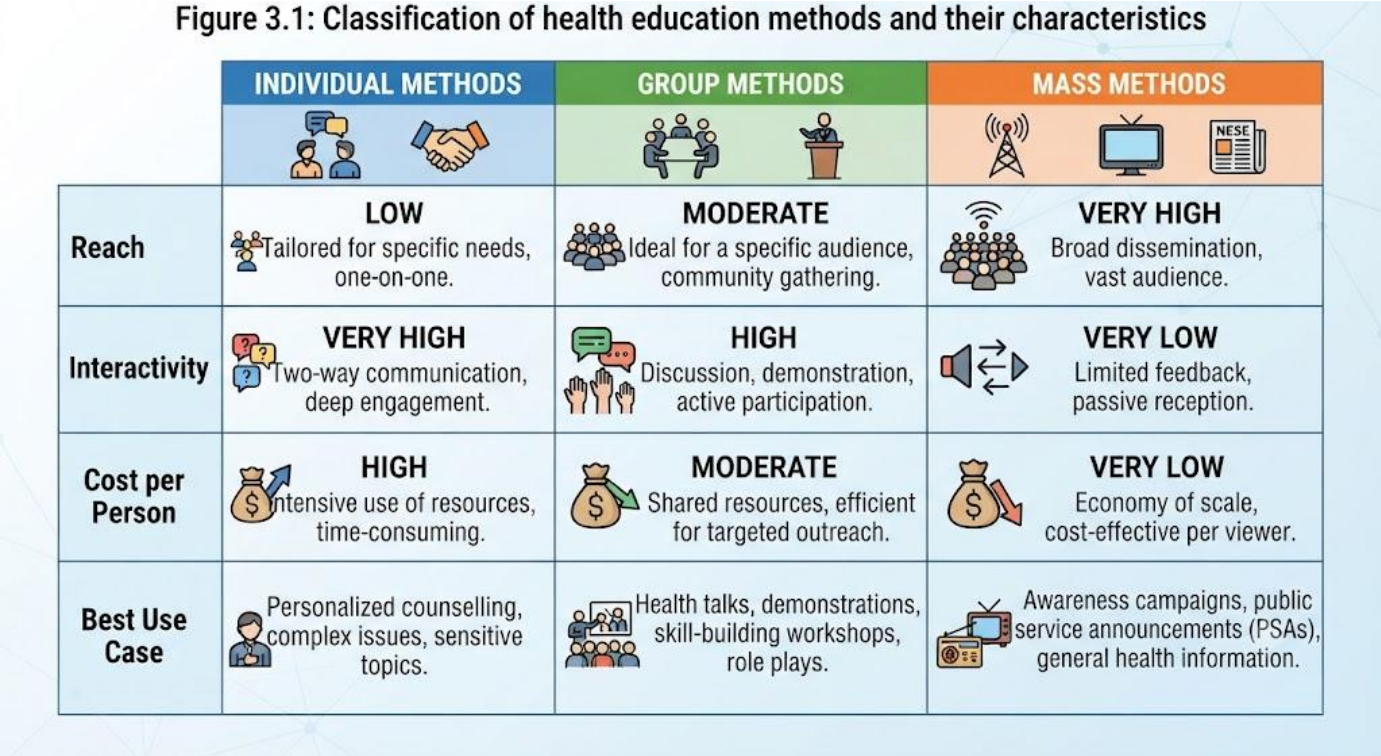

Figure 3.1: Classification of health education methods and their characteristics

Pilot questions 3.1

1. Distinguish health counselling from health advice-giving.
2. Name three specific individual health education methods.
3. What is a health talk and what are its advantages over individual methods?
4. Why is return demonstration an essential component of a practical health skills session?
5. Name three mass health education methods relevant to Nigeria and state one advantage of each.

3.2 Selection and Use of Health Education Media

3.2.1 Classification of health education media

Health education **media** are the materials, tools, and channels through which health education messages are transmitted to learners. Media are classified in several ways. By **sensory channel**:

visual media (posters, flipcharts, photographs, charts, flashcards, films, videos) are perceived primarily through sight; **auditory media** (radio, audio recordings, songs, storytelling) are perceived through hearing; and **audio-visual media** (television, video, drama, puppet theatre) engage both sight and hearing simultaneously. By **production scale**: **projected media** (films, slides, PowerPoint presentations) require projection equipment and power; **non-projected media** (posters, flannel boards, models, real objects) require no equipment and can be used in any setting.

By **dissemination mode**: **broadcast media** (radio, television) reach geographically dispersed audiences simultaneously; **print media** (newspapers, leaflets, pamphlets) are reproduced and distributed; **display media** (posters, billboards, banners) are placed in fixed locations for passive audience exposure; and **interpersonal media** (flip charts, flannel boards, models, demonstration equipment) support face-to-face educational interactions. In practice, the most effective health education sessions integrate multiple types of media: a health talk supported by a flipchart for visual reference, followed by a demonstration using real objects, reinforced by a take-home leaflet, engages multiple sensory channels and provides both immediate and sustained educational contact.

Fill in the blank: _____ media (posters, billboards, banners) are placed in fixed locations for passive audience exposure, while interpersonal media (flipcharts, models, demonstration equipment) are used to support face-to-face educational interactions.

3.2.2 Criteria for selecting appropriate media

Selecting the most appropriate media for a health education programme requires consideration of several interconnected criteria. **Audience characteristics**: the literacy level, language preference, visual acuity, age, and familiarity with different media technologies of the target audience must all inform media selection; a poster designed in English with dense text is inappropriate for a rural community with low English literacy, while a sophisticated smartphone-based interactive tool is inappropriate for elderly community members unfamiliar with digital devices. **Learning objectives**: media should match the type of learning sought; demonstrating a practical skill requires physical demonstration materials rather than purely visual or auditory

media, while reinforcing awareness of a disease risk may be effectively served by a well-designed radio spot or a striking poster.

Availability and cost: the best media are those that can actually be produced, distributed, and maintained within the available resource envelope; an expensive, high-quality video is useless if the target facility has no television or reliable electricity. **Cultural acceptability**: images, symbols, colours, and styles of communication carry cultural meanings that vary across Nigeria diverse communities; media that inadvertently incorporate culturally offensive imagery, or that depict health behaviours in ways inconsistent with local norms, will reduce message effectiveness or cause active harm to programme credibility. **Language**: materials must be in a language the audience understands comfortably, which in the Nigerian context often means local language or dialect rather than English or even the regional major language. **Availability of distribution channels**: a beautiful leaflet is useful only if it can be printed and distributed to the target population through existing channels, making the logistics of media dissemination an inseparable consideration from media design.

Fill in the blank: Media should match the type of _____ sought: demonstrating a practical skill requires physical demonstration materials, while raising awareness of a disease risk may be effectively served by a well-designed radio spot or poster.

3.2.3 Developing and pretesting health education materials

The development of effective health education materials follows a systematic process. **Needs and audience analysis** (identifying the specific knowledge gaps, attitudes, and practices to be addressed, and the specific characteristics of the target audience, as established in Series 1 and 2) defines what the material must achieve and for whom. **Content development** draws on technically accurate health information (reviewed and approved by relevant health authorities) and translates it into language and concepts accessible to the target audience, avoiding jargon and unnecessary complexity. **Design and production** applies visual communication principles (contrast, colour, hierarchy of information, culturally appropriate imagery) to produce a draft material that is both technically accurate and visually engaging.

Pretesting is a critical but frequently neglected step: before finalising and mass-producing any health education material, it should be tested with a sample of individuals from the intended target audience to assess comprehension (is the message understood as intended?), appeal (is the material attractive and engaging?), acceptability (are any images, words, or concepts offensive or inappropriate?), and persuasiveness (does the material motivate the intended action?). Pretesting consistently reveals significant gaps between what health education material developers assumed their audience would understand and what that audience actually understands, preventing the waste of resources on materials that miss their mark. Following pretesting, materials are revised and re-tested where necessary before final production and distribution.

Fill in the blank: _____ is a critical step in health education material development that tests draft materials with a sample of the intended audience before finalising them, assessing comprehension, appeal, acceptability, and persuasiveness.

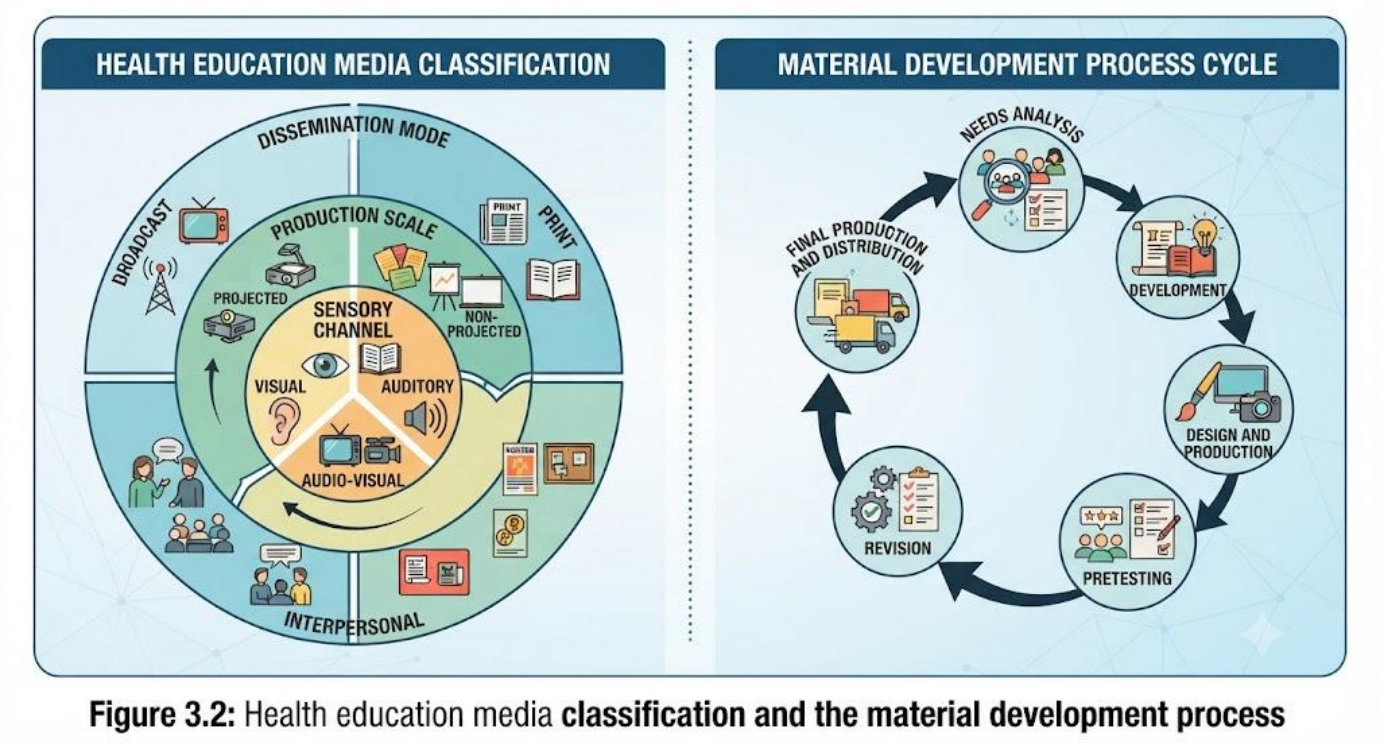

Figure 3.2: Health education media **classification and the material development process**

Figure 3.2: Health education media classification and the material development process

Pilot questions 3.2

1. Classify health education media by sensory channel.
2. Distinguish between projected and non-projected media.
3. Name five criteria for selecting appropriate health education media.
4. Why is pretesting of health education materials important?
5. Name the four qualities assessed during pretesting of health education materials.

3.3 Applying Methods and Media in the Nigerian Context

3.3.1 Combining methods and media for maximum effect

No single method or medium is sufficient to produce sustained, population-level health behaviour change on its own. The most effective health education programmes combine multiple methods and media in a deliberate, coordinated sequence that moves learners progressively from awareness through motivation to skill-building and action. This is the principle underlying **integrated health communication** or **multi-channel communication**: mass media (radio spots, television campaigns, social media content) generate broad awareness and stimulate interest; group methods (community health talks, drama, demonstrations) build understanding, motivation, and practical skills; and individual methods (counselling, home visits) address personal barriers, tailor information to individual circumstances, and support the individual through the stages of behaviour change identified in the Transtheoretical Model examined in Series 1.

This combined approach reflects the evidence on health communication effectiveness: awareness campaigns alone produce knowledge gains but limited behaviour change; one-time group education sessions produce knowledge and attitude shifts but rarely sustained behavioural adoption; sustained, multi-channel, multi-method programmes that reach people repeatedly through complementary channels and address both information and skill deficits produce the most durable health behaviour change. The **communication for behaviour change (C4BC) framework** used in Nigerian disease control programmes (Behavioural Change Communication

components of the malaria, HIV, tuberculosis, and nutrition programmes) operationalises this integrated approach, combining mass media, community mobilisation, and interpersonal communication by trained health workers in a coordinated campaign rather than leaving each method to operate in isolation.

Fill in the blank: Mass media generate broad _____ and stimulate interest, group methods build understanding and skills, and individual methods address personal barriers, forming a complementary sequence for progressive behaviour change.

3.3.2 Traditional and digital media in Nigerian health education

Nigeria has a rich tradition of **traditional communication channels** that health educators can leverage as cost-effective, culturally embedded health education media: **drama, theatre, and storytelling** (**theatre for development** groups have been successfully used for HIV, malaria, and family planning education across Nigeria, reaching non-literate rural audiences with entertaining, culturally resonant educational content); **songs and music** (health messages embedded in popular musical forms, including juju, Afrobeats, highlife, and Hausa traditional music, are memorable, emotionally engaging, and easily shared across social networks); and **town criers and community announcers** (still widely used in rural and semi-urban communities for urgent public health announcements, including outbreak alerts and vaccination campaign mobilisation).

Digital and social media have rapidly become significant health education channels in Nigeria, particularly for urban, educated, and younger populations. WhatsApp groups (used extensively by community health workers, patient support groups, and community networks for health information sharing), Facebook health pages, YouTube health education videos, and Twitter health campaigns all reach audiences that may be difficult to engage through traditional mass media. However, digital channels also carry significant **misinformation risks**: the same channels that can deliver effective health education can simultaneously spread harmful health misinformation at scale, a challenge particularly evident during the COVID-19 pandemic and during polio vaccination campaigns, where false information circulated through WhatsApp contributed to vaccine hesitancy in some communities. Health educators must therefore be

equipped not only to use digital media for health education but to support communities in critically evaluating health information encountered through these channels.

Fill in the blank: Digital and social media channels carry significant _____ risks, as the same channels that can deliver effective health education can simultaneously spread harmful health misinformation at scale, as demonstrated during COVID-19 and polio vaccination campaigns.

3.3.3 Selecting methods and media for specific Nigerian audiences

Effective health education method and media selection requires explicit attention to the specific characteristics of the intended audience. For **rural, low-literacy communities** (which constitute a substantial proportion of the Nigerian population, particularly in northern states): individual counselling by CHEWs, community health talks with demonstration and return demonstration, community drama and theatre, and radio in local languages are the most appropriate and accessible approaches; text-heavy printed materials in English are ineffective for this audience and should be replaced with pictorial materials or avoided entirely. For **market women and traders** whose time is severely constrained during working hours: brief, focused health talks during market day gatherings, concise radio spots broadcast at times when market women listen (early morning and evening), and peer health education by trained market health promoters are more effective than scheduling formal education sessions that conflict with trading hours.

For **adolescents and young people** in urban and peri-urban settings: digital and social media content (short, visually engaging videos for YouTube and TikTok, interactive WhatsApp programmes), peer education by trained youth health ambassadors, and school-based health education using participatory methods (group discussion, drama, role play) are generally more effective than didactic lectures or health talks designed for adult community members. For **women in conservative settings** where mixed-gender public gatherings are culturally restricted: women-only health talks in antenatal and postnatal settings, home visits by female CHEWs or trained female community health volunteers, and radio programmes designed specifically for women listeners provide access to health education without requiring attendance at mixed gatherings. The underlying principle across all audiences is the same: method and media

selection must start with the specific characteristics, constraints, and preferences of the intended audience, not with the convenience or preference of the health educator.

Fill in the blank: For rural, low-literacy communities, the most appropriate health education approaches include individual counselling, community health talks with demonstration, community drama, and radio in local languages, while _____ -heavy printed materials in English are ineffective and should be avoided.

Figure 3.3: Method and media selection for specific Nigerian audiences

NIGERIAN AUDIENCE SEGMENT	RECOMMENDED HEALTH EDUCATION METHODS	SUGGESTED MEDIA CHANNELS	RATIONALE FOR SELECTION
RURAL LOW-LITERACY COMMUNITIES	STORYTELLING & DRAMA DEMONSTRATIONS COMMUNITY GATHERINGS	LOCAL RADIO (Pidgin & local languages) POSTERS & FLIERS (Visual-heavy) FLIP CHARTS	High oral tradition preference, overcomes literacy barriers, leverages community trust.
MARKET WOMEN & TRADERS	PEER-TO-PEER DISCUSSION MARKET TALKS INTERACTIVE GAMES	MOBILE PHONE MESSAGING (SMS, WhatsApp) COMMUNITY LOUDSPEAKERS PRINTED MATERIALS (Posters, Handouts)	Frequent social interaction in markets, leverages existing networks, accessible via mobile.
URBAN ADOLESCENTS	EDUTAINMENT SOCIAL MEDIA CAMPAIGNS SCHOOL HEALTH PROGRAMS	SOCIAL MEDIA PLATFORMS (Instagram, TikTok) YOUTUBE (Short videos) RADIO/TV YOUTH SHOWS	High digital penetration, appeals to youth culture, creates peer influence & dialogue.
WOMEN IN CONSERVATIVE SETTINGS	HOME VISITS WOMEN'S SUPPORT GROUPS RADIO PROGRAMS	COMMUNITY RADIO LOCAL DRAMA GROUPS TRUSTED INTERPERSONAL COMMUNICATION (Community health workers)	Respects cultural norms of mobility, leverages trusted local channels, ensures privacy & comfort.

Figure 3.3: Method and media selection for specific Nigerian audiences

Pilot questions 3.3

1. What is the principle of multi-channel communication in health education?
2. Name three traditional communication channels used for health education in Nigeria.
3. What misinformation risk do digital media present for health education in Nigeria?
4. What health education methods and media are most appropriate for rural, low-literacy communities in Nigeria?

5. Why should method and media selection start with the audience rather than the educator preference?

Series Summary

This Series examined the methods and media available to health educators and the principles governing their selection and use. Health education methods were classified into three levels: individual methods (counselling, home visits, bedside teaching), which offer high personalisation and interactivity at limited scale; group methods (health talks, demonstration, return demonstration, role play, drama), which balance efficiency with interpersonal engagement; and mass methods (radio, television, print, community announcements, digital media), which achieve large-scale reach at the cost of interactivity. Each level serves a distinct function in the behaviour change process, with mass methods generating awareness, group methods building skills and motivation, and individual methods addressing personal barriers.

Health education media were classified by sensory channel (visual, auditory, audio-visual), production scale (projected, non-projected), and dissemination mode (broadcast, print, display, interpersonal), and the criteria for selecting appropriate media were examined, including audience characteristics, learning objectives, cost, cultural acceptability, and language. The systematic process for developing and pretesting health education materials was described. The Series concluded by examining the principle of multi-channel integration, the specific opportunities and risks of traditional and digital media in Nigeria, and the audience-specific method and media selection principles required for effective health education practice across Nigeria diverse communities and settings (SLOs 3.1 to 3.6).

Glossary of Terms

1. **Audio-visual media:** health education media engaging both sight and hearing simultaneously, such as television, video, and drama.
2. **Counselling:** a structured, client-centred individual health education method involving listening, reflection, and guided decision-making.
3. **Demonstration:** a group health education method showing learners how to perform a practical health skill, followed by return demonstration by learners.

4. **Display media:** health education media placed in fixed locations for passive audience exposure, such as posters and billboards.
5. **Health talk:** a facilitated group presentation and discussion on a defined health topic, the most widely used group health education method in the Nigerian PHC system.
6. **Interpersonal media:** health education media used to support face-to-face interactions, such as flipcharts, flannel boards, and models.
7. **Multi-channel communication:** the integration of mass, group, and individual methods and media in a coordinated health education programme for maximum behaviour change impact.
8. **Pretesting:** the assessment of draft health education materials with a sample of the intended target audience before finalising and mass-producing them.
9. **Return demonstration:** the practice component of a demonstration session, in which learners perform the demonstrated skill themselves under educator observation.
10. **Theatre for development:** the use of drama and performance for community education and social change, widely used for health education in Nigeria.

Concept Check Questions [Series 3]

Objective questions

- Health counselling is distinguished from advice-giving by its _____ nature, involving listening, reflecting, and guiding rather than lecturing. (Linked to SLO 3.1)
- _____ is a group method that enables learners to rehearse health-related communication scenarios in a safe, supported setting. (Linked to SLO 3.1)
- Mass health education methods are most effective as _____ -raising tools that create conditions for subsequent individual or group educational engagement. (Linked to SLO 3.2)
- _____ media are placed in fixed locations for passive audience exposure, while interpersonal media support face-to-face interactions. (Linked to SLO 3.3)
- _____ tests draft health education materials with a sample of the intended audience before finalising them. (Linked to SLO 3.4)
- For rural, low-literacy communities, text-heavy printed materials in English are ineffective and should be avoided, while _____ in local languages is among the most appropriate mass methods. (Linked to SLO 3.6)

Short-answer questions

- Compare individual, group, and mass health education methods, identifying one strength and one limitation of each. (Linked to SLOs 3.1–3.2)
- Describe the criteria for selecting appropriate health education media and apply them to a rural health education session on malaria prevention. (Linked to SLO 3.3)

Long-answer questions

- Discuss the principle of multi-channel health education and explain how traditional and digital media can be combined for maximum effect in the Nigerian context. (Linked to SLOs 3.5–3.6)

- Evaluate the process of developing effective health education materials, including the role of pretesting, and apply this process to a Nigerian health education campaign on exclusive breastfeeding. (Linked to SLO 3.4)

Answers to Concept Check Questions [Series 3]

Objective questions

1. Participatory.
2. Role play.
3. Awareness.
4. Display.
5. Pretesting.
6. Radio.

Short-answer questions

7. Individual methods: strength: high personalisation and interactivity, tailored to specific individual needs; limitation: resource-intensive, reaches only one person at a time. Group methods: strength: efficient (multiple learners per session), retains interpersonal engagement and immediate feedback; limitation: content less personalised than individual, requires facilitation skill. Mass methods: strength: very high reach, low cost per person; limitation: low interactivity, cannot address individual questions or misconceptions.
8. Criteria: audience characteristics, learning objectives, availability and cost, cultural acceptability, language, distribution channels. Applied to rural malaria prevention: audience is low-literacy, local language speakers without reliable electricity or internet, so projected media are inappropriate; radio in local language and pictorial flipcharts for CHEW health talks are appropriate; English text posters are inappropriate; demonstration of bed net hanging with real nets engages the practical learning objective; materials distributed through the PHC facility at immunisation and ANC visits leverage existing distribution channels.

Long-answer questions

9. **Basic response:** Multi-channel principle: mass media generate awareness, group methods build knowledge and skills, individual methods address personal barriers; coordinated

sequence moves learners through awareness, motivation, skill, and action. Traditional media in Nigeria: drama and theatre for development (rural, non-literate audiences), songs and music (culturally embedded, memorable, shareable), town criers and community announcers (rural, urgent announcements). Digital media: WhatsApp health groups, Facebook, YouTube, TikTok (urban, younger audiences); shareability amplifies reach. Combination: radio spots raise community awareness of malaria prevention; community drama demonstrates correct net use; CHEW counselling addresses individual concerns; WhatsApp messages to community health volunteers reinforce and track uptake.

Value-added response: The misinformation risk of digital channels is the critical caveat to their potential: the same WhatsApp network that can deliver a CHEW health education message can simultaneously carry a false rumour that the vaccine causes infertility, often spreading faster and generating more emotional engagement than the accurate message. Effective multi-channel health education in Nigeria must therefore include a digital misinformation response component, equipping community health workers and community leaders to identify, counter, and report health misinformation encountered on digital platforms, rather than treating digital media as a passive delivery channel and ignoring the information environment in which it operates.

10. **Basic response:** Development process: needs and audience analysis (identify knowledge gaps and audience characteristics); content development (accurate information in accessible language); design and production (visual communication principles, culturally appropriate imagery); pretesting (assess comprehension, appeal, acceptability, persuasiveness with sample of target audience); revision; final production and distribution. Applied to exclusive breastfeeding: audience analysis reveals low EBF rates, key misconceptions (insufficient milk, need for water), predominantly Yoruba-speaking community with low English literacy. Content: EBF benefits, common misconceptions addressed, how to know if baby is well-nourished. Design: pictorial, Yoruba language. Pretesting: sample of nursing mothers from same community to identify unclear illustrations or missed misconceptions. Revision based on feedback before printing.

Value-added response: Pretesting consistently reveals a systematic bias in health education material development: material developers (typically educated health professionals or communication specialists) systematically overestimate audience literacy and health knowledge, and underestimate the cultural distance between their own assumptions and those of the target community. A pictorial that seems self-evident to its designer may be misinterpreted by an audience whose visual literacy differs, or whose cultural associations with a depicted symbol differ. Pretesting is the only reliable protection against this bias, and skipping it to save time or resources invariably produces materials that are less effective or occasionally counterproductive.

Answers to Pilot Questions [Series 3]

Part 3.1

6. Health counselling is participatory: the counsellor listens, reflects, and guides the client toward their own informed decision. Health advice-giving is one-directional: the health worker tells the client what to do, without the listening, reflection, and guided decision-making that characterise counselling.
7. Any three of: health counselling, home visits, bedside teaching.
8. A health talk is a facilitated presentation and discussion on a defined health topic delivered to a group of ten to thirty participants. Advantages over individual methods: it reaches multiple learners in a single session (greater efficiency) while retaining interpersonal engagement and immediate feedback through question-and-answer interaction.
9. Return demonstration (having learners perform the skill themselves) is essential because observing a skill builds cognitive understanding but not the psychomotor competence and self-efficacy needed to perform it reliably in practice; supervised practice with feedback bridges this gap.
10. Any three of: radio (near-universal reach including non-literate audiences), television (visual engagement with broader than radio reach in urban areas but limited in rural

settings), community announcements/town criers (geographic targeting, vernacular language, low cost), social media (urban youth, interactive and shareable).

Part 3.2

11. Visual media (perceived through sight: posters, flipcharts, films), auditory media (perceived through hearing: radio, songs), and audio-visual media (engaging both sight and hearing: television, video, drama).
12. Projected media (films, slides, PowerPoint) require projection equipment and electrical power. Non-projected media (posters, flannel boards, models, real objects) require no equipment and can be used in any setting, including without electricity.
13. Any five of: audience characteristics (literacy, language, age, familiarity with technology), learning objectives (type of learning required), availability and cost, cultural acceptability, language, availability of distribution channels.
14. Because it reveals significant gaps between what developers assumed the audience would understand and what they actually understand, preventing the waste of resources on materials that miss their mark in comprehension, appeal, acceptability, or persuasiveness.
15. Comprehension (is the message understood as intended?), appeal (is the material attractive and engaging?), acceptability (are any elements offensive or inappropriate?), and persuasiveness (does the material motivate the intended action?).

Part 3.3

1. Multi-channel communication integrates mass, group, and individual methods and media in a coordinated sequence: mass media generate awareness, group methods build knowledge and skills, and individual methods address personal barriers, moving learners progressively from awareness to sustained behaviour change.
2. Any three of: drama and theatre for development, songs and music, town criers and community announcers.

3. The same digital channels that can deliver effective health education can simultaneously spread harmful health misinformation at scale, often faster and with greater emotional engagement than accurate health messages, as demonstrated during COVID-19 and polio vaccination campaigns in Nigeria.
4. Individual CHEW counselling, community health talks with demonstration and return demonstration, community drama and theatre for development, and radio in local languages; text-heavy printed materials in English should be avoided.
5. Because effective health education can only occur if the method and medium actually reach and engage the intended audience; methods convenient for the educator but inaccessible, inappropriate, or unappealing for the audience produce little or no learning or behaviour change, regardless of the quality of the content.

References and Attributions [Series 3]

Textual references

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9. National Open University of Nigeria (NOUN). (2023). Health education and health advocacy course material. NOUN Press.

Figures, Plates, Tables, and Boxes

11. Figure 3.1: Classification of health education methods and their characteristics Attribution: AI generated using prompt "Generate a three-column comparison table of individual, group, and mass health education methods with rows for reach, interactivity, cost, and best use." Suggested OER search string: "health education methods individual group mass counselling health talk radio demonstration OER"
12. Figure 3.2: Health education media classification and the material development process Attribution: AI generated using prompt "Generate a two-panel diagram showing health education media classification by three criteria and the material development cycle." Suggested OER search string: "health education media visual auditory audio-visual pretesting material development poster leaflet radio OER"
13. Figure 3.3: Method and media selection for specific Nigerian audiences Attribution: AI generated using prompt "Generate a table showing recommended health education methods and media for four specific Nigerian audience segments with rationale." Suggested OER search string: "health education methods media Nigeria audience rural adolescents market women conservative settings OER"

Course code: COM 403

Course title: Health Education and Health Advocacy

Course credit load: 1 Unit

Series 4: Planning Health Education Programmes

- **Part 4.1: The Health Education Planning Process**
  - Sub Part 4.1.1: Why planning matters in health education
  - Sub Part 4.1.2: Steps in planning a health education programme
  - Sub Part 4.1.3: Needs assessment as the foundation of planning
- **Part 4.2: Setting Objectives and Designing Interventions**
  - Sub Part 4.2.1: Writing SMART health education objectives
  - Sub Part 4.2.2: Selecting appropriate activities and resources
  - Sub Part 4.2.3: Developing a work plan and budget
- **Part 4.3: Implementation and Monitoring**
  - Sub Part 4.3.1: Preparing for implementation
  - Sub Part 4.3.2: Monitoring progress during implementation
  - Sub Part 4.3.3: Adapting plans in response to monitoring findings

Introduction

A health education programme that is well-conceived in theory but poorly planned in practice invariably underperforms: activities happen late or not at all, resources are wasted on inappropriate materials, staff are deployed without clear roles, and the intended population is never properly reached. Planning is the discipline that converts health education knowledge and good intentions into coordinated, realistic, and accountable action. It is the bridge between the theoretical foundation of the preceding Series and the actual delivery of health education to communities.

The aim of this Series is to describe the systematic process of planning a health education programme, from needs assessment through to the development of a workable implementation plan and budget, and to examine the monitoring activities that keep implementation on track.

We shall commence by examining why planning matters and the step-by-step planning process, with particular attention to needs assessment as the foundational input. Next, we will examine how to write clear objectives, select appropriate activities and resources, and develop a realistic work plan and budget. Finally, we will close by examining the preparation for implementation, the monitoring of progress during delivery, and the adaptation of plans in response to what monitoring reveals.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 4.1** explain why systematic planning is essential for effective health education programmes,
- **SLO 4.2** describe the sequential steps in planning a health education programme,
- **SLO 4.3** conduct a health education needs assessment using appropriate methods,
- **SLO 4.4** write SMART objectives for a health education programme,
- **SLO 4.5** develop a work plan and budget for a health education programme, and

- **SLO 4.6** describe the monitoring activities required during health education programme implementation.

4.1 The Health Education Planning Process

4.1.1 Why planning matters in health education

Planning a health education programme systematically, rather than improvising activities as they occur, produces several critical benefits. **Clarity of purpose**: a written plan forces the programme team to articulate precisely what they are trying to achieve, for whom, and by when, surfacing disagreements and ambiguities before resources are committed. **Efficient resource use**: planned activities can be costed in advance, preventing the common phenomenon of underfunded or poorly resourced implementation that falls short of what communities deserve and funding bodies expect. **Accountability**: a documented plan provides a reference against which actual implementation can be compared, making it possible to identify whether activities were completed as intended and whether outcomes were achieved, forming the basis for the evaluation examined in Series 5.

Coordination: in health education programmes involving multiple actors (CHEWs, community leaders, non-governmental organisations, local government) and multiple activities across different locations, a written plan defines who is responsible for what, by when, and with which resources, preventing duplication of effort and gaps in coverage. **Community ownership**: a participatory planning process that involves the target community in identifying needs, setting priorities, and deciding on approaches is itself a health education activity that builds community engagement and commitment to the programme, directly connecting the planning stage to the community participation principle established across this and related courses. Finally, **quality**: planned programmes systematically integrate the principles, methods, and media knowledge examined in earlier Series, rather than defaulting to whatever is familiar or convenient, consistently producing higher-quality health education than unplanned, ad hoc approaches.

Fill in the blank: A _____ planning process that involves the target community in identifying needs, setting priorities, and deciding on approaches is itself a health education activity that builds community engagement and ownership.

4.1.2 Steps in planning a health education programme

Health education programme planning follows a recognised sequence of steps. **Step 1: Assess needs** (identify the health education needs of the target population through systematic data collection, examined in Part 4.1.3). **Step 2: Define the target population** (specify precisely who the programme is intended to reach, including their key demographic, cultural, and health literacy characteristics). **Step 3: Set goals and objectives** (establish the broad goal and the specific, measurable objectives the programme will achieve, examined in Part 4.2.1). **Step 4: Select methods and media** (choose the combination of education methods and media most appropriate for the identified target population and objectives, drawing on Series 3).

Step 5: Develop educational materials (design, produce, and pretest the health education materials required for the selected methods, as described in Series 3). **Step 6: Develop the work plan and budget** (schedule activities, assign responsibilities, and cost the programme, examined in Part 4.2.3). **Step 7: Implement** (deliver the planned activities, following the preparation and readiness steps examined in Part 4.3.1). **Step 8: Monitor** (track implementation progress during delivery, examined in Part 4.3.2). **Step 9: Evaluate** (assess whether the programme achieved its objectives, examined in Series 5). **Step 10: Disseminate findings** (share what was learned with stakeholders, communities, and the wider professional community to contribute to the evidence base for health education practice). This systematic planning cycle is iterative: evaluation findings from one programme cycle inform the needs assessment and objective-setting of the next.

Fill in the blank: Health education programme planning follows a sequential process from needs assessment through goal-setting, method and media selection, materials development, work plan and budget, implementation, monitoring, _____ , and dissemination of findings.

4.1.3 Needs assessment as the foundation of planning

A **health education needs assessment** is a systematic process of collecting and analysing information about a target population health-related knowledge, attitudes, and practices, the environmental and social factors influencing these behaviours, and the assets and resources available within the community and health system to support health education. It answers the question: what do people need to know, believe, or be able to do, that they currently do not know, believe, or do, and what are the barriers and enablers that will shape an educational programme designed to address these gaps? Needs assessment establishes the factual foundation for all subsequent planning decisions: without it, programme designers are guessing rather than planning.

Needs assessment methods include: **KAP surveys** (structured questionnaires assessing knowledge, attitudes, and practices in a representative sample of the target population, providing quantitative baseline data against which post-programme change can be measured); **focus group discussions** (examining community perceptions, beliefs, and social norms that quantitative surveys cannot capture); **key informant interviews** (gathering expert knowledge from health workers, community leaders, and programme managers); **review of existing data** (health facility records, disease surveillance data, previous research in the community) to identify priority health problems and current service utilisation patterns; and **direct observation** (observing actual health practices, environmental conditions, and health education activities currently in place). A combination of these methods, triangulating across data types, provides the most complete and reliable picture of needs on which to base a health education programme.

Fill in the blank: _____ surveys are structured questionnaires assessing knowledge, attitudes, and practices in a representative sample of the target population, providing quantitative baseline data against which post-programme change can be measured.

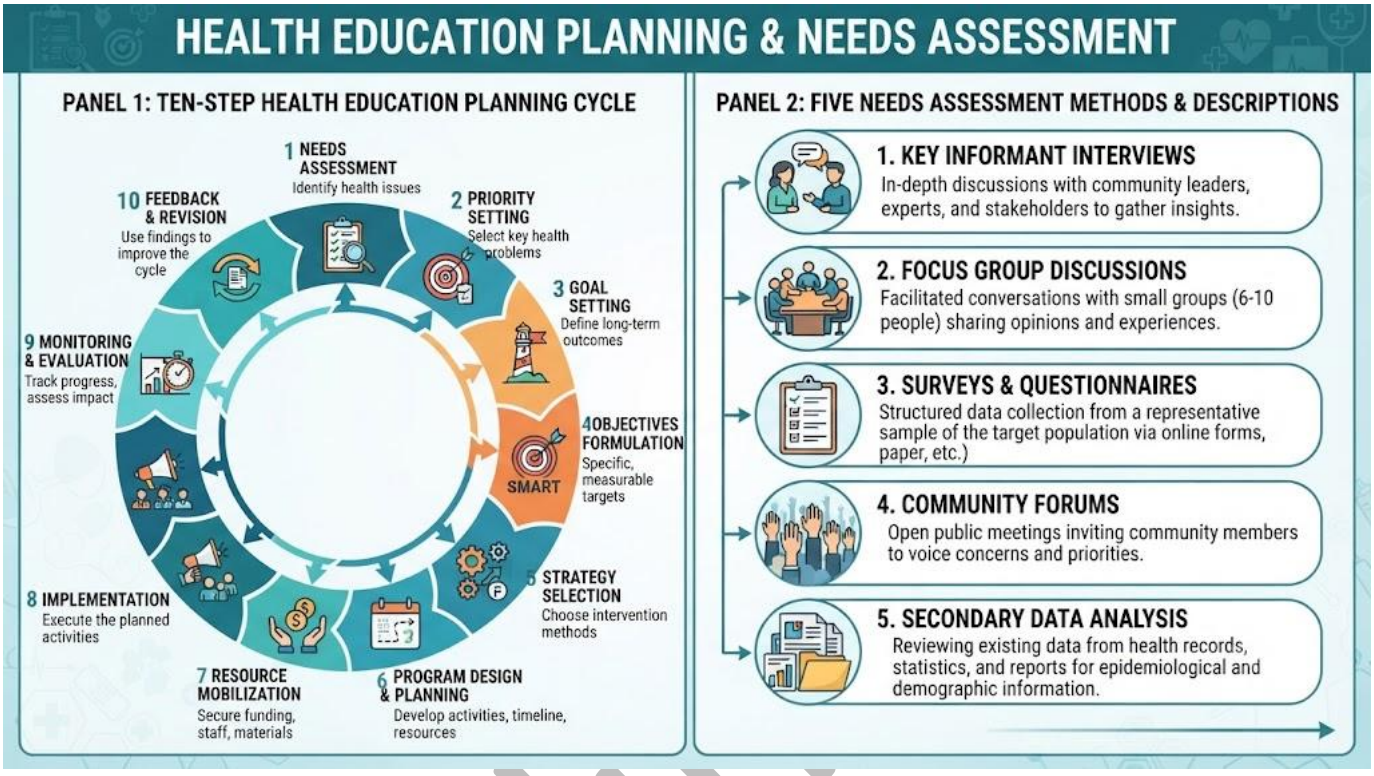

Figure 4.1: The health education planning cycle and needs assessment methods

Pilot questions 4.1

1. Name three benefits of systematic planning for health education programmes.
2. List the ten steps in planning a health education programme in order.
3. Define a health education needs assessment.
4. Name five methods used in health education needs assessment.
5. Why should a combination of needs assessment methods be used rather than relying on a single approach?

4.2 Setting Objectives and Designing Interventions

4.2.1 Writing SMART health education objectives

Health education programme objectives should be **SMART**: **Specific** (clearly defining what will be changed, in whom, and by how much, rather than vague statements of intent), **Measurable**

(expressed in terms that can be assessed with available data collection tools, so that it is possible to determine whether the objective has been achieved), **Achievable** (realistic given the resources, timeframe, and context of the programme, rather than aspirationally set at a level the programme cannot plausibly deliver), **Relevant** (directly addressing a need identified in the needs assessment and contributing to the programme broad goal), and **Time-bound** (specifying the timeframe within which the objective will be achieved).

A well-written health education objective typically follows the format: "By [date], [percentage] of [target population] will [demonstrate knowledge / hold attitude / perform behaviour] [as measured by / assessed through]." For example: "By the end of the six-month programme, at least 70% of pregnant women attending Oke Odo Primary Health Centre will correctly describe the recommended duration of exclusive breastfeeding, as measured by a structured knowledge assessment." This specificity allows the evaluator (Series 5) to make an unambiguous judgement about whether the objective was achieved, avoids the common tendency to claim programme success based on vague impressions rather than measured evidence, and gives the programme team a clear target to work toward from day one of implementation.

Fill in the blank: A well-written health education objective is SMART: Specific, Measurable, _____ , Relevant, and Time-bound, enabling unambiguous judgement of whether the objective has been achieved.

4.2.2 Selecting appropriate activities and resources

With objectives defined and the target population characterised, the programme designer selects the specific activities that will achieve each objective. Activity selection applies the methods and media knowledge of Series 3: the activity must use methods and media appropriate to the target audience (their literacy, language, and cultural context), appropriate to the learning objective (awareness-raising, skill-building, or attitude change), and feasible within the available resources (staff, time, materials, and budget). For each objective, it is helpful to identify multiple complementary activities (a mass media component for broad awareness, a group education component for skill-building, and an individual counselling component for barrier removal) rather than relying on a single activity to achieve a complex behaviour change objective.

Resource selection involves identifying the **human resources** required (which staff or volunteers will deliver each activity, and whether they require training before deployment), the **material resources** required (educational materials, demonstration equipment, audiovisual devices, stationery), the **financial resources** required (transportation, venue hire, printing, staff allowances), and the **information resources** required (data collection tools for monitoring and evaluation, and reference materials for staff). A common planning error is to focus resource planning on the visible, tangible inputs (printed materials, equipment) while neglecting the invisible but critical inputs (staff time, supervision capacity, transportation for monitoring visits) that determine whether planned activities actually reach their intended quality standard.

Fill in the blank: A common planning error is to focus resource selection on visible, tangible inputs such as printed materials and equipment, while neglecting invisible but critical inputs such as staff _____ , supervision capacity, and transportation for monitoring visits.

4.2.3 Developing a work plan and budget

A **work plan** (also called an implementation plan or activity schedule) translates the planned programme activities into a timeline, specifying: the specific activity to be conducted; the target location and population; the responsible person or team; the date or time period for implementation; the inputs (materials, transport, staff) required; and the verification source (the record or product that will confirm the activity was completed, such as an attendance register, a photograph, or a completed data collection form). A work plan is typically presented as a matrix or Gantt chart, with activities listed in rows and time periods in columns, allowing the programme manager to see the complete activity sequence and resource requirements at a glance and to identify potential scheduling conflicts or resource bottlenecks in advance.

A **programme budget** estimates the cost of each planned activity, categorised under standard budget lines: **personnel costs** (staff salaries, volunteer allowances, training fees), **material costs** (printing, procurement of demonstration equipment, audiovisual materials), **operational costs** (transportation, venue hire, communication), and **indirect costs** (overheads and management). Budget preparation requires identifying all costs realistically, including those that are often under-costed such as monitoring visits and evaluation activities, since a budget that

systematically underestimates these costs produces a programme that runs out of resources before completion. The budget should also identify the funding source for each budget line, ensuring that the full programme is adequately financed before implementation begins, rather than discovering mid-programme that a critical activity has no funding.

Fill in the blank: A work plan is typically presented as a matrix or _____ chart, with activities listed in rows and time periods in columns, allowing the programme manager to see the complete activity sequence and identify scheduling conflicts or resource bottlenecks in advance.

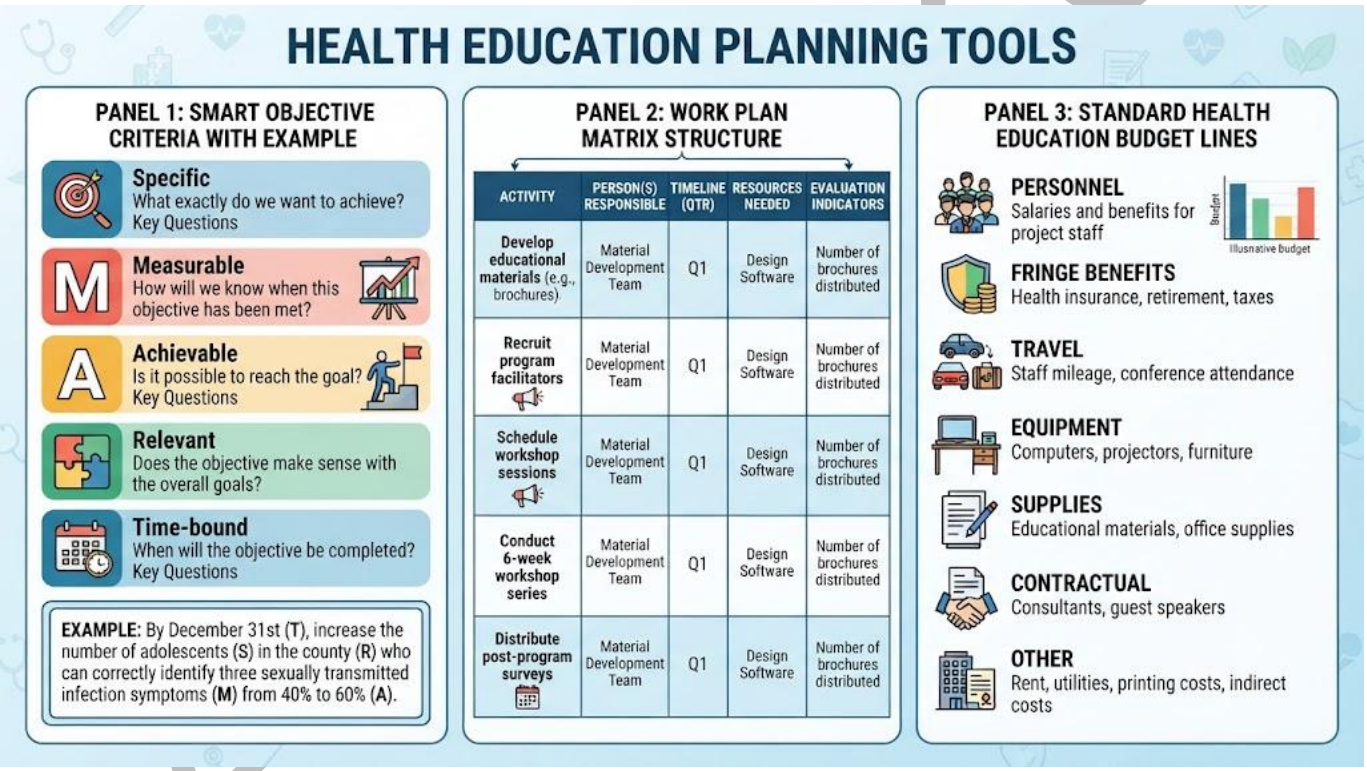

Figure 4.2: SMART objectives, work plan structure, and budget components

Pilot questions 4.2

1. What does SMART stand for in the context of health education objectives?
2. Write a SMART objective for a community health education session on handwashing.
3. What four categories of resource must be planned for in a health education programme?
4. What information is specified for each activity in a work plan?
5. Name four standard budget line categories in a health education programme budget.

4.3 Implementation and Monitoring

4.3.1 Preparing for implementation

Effective implementation does not begin on the day the first health education session is delivered; it begins with a set of preparatory activities that determine whether the session will be set up for success or for disappointment. **Staff preparation** involves ensuring all personnel who will deliver health education activities have been briefed on their specific roles, the programme objectives and methods, the target audience characteristics, and the ethical protocols for community engagement, connecting directly to the orientation principles established in Series 2. Where staff require specific skills not already in their repertoire (such as facilitation of a new type of group session or operation of audiovisual equipment), **training** must be scheduled and completed before implementation begins, not during it.

Material preparation involves ensuring all required materials (educational materials, demonstration equipment, data collection tools) are produced, pretested, available in sufficient quantity, and physically located where they are needed before the first activity is scheduled. **Community preparation** involves the community entry and sensitisation activities examined in the field posting context of the related community health courses: informing community leaders and the target population of the planned programme, its purpose and schedule, and any actions they need to take (such as ensuring women of childbearing age know about planned antenatal health education sessions). **Logistical preparation** confirms that transportation, venue arrangements, and communication systems are in place and functional. A simple **pre-implementation checklist** reviewed by the programme coordinator in the days before each activity launches is a practical tool for ensuring that all preparatory elements are in place before implementation begins.

Fill in the blank: _____ preparation involves informing community leaders and the target population of the planned programme, its purpose and schedule, and any actions they need to take before health education activities begin.

4.3.2 Monitoring progress during implementation

Monitoring is the routine, systematic tracking of programme implementation against the work plan, intended to confirm that planned activities are being conducted as scheduled, that inputs (materials, staff, budget) are being used as intended, and that any emerging problems are identified early enough to be corrected before they compromise programme outcomes. Monitoring is distinct from evaluation (which assesses whether the programme achieved its objectives, examined in Series 5) in being ongoing and operational rather than periodic and outcome-focused; monitoring answers the question "are we doing what we planned?" while evaluation answers the question "did what we did produce the intended change?"

Key monitoring activities in health education programmes include: **activity tracking** (recording which planned activities were conducted, when, where, and with how many participants, using attendance registers and activity reports); **process monitoring** (observing selected health education sessions to assess delivery quality, using a structured observation checklist applied by the supervisor or programme coordinator); **input tracking** (confirming that materials, staff, and budget are being used as planned, and identifying deviations such as staff absence, material stockouts, or budget overspend); and **stakeholder feedback** (routine collection of simple feedback from participants and community contacts on whether the programme is meeting their needs and expectations, distinct from the formal outcome evaluation examined in Series 5). Monitoring data should be compiled regularly (weekly or monthly, depending on programme duration) and reviewed by the programme team, not merely collected and filed.

Fill in the blank: Monitoring is distinct from evaluation in being ongoing and _____ rather than periodic and outcome-focused; monitoring asks whether planned activities are being conducted, while evaluation asks whether they produced the intended change.

4.3.3 Adapting plans in response to monitoring findings

Monitoring is only useful if the information it generates is acted upon. **Adaptive management** is the practice of using monitoring data to make timely, evidence-based adjustments to implementation, rather than rigidly following the original work plan regardless of what monitoring reveals. Common monitoring findings that warrant plan adaptation include: **lower**

than expected attendance at group sessions (requiring investigation of barriers: scheduling conflicts, distance, lack of community awareness, cultural concerns) and corresponding adjustment of timing, venue, or mobilisation approach; **staff underperformance** (requiring additional supervision, retraining, or reallocation of responsibilities); **material shortages** (requiring expedited resupply or substitution with alternative materials); and **emerging community concerns** or **external events** (a disease outbreak, a community conflict, or a national celebration) that may make it necessary to reschedule activities or adapt content to the changed context.

Adaptive management requires the programme coordinator to maintain a balance between **fidelity** (implementing the programme as planned and as evidence supports) and **flexibility** (responding to real-world implementation conditions that the plan could not fully anticipate). This balance is achieved by distinguishing between adaptations that are consistent with the programme theory and learning objectives (changing a session venue to improve attendance without changing the content or method) and adaptations that would fundamentally undermine the programme ability to achieve its objectives (dropping the demonstration component of a skill-building session because it is inconvenient, in a programme where demonstration and return demonstration are the core mechanism of behaviour change). The programme coordinator, drawing on the supervisory principles established in Series 2, has the authority and responsibility to make the former category of adaptation without waiting for formal approval, while escalating the latter for team review.

Fill in the blank: _____ management is the practice of using monitoring data to make timely, evidence-based adjustments to implementation, balancing fidelity to the programme design with flexibility to respond to real-world implementation conditions.

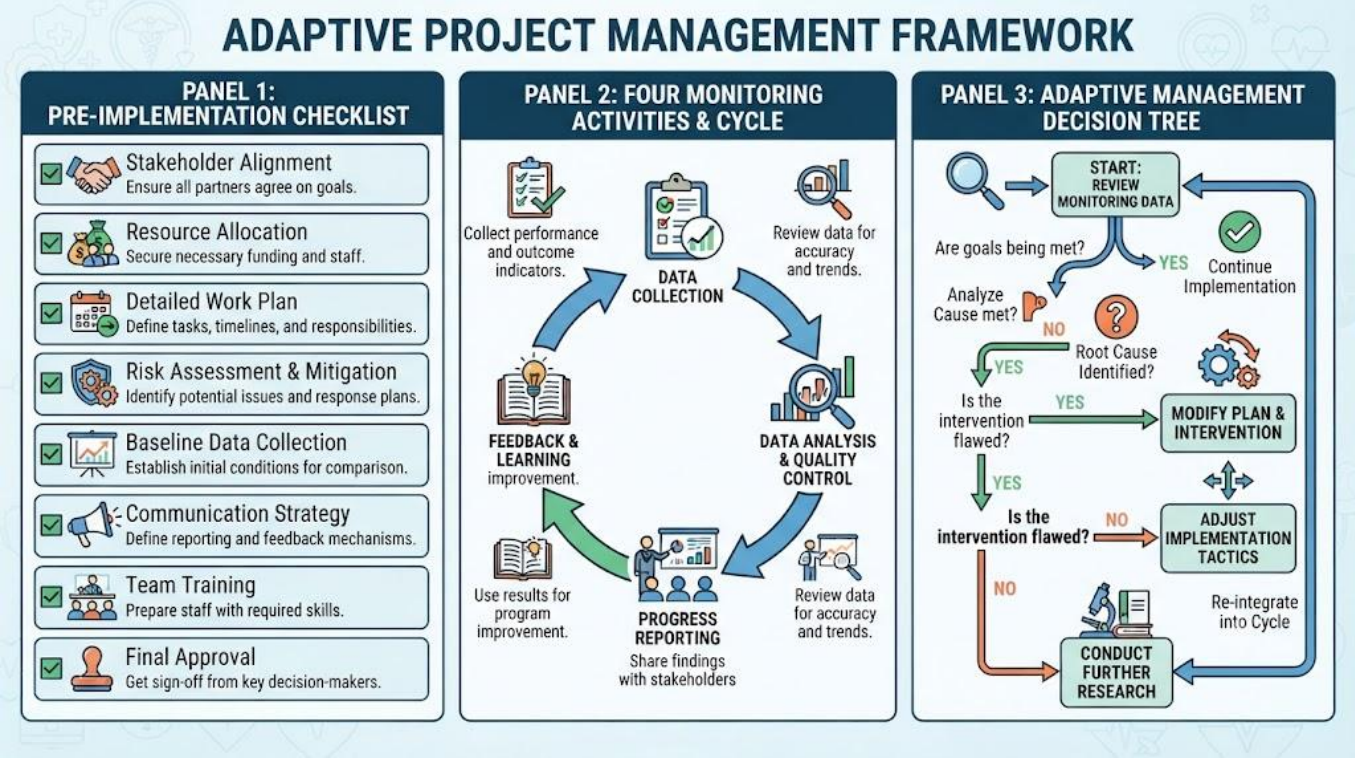

Figure 4.3: Implementation preparation, monitoring, and adaptive management

Pilot questions 4.3

1. Name four categories of pre-implementation preparation.
2. Why is community preparation important before health education activities begin?
3. Distinguish between monitoring and evaluation in health education.
4. Name four monitoring activities used in health education programme implementation.
5. What is adaptive management and what distinguishes acceptable adaptations from those requiring team review?

Series Summary

This Series examined the systematic planning of health education programmes as the discipline that converts health education knowledge into coordinated, accountable action. The case for planning was established through its benefits of clarity, efficiency, accountability, coordination, community ownership, and quality. The ten-step planning cycle was described, from needs assessment through implementation, monitoring, evaluation, and dissemination. Needs assessment was examined as the factual foundation of planning, with five methods: KAP surveys, focus groups, key informant interviews, data review, and direct observation, triangulated to produce a reliable picture of community health education needs.

Objectives were examined through the SMART criteria, and a worked objective format was demonstrated. Activity and resource selection applied the methods and media knowledge of Series 3 to the planning context, and work plan and budget development were described as the operational tools that translate plans into action. Implementation preparation, systematic monitoring through activity tracking, process monitoring, input tracking, and stakeholder feedback, and adaptive management through evidence-based plan adjustment were examined as the operational disciplines that ensure planned health education activities are actually delivered to the intended standard, setting the stage for the evaluation content of Series 5 (SLOs 4.1 to 4.6).

Glossary of Terms

1. **Adaptive management:** the practice of using monitoring data to make timely, evidence-based adjustments to health education programme implementation.
2. **Budget:** a financial estimate of the costs required to implement a health education programme, organised by budget line categories.
3. **Evaluation:** the systematic assessment of whether a health education programme achieved its stated objectives; distinct from monitoring.

4. **Fidelity:** the degree to which a programme is implemented as planned and as the evidence base supports.
5. **KAP survey:** a structured questionnaire assessing knowledge, attitudes, and practices in a representative sample of a target population.
6. **Monitoring:** the routine, systematic tracking of programme implementation against the work plan to confirm activities are being conducted as planned.
7. **Needs assessment:** a systematic process of collecting and analysing information about a target population health education needs, barriers, and assets.
8. **Process monitoring:** observation of selected health education sessions to assess delivery quality using a structured checklist.
9. **SMART objectives:** health education objectives that are Specific, Measurable, Achievable, Relevant, and Time-bound.
10. **Work plan:** an implementation schedule specifying activities, locations, responsible persons, timelines, required inputs, and verification sources for a health education programme.

Concept Check Questions [Series 4]

Objective questions

- A _____ planning process involving the community in identifying needs and setting priorities is itself a health education activity that builds community ownership. (Linked to SLO 4.1)
- The ten planning steps begin with needs assessment and end with _____ of findings to stakeholders and the professional community. (Linked to SLO 4.2)
- _____ surveys are structured questionnaires assessing knowledge, attitudes, and practices in a representative sample. (Linked to SLO 4.3)
- A SMART objective is Specific, Measurable, Achievable, _____ , and Time-bound. (Linked to SLO 4.4)
- A work plan is typically presented as a matrix or _____ chart, with activities in rows and time periods in columns. (Linked to SLO 4.5)
- Monitoring asks whether planned activities are being conducted, while _____ asks whether they produced the intended change. (Linked to SLO 4.6)

Short-answer questions

- Describe the ten steps in planning a health education programme. (Linked to SLO 4.2)
- Explain the SMART criteria for writing health education objectives and write one SMART objective for a malaria prevention programme in a rural Nigerian community. (Linked to SLO 4.4)

Long-answer questions

- Discuss the health education needs assessment process, describing the methods used and explaining how findings inform subsequent planning decisions. (Linked to SLOs 4.2–4.3)
- Evaluate the role of monitoring in health education programme implementation, including the types of monitoring activities, the principle of adaptive management, and how to distinguish acceptable from unacceptable plan adaptations. (Linked to SLO 4.6)

Answers to Concept Check Questions [Series 4]

Objective questions

1. Participatory.
2. Dissemination.
3. KAP.
4. Relevant.
5. Gantt.
6. Evaluation.

Short-answer questions

7. Step 1: Assess needs. Step 2: Define the target population. Step 3: Set goals and objectives. Step 4: Select methods and media. Step 5: Develop educational materials. Step 6: Develop the work plan and budget. Step 7: Implement. Step 8: Monitor. Step 9: Evaluate. Step 10: Disseminate findings.
8. SMART: Specific (clear about what will change, in whom), Measurable (assessable with available tools), Achievable (realistic given resources and context), Relevant (addressing an identified need), Time-bound (with a specified timeframe). Malaria prevention example: "By the end of the three-month programme, at least 75% of mothers of children under five in Gboko ward will correctly demonstrate how to hang and use an insecticide-treated bed net, as assessed by structured observation during home visits."

Long-answer questions

9. **Basic response:** Needs assessment systematically collects information about health education needs, barriers, and assets. Methods: KAP survey (quantitative baseline on knowledge, attitudes, practices); focus group discussions (social norms and community perceptions); key informant interviews (expert knowledge from health workers and leaders); review of existing data (facility records, surveillance data); direct observation (actual health practices and environmental conditions). Triangulating across methods provides the most complete picture. Findings inform: which health problems to prioritise,

which knowledge gaps and misconceptions to address, which barriers and enablers exist, which community assets can be leveraged, and which methods and media are appropriate for the target population.

Value-added response: The most common planning failure in Nigerian health education programmes is not the absence of planning but the substitution of assumption for genuine needs assessment: programme designers assume they know what communities need to learn, design a programme around those assumptions, and then discover during implementation or evaluation that the real barriers and knowledge gaps were different from what they assumed. A genuine needs assessment, even a rapid one using only a few key informant interviews and review of facility data, systematically reduces this assumption-to-reality gap at modest cost relative to the programme investment it protects.

10. **Basic response:** Monitoring is routine, systematic tracking of implementation against the work plan, distinct from evaluation (which assesses outcomes). Types: activity tracking (which planned activities were conducted, when, with how many participants); process monitoring (quality of session delivery assessed by structured observation); input tracking (materials, staff, and budget used as planned); stakeholder feedback (routine participant and community feedback). Adaptive management: using monitoring data for timely, evidence-based adjustments, balancing fidelity (implementing as planned) and flexibility (responding to real conditions). Acceptable adaptations: changing session venue or timing without changing content or method. Unacceptable adaptations (requiring team review): dropping the core mechanism of behaviour change (e.g. removing demonstration from a skill-building session) or fundamentally changing the target population or objectives.

Value-added response: Monitoring is the activity most consistently under-resourced in Nigerian health education programmes, both in budget allocation and in supervisory time. When monitoring is neglected, programme teams discover only at evaluation that activities were not conducted as planned, that materials ran out mid-programme, or that attendance was consistently low, at which point the opportunity to correct these problems has passed. Investing proportionate monitoring resources, including supervisory site visits and regular

data review meetings, is not optional for effective programme management but a prerequisite for converting planned activities into achieved objectives.

Answers to Pilot Questions [Series 4]

Part 4.1

6. Any three of: clarity of purpose, efficient resource use, accountability, coordination, community ownership, quality of health education delivered.
7. Step 1: Assess needs. Step 2: Define target population. Step 3: Set goals and objectives. Step 4: Select methods and media. Step 5: Develop educational materials. Step 6: Develop work plan and budget. Step 7: Implement. Step 8: Monitor. Step 9: Evaluate. Step 10: Disseminate findings.
8. A systematic process of collecting and analysing information about a target population health-related knowledge, attitudes, and practices, the factors influencing these behaviours, and the assets and resources available to support health education.
9. KAP surveys, focus group discussions, key informant interviews, review of existing data, and direct observation.
10. Because each method captures different types of information and has different limitations; triangulating across multiple methods provides a more complete and reliable picture of needs than any single approach can offer alone.

Part 4.2

11. Specific, Measurable, Achievable, Relevant, and Time-bound.
12. Example: "By the end of the two-month programme, at least 80% of mothers attending Garki PHC will correctly state the recommended six steps of handwashing, as measured by a structured knowledge assessment at the final session."

13. Human resources (staff and volunteers), material resources (educational materials and equipment), financial resources (budget for all activities), and information resources (data collection tools and reference materials).
14. The specific activity, target location and population, responsible person or team, date or time period, inputs required, and verification source confirming completion.
15. Personnel costs (staff salaries, volunteer allowances), material costs (printing, equipment), operational costs (transportation, venue hire, communication), and indirect costs (overheads, management).

Part 4.3

1. Staff preparation, material preparation, community preparation, and logistical preparation.
2. Because it ensures community leaders and the target population are informed of the programme purpose and schedule, builds community awareness and motivation to participate, and allows community members to take any necessary preparatory actions before activities begin.
3. Monitoring is the ongoing tracking of whether planned activities are being conducted as intended; it asks "are we doing what we planned?" Evaluation is the periodic assessment of whether the programme achieved its stated objectives; it asks "did what we did produce the intended change?"
4. Activity tracking (recording activities conducted, timing, and attendance), process monitoring (observing session delivery quality), input tracking (confirming materials, staff, and budget used as planned), and stakeholder feedback (routine participant and community feedback on programme delivery).
5. Adaptive management is the use of monitoring data to make timely, evidence-based adjustments to implementation. Acceptable adaptations (not requiring team review) are those consistent with the programme theory and objectives, such as changing a session venue. Adaptations requiring team review are those that would fundamentally undermine

the programme ability to achieve its objectives, such as dropping the core mechanism of behaviour change.

References and Attributions [Series 4]

Textual references

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9. National Open University of Nigeria (NOUN). (2023). Health education and health advocacy course material. NOUN Press.

Figures, Plates, Tables, and Boxes

11. Figure 4.1: The health education planning cycle and needs assessment methods Attribution: AI generated using prompt "Generate a two-panel diagram showing the ten-step health education planning cycle and five needs assessment methods with descriptions." Suggested OER search string: "health education planning cycle needs assessment KAP survey focus group steps OER"
12. Figure 4.2: SMART objectives, work plan structure, and budget components Attribution: AI generated using prompt "Generate a three-panel diagram showing SMART objective criteria with example, a work plan matrix structure, and standard health education budget lines." Suggested OER search string: "SMART objectives health education work plan Gantt chart budget personnel materials operational OER"
13. Figure 4.3: Implementation preparation, monitoring, and adaptive management Attribution: AI generated using prompt "Generate a three-panel diagram showing a pre-implementation checklist, four monitoring activities with cycle, and an adaptive management decision tree." Suggested OER search string: "health education

implementation monitoring adaptive management checklist process monitoring activity tracking OER"

Course code: COM 403

Course title: Health Education and Health Advocacy

Course credit load: 1 Unit

Series 5: Strategies and Evaluation of Health Education

- **Part 5.1: Health Education Strategies**
  - Sub Part 5.1.1: Definition and types of health education strategies
  - Sub Part 5.1.2: Community mobilisation as a health education strategy
  - Sub Part 5.1.3: Advocacy as a health education strategy
- **Part 5.2: Evaluation of Health Education Programmes**
  - Sub Part 5.2.1: Purpose and types of evaluation
  - Sub Part 5.2.2: Evaluation designs and methods
  - Sub Part 5.2.3: Measuring knowledge, attitude, and behaviour change
- **Part 5.3: Using Evaluation Findings and Synthesis**
  - Sub Part 5.3.1: Interpreting and reporting evaluation findings
  - Sub Part 5.3.2: Using evaluation findings to improve health education practice
  - Sub Part 5.3.3: Health education and advocacy: synthesis and the way forward

Introduction

The final Series of this course brings together the strategic and evaluative dimensions of health education, completing the cycle that began with defining health education in Series 1 and passed through roles, methods, and planning in the intervening Series. Strategy answers the question of how to organise and sustain health education at scale, beyond the level of individual sessions or single programmes. Evaluation answers the question of whether those efforts have actually produced the health behaviour change they were designed to achieve.

The aim of this Series is to describe the major strategies used to organise and deliver health education at scale, with particular attention to community mobilisation and health advocacy; to examine the purpose, types, designs, and methods of health education programme evaluation; and to address how evaluation findings are interpreted, reported, and used to improve practice, concluding the course with a synthesis of health education and advocacy as an integrated discipline.

We shall commence by defining health education strategies and examining community mobilisation and advocacy as the two most significant strategic approaches. Next, we will examine the evaluation process, from purpose through design, method, and measurement. Finally, we will close by examining how findings are used and by synthesising the health education and advocacy competencies developed across the full course.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 5.1** define health education strategies and describe the major strategic approaches,
- **SLO 5.2** explain community mobilisation as a health education strategy,
- **SLO 5.3** explain health advocacy as a strategy and describe its tools and approaches,
- **SLO 5.4** distinguish between formative, process, and summative evaluation in health education,
- **SLO 5.5** describe the designs and methods used to evaluate health education programmes,

- **SLO 5.6** explain how to measure knowledge, attitude, and behaviour change in health education evaluation, and
- **SLO 5.7** describe how evaluation findings are interpreted, reported, and used to improve health education practice.

5.1 Health Education Strategies

5.1.1 Definition and types of health education strategies

A **health education strategy** is a broad plan or approach that organises and directs health education efforts toward achieving defined health outcomes, operating at a level above individual methods or activities. Whereas a method describes how a single educational encounter is conducted (counselling, health talk, demonstration), a strategy describes how a portfolio of methods and activities is organised, sequenced, and sustained to produce population-level health behaviour change that no single method could achieve alone. The distinction parallels the difference between a military tactic (a specific battle action) and a military strategy (the overall campaign plan): tactics serve the strategy, and the same tactic can be applied in the service of fundamentally different strategies.

The major health education strategies include: **information, education, and communication (IEC)**, which uses mass media, print, and community-level educational events to build knowledge and awareness across large populations; **communication for behaviour change (C4BC or BCC)**, which applies social and behavioural theory to design targeted, multi-channel communication programmes aimed at specific behaviour change; **community mobilisation**, which builds community awareness, motivation, and collective capacity to act on health issues from within; **health advocacy**, which influences the policies, systems, and resource allocations that shape the health enabling environment; and **social marketing**, which applies commercial marketing principles (audience segmentation, product positioning, promotion, pricing, and place/distribution) to health behaviour change. This Series examines community mobilisation

and advocacy in depth, as they are the strategies most directly connected to the community health practice context of this course.

Fill in the blank: A health education _____ is a broad plan that organises and directs health education efforts toward population-level health outcomes, operating above the level of individual methods or activities.

5.1.2 Community mobilisation as a health education strategy

Community mobilisation is the process through which community members are encouraged, supported, and enabled to identify their own health priorities, organise their collective resources and capabilities, and take action to address those priorities, with technical support from health educators and public health practitioners but ultimately driven by the community own energy and ownership. It differs from community education (delivering health messages to a community) in being participatory, action-oriented, and sustainability-focused rather than message-focused: the goal is not a community that knows more about health but a community that is actively engaged in improving its own health conditions.

Community mobilisation approaches include **community dialogue** (facilitated discussions among community members and leaders to identify and prioritise local health concerns), **community action planning** (participatory processes in which community members develop their own plans for addressing identified health priorities), **community health committees** (permanent structures within which community members exercise oversight of local health services and coordinate community health action, such as the ward health committees established within the Nigerian PHC system), and **community-led total sanitation** (CLTS, the approach used for open-defecation-free communities examined in related courses). In Nigeria, successful community mobilisation has been demonstrated in immunisation campaigns, community-based malaria prevention, and community water and sanitation improvement, consistently showing that community-driven interventions are more sustainable and better maintained than externally imposed technical solutions.

Fill in the blank: Community mobilisation differs from community education in being participatory, action-oriented, and _____ -focused rather than message-focused, aiming for a community actively engaged in improving its own health conditions.

5.1.3 Advocacy as a health education strategy

Health advocacy, introduced in Series 1 as the outermost ring of the nested health promotion model, is the strategic use of communication, evidence, coalition-building, and influence to change the policies, resource allocations, and social norms that shape population health. As a health education strategy, advocacy operates at a level above the individual and community, seeking to create the policy and environmental conditions that make health-enabling choices easier, safer, and more affordable for everyone, not only those who have received direct health education. Examples of health advocacy in Nigeria include lobbying for the implementation of the Basic Health Care Provision Fund, campaigning for tobacco tax increases, advocating for improved sanitation infrastructure in underserved communities, and working with traditional and religious leaders to create social norms supportive of immunisation acceptance.

Effective health advocacy uses a combination of **evidence** (rigorous data on the scale of the problem and the effectiveness of proposed solutions), **coalition-building** (assembling a broad alliance of organisations and individuals whose collective influence exceeds what any single actor could achieve), **media engagement** (using print, broadcast, and social media to build public awareness and political pressure around health issues), **direct policy engagement** (meeting with legislators, ministry officials, and decision-makers to present evidence and make the case for policy change), and **community voice** (ensuring that the communities most affected by health issues speak directly to decision-makers rather than being represented only by professionals on their behalf). Health advocacy is not the same as lobbying for organisational self-interest; it requires both evidence-based commitment to the public health goal and transparent, ethical conduct in how influence is exercised.

Fill in the blank: Effective health advocacy combines evidence, coalition-building, media engagement, direct policy engagement, and _____ voice, ensuring communities most affected by health issues speak directly to decision-makers.

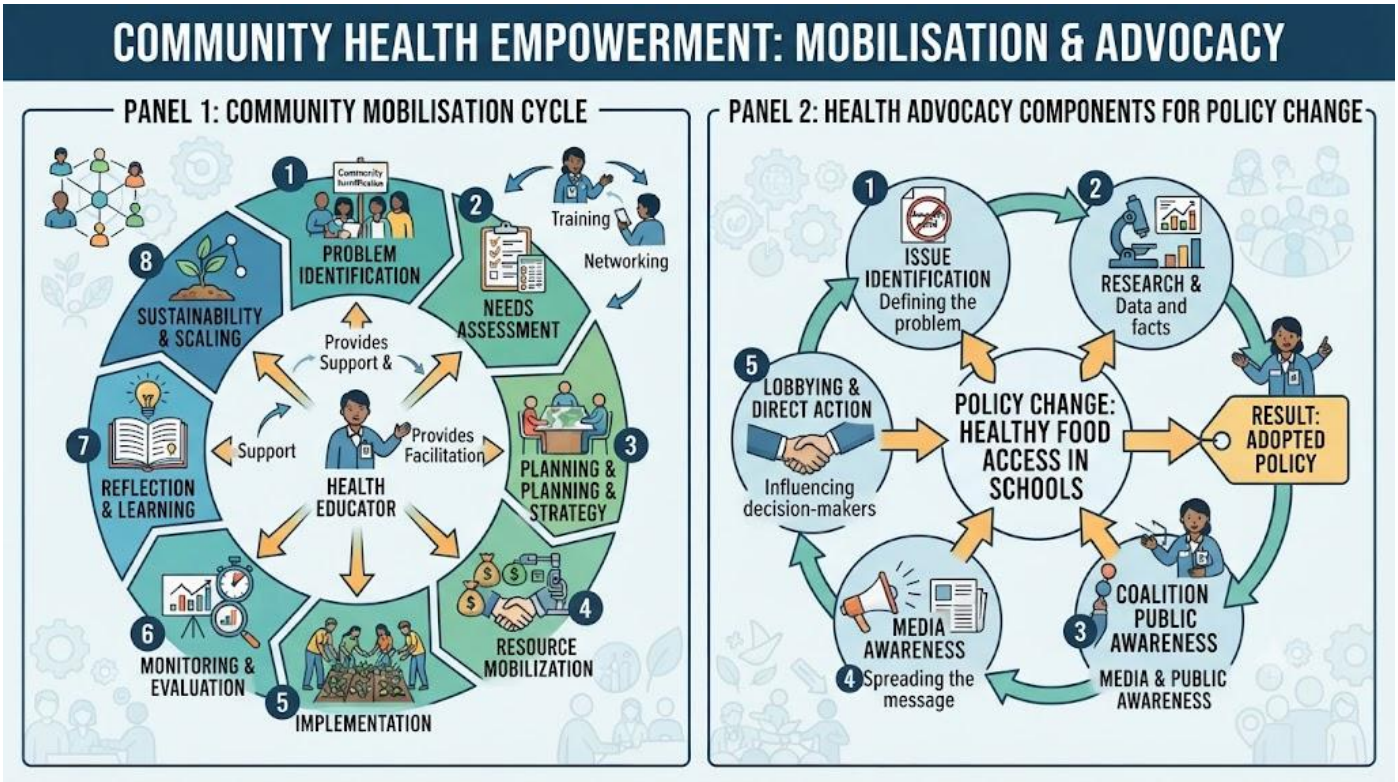

Figure 5.1: Health education strategies: community mobilisation and advocacy

Pilot questions 5.1

1. Distinguish between a health education method and a health education strategy.
2. Name five major health education strategies.
3. How does community mobilisation differ from community education?
4. Name three community mobilisation approaches used in Nigerian health education.
5. Name five components of effective health advocacy.

5.2 Evaluation of Health Education Programmes

5.2.1 Purpose and types of evaluation

Evaluation of health education programmes serves several purposes: **accountability** (demonstrating to funders, health authorities, and communities that resources were used

effectively and that the programme delivered on its commitments), **learning** (identifying what worked, what did not work, and why, generating evidence to improve future health education programmes), **advocacy** (providing evidence of health education impact to make the case for sustained or expanded investment), and **programme improvement** (identifying specific weaknesses in the current programme that can be corrected in the next cycle, drawing directly on the adaptive management principle of Series 4). Without evaluation, health education programmes operate on faith that they are producing their intended outcomes rather than on evidence, making it impossible to distinguish effective from ineffective practice or to justify continued investment.

Health education evaluation is classified by its timing and purpose into three types. **Formative evaluation** occurs before or during programme development, testing whether planned approaches (methods, materials, messages) are appropriate, understandable, and acceptable to the target population; the pretesting of health education materials examined in Series 3 is a form of formative evaluation. **Process evaluation** (also called implementation evaluation) assesses how well the programme was implemented: were activities conducted as planned, did the intended population receive the programme, and was delivery quality adequate? It corresponds closely to the monitoring activities described in Series 4. **Summative evaluation** (also called outcome evaluation) assesses whether the programme achieved its intended knowledge, attitude, or behaviour change objectives, measured at the conclusion of the programme or at a defined follow-up point.

Fill in the blank: _____ evaluation assesses whether a health education programme achieved its intended knowledge, attitude, or behaviour change objectives, measured at the conclusion of the programme or at a defined follow-up point.

5.2.2 Evaluation designs and methods

The **evaluation design** determines whether an observed change in knowledge, attitude, or behaviour can be confidently attributed to the health education programme rather than to other concurrent influences. The **pre-test/post-test design** (measuring the outcome at baseline, before the programme, and again at follow-up, after the programme) is the most common design in

health education evaluation, demonstrating that change occurred over the programme period. It cannot, however, rule out the possibility that the observed change was caused by something other than the programme (seasonal health campaigns, media coverage, or natural trends). The **pre-test/post-test with control group design** adds a comparison group that did not receive the programme but is measured at the same time points, allowing the change in the programme group to be compared with the change in the control group; if the programme group changes more, this provides stronger evidence that the programme was responsible for the difference.

In practice, randomised controlled designs are rarely feasible in community health education settings, and most evaluations use quasi-experimental or observational designs. **Data collection methods** include: **structured questionnaires** (for measuring knowledge and self-reported attitudes and practices, the most commonly used method in health education evaluation); **structured observation** (directly observing practices such as handwashing technique, bed net use, or infant feeding behaviour, providing more objective evidence than self-report but more resource-intensive); **biological or clinical measures** (such as nutritional status, immunisation coverage, or sexually transmitted infection rates, providing objective outcome data but requiring additional clinical resources); and **qualitative methods** (focus groups and interviews to understand why changes did or did not occur and what the community experience of the programme was), which complement rather than replace quantitative outcome measures.

Fill in the blank: The pre-test/post-test with _____ group design adds a comparison group not receiving the programme, allowing the change in the programme group to be compared to the change in the comparison group for stronger attribution evidence.

5.2.3 Measuring knowledge, attitude, and behaviour change

Health education outcomes are measured across three domains corresponding to the KAP framework introduced in Series 1. **Knowledge** is measured through written or oral test questions assessing recall and understanding of the health information addressed in the programme: true/false items, multiple-choice questions, and open-ended questions that require the respondent to explain or demonstrate understanding rather than merely recognise a correct answer. Knowledge measurement is the most straightforward evaluation domain but is also the least

clinically significant: changes in knowledge do not guarantee changes in attitude or behaviour, and programmes that demonstrate knowledge gains without corresponding behaviour change have not achieved their core purpose.

Attitude measurement uses Likert scale items (statements rated from strongly agree to strongly disagree), semantic differential scales, or open-ended questions probing beliefs, values, and perceived social norms. Attitude measurement is more complex than knowledge measurement because attitudes are multidimensional, socially influenced, and sometimes reported inaccurately due to social desirability bias (respondents answering as they think they should feel rather than as they actually feel). **Behaviour** measurement is the most important and most challenging domain: self-reported behaviour (asking respondents what they do) is subject to recall error and social desirability bias; direct observation of behaviour is more accurate but expensive and often impractical for private behaviours; and biological or clinical proxies (immunisation card records, anthropometric measurements, clinic attendance data) provide objective evidence of some health behaviours but are not available for all the behaviours that health education programmes address.

Fill in the blank: _____ scale items, rating agreement with health attitude statements from strongly agree to strongly disagree, are commonly used to measure attitude change in health education programme evaluation.

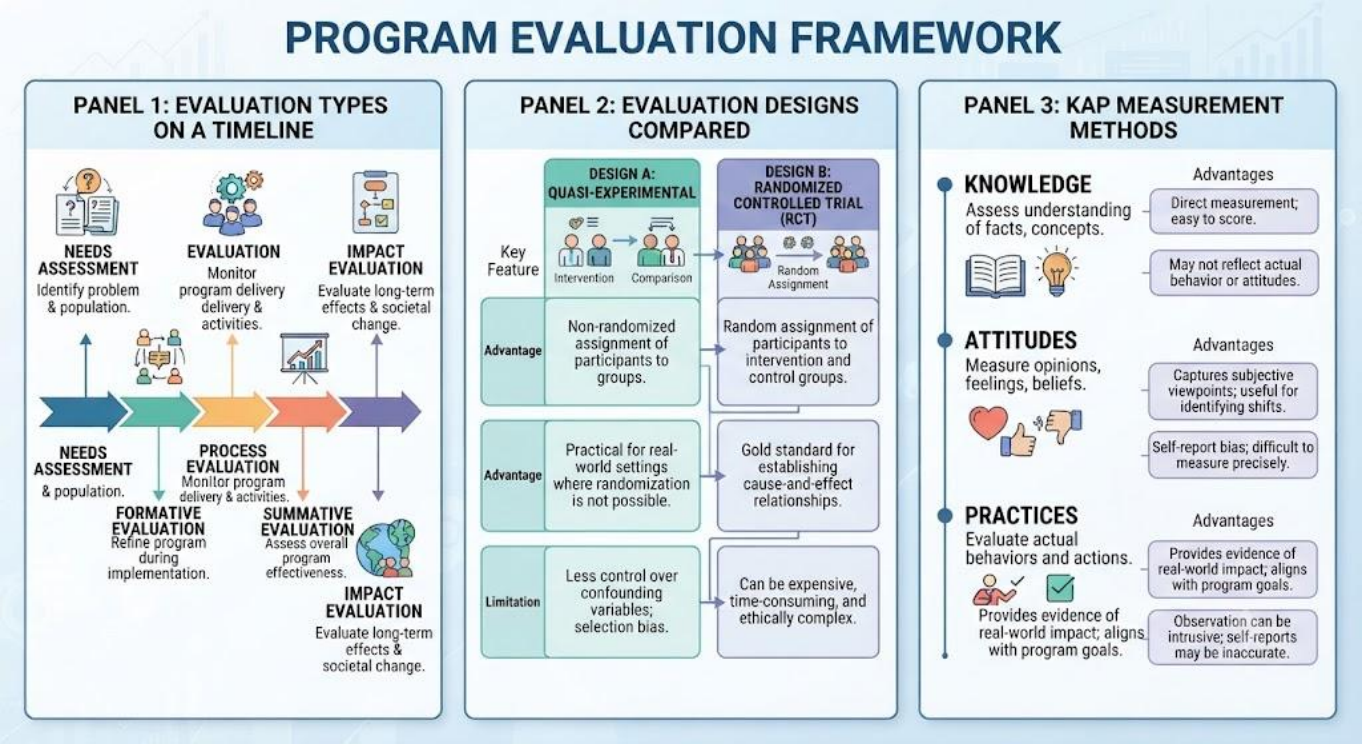

Figure 5.2: Evaluation types, designs, and KAP outcome measurement

Pilot questions 5.2

1. Name four purposes of health education programme evaluation.
2. Distinguish between formative, process, and summative evaluation.
3. What limitation of the pre-test/post-test design does adding a control group address?
4. Name four data collection methods used in health education evaluation.
5. Why is behaviour the most important but most challenging domain to measure in health education evaluation?

5.3 Using Evaluation Findings and Synthesis

5.3.1 Interpreting and reporting evaluation findings

Interpretation of health education evaluation findings requires more than calculating whether outcome measures changed between pre-test and post-test. The evaluator must consider:

statistical significance (whether the observed change is large enough to be unlikely due to chance, typically assessed through appropriate statistical tests); **practical significance** (whether the magnitude of the change is large enough to be meaningful for health outcomes, since a statistically significant one-percentage-point increase in handwashing practice is unlikely to produce meaningful reductions in diarrhoeal disease); **attribution** (the degree to which the programme can reasonably be credited with the observed change, given the evaluation design used and any concurrent influences that may have affected the outcome); and **equity** (whether the programme reached and produced changes among the most vulnerable subgroups, or whether average changes conceal widening disparities between those who benefited and those who did not).

Evaluation **reports** should follow a clear structure: an executive summary for busy decision-makers; background describing the programme context and objectives; methodology explaining the evaluation design, data collection methods, and limitations; results presenting the findings against each stated objective; discussion interpreting what the findings mean and why; conclusions and recommendations providing actionable guidance for programme improvement; and appendices containing data collection instruments and detailed data tables. Evaluation reports should be written in language accessible to their intended primary audience: a report for community health workers and LGA health management teams requires different language and level of technical detail than a report for a national programme management team or an international funding body. Sharing evaluation findings with the host community itself, in an accessible, non-technical summary, is both an ethical obligation and a practical investment in sustaining community trust and cooperation for future programmes.

Fill in the blank: Evaluation findings must be assessed for statistical significance, practical significance, _____ (whether the programme can be credited with the observed change), and equity (whether the most vulnerable subgroups were reached and benefited).

5.3.2 Using evaluation findings to improve health education practice

Evaluation findings are valuable only if they are acted upon. The most common and most damaging failure in health education evaluation is the completion of a rigorous evaluation whose

findings are filed away without informing subsequent programme design, a phenomenon sometimes called the **"evaluation-implementation gap"**. Closing this gap requires: a programme review meeting at which the full programme team discusses evaluation findings together, distinguishing what worked from what did not and generating specific, actionable lessons; a written **lessons learned** document that captures these findings in a format accessible to future programme designers; and an explicit commitment, documented in the design of the next programme cycle, to how lessons from the current evaluation have been incorporated into the new design, methods, or implementation approach.

Evaluation findings also contribute to the broader evidence base for health education practice when they are **disseminated** beyond the immediate programme team, through publication in professional journals, presentation at conferences, sharing with LGA and state health management teams, and inclusion in national health education policy reviews. Nigeria health education practice, like health education practice globally, has a systematic tendency to repeat the same approaches regardless of whether they have been shown to work in the local context, because evaluation findings are rarely disseminated effectively. Health education practitioners who evaluate their work rigorously and share their findings responsibly, even when findings are mixed or negative, contribute disproportionately to the cumulative improvement of health education practice in their communities and their country.

Fill in the blank: The _____ -implementation gap describes the common failure in which a completed health education evaluation produces findings that are filed away without informing subsequent programme design.

5.3.3 Health education and advocacy: synthesis and the way forward

This course has traced health education from its foundational principles and theoretical models through the roles and communication skills of practitioners, the methods and media available for delivery, the systematic planning process, the strategic organisation of health education at scale, and finally to the evaluation of outcomes. Throughout this arc, a consistent theme has recurred: health education is most effective when it is grounded in a genuine understanding of the target community knowledge, attitudes, practices, and context; delivered through methods and media

appropriate to that community; supported by complementary strategies including community mobilisation and advocacy that address the enabling environment as well as individual knowledge; planned systematically with clear, measurable objectives; and evaluated rigorously so that practice continuously improves.

The integration of **health education** and **health advocacy** as a unified discipline reflects the recognition that individual behaviour change, however well-supported by excellent health education, cannot sustainably improve population health if the structural, policy, and environmental determinants of health are not also addressed. A mother who knows and wants to use oral rehydration therapy but cannot afford or access it needs advocacy for better essential medicine supply, not more education about why ORT is beneficial. A community that wants to stop open defecation but has no sanitation infrastructure needs advocacy for government investment, not more hygiene education. The health educator who understands both the individual dimensions of health behaviour change and the structural dimensions of health equity, and who can work at both levels simultaneously, embodies the full professional competence that this course has sought to develop.

Fill in the blank: The integration of health education and health _____ as a unified discipline reflects the recognition that individual behaviour change cannot sustainably improve population health if the structural, policy, and environmental determinants of health are not also addressed.

Figure 5.3: The health education and advocacy cycle: from principles to impact

Pilot questions 5.3

1. Name four considerations in interpreting health education evaluation findings.
2. What should an evaluation report contain?
3. What is the evaluation-implementation gap and how can it be closed?
4. Name two ways evaluation findings can be disseminated beyond the immediate programme team.
5. Why does effective health education require integration with health advocacy?

Series Summary

This final Series completed the course by examining health education strategies and programme evaluation. Health education strategies were defined as broad plans organising educational efforts toward population-level outcomes, above the level of individual methods, and the major strategies of IEC, C4BC, community mobilisation, advocacy, and social marketing were described. Community mobilisation was examined as a participatory, sustainability-focused strategy organising community capacity for self-directed health action, with Nigerian applications in immunisation, malaria, and sanitation programmes. Health advocacy was examined as the strategic use of evidence, coalition-building, media engagement, and community voice to change policies and environments that shape population health.

Programme evaluation was described across its three types (formative, process, and summative) and examined through its designs (pre-test/post-test; pre-test/post-test with control group) and data collection methods (questionnaires, observation, biological measures, qualitative methods). The measurement of knowledge, attitude, and behaviour change was examined across the three domains of the KAP framework, with the limitations of self-report highlighted for behaviour measurement. Interpretation and reporting of findings, the evaluation-implementation gap, and the dissemination of lessons were addressed, and the Series and course concluded by synthesising health education and advocacy as an integrated discipline grounded in community understanding, appropriate methods, systematic planning, and rigorous evaluation (SLOs 5.1 to 5.7).

Glossary of Terms

1. **Attribution:** the degree to which a health education programme can reasonably be credited with an observed change in outcome, given the evaluation design used.
2. **C4BC (Communication for Behaviour Change):** a health education strategy applying social and behavioural theory to design targeted, multi-channel communication programmes for specific behaviour change.

3. **Community mobilisation:** a health education strategy enabling communities to identify their own health priorities and take collective action, driven by community ownership.
4. **Evaluation-implementation gap:** the common failure in which evaluation findings are completed but not acted upon to improve subsequent programme design.
5. **Formative evaluation:** evaluation conducted before or during programme development to test whether planned approaches are appropriate, understandable, and acceptable to the target population.
6. **IEC (Information, Education, and Communication):** a health education strategy using mass media, print, and community events to build health knowledge and awareness.
7. **Likert scale:** a rating scale commonly used to measure attitudes, asking respondents to rate their agreement with statements from strongly agree to strongly disagree.
8. **Process evaluation:** evaluation assessing how well a health education programme was implemented, whether activities were conducted as planned, and whether quality was adequate.
9. **Social marketing:** a health education strategy applying commercial marketing principles (segmentation, positioning, promotion, price, place) to health behaviour change.
10. **Summative evaluation:** evaluation assessing whether a health education programme achieved its intended knowledge, attitude, or behaviour change objectives.

Concept Check Questions [Series 5]

Objective questions

- A health education _____ is a broad plan organising educational efforts toward population-level outcomes, above the level of individual methods or activities. (Linked to SLO 5.1)
- Community mobilisation differs from community education in being participatory, action-oriented, and _____ -focused. (Linked to SLO 5.2)
- _____ evaluation assesses whether a health education programme achieved its intended KAP objectives, measured at the conclusion of the programme. (Linked to SLO 5.4)
- The pre-test/post-test with _____ group design provides stronger attribution evidence than pre-test/post-test alone. (Linked to SLO 5.5)
- _____ scale items rating agreement with attitude statements from strongly agree to strongly disagree are commonly used to measure attitude change. (Linked to SLO 5.6)
- The evaluation-_____ gap describes the common failure in which completed evaluation findings are not acted upon to improve subsequent programme design. (Linked to SLO 5.7)

Short-answer questions

- Describe community mobilisation as a health education strategy, giving two Nigerian examples of its application. (Linked to SLO 5.2)
- Distinguish between formative, process, and summative evaluation, explaining the purpose of each in a health education programme. (Linked to SLO 5.4)

Long-answer questions

- Evaluate the components and conduct of health education programme evaluation, covering evaluation types, designs, data collection methods, and the measurement of KAP outcomes. (Linked to SLOs 5.4–5.6)

- Discuss health education and advocacy as an integrated discipline, explaining why effective health education requires both individual-level educational approaches and structural advocacy. (Linked to SLOs 5.1–5.3, 5.7)

Answers to Concept Check Questions [Series 5]

Objective questions

1. Strategy.
2. Sustainability.
3. Summative.
4. Control.
5. Likert.
6. Implementation.

Short-answer questions

7. Community mobilisation is a participatory strategy enabling communities to identify health priorities and take collective action, driven by community ownership rather than external direction. Nigerian examples: immunisation campaigns in which community leaders and traditional rulers have actively mobilised their communities for vaccination uptake during National Immunisation Days; community-led total sanitation (CLTS) programmes in which community members collectively decided to end open defecation and constructed their own latrines without external subsidy.
8. Formative evaluation: occurs before or during programme development; tests whether planned methods, materials, and messages are appropriate, understandable, and acceptable to the target population; purpose is to improve the programme before it is fully implemented. Process evaluation: occurs during implementation; assesses whether activities were conducted as planned and whether delivery quality was adequate; purpose is to identify and correct implementation gaps. Summative evaluation: occurs at programme conclusion; assesses whether the programme achieved its intended

knowledge, attitude, or behaviour change objectives; purpose is to determine effectiveness and inform future programme design.

Long-answer questions

9. **Basic response:** Evaluation types: formative (before/during development, tests appropriateness), process (during implementation, checks fidelity and quality), summative (at conclusion, assesses KAP outcomes). Designs: pre-test/post-test (measures change over programme period, cannot rule out external influences); pre-test/post-test with control group (adds comparison group not receiving programme, provides stronger attribution evidence). Data collection methods: structured questionnaires (knowledge and self-reported KAP), structured observation (directly observed behaviour), biological/clinical measures (objective outcomes), qualitative methods (why changes occurred or not). KAP measurement: knowledge (test questions, true/false, multiple-choice); attitude (Likert scales, semantic differential); behaviour (self-report, direct observation, biological proxies, each with different accuracy and feasibility trade-offs).

Value-added response: The sequence from formative to process to summative evaluation mirrors the sequence from planning to implementation to outcome, and neglecting any stage undermines the others: a programme that skips formative evaluation may deliver messages the community does not understand; one that skips process evaluation may evaluate outcomes without knowing whether the programme was actually delivered as planned; one that skips summative evaluation cannot demonstrate impact or improve the next cycle. The practical constraint that most Nigerian health education programmes face is not knowing which evaluation type to conduct but having sufficient resources and time to conduct any of them rigorously; where this is a binding constraint, a simple pre-test/post-test questionnaire measuring the primary KAP objectives is infinitely more valuable than no evaluation at all.

10. **Basic response:** Health education strategies: IEC (knowledge and awareness), C4BC (targeted behaviour change), community mobilisation (collective community action), advocacy (policy and environmental change). Community mobilisation: participatory, sustainability-focused, Nigerian examples in immunisation and CLTS. Advocacy:

evidence, coalition-building, media engagement, policy engagement, community voice; changes the enabling environment for health action. Integration: health education alone cannot produce sustainable population health improvement if structural barriers remain; a mother educated about ORT who cannot access it needs advocacy for medicine supply; a community educated about sanitation without infrastructure needs advocacy for investment. The health educator must work at both individual and structural levels simultaneously.

Value-added response: This integration is not merely a conceptual nicety; it is the practical lesson that emerges from the evidence on what produces durable population health improvement across Nigeria. The communities with the best health outcomes are not those that received the most health education campaigns, but those where health education was combined with functional health services, adequate medicine supply, enforced public health law, community political voice, and accountable health governance. Producing the health practitioners who understand and can act on this full system, rather than limiting their competence to individual-level educational encounters, is the ultimate purpose of this course.

Answers to Pilot Questions [Series 5]

Part 5.1

6. A method describes how a single educational encounter is conducted (e.g. counselling or demonstration). A strategy is a broader plan organising a portfolio of methods and activities toward population-level behaviour change that no single method could achieve alone.
7. Information, Education, and Communication (IEC), Communication for Behaviour Change (C4BC), community mobilisation, health advocacy, and social marketing.
8. Community education delivers health messages to a community (information transfer). Community mobilisation enables communities to identify their own health priorities and take collective action, driven by the community own energy and ownership rather than by external professionals.

9. Any three of: community dialogue, community action planning, community health committees, community-led total sanitation (CLTS).
10. Evidence, coalition-building, media engagement, direct policy engagement, and community voice.

Part 5.2

11. Any four of: accountability, learning, advocacy (making the case for investment), and programme improvement.
12. Formative evaluation: conducted before or during programme development to test appropriateness of planned methods and materials. Process evaluation: conducted during implementation to assess whether activities were conducted as planned and delivery quality was adequate. Summative evaluation: conducted at programme conclusion to assess whether KAP objectives were achieved.
13. The pre-test/post-test design cannot rule out external influences causing the observed change; adding a control group that is measured at the same time points but does not receive the programme allows the change in the programme group to be compared to the change in the control group, providing stronger evidence that the programme caused the difference.
14. Any four of: structured questionnaires, structured observation, biological or clinical measures, qualitative methods (focus groups and interviews).
15. Behaviour is the most important domain because it is the ultimate purpose of health education; it is the most challenging because self-reported behaviour is subject to recall error and social desirability bias, direct observation is resource-intensive and impractical for private behaviours, and biological proxies are not available for all relevant health behaviours.

Part 5.3

1. Statistical significance (is the change unlikely due to chance?), practical significance (is the magnitude of change clinically meaningful?), attribution (can the programme be credited with the change?), and equity (did the most vulnerable subgroups benefit?).
2. Executive summary, background, methodology, results, discussion, conclusions and recommendations, and appendices.
3. The evaluation-implementation gap occurs when completed evaluation findings are not acted upon to improve subsequent programme design. It can be closed through a programme review meeting discussing findings with the full team, a written lessons-learned document, and an explicit commitment in the next programme design showing how lessons have been incorporated.
4. Any two of: publication in professional journals, presentation at conferences, sharing with LGA and state health management teams, inclusion in national health education policy reviews.
5. Because individual behaviour change, however well-supported by health education, cannot sustainably improve population health if structural, policy, and environmental barriers prevent community members from acting on what they have learned; advocacy is needed to create the enabling environment in which health education produces lasting behavioural and health outcomes.

References and Attributions [Series 5]

Textual references

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7. Nutbeam, D., & Bauman, A. (2006). Evaluation in a nutshell: A practical guide to the evaluation of health promotion programs. McGraw-Hill.
8. World Health Organization. (2021). Advocacy, communication and social mobilisation for TB control: A guide to developing knowledge, attitude and practice surveys. WHO.
9. National Open University of Nigeria (NOUN). (2023). Health education and health advocacy course material. NOUN Press.

Figures, Plates, Tables, and Boxes

11. Figure 5.1: Health education strategies: community mobilisation and advocacy Attribution: AI generated using prompt "Generate a two-panel diagram showing the community mobilisation cycle with the health educator in a supporting role, and health advocacy components around a policy change goal." Suggested OER search string: "community mobilisation health advocacy strategy coalition-building evidence policy change Nigeria OER"
12. Figure 5.2: Evaluation types, designs, and KAP outcome measurement Attribution: AI generated using prompt "Generate a three-panel diagram showing evaluation types on a timeline, two evaluation designs compared, and KAP measurement methods with advantages and limitations." Suggested OER search string: "health education evaluation formative process summative pre-test post-test control group KAP measurement OER"
13. Figure 5.3: The health education and advocacy cycle: from principles to impact Attribution: AI generated using prompt "Generate a circular synthesis wheel showing the five health education and advocacy course themes as segments feeding into community health impact at the centre." Suggested OER search string: "health education advocacy synthesis evaluation strategies planning methods roles principles Nigeria OER"