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Coordinating Educational Initiatives Processed By a Variety of Program Actors within the Primary Health Care Setting

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Abstract: **Introduction**: The field of health education is dedicated to promoting healthy behaviors (Green et al., 1980; Tone and Tilford, 1994). Notable researchers, including Green et al. (1980), Sunderland (1979), French and Adams (1986), Smail (1992), and Macdonald (1994), have contributed significantly to health education research. Publications like Jinadu and Adetugbo (1992), Das Gupta, Gauri, and Khemani (2003), and the Nigerian Demographic and Health Survey (2008) have provided valuable insights, especially in developing countries like Nigeria.

Alternatively, the literature by distinguished health behavior researchers extensively highlights instances of inadequately coordinated or confused educational activities, serving as potential catalysts for health misinformation. As emphasized by Houlden et al. (2021), this complicates endeavors to promote healthy decision-making. The understanding of the intricacies in these scenarios is inherently linked to the accessibility of dependable data.

The insufficiency of data that assesses the effects of health education in developing nations, exemplified by Nigeria (FMOH, 2004), seems to impede efforts towards policy reform. The efficacy of health education is consistently under scrutiny due to the lack of well-defined methodologies, frameworks, and tangible program achievements. Within the primary healthcare (PHC) setting, various terms such as "social mobilization" and "Information Education Communication (IEC)" are casually employed, contributing to a complex interplay.

There are deficiencies in the management processes of health education, and its alignment with PHC programs is not well-defined. Policies often prioritize program acceptance rather than the specific behavioral and non-behavioral impacts. The Ward Minimum Health Care Package (WMHCP) aims to deliver ward-level services but lacks clear health education strategies.

This study addresses the disarray in PHC health education, with a focus on integrated maternal, newborn, and child health (IMNCH) in Ekiti State. It aims to explore how community needs influence health education practices, a topic of global debate (Brieger and Edozien, 1982; Ransome-

Kuti et al., 1990; Macdonald, 1994). Management elements play a vital role in strengthening health education standards and achieving measurable results, which is also relevant in the Nigerian context.

Objectives: This study aims to identify the educational efforts undertaken by various program stakeholders operating within the primary healthcare setting.

A primary focus is placed on critically evaluating the prevailing organizational models within educational interventions to identify potential deficiencies and inefficiencies hindering the optimal delivery of health education services. Additionally, the study aims to quantify these gaps through statistical analysis, shedding light on specific areas requiring immediate attention and intervention.

Data Analysis Method: The research methodology employs a rigorous approach, including well-structured surveys and in-depth interviews with health education professionals across diverse tiers of the PHC framework. Quantitative data undergoes comprehensive statistical analysis, revealing essential percentages and numerical trends. Qualitative responses are thematically analyzed in detail, providing nuanced insights into challenges and potential solutions.

Results: The empirical findings of this study shed light on critical aspects of the PHC health education landscape. The study reveals that 72% of health education professionals are female, indicating a significant gender disparity within the workforce. Remarkably, 89% of these professionals received training primarily on the job or through workshops, underscoring the absence of formal educational protocols. The study also finds that 68% of health education professionals operate within the dispersed organizational model, while 22% adopt coexisting models, and 10% employ specialist approaches. Furthermore, 56% of respondents express a reliance on external partners for planning, highlighting a concerning dependency on non-internal resources. Strikingly, 85% of health education professionals lack concrete selection criteria for educational targets, underscoring a critical gap in strategic planning.

Conclusion: The comprehensive analysis emphasizes the urgent need for standardized guidelines, strategic planning, and coordinated efforts to enhance the efficacy and impact of health education interventions within PHC settings. The numerical data presented underscores the seriousness of the situation, necessitating immediate policy revisions and targeted interventions.

Recommendations: Urgent policy revisions are imperative, with a focus on gender equality, standardized training, and structured planning protocols for health education professionals. The national health policy should prioritize comprehensive strategies for health education, emphasizing internal coordination and reduced dependence on external partners. Additionally, substantial investments in capacity-building initiatives, particularly formal education for health education professionals, are vital to bridge the training gap.

Keywords: Health Education Workers, Primary Health Care, Standardization, Educational Interventions, Organizational Models, Gender Disparity, Research and Development.

INTRODUCTION

Commonly understood as a set of activities aimed at motivating individuals to voluntarily modify their behaviors to enhance their well-being, health education plays a pivotal role in promoting a healthy lifestyle by fostering positive changes in health-related habits. In this context, health education assumes a central position in any educational initiative geared toward facilitating health-related behaviors.

Numerous researchers, such as Green et al. (1980), Sunderland (1979), French and Adams (1986), Smail (1992), and Macdonald (1994), have significantly contributed to the body of research on health education and its practical application. Publications like Jinadu and Adetugbo (1992), Das Gupta, Gauri, and Khemani (2003), the National Primary Health Care Development Agency (2007), and the Nigerian Demographic and Health Survey (NDHS) of 2008 have provided valuable insights, particularly in the context of developing nations like Nigeria.

However, it's important to note that a lack of comprehensive data, especially in developing countries like Nigeria (FMOH, 2004), often hampers efforts to refocus attention on the necessity for specific policy modifications or an overall reform of health education. This scarcity of empirical evidence addressing what approaches, frameworks, and program successes have worked undermines confidence in the effectiveness of health education.

The oversimplification of health education as a general responsibility for all healthcare providers, without the need for specialized training, adds to this confusion (Macdonald, 1994; Coalition of National Health Education Organizations, 1999). Consequently, stereotypical approaches and terminologies dominate the landscape of educational interventions, with phrases like "social mobilization," "information," "education," and "communication" (IEC) frequently taking precedence in primary healthcare (PHC) settings, often stemming from governmental directives (as seen in FMOH, 2004; 2007).

Nevertheless, there are observable gaps in the input and output processes of health education that cast doubt on its effectiveness. Critical analysis reveals that PHC programs that health education is intended to support often lack tangibility compared to the priority assigned to health education in policy documents outlining the structuring of health education activities. The purpose of health education frequently appears to be geared solely toward enhancing the acceptability of specific programs of interest, as evident in national health policies and the Ward Minimum Health Care Package (WMHCP).

The targeting of both behavioral and non-behavioral impacts is not explicitly stated in some policy documents (FMOH, 2004; NPHCDA, 2007). Rather, this seems to be presented in the form of advertising campaigns that can be perceived as somewhat crude propaganda tools. Although the policy paper may not explicitly address the contributions of health education to the PHC plan, the WMHCP aims to provide ward-level services within the framework of effective healthcare initiatives, which does not entirely exclude the use of health education as one of its building blocks.

In theory, a successful health education intervention should extend beyond merely including a program in the agenda to a point where it also promotes proper health-related actions (Green et al; Tones and Tilford, 1994; Fawole et al, 1999). Given the relevance of health education to the WMHCP, it should ideally result in a more substantial foundation for practical planning and implementation than currently evident in the document.

In light of these contexts, the consequences of unmet educational objectives may seem concealed, but the significance of health education's role becomes increasingly apparent, depending on the healthcare program's indicators it aims to serve. The importance of health education to the fundamental needs of the community has been a subject of considerable debate, not only in Africa but also in regions like Asia and South America (Brieger and Edozien, 1982; Ransome-Kuti et al, 1990; Macdonald, 1994). The role of management elements in strengthening health education standards and achieving measurable results has proven to be a complex challenge, and Nigeria is no exception in this discourse.

The current study was inspired by the worry that the PHC system's health education practice lacked essential organization. It chooses a PHC intervention which statutorily demands cohesive interactive working team, i.e., integrated maternal, newborn and child health (IMNCH) in order to understand the extents to which management concept applies in IMNCH health education activity. It proposes to investigate the case of Ekiti-State, looking at how community educational requirements are given consideration, drawing representative samples from which their health education practices may be discernible. Therefore, the main objective of the study is to identify the educational efforts undertaken by various program stakeholders operating within the primary healthcare setting.

Research Questions:

1. What are the proficiency levels acquired by this group in performing the health education function within the IMNCH component program?
2. What are the types of health education activities implemented for IMNCH services in accordance with established standards?
3. What is the pattern of practice in planning, programming, and implementing health education work, including the type and style of support received?
4. What is the pattern of practice in reporting activities and archiving materials used for educational activities?
5. What is the level of organization and coordination structures among different levels implementing health education for IMNCH (State, LGA, and Ward/HF levels)?
6. What is the pattern of practice in documenting achievements and quality, with a focus on attitudes towards encouraging behavior change?

Research Hypotheses (Null and Alternative):

H0: There is no relationship between the organization of educational activities by health education workers and the potential ambiguity that may arise with educational outcomes.

H1: There is a relationship between the organization of educational activities by health education workers and the potential ambiguity that may arise with educational outcomes.

Materials and Methods

Research Study Design:

The study employed a descriptive cross-sectional design, utilizing a self-administered questionnaire as the primary data collection instrument. The chosen design aimed to assess the level of coordination among various steps involved in health education tasks and the availability of resources. This research was conducted in Ekiti State. As per estimates from the 2012 National Population Census, Ekiti State had a population of 2,863,498, and IMNCH services were targeted at 25% of this population, in accordance with national guidelines (FMOH, 2004; 2007; NPHCDA, 2007). This target population encompassed children under the age of 5, constituting 20% of the total population (572,700), and pregnant women, making up 5% (147,613). It's crucial to emphasize that these population figures were provided for illustrative purposes and did not necessarily represent the study's sample. The primary focus of the study was on healthcare providers, as specified in the sampling units, highlighting the importance of aligning educational interventions with health intervention objectives. The sample population consisted of healthcare workers in Ekiti State, Nigeria, who integrated health education into their roles related to IMNCH.

Sampling Method:

To identify potential participants engaged in health education work, a random sampling approach was employed to select wards and healthcare facilities (HFs). While keeping all other variables constant, participants were drawn from 20% of the total 293 existing HFs to create a representative sample for the study. These selected HFs constituted a portion of the sampling framework, comprising 40% (6) of the 16 local government areas (LGAs) divided into three senatorial districts in the State. Health educators were included in the participation pool at both the State and LGA levels.

Data Collection Method and Analysis:

The data collection instruments were incorporated into a questionnaire containing questions about demographic information and the five psychometric instruments. Data collection was carried out through interviewer-administered surveys. All collected data were input into IBM SPSS Statistics version 20 for analysis. The analysis primarily involved descriptive statistics, with data presented

through frequency tables and percentages. Additionally, inferential statistics, including the chi-square test, were utilized. Pearson's product moment correlation coefficients were computed to assess relationships between dependent and independent variables.

Ethical Issues:

Given that the study aimed to gather information from primary healthcare professionals, ethical considerations were of paramount importance. The involvement of subjects working within a statutory authority necessitated informing their superiors about the research's purpose and outlining the significance of the samples' participation**.**

RESULTS

Demographic characteristics of the respondents

Table 4.1.1: Distribution pattern of respondents by cluster LGAs and the sampling strata

S/N	Cluster LGAs	HF/Ward stratum	LGA/State stratum	Total
1	Ado LGA/State	14	7	**21 (27%)**
2	Oye	11	4	**15 (19%)**
3	Ekiti SW	9	4	**13 (16%)**
4	Ikere	7	4	**11 (14%)**
5	Ise-Orun	7	3	**10 (13%)**
6	Efon	6	3	**9 (11%)**
Total		**54 (68%)**	**25 (32%)**	**79 (100%)**

The table shows that 54 (68%) of the respondents were from the HF/Ward stratum and 25 (32%) respondents were from the LGA/State stratum.

Table 4.1.10: Distribution pattern of responses concerning the key areas of responsibility compared by respondents' health care work title

S/N	Key area of responsibilities	Health care work title							Total
		CHEW/CHO	Ward focal person / OIC	Health educator	Nutrition officer/ focal person	Malaria control officer/focal person	Immunization officer/focal person	Nursing officer	
1	Clinic and community-based health care	23	2	0	3	1	0	4	**33 (42%)**
2	Immunization and community related services	16	5	0	0	0	6	0	**27 (34%)**
3	PHC component education	0	0	7	0	0	0	0	**7 (9%)**
4	Malaria control and education	0	0	0	0	5	0	0	**5 (6%)**

5	Nutrition and education	0	0	0	4	0	0	0	**4 (5%)**
6	Reproductive health care and mobilization	1	1	0	0	0	0	1	**3 (4%)**
Total		**40 (51%)**	**8 (10%)**	**7 (9%)**	**7 (9%)**	**6 (8%)**	**6 (8%)**	**5 (6%)**	**79 (100%)**

Table 4.1.10 shows that the majority 23 of the 40 (51%) respondents who identified by the CHEW/CHO title performed clinic-based child welfare / community services, 16 of the respondents in similar category performed immunization / community related services. All the seven respondents who identified as health educator indicated PHC component education.

The six respondents that identified as immunization officer / focal person kept responsibilities in similar scope (ie, immunization and community related services). Five of the 6 (8%) respondents who identified by malaria control programme also kept responsibilities within the scope.

4.2 Skills acquired by the respondents and level

Table 4.2.1: Distribution pattern by type of qualification, obtained

S/N	Qualification obtained	Total
1	BSc. Degree in Health Education (**Formal training**)	9 **(11.4%)**
2	MSc. Degree in Health Education (**Formal training**)	1 **(1.3%)**
3	Advanced Dip Certificate in Health Education (**Formal training**)	1 **(1.3%)**
4	Informal or non-health education specific exposure	68 **(86.1%)**
Total		**79 (100%)**

The table shows two major groupings (ie, formal and informal) to illustrate the type of qualification cohort of the respondents in relation to health education. On the formal category were nine (11%) of the respondents with BSc degree in health education, and a respondent each for MSc degree and advanced diploma respectively. Thus, the category of respondents that indicated having formal exposure formed an aggregate of 11 (14%).

The remaining 68 (86%) respondents had either only informal exposure to health education or had qualification that was not specifically in the area of health education.

Table 4.2.2: Frequency distribution of responses by the degree of training exposures (formal and informal)

S/N	Level of training exposures	Total
1	Formal training **plus** workshop (informal) exposure	6 **(8%)**
2	Formal training **plus** on the job(informal) exposure	3 **(4%)**
3	Formal training only	2 **(3%)**
4	Non h/education specific qualification **but** on the job exposure	39 **(49%)**
5	Non h/education specific qualification **but** workshop exposure	25 **(32%)**
6	Had neither formal nor informal h/education qualification	4 **(5%)**
Total		**79 (100%)**

6(8%) of the respondents had formal health education training with additional workshop exposure, 3 (4%) had on-the-job exposure as an addition and 2% had just formal training exposure. Among

the respondents that had non-health education specific qualification were the 39 (49%) who had on-the-job exposure and the 25 (32%) who had workshop exposure.

Figure 4.2.2 shows the proportion in categories by the level of health education exposure. The depiction emerged in four categories by the type of exposure if any, whether formal, informal or combined and if none at all.

Table 4.2.6: Category of the level of training exposures compared by respondents' years of working experience

S/N	Category of training exposures on h/education	Year of working experience						
		1-5 years	6-10 years	11-15 years	16-20 years	21-25 years	above 25 years	Total
1	Formal and informal training exposures	1	2	2	1	2	1	**9 (11%)**
2	Formal training only	0	0	0	0	1	1	**2 (3%)**
3	Only informal exposures (workshop and on-the-job)	17	17	12	5	12	1	**64 (81%)**
4	Had neither formal nor informal exposures	2	2	0	0	0	0	**4 (5%)**
Total		**20 (25%)**	**21 (27%)**	**14 18%)**	**6 (8%)**	**15 (19%)**	**3 (4%)**	**79 (100%)**

The table shows that the category of respondents who had combined (ie, formal and informal) exposures about health education emerged across the six categories of years of working experience. Similarly, the category of respondents who had just informal exposures featured in varying proportions across the six categories.

4.3 Pattern of practice in planning, programming and implementing health education work based on standard procedure or guideline

Table 4.3.1: Compare the pattern of responses about work plan for educational activities with results from the 'archival data (AD) checker list', applied concomitantly with the SAQ

S/N	Work plan availability	Yes	No
		Total respondents	**Total** respondents
1	Normally have work plan for educational work, conducted (**SAQ**)	44 **(56%)**	35 **(44%)**
2	Educational work plan / schedule specific to routine programme **not** campaign or supplemental programmes (**AD checker list's assessment**)	0 **(0%)**	79 **(100%)**
3	Educational work plan / schedule, specific to campaign / supplemental programmes **not** routine programme (**AD checker list's assessment**)	16 **(20%)**	63 **(80%)**

Table 4.3.1 shows that 44 (56%) respondents indicated to have work plan for educational activities concerning IMNCH services. By the AD checker list, only 16 (20%) respondents had educational schedules / work plan that was only specific for supplemental programme rather than for routine activities at the duty post. Figure 4.3.1 compares results generated via the SAQ and the AD checker list about availability of respondents' work plan or schedule.

Table 4.3.8: Distribution pattern of responses on methods, involved at deriving educational messages for the target audience, compared by the respondents' key area of responsibility

S/N	Methods involved at deriving educational messages for the target audience	Health care services / key area of responsibility						Total
		Clinic- & comm-based health care	Immunization & comm related services	Reproductive health care & mobilizatn	PHC component education	Malaria control & education	Nutrition & education	
1	Depend on messages produced by other levels / partners	33	22	3	0	0	1	**59 (75%)**
2	Modify / reproduce educational messages from partner thru education unit for local use	0	2	0	0	4	1	**7 (9%)**
3	Adapt and reproduce educational messages by national / partners posted thru the State for local use	0	1	0	3	1	0	**5 (6%)**
4	Develop / produce educational messages and circulate for use	0	0	0	2	0	2	**4 (5%)**
5	Work with via education unit or mass media to produce educational messages and circulate	0	2	0	0	0	0	**2 (3%)**
6	Adapt and reproduce educational messages by national / partners for local use	0	0	0	2	0	0	**2 (3%)**

S/N	Methods involved at deriving educational messages for the target audience	Health care services / key area of responsibility						Total
		Clinic-& comm-based health care	Immunization & comm related services	Reproductive health care & mobilizatn	PHC component education	Malaria control & education	Nutrition & education	
1	Depend on messages produced by other levels / partners	33	22	3	0	0	1	**59 (75%)**
2	Modify / reproduce educational messages from partner thru education unit for local use	0	2	0	0	4	1	**7 (9%)**
3	Adapt and reproduce educational messages by national / partners posted thru the State for local use	0	1	0	3	1	0	**5 (6%)**
4	Develop / produce educational messages and circulate for use	0	0	0	2	0	2	**4 (5%)**
5	Work with via education unit or mass media to produce educational messages and circulate	0	2	0	0	0	0	**2 (3%)**
6	Adapt and reproduce educational messages by national / partners for local use	0	0	0	2	0	0	**2 (3%)**
Total		**33 (42%)**	**27 (34%)**	**7 (9%)**	**7 (9%)**	**5 (6%)**	**4 (5%)**	**79 (100%)**

Table 4.3.8 shows that 33 of the 59 (75%) respondents who indicated dependence on other levels / partners for educational messages were on clinic based child welfare and related services while 22 respondents in the category were on immunization services. Four of the seven (9%) respondents who indicated modifying / reproducing messages from other levels for local use were on malaria control and component education. Three of the five (6%) who indicated adapting and reproducing messages from the national, were on PHC component education.

4.5 Organisation/coordination structure about health education work for IMNCH services

Parts 4 and 5 of the SAQ explored the views and experiences of respondents about coordinated reporting system. The variables explored products of existing standards through monitoring and evaluation (M&E), targeting feedback and control as the results in this perspective captured category of monitors by the regular period of monitoring. Monitoring and evaluation forms an aspect of the indicator for organisation and coordination.

Results about the experiences of respondents, on coordinated reporting cross tabulate with results on availability or evidence of educational work plan. This stands as a dependent factor of organisation and coordination in health education work at establishing a relationship. Table 4.5.1 shows the response pattern in terms of the monitoring and evaluation of respondents' educational activities by the period of monitoring.

Table 4.5.1: Pattern of the responses about the monitoring and evaluation system for health education work

S/N	Category of the monitoring and evaluation system	Total
1	State team on routine supportive supervision	23 **(29%)**
2	State team on campaign activities	20 **(25%)**
3	LGA level PHC team on routine supportive supervision	11 **(14%)**
4	National level team on evaluation of special projects	5 **(6%)**
5	State health education office on routine supportive supervision	4 **(5%)**
6	Don't know	16 **(20%)**
Total		**79 (100%)**

Table 4.5.1 shows that 23 (29%) of the respondents indicated the State team as a category of monitor during the period of routine supportive supervision. Still, the State team, indicated by 20 (25%) of the respondents reckoned with such monitoring as conducted during campaign activities. Sixteen (20%) do not know about monitoring and evaluation of educational activities. Table 4.5.2 examines the pattern by respondents' key area of responsibility.

Table 4.5.2: Compares the response pattern on the monitoring and evaluation system for health education work by the respondent's key area of responsibility.

S/N	Category of the monitoring and evaluation system	Health care services / key area of responsibility						Total
		Clinic- & comm-based health care	Immunization & comm related services	PHC component education	Malaria control & education	Nutrition & education	Reproductive health care & mobilizatn	
1	State team on routine supervision	6	7	4	3	3	0	**23 (29%)**
2	State team on campaign activities	9	9	1	0	1	0	**20 (25%)**
3	LGA level PHC team on routine supervision	4	5	0	0	0	2	**11 (14%)**
4	National level team on evaluation of special projects	2	2	0	1	0	0	**5 (6%)**
5	State health education office on routine supervision	1	1	2	0	0	0	**4 (5%)**
6	**Don't know**	9	5	0	1	0	1	**16 (20%)**
Total		**33 (42%)**	**27 (34%**	**7 (9%)**	**5 (6%)**	**4 (5%)**	**3 (4%)**	**79 (100%)**

Table 4.5.2 shows high indication for the State team on the routine supportive supervision period by 23 (295) of the respondents and State team during campaign monitoring period by 20 (25%) of the respondents. Respondents on clinic based child welfare services and those on immunization services contributed to the high indications.

Still, it is noticeable that the highest number of respondents on PHC component education, malaria control and nutrition contributed to indications for the State team monitors on routine supportive supervision. Table 4.5.3 assesses the distribution pattern by the official duty post of respondents.

Figure 4.6.1 depicts the response patterns about the proportion of respondents that compiled reports. Table 4.6.1 compares the response pattern by respondents' key area of responsibility.

Figure 4.6.1: Distribution pattern of the responses on compilation and filing of educational reports

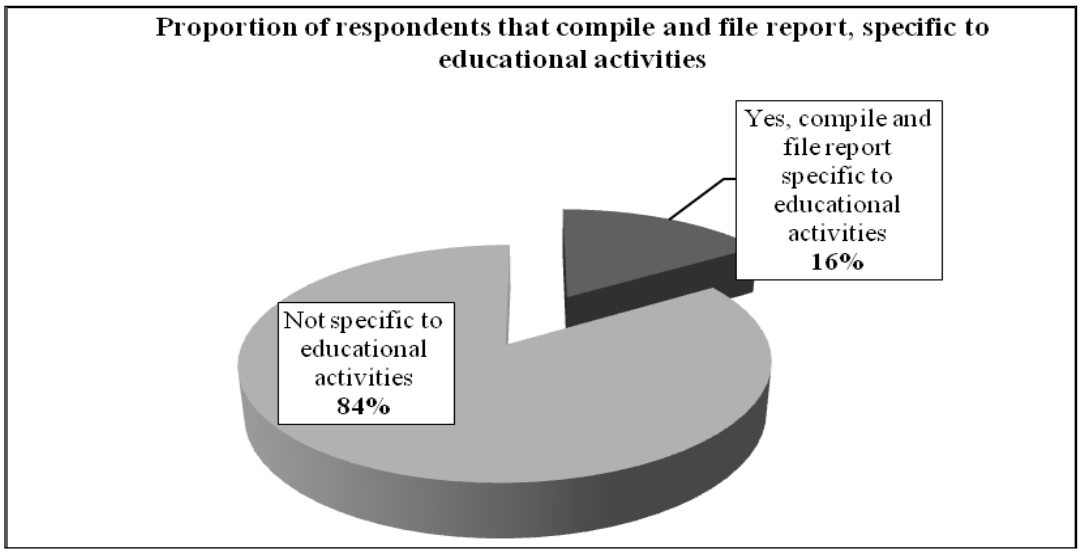

Figure 4.6.1 shows that 16% compiled and filed reports, specific to educational activities. Table 4.6.1 shows the distribution pattern by respondents' key areas of responsibility.

Table 4.6.1: Compares a pattern of the responses on compilation and filing of desk reports by the respondents' key area of responsibility

S/N	Health care services / key area of responsibility	Compilation and filing of desk reports on educational activities		Total
		No	Yes	
1	Clinic and community-based health care services	33	0	**33 (42%)**
2	Immunization / community related services	22	5	**27 (34%)**
3	PHC component education	1	6	**7 (9%)**
4	Malaria control and education	4	1	**5 (6%)**
5	Nutrition and education	3	1	**4 (5%)**
6	Reproductive health care & mobilization	3	0	**3 (4%)**
Total		**66 (84%)**	**13 (16%)**	**79 (100%)**

Table 4.6.1 shows that six of the seven (9%) respondents who compile and file desk reports on educational activities were respondents on PHC component education. Table 4.6.2 shows the distribution pattern by cluster LGAs.

Table 4.6.2: Compares a pattern of the responses on compilation and filing of desk reports by the respondents' cluster LGAs

S/N	Cluster LGAs	Compilation and filing of desk reports on educational activities		Total
		No	Yes	
1	Ado LGA/State	15	6	**21 (27%)**
2	Oye	13	2	**15 (19%)**
3	Ise-Orun	9	1	**10 (13%)**
4	Efon	8	1	**9 (11%)**
5	Ikere	10	1	**11 (14%)**
6	Ekiti SW	11	2	**13 (16%)**
Total		**66 (84%)**	**13 (16%)**	**79 (100%)**

Table 4.6.2 showed that six of the 12 (15%) respondents who compiled and filed desk reports on educational activities were in Ado LGA/State cluster. Table 4.6.3 shows the distribution pattern by the official duty post of respondents.

4.7 Pattern of practice at documenting achievements / quality

The results generated through this indicator dwelt in part five of the SAQ, measured by educational activities, mostly captured in a report, the action taken with compiled report and feedback to illustrate achievements and quality. The variables also entailed documentation of educational outcomes, thrusting on the results from the AD checker list.

Chi-square test, applied to results generated from contents of educational reports, as a variable of educational outcomes and work plan, which constitutes an indicator of coordination. Figure 4.6.1 under section 4.6 above already showed that only 13 (16%) of the respondents compile and file desk reports on educational activities. Table 4.7.1 depicts the pattern of responses concerning educational activities, mostly captured in respondents' desk report.

Table 4.7.1: Type of educational activities, mostly captured in reports

S/N	Category of the educational activities, mostly captured in reports	Total
1	Campaign data / mobilization material	7 **(9%)**
2	Not separated in campaign programme report, education aspect given to health educators as inputs for educational report	3 **(4%)**
3	Immunization (RI / SIA) reports	1 **(1%)**
4	Programme education / mobilization activities (health talk)	2 **(3%)**
5	Did not compile specific reports on educational activities	66 **(84%)**
Total		**79 (100%)**

Table 4.7.1 shows that campaign activities / material distribution were mostly captured in the report of seven (9%) of the 13 (16%) respondents that compiled and filed reports, specific to educational

activities while the remaining three (4%) did joint reporting. Table 4.7.2 examines the pattern by the respondents' key area of responsibility.

Table 4.7.2: Compare the type of educational activities, mostly captured in reports by the respondents' key area of responsibility

S/N	Category of educational activities, mostly captured	Health care services / key area of responsibility						Total
		Clinic-& comm-based H/care	Immunization & comm related services	PHC component education	Malaria control & education	Nutrition & education	Reproductive H/care & mobilizatn	
1	Campaign data & demonstration materials	0	0	6	1	0	0	**7 (9%)**
2	Not separated in campaign programme report	0	2	0	0	1	0	**3 (4%)**
3	Immunization	0	1	0	0	0	0	**1 (1%)**
4	Programme education & mobilization (health talk)	0	2	0	0	0	0	**2 (3%)**
5	Did not compile the specific report	33	22	1	4	3	3	**66 (84%)**
Total		**33 (42%)**	**27 (34%)**	**7 (9%)**	**5 (6%)**	**4 (5%)**	**3 (4%)**	**79 (100%)**

Table 4.7.2 shows that all the seven (ie, 9% of respondents) who captured campaign / material distribution were on PHC component education. Table 4.7.3 examines the pattern by respondents' official duty post.

All the 33 (42%) respondents on the clinic and community based health care services were among the 66 (84%) respondents who did not compile reports on educational activities, followed by the 22 respondents on immunization services. Table 4.7.3 examines the pattern by respondents' official duty post.

Table 4.8.1: Cross tabulation of the variables about educational outputs and the organisation

Organization and the outputs variables		Evidence seen of compiled and filed reports on educational activities		Total
		No	**Yes**	
Evidence seen of action taken with such compiled educational reports	**No**	66	0	66
	Yes	0	13	13
Total		**66**	**13**	**79**

Table 4.8.1 shows the pattern of distribution concerning the respondents with an evidence of compiled reports and those with an evidence of action taken with such compiled educational reports. Table 4.8.2 shows the statistical differences between the two groups.

Table 4.8.2: The Chi-Square Test

The test	Value	Degree of freedom	Asymptotic Sig (2-sided)
Pearson Chi-Square	79.000[a]	1	.001
No. of Valid Cases	79		
Cells (25.0%) have expected count less than 5. The minimum expected count is 2.14			

The Chi-Square result shows an alpha value of 79.000 on one degree of freedom with an asymptotic significance of .001. A depiction of either organization or outcome in the educational activities of the respondents was indecisive without a clarification of the status.

Therefore, in an attempt to establish whether the status about the organization of the respondents' educational activities was good or poor, a further test for the significance of the differences between the evidence about archiving and that of a work plan applied. Availability of a work plan was an indicator that measured coordination. Still, a similar test applied to examine the status for the outcome indicator in the context of the hypothesis.

Table 4.8.3: Relationship between organization and educational outcomes

Organisation and outcomes variables		Evidence seen of documented achievements from educational activities (outcomes)		**Total**
		No	**Yes**	
Evidence seen of compiled and filed reports on educational activities	**No**	66	0	**63**
	Yes	4	9	**13**
Total		**70**	**9**	**79**

Table 4.8.3 shows a pattern of the responses about evidence seen of archiving of educational activities and results on evidence seen of documented achievements from educational activities. Table 4.8.4 illustrates the statistical differences between the two variables.

Table 4.8.4: The Chi-Square Test

The test	Value	Degree of freedom	Asymptotic Sig (2-sided)
Pearson Chi-Square	51.567[a]	1	.001
No. of Valid Cases	79		
Cells (25.0%) have expected count less than 5. The minimum expected count is 1.48.			

The Chi-Square result shows an alpha value of 51.567 on one degree of freedom with an asymptotic significance of .001. Section 4.8.2 articulates the record keeping characteristics of the respondents, using the AD linked results for evidence about the content of a record kept.

Discussion, conclusions and recommendations

5.1 The discussion

The study comprised 18% of the total population, with respondents from six Local Government Area (LGA) clusters. Ado LGA/State cluster had the highest representation at 27%, while Efon

LGA cluster had the lowest at 11%, aligning with the study's sampling design. Demographically, the majority of respondents were health facility-based, with a higher proportion of females. State-based respondents were exclusively female. Among respondents, 68% were community health extension worker's/community health officers (CHEWs/CHOs), predominantly based in health facilities. LGA-based respondents, constituting 27%, were mainly from the nursing profession.

Environmental health officers (EHOs) made up 5% of the State-level respondents, equal to the proportion at the LGA level. Notably, there were no CHEW/CHOs among the State-based sample, aligning with Primary Health Care (PHC) human resource visions for grassroots healthcare.

Comparisons with a study in Kogi and Lagos States and the FMOH (2007) list revealed a similar dominance of community health practitioners, supporting the envisioned PHC human resource distribution. The respondents' diverse professional backgrounds (CHEW/CHO, nursing officers, environmental health officers, and others) align with theories on multi-professional involvement in health education. Respondents generally identified with titles reflecting their professional background or supervised health care role.

While CHEW/CHO respondents maintained a constant professional identity, others often adopted titles reflecting their specific health care responsibilities. Various health programs were supervised by professionals from different backgrounds, with nursing respondents showing the widest spread across titles.

Distinct responsibilities within healthcare were linked to specific titles, exhibiting consistency, particularly in roles related to health education, malaria control, and nutrition. Those identifying as Ward Focal Person/Officer predominantly shouldered responsibilities related to immunization and community-related services.

In a study by Das Gupta et al (2003) in Kogi and Lagos States on decentralized Primary Health Care (PHC), community health officers, including junior and senior community health extension workers, were disproportionately dominant compared to medical and other health worker categories in the sampled health settings. This finding aligns with patterns observed in the current study, where the proportion of community health workers surpassed that of other health workers.

A similar perspective is reflected in a categorization of health workers in Nigeria by FMOH (2007), emphasizing the prevalence of community health practitioners compared to other categories. Consequently, the results illustrate a manifestation of the envisioned PHC human resources strategy, particularly at the grassroots level.

The diversity in respondents' professional backgrounds, encompassing CHEW/CHO, nursing officers, environmental health officers, and others, aligns with established theories on multi-professional involvement in health education (refer to Baric, 1976, Green et al, 1980; Ochor, 1983; Macdonald, 1994). However, it's noteworthy that respondents adhered to titles reflecting either their professional background or the type of health care role they supervised. A high proportion of the respondents based their identities on a title generated by the specific health care work they supervised and took recognition after such programed either as an officer or as a focal person. Such included immunization, nutrition, health education and malaria control are within the study design even as certain respondents in charge of ward / health facility activities identified as ward focal person / officer in charge (WFP/OIC).

The majority of community health respondents, including CHEW/CHO and two nutritionists (as indicated in Table 4.1.7), consistently maintained their professional identity while overseeing health work. In contrast, there was variability among other respondent categories, with many adopting the title of the specific health care work they supervised.

Health care programs were generally overseen by professionals with diverse backgrounds, with nursing respondents displaying the broadest representation across different health care work titles, as detailed in Table 4.1.7. Four health professional categories in the sample assumed the title of malaria control officer/focal person, while three respondents adopted the nutrition title.

The titles of immunization officer, health educator, and ward focal person/OIC were commonly adopted by respondents from two health professional backgrounds, predominantly nursing. Although EHOs were a small proportion in the sample, they exclusively identified with the health educator title. Additionally, the lone health information technician in the sample assumed the title of malaria control officer/focal person. Respondents also indicated a key area of health care responsibility that seemed an emphasis of the health care work title, specified by the majority. Therefore, in comparing the health care work title with the key area of health care responsibilities, results for the health educator, malaria control and nutrition respondents appear consistent with the health care responsibilities, indicated. The majority of the respondents that identified as WFP/OIC by title were among the 34% on immunisation and community related services. A large majority (42%) was responsible for clinic and community-based health care, and 34% were for immunisation and community related services. The CHEW/CHO respondents were a dominant professional group in both the areas of health care responsibility. A further probe showed that those that identified by the health educator title emerged only from two professional backgrounds i.e., nursing and environmental health with the proportion of the respondents in the category of the latter (3/4) larger than that of the former (4/18). The above emphasis is pertinent partly because the main concern of the current study rests on health education management. The emerging result underscores an assertion in the findings by Das Gupta et al (2003) that environmental health officers (EHOs) tend to specialize in sanitation inspection and health education. The consistency of the assertion is subject to a critical examination under the results, yielded under subsequent assessing tasks related to establishing the objective of current study.

Experts such as Baric (1976) posit that the integration of health education into health care activities imply that inputs to the educational activities could depend on personal preference of the individual professional. The observable variations in the identity of the respondents, not limited to the official job title but to either the professional title or a health care work, linked title arguably, offers latitude for such dependence even in multiple scopes.

With increasing arguments for role delineation among health workers who engage in health education (Baric, 1976; Neutens, 1984), the results from the respondents' varied titles and professional background define a purpose for such need. Neutens (1984) aptly advised that such delineation should evolve via research at provoking effective coordination processes in health education work. This result poses a case for subscription to such advice.

On the aggregate, only 14% of the respondents had a formal training while 86% had a non-health education specific training (Figure 4.2.1 refers). However, a good proportion of the 14% respondents with formal health education exposure had a BSc degree (see Table 4.2.1). All the EHOs (4/4) had a formal health education exposure thus; consistent with the assertion earlier credited to the findings by Das Gupta et al (2003).

Among the respondents that had a non-health educational specific training were the 81% that had an informal exposure (Figure 4.2.2 refers). A huge proportion of the CHEW/CHO respondents constituted the highest majority, followed by majority of the nursing respondents (Table 4.2.3 refers). The respondents with such informal exposure had it essentially through workshops and on-the-job training.

The results appear similar to some findings by Stetson and Davis (1999) about the mode in which many health educators in developing countries enhanced their proficiency in the field of health education. The results are also consistent with the observations made by Ransome Kuti et al (1990); specifically asserting that UNICEF represents a key donor agency offering capacity training in the area of health education to health workers in Nigeria.

On the average, a quarter of the respondents had between 14.5 to 17.5 years of working experience while the majority (52%) had between 3.5 to 7.5 years of experience on the field. Experience counts in employment markets (Haralambos and Holborn, 1991), an attainment of between three to seven years in a field would seem a fine interval for skills improvement. The majority of the respondents are thus, much likely to have good level of working experience.

The level of skills acquired by the respondents in performing health education functions, constituted a specific task of the current study, which a part of the above results assisted to achieve. From the findings, it is obvious that health education workers emerge from different professional backgrounds, which seems consistent with findings in some of the previous studies (Stetson and Davis, 1999; Das Gupta et al, 2003).

The CHEW/CHO appeared comparably dominant among the category of health workers, sampled. The highest proportion of the category had a very poor exposure to formal health education training (see Table 4.2.3). Whereas the ward minimum health care package (NPHCDA, 2007) indicated that by the end of 2012, at least two health workers per ward will train as health educators, the effect of which seems shaky by the current result. Among the 68% ward/health facility based respondents, was just a tiny fraction that trained formally as health educators. A huge majority (49/54) of this category had an informal training exposure. The fieldwork that yielded these results held when the WMHCP plan period should be rounding up (i.e., December 2012) just to illustrate a possible gap in the WMHCP's, goal achievements. The respondents' opinion in terms of pattern of practice in the planning and programming of educational work was another task within the specific objectives set by the current study. Results from both the SAQ and the archival data (AD) checker list were crucial for necessary comparisons.

The SAQ indicated that 56% of the respondents claimed to have a work plan for educational activities while results from the AD checker list on the same variable skewed almost to the negative direction. It showed that just 20% of the respondents had evidence of an educational work plan and such was only specific to campaign /supplemental, programme .

There was barely an evidence to document for an educational work plan for the respondents' routine programmes . However, the respondents with evidence of a work plan were mostly LGA/State based .The highest proportion that had no evidence of a work plan for educational activities was HF based. Experience informs that a work plan can articulate certain units of intention for proper organization of strategies aimed for the implementation of a programed. Glanz and Rimer (1990) argue that a theory directed educational or behavior change programme stimulate needs for organized methods, setting of targets, objectives, timeline, budget and the expected outcome of an intended programme that achievements can be measurable. The lack of evidence for a work plan depicts that the implementation of an educational activity simply rested on assumptions with the expected outcomes, ill-defined and balanced on guesswork. The situation mimics a platform often perceived as creating 'more of the same' educational work, to which critics of health education categorically punched the holes (see Kelvin, 1980; Rawson, 1992; Macdonald, 1994).

From a management angle, Cole (1986) posits that planning is a strategic level process with the emerging activities having a bearing with strategic goals of an organisation. A growing body of evidence supports this view (Baric, 1976; Kickbush, 1990; Macdonald, 1994), still, strategic planning about health education seems overshadowed in some developing countries' policy papers by concerns for reduction in disease morbidity and mortality (FMOH, 2004).

The strategic goals in the context of the Nigeria's health policy (FMOH, 2004), scarcely feature a clear structure for health education processes. Yet, in pursuance of reductions in morbidity and mortality rates, the document (FMOH, 2007) lamented that only a marginal rate existed between 2000 and 2004.

Evidence abounds that significant reduction in morbidity and mortality has a bearing with human behaviours (see McKeown, 1976; Ashton and Seymour, 1986; Tanahill, 1992; Giesecke, 2002). Experts argue that a country's health policy inspires modalities for health intervention strategies (Jobert, 1985; Baric, 1994) and the health education practice, exposed to necessary reforms (Sunderland, 1979; Baric, 1994) to match the strategies. The ward minimum health care package (NPHCDA, 2007) represents a type of strategic document. It professes that health education and community mobilization are a key element at achieving set goals. Such goals included establishing a broad health care system based on PHC that is promotive, protective, preventive, restorative and

rehabilitative to every citizen within available assets (FMOH, 2004), supported in the WMHCP (NPHCDA, 2007).

The work schedule for the health education and community mobilization components in the context of the WMHCP reflect no operational strategy for the implementation (see, NPHCDA, 2007). Therefore, the current results about poor evidence for a work plan in the educational work of most respondents seems resonate of the contents of both the strategic plan (FMOH, 2004) and of the ward minimum health care package for health education work.

The findings seem an illustration of concerns raised in many health education publications that poor planning and coordination in health education work jeopardises reasonable outcomes (Baric, 1976; Ochor, 1983; Macdonald, 1994). Still, there are accounts that when a health programme links with educational or behaviour theory; identifies targets, methods and evaluation of change, the benefits are most likely obvious (Glanz and Rimer, 1990).

In respect of methods used at deriving educational messages, a large part of the respondents (75%) depended on messages produced by other levels, mainly partner agencies (Table 4.3.7 refers). The highest proportion was health facility based. A split quarter (5/21) of LGA based respondents adapted and reproduced educational messages by partner while, the other quarter were with the majority that depended on produced messages by the other levels.

Almost all the State based respondents (3/4) showed a similar bias in adapting and reproducing educational messages from partners (Table 4.3.7 refers). In terms of IEC materials, all the State based respondents (4/4) in a similar trend as observed with educational messages, still adapted and reproduced IEC materials from partner agencies (Tables 4.3.7 and 4.3.10 refer).

The majority of the health facility based respondents either used old IEC materials or depended on the modified ones (supplied largely by partner agencies) by the State or LGA (Table 4.3.10 refers). A third of LGA based respondents (7/21) similarly adapted and reproduced IEC materials supplied by partner agencies unlike a split group observed on the methods used in deriving educational messages.

Even if reliance on agencies for educational supplies was the order, using IEC materials for an example, it seems grounded by health education theories that such materials gain exposure to some level of pre-testing (see, Lefevbre, 1992; Green et al, 1980). Pre-testing forms a vital criterion in the quality management cycle (QMC) context, as the consumer gets important priority at the production of promotional materials (see, Cole, 1997) Thus, educational materials derive inputs from a sample of the consumer targets towards encouraging sustainable service demand and utilisation. Still, the reviews showed that the involvement of consumer targets is an endorsed standard to whet the platforms of ownership of educational contents and promote a strong basis for acceptability (see, Lefevbre, 1992; Wallenstein and Bernstein, 1994; Cole, 1997).

Otherwise, where the consumer target of an educational activity appeared ill involved and the educational messages and materials for such targets were only derivable from a source outside the targets' cultural system, it may not yield the desired response from such consumer targets. Yet, there was no aspect of the results that suggest pretesting method at deriving educational materials let alone involving consumer targets.

From the perspective of diagnostic health education planning (see, Green et al, 1980), pretesting forms a standard means of producing health education products. Therefore, the expectation for pretesting of educational materials seems overwhelmed by the prospect of deriving educational supplies from development partners perhaps, without considerations about the potentialities in such donated supplies.

Based on the absence of pretesting in the respondents' indications about means for deriving educational materials suggests a gap. Still, given PHC's interests about community involvement in matters, relating to their health, the result also posits that such omission seems critical. It presupposes that the PHC principle of community participation (WHO, 1978) seems lost out of

balance. The weight of an endorsement made for a PHC driven system (Ransome-Kuti et al, 1990) appeared, baseless. Critics abound questioning the effectiveness of health education and argue that the variation in its activities were 'more of the same' (see Rawson and Grigg, 1988; Rawson, 1992). The aspect that showed respondents' dependence on external educational commodities could be a further amplification of the critics' concerns considering that inputs of the respondents to educational package could appear more passive than active by such acts of dependence.

However, clinic-community based and immunisation-community related work formed the respondents' key area of responsibilities (see Tables 4.3.8). Dependence on the other level or partner agencies for educational materials appeared strongly from the indication by most respondents. The findings seem a further illustration of a view by Stetson and Davis (1999) that NGOs play key roles in the shaping of educational strategies in developing countries. A huge proportion (75%) of the respondents ran their IMNCH related educational package as a content of the programme, mostly health facility based. A high proportion of the LGA based respondents (16%) ran the package as integral part of the programme and 9%, still mostly LGA based ran it as a major programme.

The respondents on clinic-community based and immunization-community related work mostly ran the educational package as a content of the programme. The majority on malaria control ran the package as an integral part of the programme while all of the 9% respondents on PHC component education ran it as a major programme.

The outcomes about the methods used in the running of education packages of IMNCH services invoke the worth of Baric's (1976) organisational models. These are the coexisting, dispersed and specialist models, illustrating some standards that could be shaping the management of health education processes.

The result concurs with a growing body of evidence suggesting that educational functions in PHC system are a shared responsibility among a variety of the professionals even within the same setting (see Ochor, 1983; Macdonald, 1994; Stetson and Davis, 1999). The result posits that the 16% of the respondents that ran IMNCH educational package as an integral component of the programme trailed the verge of a coexisting model. By implication, the educational activities of a specialist should coexist with those integrated into the IMNCH package of the 16% respondents (see Baric, 1976; Adeniyi and Brieger, 1981). The specialist matter is debatable under the results dwelling on type of skills acquired by the respondents. Still, respondents having malaria control and nutrition as a key area of responsibilities was among the 16% that ran the package as an integral.

The 75% respondents who ran the educational package as a content of the programme showed a pattern of practice relating to the dispersed method of educational intervention (see, Baric, 1976; Ochor, 1983). The majority of the respondents had clinic-community based and immunisation / community related services as key areas of their responsibilities. By a school of thought, the dispersed model involves sharing health education duties among a variety of experts working in settings where there is no formal health education service (Baric, 1976). The majority of the respondents in this category were health facility based where educational activities informally run concurrently within a framework of health care service delivery. Therefore, the result appears consistent with the ideology of the model. The 9% respondents that ran the educational package in the context of a formal service within PHC offered it as a major programme, and were essentially the same group of respondents that identified specifically as health educators. Still, extant literature posits that health education specialist is a higher-level status than that of a health educator (see Baric, 1976; Adeniyi and Brieger, 1981). Health education credentialing related publications suggest that the position of a specialist demands a master's degree holder (Adeniyi and Brieger, 1981; NCHEC, 1985; 1996). This is a pre-requisite, which just one out of the 14% respondents with a formal health education exposure matches (see Table 4.2.1). The specialist manages and coordinates the educational roles of the other related experts (Baric, 1976; Adeniyi and Brieger, 1981; NCHEC, 1996).

The result about health education skills emphasises the dearth of specialist among the categories of health education workers, sampled and concurs with the concerns about health education resources

in Nigeria (Adeniyi and Brieger, 1981; Ochor, 1983). For example, Ransome Kuti et al (1990) regret that the scarcity of well-trained health educators, poor budgetary allocation and inadequate facilities hamper the functions of health education.

Ochor (1983) perceive little or no policy attention towards improving the course of health education processes, which the current finding corroborates. Still, the recent health policy reform (FMOH, 2004; 2007) shows no sophistication for an improvement from the long-standing situation. This seemed critiqued in the work of Ochor yet, dispersed approach appears a dominant practice among the health workers, sampled.

Reflecting on the virtue of a coexisting model in terms of the 16% that ran integral package and looking at the scanty number of those with a specialist qualification, the respondents' educational work linked to a dispersed model might be understandable. The result showing a respondent with such specialist qualification posits that the educational activities of the other health workers could be better than currently discovered, coexisting with that of a specialist. A huge proportion of the respondents (53%) had no criteria for targeting groups for educational activities while 46% ordinarily used the specific programme targets. The majority of the respondents who saw campaign opportunity at selecting targets for educational activities still had no criteria. The result assumes that the educational work of such category of respondents could be incidental. It thus seems pertinent to single out the opinion variation of the 9% respondents on PHC component education (Table 4.3.19 refers), and notably health educators. Out of the seven respondents concerned (9%), two adopted audience segmentation as a criterion at selecting the target for an educational intervention while a respondent engaged a high risk analysis as a criterion.

Even though a further probe into the respondents' purpose for choosing criteria was a limitation, Akinyele (1999) argues that health workers need to have the right frame of philosophy, upon which their plans and actions can anchor. Target setting according to some management views (Cole, 1986; Akinyele, 1999; Ojeifo and Azelama, 2007), is a key facet in forecasting processes and notably a crucial thinking in health care programmes' planning.

It could seem fine that a health worker adopted a maternal group as the target for an educational activity designed for a maternal and child health programme; a criterion forms a part of the aptness of the methodologies. Experience shows that an educational activity that lacks criterion in targeting its audience is comparable to what Tanahill (1992) describes as tantamount to a neglect of methodological issues, resulting in oversimplification of purpose.

Health education focuses on a dynamic miscellany of target groups for an objective multiplier effects in an educational activity, (Green et al, 1980; Tones and Tilford, 1994; Stetson and Davis, 1999). Even where it is patient or individually focused, the need to target family, community and groups for basic compliance and facilitation of health promoting action remained a constant educational objective (Green et al, 1980; Brieger and Edozien, 1983).

The respondents who adopted either the segmentation or high-risk analysis criteria appear to be insignificant in number. The respondents' efforts arguably hinged on a specific educational plan possibly to analyse merits and demerits towards further necessary action. Both the attempts seem to conform to certain diagnosis and planning principles of health education (see Green et al, 1980; Tones, 1986; Green and Krueter, 2005).

Thus, in subscription to Akinyele's (1999) argument, the two-health-education workers who conducted educational activities based on criteria selected target audience likely operated on a frame of philosophy that probably anchored their educational plans. The educational actions of the respondents could seem a display of a good knowledge of the theory, the meaning and goal underlying health education at making reasonable impacts (Stetson and Davis, 1999).

The need to have such clear understanding seems to explain the views expressed by 95% of the respondents who thought standard procedure or guideline was desirable for educational interventions. Such expressed views underscore the results concerning the respondents' awareness about availability of standard procedure or guideline for educational activities while only 29%

indicated awareness and stated title of educational models. A model mentioned by 11% of the respondents was the knowledge, attitude and practices (KAP). A very small fraction of the respondents indicated communication and empowerment models. However, it is crucial to place emphasis on these models as shown by a few respondents, given the popularity of such models in health education (see, French and Adams, 1986; Baric, 1994; Tones and Tilford, 1994; Stetson and Davis, 1999). In the above context, a good number of the 9% respondents who functioned on PHC component education as a key area of their responsibilities demonstrated knowledge of a standard procedure. When compared with the category of health education training exposures, it emerged that all the respondents that had exposures (ie, formal and informal) in health education reported awareness of a model. It thus seems significant. Overall, these results helped to establish a pattern of practice in the planning and programming of the health education work of the respondents. It shows that majority of the respondents lacked evidence of a work plan for educational activities with no evidence at all for routine but supplemental / campaign work. The ubiquity of the dispersed method in the educational practice of the respondents was apparent. Still, the dependence of the respondents on educational materials and messages from donor agencies is a factor for attention. However, the result corroborates the views of experts (Macdonald, 1994; Flanagan, 1996; Stetson and Davis, 1999) over the influential roles of partner agencies on the educational interventions of developing countries.

Perhaps not total dependence, a submission in the policy paper (FMOH, 2004) on fostering partnerships for health development seems underscoring to the result. However, the implication of educational interventions without a work plan can be further explicable under the task dealing with organisation / coordination structure of health education, to illustrate some pertinence.

Meanwhile, the respondents' educational packages for IMNCH related services were in multiples and diverse but seems in consonance with the key areas of their responsibilities. The majority of the respondents (68%) that did client and patient education were on clinic-community based services, so was the 62% that did home visiting/community link services and all the 32% that did discussion and counselling.

Respondents on immunisation and community related services as a key area of responsibility mostly did community-client mobilization and ward development relations as an educational package. The same category of respondents were mostly health facility based, so was all the 68% and 62% that did clinic client education and home visiting, respectively. The highest majority were from the CHEW/CHO background.

This result appears similar to a finding in a study by Das Gupta et al (2003) about work done by different categories of health workers. In the study, the CHEW/CHO competed only with nursing staff especially in outpatient care and health education.

The emergence of client education illustrates a viewpoint of health education experts on its pertinence as problem solving approach to addressing illness and wellness (Brieger and Edozien, 1983; Delaune and Ladner, 1998). Several health education accounts posit that the appraisal of patient education relies on the basic cognitive approach of KAP model (Green et al, 1980; Baric, 1994); known only to 9% respondents. Community education and mobilisation formed a type of educational activities indicated by 15% of the respondents, most of whom were LGA based, many were also part of the 14% that did group sensitization and likewise the 13% that did social marketing. All the State based (5%) respondents were among the proportions that did community education and mobilisation, group sensitization and social marketing, respectively.

The educational activities, indicated above concur with the kinds classified under the empowerment and health communication models (Tones and Tilford, 1994; Stetson and Davis, 1999). Still, the amount of respondents that earlier claimed awareness for these two models (Tab were comparably small (ie, 4% and 3% respectively) to those that indicated the educational activities grouped under the models.

Although, the majority of the health facility based respondents notably did community related educational activities, none in the category claimed awareness of an empowerment method (Tables 4.3.26 and 4.4.4 refer). The result could be an exhibition of incidental planning in the respondents' educational activities. Understanding the result as mimicry of a coexisting approach in organizational perspective, it conceivably, underlines a lack of specialist's touch. Whereas, the majority of the respondents that demonstrated a poor level of awareness over the existence of educational models made indication of educational activities normally grouped under such approaches (see Tones and Tilford, 1994; Stetson and Davis, 1999). Such outcome recalls an argument by Jobert (1985) about the deficiencies trailing health education approaches that offer it as a commodity in health care interventions. It appeared as though the respondents applied educational methods based on assumptions or previous educational work, done. Experts argue that such could be a factor of the preponderant problems emanating within programme to imply some level of neglect as part of methodological issues in the educational programming of respondents (see, Green et al, 1980; Tanahill, 1992). Green et al (1980) assert that educational efforts short of a clear perception of preponderant issues emanating from 'within programme' 'within organisation' and inter-organisational could defy sound planning and proper management. The result could be a consequence of the existing strategic standards for health education by the policy documents (FMOH, 2004; 2007).

Thus, the quality of the educational work of the respondents may be questionable where policy guidelines were explicit with articulate standard procedures. The planning and programming of an educational activity seem arguably a matter for the individual health education worker, presumably under a dispersed organisational model and without recourse to health education philosophy and specialist attention.

Cole (1997) argues that quality management begins with a consideration of the consumer target, asserting that the consumer wants and needs translate into specifications before services can begin. With such dependence on educational messages and materials from partner agencies, the tendency that consideration for the consumers' wants and needs was nonexistent in the educational work of the respondents seemed high. Still, the policy documents (FMOH, 2004; 2007) possibly defined the quality of the processes for the production of educational products to which its specifications probably emerged in the practice as shown via the experiences of the respondents (see, Baric 1994). Meanwhile, an aggregate of 62% respondents shared an opinion that availability of a guideline is a pre-requisite in the planning and programming of educational work. An aspect aimed at understanding the type of supports derived by respondents for educational activities was an addendum to the task of establishing the pattern of practice in educational planning and programming of the respondents. Two categories of stakeholders emerged in the responses of the participants and these were the functional and the provider stakeholders.

From the respondents' experience, the functional stakeholders that supported educational work exist within the health sector, other governmental sectors and community settings. The most enlisted category of the stakeholders was the WFPs/OICs by 33% respondents, followed by the community-based organizations (CBOs) by 30% respondents.

The type of educational work mostly supported by the WFPs/OICs and health facility staff was client counselling. Although, the type mostly supported by the CBOs was community sensitization and mobilization, the WFP/OIC did more of this type of educational work than found with any other functional stakeholders, indicated by the respondents. In aggregate, 65% respondents indicated community sensitization but staggered in nearly equal proportions among the various categories of the stakeholders that emerged on such educational activity. Therefore, it seems to imply that all the categories of functional stakeholders indicated by the respondents performed community sensitization role even though it was in varying proportions.

Despite the above, the result about the WFPs/OICs being a part of the functional stakeholder group, indicated by the respondents may seem peculiar to critical minds. It seems consistent with the aim of the WMHCP to boost the capabilities of PHC workers at the grassroots for the delivery of a

minimum set of PHC interventions, including educational roles to meet the basic health requirements of a majority of Nigerians (see, NPHCDA, 2007).

The result could also be an illustration of the polyvalent nature of health workers' roles often exerted while performing their primary functions as health care workers. Such seems well documented as a common experience in many developing countries (see, Macdonald, 1994; Das Gupta et al, 2003). The emergence of the WFPs/OICs as health sector stakeholders implies that the category extends their health care roles beyond patient-clientele routines**.**

The collection of educational roles credited to the WFPs/OICs seems a practical expression of improvements in the aptitude of PHC workers. Apart from client counselling, WFPs/OICs also featured on community sensitization and mobilization with more significant indications from the respondents than observed with the CBO category (see, Table 4.4.8). Yet, the educational role mostly credited to the CBOs was community sensitization and mobilization.

The other categories of functional stakeholders credited with community sensitization and mobilization role were governmental agencies and a mixed class of influential others outside of the health sector. These categories of functional stakeholders emerged from a variety of backgrounds within the different agencies and communities to support the respondents' educational activities as volunteers or community/ward development committee members. Still, the community sensitization role of those stakeholders, outside the health sector concurs with an aspect of the WMHCP proposal about developing ward level committees for health care roles (NPHCDA, 2007). It also identifies with the PHC's principle of community involvement and participation, which seems well documented in extant literature (WHO, 1978; Ransome-Kuti et al, 1990; Macdonald, 1994). Health experts argue that the active citizen involvements in empowerment-linked methods generate a solid foundation for community ownership (UNICEF, 1993; Lefevbre, 1992; Tones and Tilford, 1994). The community sensitization and mobilization roles credited to most categories of the stakeholders are clearly part of empowerment approaches, but the extent of generating community ownership remains explicable under the achievement-probing task.

Such educational roles accruing from stakeholders both within and outside the health sector seems underpinning to multi-sectoral involvements, effective partnership and collaboration enshrined as a strategy in the policy document (FMOH, 2004). The aim of such approach is about enhancing people's access to health services and information while its realization is explicable in the respondents' pattern of practice in documenting achievement and quality.

The manner by which the respondents involved functional stakeholders on the variety of educational methods, shown depicts a pattern mostly linked to the dispersed method in the organizational models of health education practice (Baric, 1976). In the context of such model, the educational roles of the group of stakeholders outside the health sector evolve as inputs from voluntary change agents having a role in health promotion services (Baric, 1976).

Even though, both the coexisting and specialist models, as composites of the organizational models of educational intervention seem yet, scarcely functional in the findings, the place of external stakeholders in educational roles suggests a respite point in the respondents' work. Hence, the intervals by which the respondents involved functional stakeholders demand some clarity to appreciate the style of involvements based on the types, already indicated.

The intervals of involvement emerged from a list of response options, narrowed to the three categories such as 'very often' 'when needed' and 'very rarely'. The interval scales thus depict the relative periods by which the respondents involved functional stakeholders.

The respondents' IMNCH packaged educational work also compares with the intervals for involvement to value the focus about stakeholders' educational roles as maybe directed by respondents' capacity. In general, 51% of the respondents involved functional stakeholders, only when needed with the CBOs having the highest proportion of the indications, followed by the other groups, similarly from outside the health sector.

Among the categories of functional stakeholders involved very often by the respondents were the WFPs/OIC and the health facility workers (both exist naturally within the health sector). The WFPs/OICs had the highest proportion of the indications.

Comparing the targets of an educational package by the involvement intervals of functional stakeholders, the campaign target was topmost, trailed by immunization, which comprised both the routine and supplemental targets (Table 4.4.10 refers). Experience impresses that a veteran health care worker could argue that both the campaign and immunization targets were identical groups with children and women of childbearing age, constituting the regular focus.

For instance, polio eradication initiative (PEI) is a type of campaign in poliomyelitis high-risk countries like Nigeria and drives supplemental immunization activities (SIAs) in the country (see, FMOH 2004). The maternal, newborn and child health week (MNCHW) forms a crucial part of IMNCH interventions, operated twice a year and thus assuming the campaign status (FMOH, 2007). The package of MNCHW also entails immunization services.

The realization that the constant target for immunisation activities exists in two major groupings aids an understanding about the focus of such hypothetical argument. Under routine immunisation services, for example, women of childbearing age (WCBA) and children less than a year old form the targets while children below five years old constitutes the target for campaigns whether in the SIAs or during the MNCHW.

Hence, the mere selection of a programme targets for an educational activity such as revealed with campaign and immunisation would seem ordinarily too simplistic, ambiguous and ill defined. The WCBA group for instance could be a veritable target for educational activities while children in such age cohorts less than five years old, (both in campaign and routine immunisation contexts) are much unlikely to be a proper choice for an educational activity.

It is only commonsensical as children in such age brackets would be in their infancy and unlikely to have the capabilities needed to understand the purpose and relevance of educational plans let alone act on the messages. This point extols the significance of the work plan that is operational on a concurrent basis at elucidating areas of improvements mistrust, inadequacies and improprieties in the educational interventions of the respondents.

Therefore, the above hypothetical argument could be relevant to extents of implying that those respondents that used a programme as the criteria to select targets for educational work (see, Table 4.3.18) probably lacked a consideration about the inherent implications. Such action seems a re-invention of what Tanahill (1992) portrays as ill-defined situation and ‘a neglect of methodological issues’ with the consequence of gross oversimplification of plans.

Perhaps in a subscription to Tanahill’s view, Wallerstein and Bernstein (1994) assert that health education practice needs a repertoire of methods to match different targets’ needs in other to meet changing situations and chances. Still, Stetson and Davis (1999) argue the need for debates that can strengthen the skills of health education workers in selection, planning, implementation and evaluation of suitable approaches by organisational objectives and goals.

Just as IMNCH component programmes vary in types (see, FMOH, 2007) likewise, the strategies of health education (see Green et al, 1980; Tones and Tilford, 1994). In a subscription to the view of the experts (Wallerstein and Bernstein, 1994; Stetson and Davis, 1999), there can only be a measurable response from targets of an educational activity when the criterion used in selecting targets is matching to the selection of the educational strategies.

However, the findings imply a potential disorder in articulating specific scopes for educational processes during the provision of routine health care services. The significance of target segmentation in educational endeavors, as outlined by Green et al. in 1980, appears compromised, possibly due to an awareness that the target audience readily exists for specific Integrated Maternal, Newborn, and Child Health (IMNCH) programs, as indicated in FMOH publications from 2004 and

2007. This may also reflect an assumption that the same target is suitable for the program's educational interventions.

The fact that some respondents identified campaign targets suggests a gap in their ability to distinguish between educational targets and program objectives. This gap could stem from the respondents' health education experiences and may be partly influenced by the dispersed model subtly endorsed by the policy outlined in FMOH 2004, which organizes educational plans without necessarily aligning them with the overarching goal of health education.

Conclusions and policy implications

According to the current study's findings, the investigation concludes the following:

In the primary healthcare (PHC) setting, there is a notable predominance of female health education workers compared to their male counterparts. These professionals come from diverse healthcare backgrounds, including community-health extension workers'/community health officers (CHEW/CHOs), nursing officers, environmental health officers, nutritionists, and health information technicians.

A significant number of health education workers received training exclusively during their job and through workshop experiences, specifically in health education practices. At the health facility level, most of these workers incorporate educational packages as part of their Integrated Maternal, Newborn, and Child Health (IMNCH) services. Meanwhile, those at the Local Government Area (LGA)/State levels either integrate such packages into PHC services or consider them a major program within the context of PHC component education.

Interestingly, a substantial portion of health education workers lacks awareness of any standardized operational procedures or guidelines for educational interventions. Considering the diversity of professionals involved in educational activities, the prevailing organizational model for educational intervention seems to be a dispersed approach. There is no observable evidence of either a coexisting or specialist model in the respondents' patterns of practice. Regardless of the professional background and level of working experience, the health education workers tend to identify with the health care work title or health care responsibility of assignment. The health care roles of many of the health facility based health education workers tend to be polyvalent and more likely operated at both the clinic and community levels unlike seen with those at the LGA/State levels.

A greater proportion of the environmental health workers with formal health education training tend to perform health education responsibilities as a major function than other health care workers within the PHC setting. Still, health education activities within the setting seem operated more on a dispersed approach than the other organizational models (ie, coexisting and specialist) of intervention notable in extant literature.

There is a tendency that the planning and programming of educational activities within the PHC setting rely on development partners and donor agencies for information, education and communication (IEC) messages and materials to reach out to the public. The place of a work plan in the educational work of the health education workers seem almost nonexistent as campaign activities appear mostly central to educational efforts directed at IMNCH services.

Apart from the target groups established by the concurrent protocols of a specific PHC intervention, most PHC programme related education work lacked specific criteria, backing the selection of targets for educational activities. Thus, targets of educational activities seem ill defined and educational interventions structured, merely on assumptions, incidental planning and or on the educational intervention of the previous health care work done.

The majority of the health education workers on IMNCH services share good opinions about the relevance of standard procedures or operational guidelines in health education work. Despite such opinion, most of the health education workers lacked understanding about the relevance and the manner of application of such educational approaches as KAP / KAPB, empowerment and communication in education interventions.

Health education workers at the HF level mostly did more of clinic patient education and community link activities than community / ward- development-committee relations and counseling. The majority of those at the LGA level seem to limit their focus only to such educational work as community education and group sensitization activities more than considered a need to combine such with social marketing strategies (media and advocacy).

State-level health education workers mostly engaged in community education, group sensitization and social marketing strategies. Even though on seldom basis, a good proportion of the health education workers engaged functional stakeholders from outside the health sector in such educational activities as community sensitization and essentially during SIA campaign periods more than seen with other routine IMNCH activities.

Both the functional and provider stakeholders seemed to have vital roles in the educational work of the participants but in diverse ways. While such functional stakeholder groups tend to offer supports mostly in the operational realms of educational activities, the provider stakeholders seemed to offer supports in the context of logistics related resources.

Still, the pertinence of the quality management cycle failed to reflect in the findings from the means by which the health education workers derived educational materials and messages, except for the increased reliance on partner agencies. Thus, a purpose set to understand the quality of the processes involved in the production of the product (ie, content educational messages and materials) to which specification will apply (Baric, 1994) seemed defeated.

There was no clear evidence about behaviour change documentation in the respondents' record of achievements. Most of the health education workers, across the various categories sampled at the HF/ward and LGA/State levels, lacked evidence of educational outcomes.

In summary, the findings reveal intricacies in the distribution of health education responsibilities among various experts, allowing room for stereotypical practices without a structured approach, standardization, or adherence to health education professionalism. Consequently, the overall results cast doubt on the effectiveness of the respondents' integrated maternal and child health (IMNCH) activities, suggesting a lack of alignment with established standards.

In light of these conclusions, the policy implications highlight the necessity for a reassessment of the health education roles played by diverse professionals, aligning them with the objectives of the national health policy. The importance of such a role review is emphasized by experts who advocate for clear delineation of responsibilities among health education workers.

For instance, Baric (1976) underscores the need for role delineation, particularly in situations involving multiple professionals, to prevent unnecessary complacency in the absence of effective coordination. Neutens (1984), within an investigative context, argues for delineation research to enhance coordination processes, taking into account both specialist and coexisting models of educational intervention, as suggested by Adeniyi and Brieger (1981).

In light of the conclusions drawn from the current study and their policy implications, the recommendations, reflecting the majority opinions of the respondents, are outlined as follows:

1. The government should enact policies aimed at fostering the growth and professionalization of health education work. This would contribute to a more dynamic and professional implementation of educational processes, addressing the observed shortcomings in the current Ekiti-State context.
2. The National Council on Health (NHC) should reassess the status of health education planning, management, and coordination within the existing health policy framework. Additionally, it should create platforms to enhance the strategic management of health education.
3. The National Council on Health (NHC) should facilitate the effective collaboration of health education professionals in planning, management, and coordination. Given the diverse

categories of healthcare professionals and partner agencies involved, this collaboration is crucial.

4. The National Council on Health (NHC) should initiate projects focused on role delineation, drawing insights from best practices observed in countries like the UK and the United States of America.
5. Future in-depth studies should explore methodological issues in health education planning and programming. Utilizing qualitative research designs and considering a large sample size would provide valuable insights into these areas.

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