Unizik Journal of Educational Research, Science and Vocational Studies (UJERSVOCS)
Volume 4 (1); January-April, 2026; https://unilaws.org/ujervs
E-ISSN (Online): 1595-6199 **ISSN (Print): 1595-6202**

HEALTH EDUCATION OFFICERS' AWARENESS AND APPLICATION OF HEALTH PROMOTION STRATEGIES FOR COMMUNITY DEVELOPMENT IN ANAMBRA STATE

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ABSTRACT

This study investigated health education officers' awareness and application of health promotion strategies for community development in Anambra State. Four research questions and four hypotheses guided the study. Descriptive survey research design was adopted for the study. The population of the study comprised all the 1,187 health education officers (Officers in Charge; OIC) in 1,187 (685 public-owned and 502 privately owned) health centres in Anambra State. The sample size of the study was 237 (137 public-owned and 100 private-owned; health education officers) drawn using proportionate stratified random sampling technique. Researcher-structured rating scales titled "Awareness of Health Promotion Strategies for Community Development Rating Scale (AWHPSCDRS) and Application of Health Promotion Strategies for Community Development Rating Scale (APHPSCDRS)" were used for data collection. The instrument was validated by three experts in the Faculty of Education, Nnamdi University, Awka. The data from the trial test were analyzed using Kuddar Richardson (K-R21) for AWHPSCDRS and Cronbach Alpha method for APHPSCDRS respectively. Data were analyzed using descriptive statistics (frequency, percentage, aggregate mean, standard deviation) and inferential statistics (chi-square, and independent t-test). The findings revealed that health education officers in Anambra State exhibit strong awareness and effective application of diverse health promotion strategies, notably policy advocacy and media campaigns as essential tools for advancing community development. The findings also revealed that public and private health education officers in Anambra State do not differ significantly in their awareness and application of health promotion strategies for community development. Based on the study findings, the study recommended among others that the Ministry of Health, non-governmental organizations, community leaders, and policymakers should provide continuous training, funding, and logistical support to sustain health education officers' effective application of policy advocacy, media campaigns, community engagement, and service integration.

Keywords: Health Education Officers; Awareness; Application; Health Promotion; Health Promotion Strategies; Community Development.

Introduction

Most prosperous nations of the world could be seen to have used education as a vehicle for their economic, political, sociocultural and infrastructural development. It is universally recognized as an instrument for enlightenment and progress. It is with this understanding that education is considered an indispensable input

for national development, and an avenue for empowering citizens of any nation (Onyali & Nnebedum, 2016). Obi and Anizoba (2018) considered education9 as the development of person's head, heart 5and hands for his self-fulfillment and optimum service to humanity. Education, in this perspective is perceived as a cornerstone for economic growth and societal development, and a principal means of improving the welfare of individuals. The Federal Government of Nigeria has adopted education as an instrument for effecting national development and social change (Federal Republic of Nigeria [FRN], 2013). To achieve this goal, FRN (2013) emphasized that quality education should be given at all levels of education to every categories of human, irrespective of sex, colour, social and economic status. In Nigeria, there are various field of education including health education and health promotion. Health promotion refers to the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It encompasses a range of activities aimed at enhancing individual and community well-being, including education, lifestyle changes, public policy, and environmental improvements. The goal of health promotion is to empower individuals and communities to take actions that promote health, prevent disease, and enhance quality of life. In Nigeria, the objectives of health promotion are to enhance public health by educating individuals and communities about preventive measures against diseases such as malaria, HIV/AIDS, and other prevalent health issues. Furthermore, to empower people to adopt healthy lifestyles, promoting physical activity, balanced nutrition, and good sanitation practices is essential to reducing the burden of preventable diseases. Most importantly to improve access to healthcare services and facilities, particularly in underserved areas, requires equitable health outcomes across the population (Federal Ministry of Health [FMH], 2020). This means that health promotion is a holistic approach that addresses not only physical health but also mental and social well-being, emphasizing prevention over treatment to improve overall quality of life. In essence, health promotion is recognized as a prerequisite for quality human life as well as a sine qua non for reducing the burden of preventable diseases through proactive health promotion strategies.

Admittedly, attainment of the primary objectives of health promotion demands active community participation, access to resources, collaboration among stakeholders, and addressing social determinants of health. Consequently, the achievement of health promotion objectives enhances community development. Community development refers to a process where community members come together to take collective action and generate solutions to common problems. Eze, Idigbe, Chukwuocha and Arinze-Onyia (2021) posited that community development is a broad term that encompasses a range of activities and initiatives aimed at improving various aspects of community life, including economic, social, cultural, and environmental dimensions. Historically, community development has roots in social work and grassroots movements, emphasizing empowerment, participation, and social justice. Glick, Huang, Mehra and Thiede (2021), defined community development as a participatory process where community members collectively identify and address their health issues, leveraging local knowledge and resources to improve health outcomes and enhance quality of life. This process according to Glick et al. (2021) involves building the capacity of individuals and groups within a community to plan, implement, and sustain health initiatives that includes developing skills, fostering leadership, and promoting collaborative action to address community development. It promotes a comprehensive view of health that includes mental well-being, social cohesion, and economic stability as integral components of overall health. In the field of health education and health promotion, the health education officers are important personnel with the obligation of overseeing the attainment of the laudable objectives of health promotion programmes as stipulated in the Federal Ministry of Health Guidelines in 2016. As professionals they specialize in promoting and facilitating health education initiatives within communities, schools, healthcare settings, or other institutions. As a result, the health education officers have the responsibility

of educating and informing people about health-related topics such as disease prevention, healthy lifestyles, nutrition, and safe sexual health practices; developing educational materials; organizing workshops and seminars; conducting outreach programmmes; and advocating for health policies. It is this crucial role of empowering individuals and communities to make informed decisions that inspire quality oriented strategies to support constant innovations, changes and improvements in the field of health promotion. By the virtue of their function, health education officers remain key figure in community development through the application of innovative health promotion strategies.

Health promotion strategies are approaches aimed at enhancing the health and well-being of individuals and communities. Adebayo, Labiran and Essien (2016) conceptualized health promotion strategies as activities aimed at increasing individuals' knowledge and awareness about health-related issues, encouraging healthy behaviours, and providing the skills needed to make informed health choices. These activities focus on prevention, education, and the promotion of healthy behaviours. They also involve implementing policies and modifying physical and social environments to support healthy lifestyles, such as creating smoke-free areas, promoting access to healthy foods, and ensuring safe recreational spaces (Sanusi & Salako, 2018). Health promotion strategies according to Ogboghodo, Okogbenin, Obasohan and Adebisi-Adelani (2020) are the initiatives that engage local communities in the planning and implementation of health promotion activities, leveraging local resources and addressing specific community health needs. The initiatives and strategies are designed to help individuals adopt and maintain healthy behaviors through counseling, support groups, and the use of tools like health apps and reminders. Ojewole, Okafor and Maduforo (2021) noted that health promotion strategies aimed at increasing individuals' knowledge and awareness about health-related issues, encouraging healthy behaviours, and providing the skills needed to make informed health choice. Although health promotion strategies that are recorded in literature are numerous, Fajemilehin and Adeyemo (2023) isolated the following as being ideal for community development: health policy advocacy, media campaigns, community engagement, health service integration, behavioural interventions, environmental changes, workplace wellness programmes, and policy development. In this study, health policy advocacy and media campaigns were adopted as health promotion strategies that could be applied by health officers for community development in Anambra State. The strategies were selected on the basis of their similarity to environmental conditions in Anambra State; which is the area of this research study.

Health policy advocacy refers to activities aimed at influencing public policies, laws, and regulations to improve health outcomes and healthcare systems. Adepoju, Alawode and Oladipo (2021) remarked that health policy advocacy involves working to influence public policy and resource allocation to support health promotion initiatives. This includes building coalitions and partnerships among various groups to strengthen advocacy efforts and create a unified voice for health policy changes. Barry et al. (2018) viewed health policy advocacy as engaging in the legislative process to support or oppose specific health policies, often through lobbying, drafting policy proposals, and providing expert testimony. Barry et al. (2018) further stated that monitoring the implementation of health policies and holding decision-makers accountable for their commitments and actions are aspects of health policy advocacy. This implies that health policy advocacy aims to create an environment where healthier choices are easier and accessible for everyone, ultimately improving population health and reducing health disparities. Health policy advocacy is a vital strategy in health promotion and community development that entails the use of various tactics and interventions to influence public policy and resource allocation decisions within political, economic, and social systems that directly affect people's health. Educating and raising public awareness, shaping public opinion, and mobilizing support for policy

changes through widespread dissemination of information and persuasive messaging requires powerful media campaigns.

Media campaigns are strategic initiatives aimed at disseminating targeted messages to the community through various media channels. Owolabi and Ojewole (2017) described media campaign as spreading of information about specific health issues, such as vaccination drives or disease prevention methods, through various media channels. These campaigns utilize platforms such as television, radio, social media, and print media to raise awareness about health issues and encourage positive behavioural change. By employing persuasive messaging and engaging storytelling, media campaigns seek to educate, motivate, and empower individuals to adopt healthier lifestyles and make informed decisions about their well-being (Onuoha & Uzochukwu, 2018). Effective media campaigns often involve collaboration between health experts, community leaders, and media professionals to ensure that messages resonate with the target audience and drive meaningful action. Gidado et al. (2015) averred that media campaigns involve using various media platforms to disseminate information and influence behavioural change within a community. These campaigns typically aim to raise awareness about health issues, promote healthy behaviours, and encourage community participation in health-related activities. Ultimately, media campaigns play a crucial role in community development by fostering a culture of health, promoting social norms that prioritize well-being, and reducing health disparities (Dada & Adeosun, 2019; Ojewole et al., 2021). Media campaigns however, can foster community engagement by encouraging participation in health-related activities, such as blood donation drives, community clean-ups, or health fairs, through media platforms to mobilize community involvement and support.

Thus far, it evident that literature corroborates the use of health promotion strategies for promoting community development. This implies that awareness and application of health promotion strategies by public and private health education officers are important variables that positively influence community development. In contrary, health education officers' lack of awareness and/or application of health promotion strategies may be as good as denying the community the opportunities of development health wise. Undoubtedly, Adebayo, Labiran and Essien (2016) reasoned that non-implementation of health promotion strategies by health institutions signals a big challenge to quality development of the communities such that the communities stand the risk of facing increasing disease prevalence, reducing productivity, escalating healthcare costs, and limiting economic and social progress. It is against the foregoing background that the researcher conceived the idea to investigate health education officers' awareness and application of health promotion strategies for community development in Anambra State. However, institutional type is considered in this study as an important moderator variable in the awareness and application of the strategies identified in this study.

Statement of the Problem

Community development in Anambra State is expected to thrive on improved health outcomes, enhanced productivity, and strengthened social well-being. Expectedly, vibrant communities should benefit from effective health promotion programmes that reduce preventable diseases, improve sanitation practices, and encourage healthy lifestyles. Regrettably, community development in the state is increasingly threatened by persistent health challenges that undermine social well-being, economic productivity, and the overall quality of life. Although several governmental and non-governmental agencies have initiated programmes aimed at improving community health, many communities still struggle with preventable diseases, inadequate health awareness, and low participation in health-oriented initiatives. These persisting issues suggest that the expected improvements in community development have not been fully achieved. Observations by the researcher, coupled with informal discussions with community leaders, reveal recurring lapses in sustaining healthy behaviours, mobilizing residents for collective health actions, and promoting environments that support well-

being. Such gaps raise concerns that insufficient awareness and poor application of modern health promotion strategies may be hindering the attainment of robust and sustainable community development in the state. Further preliminary interactions with selected health education officers indicate that only a limited number consistently adopt comprehensive health promotion strategies such as health policy advocacy and targeted media campaigns. While many officers possess basic awareness of these strategies, their practical application appears inconsistent and often inadequate to stimulate measurable improvements in community health outcomes. If these shortcomings persist, communities may remain vulnerable to avoidable illnesses, low responsiveness to health initiatives, weak empowerment structures, and slow progress in key developmental indicators. This situation therefore creates a compelling need to empirically investigate health education officers' awareness and application of health promotion strategies for community development in Anambra State.

Purpose of the Study

The purpose of the study was to investigate health education officers' awareness and application of health promotion strategies for community development in Anambra State. In specific terms, the study sought to determine:

1. health education officers' awareness of health policy advocacy strategies for community development in Anambra State;
2. health education officers' awareness of media campaigns strategies for community development in Anambra State;
3. the strategies health policy advocacy that health education officers apply for community development in Anambra State; and
4. the strategies of media campaigns that health education officers apply for community development in Anambra State.

Research Questions

The following research questions were raised and answered in the study.

1. Are health education officers' aware of health policy advocacy strategies for community development in Anambra State?
2. Are health education officers' aware of media campaigns strategies for community development in Anambra State?
3. What are the strategies of health policy advocacy that health education officers apply for community development in Anambra State?
4. What are the strategies of media campaigns that health education officers apply for community development in Anambra State?

Hypotheses

The following null hypotheses were formulated and tested at 0.05 level of significance:

1. Health education officers do not differ significantly on their awareness of health policy advocacy strategies for community development in Anambra State.
2. Health education officers do not differ significantly on their awareness of media campaigns strategies for community development in Anambra State.
3. There is no significant difference in the mean ratings of health education officers on the application of health policy advocacy strategies for community development in Anambra State.
4. There is no significant difference in the mean ratings of health education officers on the application of media campaigns strategies for community development in Anambra State.

Theoretical Framework

The theoretical framework for the study is anchored on the Health Belief Model (HBM) and the Social Ecological Model (SEM), discussed below.

Health Belief Model (HBM)

The Health Belief Model, developed by Irwin Rosenstock in 1950s and later expanded by Becker and other scholars, explains health-related behaviour as a function of individuals' beliefs and perceptions about health issues. The model emphasizes perceived susceptibility (belief about the likelihood of experiencing a health problem), perceived severity (belief about the seriousness of the condition), perceived benefits (belief in the effectiveness of recommended actions), perceived barriers (perceived obstacles to action), cues to action, and self-efficacy. In this empirical study, the HBM is relevant because health education officers' awareness of health risks, understanding of community health challenges, and beliefs about the benefits of health promotion strategies significantly influence their motivation, commitment, and consistency in applying such strategies. The model is suitable as it provides a clear framework for examining how officers' cognitive awareness and personal beliefs translate into practical health promotion activities that can enhance behavioural change, improve preventive practices, and foster sustainable community development in Anambra State.

Socio-Ecological Model (SEM)

The Socio-Ecological Model, popularized by Urie Bronfenbrenner in 1970s, explains human behaviour as the outcome of dynamic interactions across multiple levels of influence, including individual, interpersonal, organizational, community, and policy levels. At the individual level, personal knowledge, attitudes, and skills shape behaviour; at the interpersonal level, family, peers, and social networks exert influence; while organizational and community structures, as well as public policies, provide enabling or constraining environments. The relevance of the SEM to this study lies in its recognition that effective community development and health promotion depend not only on health education officers' awareness and skills but also on institutional support, cultural norms, community participation, available resources, and supportive health policies. The model is suitable because it offers a holistic perspective for analyzing how health education officers operate within complex social systems, making it appropriate for understanding the multifaceted factors that influence the application of health promotion strategies for sustainable community development in Anambra State.

Theoretical Review

Health Promotion Strategies for Community Development

Health promotion strategies are essential to improving the well-being of communities and fostering sustainable development. These strategies seek to enable individuals, communities, and governments to address the social, economic, and environmental determinants of health. The World Health Organization (2023) defined health promotion as the process of enabling people to increase control over, and to improve, their health. In Nigeria, community development relies heavily on the effectiveness of health promotion initiatives, as health is a key factor influencing social and economic progress. An empirical study on health education officers' awareness and application of health promotion strategies for community development would shed light on the practical implementation of these strategies and their impact on communities. With growing awareness about the importance of a healthy population for economic productivity and quality of life, there has been a push for more effective health policies and programmes. Key strategies identified in his study for promoting health

include health policy advocacy and media campaigns. These strategies, if effectively implemented, can bridge the gap between health knowledge and practice, leading to healthier and more empowered communities.

Health Policy Advocacy for Community Development

Health policy advocacy plays a critical role in influencing health outcomes and supporting community development. Health education officers, through policy advocacy, seek to influence policymakers and government agencies to prioritize health issues within their development agenda. According to Nwachukwu et al. (2020), health policy advocacy in Nigeria has been instrumental in bringing attention to issues like maternal health, immunization, and nutrition. Health education officers, aware of the role of policy in community health, use their platforms to advocate for stronger public health policies, resource allocation, and the implementation of health services. These advocates focus on creating policies that address the root causes of health inequalities, such as poor sanitation, lack of education, and limited access to healthcare. The effectiveness of health policy advocacy depends on the active involvement of health education officers in lobbying for laws and regulations that support community development. Studies by Eze, Oguonu and Aja (2021) showed that in Nigerian rural communities, where health policies often fail to address local needs, advocacy from health education officers has led to improved health programmes and the establishment of local health initiatives, which have, in turn, contributed to overall community development.

Media Campaigns for Community Development

Media campaigns are a powerful tool in health promotion because it helps to reach large populations with health messages that can transform behaviour and attitudes. Health education officers use various media platforms, including radio, television, social media, and print media, to disseminate information on health risks, preventive measures, and available services. In Nigeria, where health literacy can be low in rural areas, media campaigns help bridge the knowledge gap and raise awareness about important health issues. According to Okeke, Onah and Eze (2019), the success of media campaigns in Nigeria has been evident in the reduction of the stigma around HIV/AIDS and the promotion of healthy practices like hand washing, vaccination, and maternal care. Health education officers apply media campaigns not only to inform but also to influence public opinion and encourage positive health behaviours. For instance, in response to the COVID-19 pandemic, health education officers in Nigeria and Anambra State in particular used social media platforms to spread information about safety protocols, vaccination campaigns, and health guidelines. The empirical study conducted by Akinmoladun, Adeyemi and Afolabi (2022) highlighted that health education officers who effectively utilized media campaigns reported higher levels of public engagement and improved community health outcomes.

Methodology

The study adopted a descriptive survey research design. Nworgu (2021) noted that a descriptive survey design is one which aimed at collecting data on and describing in a systematic manner, the characteristics features or facts about a given population. The study was carried out in Anambra State, South-East, Nigeria using Health Centres in Anambra State. The population of the study comprised all the 1,187 health education officers (Officers in Charge; OIC) in 1,187 (685 public-owned and 502 privately owned) Health Centres in Anambra State (ANSMoH, 2024). The sample size of the study was 237 (137 public-owned and 100 private-owned; health education officers) which is 20 percent of the entire population drawn using proportionate stratified random sampling technique. The instrument for data collection was structured rating scale by the researcher titled “Awareness of Health Promotion Strategies for Community Development Rating Scale (AWHPSCDRS) and Application of Health Promotion Strategies for Community Development Rating Scale (APHPSCDRS)”. The instrument was developed from the review of related literature, consultation with experts, and the specific purposes of the study and was made up of three sections. Section A of the instrument elicited

data on the institution type and senatorial zone of the research participants (health education officers). Section B of the instrument was Awareness of Health Promotion Strategies for Community Development Rating Scale. Precisely, Section B of the instrument contains 20 items spread across two clusters (A-B) and elicited data on health education officers' awareness of health promotion strategies for community development. Cluster A-B contains ten items each on: awareness of health policy advocacy strategies and media campaigns strategies respectively. This section was structured on a dichotomous response format of Aware or Not Aware. Section C of the instrument contains 40 items spread across four clusters (C-D) and elicited data on health education officers' application of health promotion strategies for community development. Cluster C-D contains ten items each on: application of health policy advocacy strategies and media campaigns strategies respectively. These clusters were structured on a 4-point response rating scale of Strongly Agree (SA); Agree (A); Disagree (D); and Strongly Disagree (SD); which were weighted 4 points, 3 points, 2 points, and 1 point respectively. The instruments were validated by three experts in Faculty of Education Nnamdi Azikiwe University, Awka. To determine the reliability of the instrument, a pilot test was conducted using samples of 20 health education officers in Enugu State; who were no part of the study. The responses of the health education officers were analyzed to measure the internal consistency of the items in Section B of the rating scale (i.e clusters A-B). This was done using Kuder-Richardson (K-R_{21}). The following coefficients were obtained: 0.813 and 0.794 for awareness of health policy advocacy strategies and media campaigns strategies respectively. Furthermore, the responses of the health education officers were analyzed to determine the internal consistency of the items in Section C of the rating scale (i.e clusters C-D) using Cronbach Alpha. The following coefficients were also obtained: 0.831 and 0.870 for application of health policy advocacy strategies and media campaigns strategies respectively. The coefficient values so obtained were considered high enough to permit the use of the instrument for the study. The researchers administered the instrument to the respondents with the help of six research assistants. Out of the 237 copies administered, 234 (135 public and 99 private) copies were retrieved properly completed, and used for data analysis. This gave a return rate of 98.73%, which the researcher considered adequate for the study. Descriptive statistics (frequency, percentage, mean and standard deviation) were used to answer the research questions. A score of 50% was taken as benchmark for accepting an item as "Aware" while below 50% was taken as "Not Aware". For answering research questions five to eight, the descriptive statistics of mean and standard deviation were utilized. A criterion mean of 2.50 was used in accepting an item as "Agree" while those with 2.49 and below was grouped as "Disagree". Chi-square statistics was used in testing hypotheses one to two while t-test analysis was used for testing hypotheses three to four. The p-value was used to determine the significance of the difference for all hypotheses. The decision rule was: a null hypothesis was not retained where the calculated p-value was less than the stipulated level of significance (0.05); while a null hypothesis was accepted or upheld where the calculated p-value was greater than the stipulated level of significance. All analyses were carried out using Statistical Package for Social Sciences (SPSS), Version 26.

Unizik Journal of Educational Research, Science and Vocational Studies (UJERSVOCS)
Volume 4 (1); January-April, 2026; https://unilaws.org/ujervs
E-ISSN (Online): 1595-6199 ISSN (Print): 1595-6202

Results Presentation and Discussions

Analysis of Respondents Personal Data

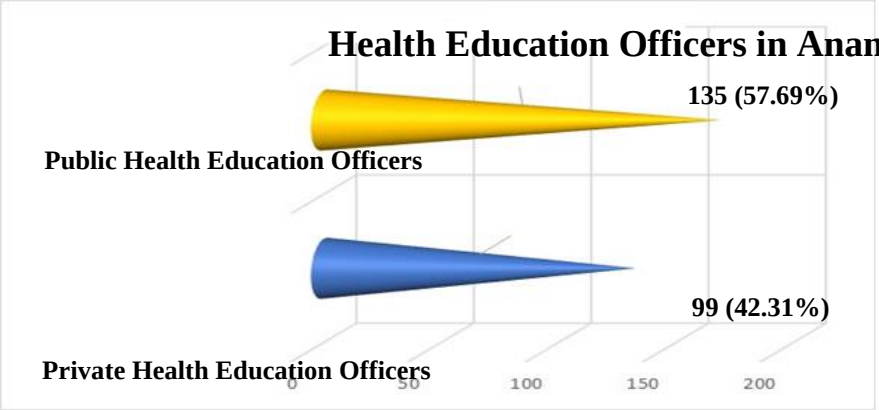

Fig. One: Health Education Officers in Anambra State
Source: Field Survey, 2025.

Figure One revealed the health education officers that participated in providing the necessary data for analysis in the study. The results indicated that 135 (57.69%) of the respondents were in public health centres in Anambra State; while 99 (42.31%) of the respondents were private health centres in Anambra State. This signifies that more of the health education officers are in public health institutions (health centres) in Anambra State.

Research Question One and Hypothesis One

Research Question One: Are health education officers' aware of health policy advocacy strategies for community development in Anambra State?

Table One: Frequency and percentage responses on health education officers' awareness of health policy advocacy strategies for community development

S/N	Health Education Officers (N = 234)	Aware		Not Aware		Remark
		F	%	F	%	
1.	Community mobilization to create demand for policy change.	201	85.9	33	14.1	Aware
2.	Building relationships with key stakeholders to support advocacy initiatives.	179	76.5	55	23.5	Aware
3.	Public awareness campaigns to educate the community on health issues that demand policy changes.	188	80.3	46	19.7	Aware
4.	Lobbying to support health policies that benefit the community.	174	74.3	60	25.7	Aware
5.	Forming partnerships with other organizations to strengthen the advocacy movement.	159	67.9	75	32.1	Aware
6.	Using credible data to back advocacy efforts that provide proof of the need for policy change.	197	84.2	37	15.8	Aware
7.	Grassroots advocacy that fosters a bottom-up approach to policy change.	184	78.6	50	21.4	Aware
8.	Utilizing legal frameworks to advocate for new regulations that improve community health.	185	80.3	49	19.7	Aware

9.	Equipping community members to engage in effective policy advocacy.	189	80.8	45	19.2	Aware
10.	Continuously assessing advocacy efforts to measure their effectiveness.	176	75.2	58	24.8	Aware
	Aggregate					
	Aggregate	**183**	**78.2**	**51**	**21.8**	**Aware**

Table One shows the frequencies and percentage responses of health education officers on their awareness of health policy advocacy strategies for community development in Anambra State. The results indicate that health education officers are aware of all the ten listed strategies for community development as over 50% (78.2) of the health education officers affirmed that they are of each of the ten strategies outlined.

Hypothesis One: Health education officers do not differ significantly on their awareness of health policy advocacy strategies for community development in Anambra State.

Table Two: Summary of the Chi-Square analysis on health education officers' awareness of health policy advocacy strategies for community development

Source of Variation	N (234)	Df	A	χ^2Cal	χ^2Crit.	P-value	Remark
Public	(N=135)	1	0.05	1.636[a]	1.132	.281	No Significant
Aware	106 (78.5)						
Not Aware	29 (21.5)						
Private	(N=99)						
Aware	78 (78.8)						
Not Aware	21 (21.2)						

Two-Sample Statistics

The chi-square test analysis in Table Two shows that χ^2 (1, N = 234) = 1.636, and the P-value = 0.281 is greater than 0.05 significant level. The null hypothesis was upheld while the alternative hypothesis was not upheld; thus, public and private health education officers do not differ significantly on their awareness of health policy advocacy strategies for community development in Anambra State.

Discussion of the Findings

The analysis in Table One indicates that health education officers' are aware of the outlined health policy advocacy strategies for community development. The analysis in Table Two also shows that public and private health education officers do not differ significantly on their awareness of health policy advocacy strategies for community development. The aggregate awareness score of 78.2% demonstrates a strong self-reported understanding of health-policy advocacy strategies in Anambra State. Statistically, the non-significant difference (p = 0.281 at the 0.05 level) indicates that sectorial affiliation; whether public or private does not significantly influence the officers' awareness. This suggests that exposure to training, professional development, or policy-related experiences have been broadly distributed across the two groups, creating a shared knowledge base. At a practical level, the finding is encouraging because it provides evidence that health-education officers, regardless of their institutional background, are well-positioned to promote community health development through advocacy. The above findings are in agreement with the results of an earlier study by Job, Johnston, Westgate, Skinner, Ward and Ballard (2024) which found that community health workers already perceived themselves as advocates and that participatory training improved their advocacy identity and readiness, confirming that baseline awareness can be translated into practical capacity. Similar results were equally found in related study by Kuehne, Kalkman, Joshi, Tun, Azeem, Buowari, Amugo, Kallestrup and Kraef

(2022) which emphasized that healthcare providers are natural advocates but often lack tools and resources, pointing to the gap between awareness and practice. Resnick, Anigo, and Anjorin (2022) further illustrated that organizational capacity and networks enhance the efficacy of advocacy, demonstrating that awareness, when coupled with structural support, is operationally useful. In contrast, Okedo-Alex, Uneke, Ibe, and Uro-Chukwu (2021) reported poor knowledge of specific advocacy components, particularly budgeting and legal tactics, among policymakers and researchers in Nigeria. This divergence likely arises from differences in the populations studied (frontline officers vs. policymakers), the scope of measurement (general awareness vs. technical skills), and contextual training opportunities. Collectively, these studies highlight that while health-education officers in Anambra State report high awareness, sustained investment in skill development and institutional support is required for advocacy to meaningfully impact community health outcomes.

Research Question Two and Hypothesis Two

Research Question Two: Are health education officers' aware of media campaigns strategies for community development in Anambra State?

Table Three: Frequency and percentage responses on health education officers' awareness of media campaigns strategies for community development

S/N	Health Education Officers (N = 234)	Aware		Not Aware		Remark
		F	%	F	%	
11.	Using street live performances to educate the community on health issues.	194	82.9	40	17.1	Aware
12.	Developing mobile websites that connect community members to local health services.	199	85.0	35	15.0	Aware
13.	Distributing easy-to-understand flyers at community centers to provide health information to those without digital access.	186	79.5	184	20.5	Aware
14.	Organizing community fitness events to promote physical activity, with coverage on social media.	212	90.6	22	9.4	Aware
15.	Using targeted online ads to reach specific segments of the community with personalized health messages.	177	75.6	57	24.4	Aware
16.	Creating engaging videos that demonstrate healthy practices shared at community events.	168	71.8	66	28.2	Aware
17.	Developing public service announcements for media houses that emphasize the importance of healthy habits.	192	82.0	42	18.0	Aware
18.	Hosting live Q&A sessions with health experts to provide valuable information that address community questions.	172	73.5	62	26.5	Aware
19.	Partnering with local health professionals to share expert advice.	184	78.6	50	21.4	Aware
20.	Leverage platforms like Facebook to encourage healthy behaviours in the community.	197	84.2	37	15.8	Aware
	Aggregate	**188**	**80.3**	**46**	**19.7**	**Aware**

Unizik Journal of Educational Research, Science and Vocational Studies (UJERSVOCS)
Volume 4 (1); January-April, 2026; https://unilaws.org/ujervs
E-ISSN (Online): 1595-6199 ISSN (Print): 1595-6202

The analysis displayed in Table Three shows that health education officers are aware of all the enumerate media campaigns strategies for community development. This is evidenced in their percentage responses as over 50% (80.3) of the education officers acknowledge that they are aware of all the media campaigns strategies for community development as contained in the instrument.

Hypothesis Two: Health education officers do not differ significantly on their awareness of media campaigns strategies for community development in Anambra State.

Table Four: Summary of the Chi-Square analysis on health education officers' awareness of media campaigns strategies for community development

Source of Variation	N (234)	Df	A	χ^2Cal	χ^2Crit.	P-value	Remark
Public	(N=135)	1	0.05	2.027[a]	1.557	.217	No Significant
Aware	102 (75.6)						
Not Aware	33 (24.4)						
Private	(N=99)						
Aware	76 (76.8)						
Not Aware	23 (23.2)						

Two-Sample Statistics

The analysis in Table Four shows that public and private health education officers do not differ significantly on their awareness of media campaigns strategies for community development in Anambra State as the p-value (0.217); X^2 (1, N = 234) is greater than the stipulated 0.05 significant level. Therefore, the null hypothesis was upheld while the alternative hypothesis was not upheld.

Discussion of the Findings

The study findings as presented in Table Three reveal that public and private health-education officers in Anambra State generally accepted that they are aware of media-campaign strategies for community development (aggregate awareness = 80.3%). Inferential chi-square analysis as displayed in Table Four shows no statistically significant difference between public and private officers' awareness levels ($p = 0.217$, $\alpha = 0.05$). The study's descriptive and inferential results point to a strong, broadly shared self-reported familiarity with media campaign strategies among health education officers in Anambra State. An 80.3% aggregate awareness score indicates that, on average, officers endorse knowledge of planning, message design, channel selection (radio, social media, print, community meetings), and basic campaign evaluation concepts. Practically, this level of reported awareness is encouraging because health education officers are frontline translators of public health messaging into community action; their familiarity is a necessary first step for effective programme design and local adaptation. The absence of a significant difference ($p = 0.217$) between public and private officers suggests homogeneity in training exposure or shared information ecosystems (joint workshops, common national guidelines, or similar professional networks). It also means that policy or capacity-building recommendations need not be sector-segmented; joint training or cross-sector collaboration could efficiently raise practical skills across both groups. Agreeing with the above empirical findings, Evans, Bingenheimer, Long, Ndiaye, Donati, Rao, Akaba and Agha (2023) quasi-experimental evaluation of a social-media COVID-19 vaccination campaign in Nigeria found that well-designed digital campaigns increased awareness and vaccination intentions among diverse participants, demonstrating that campaign exposure correlates with improved knowledge and uptake; this aligns with the high self-reported awareness among health officers who participated in or observed such

campaigns. Olaoye and Onyenankeya (2023) reviewed SSA health-communication studies and found that personnel awareness of media tools is a common prerequisite for campaign success. In similar vein, Nwodu, Okorie and Iheanyichukwu (2024) reported substantial campaign exposure among Anambra residents, thereby highlighting the salience of media in local health promotion. Disagreeing with the study finding, an early COVID-19 analysis by Gever (2020) concluded that Nigerian media initially failed to provide sufficient or timely health warnings and that gaps existed between official messaging intentions and actual media content/reach; this contradicted the high self-reported officer awareness because institutional or media performance does not always translate into comprehensive community awareness or effective campaign impact. Possible reasons for disagreement include timing: Gever's study focused on the earliest pandemic phase when awareness systems were still immature; different units of analysis (media/system performance and personnel's self-awareness), and methodological differences (content analysis and audience measures vs. self-report surveys). In short, health officers may report high awareness of campaign strategies even while media systems at certain times or locations underperformed in message delivery or reach.

Research Question Three and Hypothesis Four

Research Question Three: What are the strategies of health policy advocacy that health education officers apply for community development in Anambra State?

Table Five: Mean Responses on the Application of Health Policy Advocacy Strategies for Community Development

		Public = 135			**Private = 99**		
S/N	**Items Descriptions**	**X**	**SD**	**Remarks**	**X**	**SD**	**Remarks**
1	Community mobilization to create demand for policy change.	3.35	0.74	HE	3.17	0.93	Agree
2	Building relationships with key stakeholders to support advocacy initiatives.	3.40	0.79	HE	3.05	0.93	Agree
3	Public awareness campaigns to educate the community on health issues that demand policy changes.	3.19	0.71	HE	2.98	0.78	Agree
4	Lobbying to support health policies that benefit the community.	3.40	0.79	HE	2.96	0.902	Agree
5	Forming partnerships with other organizations to strengthen the advocacy movement.	3.03	0.88	HE	2.77	0.87	Agree
6	Using credible data to back advocacy efforts that provide proof of the need for policy change.	2.68	0.84	HE	2.58	0.77	Agree
7	Grassroots advocacy that fosters a bottom-up approach to policy change.	3.15	0.91	HE	3.07	0.76	Agree
8	Utilizing legal frameworks to advocate for new regulations that improve community health.	3.07	0.81	HE	3.38	0.87	Agree
9	Equipping community members to engage in effective policy advocacy.	3.16	0.78	HE	3.36	0.86	Agree
10	Continuously assessing advocacy efforts to measure their effectiveness.	3.35	0.74	HE	2.77	1.00	Agree
	Average	**3.18**	**0.80**	**HE**	**3.01**	**0.87**	**Agree**

Table Five reveals the mean ratings of public and private health education officers on health policy advocacy strategies they apply for community development in Anambra State. The results show that the average mean score ratings of public-owned and private-owned health education officers in Anambra State are 3.18 and

3.01 with corresponding standard deviations of 0.80 and 0.87 respectively. The findings indicate that health education officers are highly aware of health policy advocacy strategies for community development. The relatively low standard deviation of 0.80 and 0.87 suggest remarkable homogeneity in the health education officers' responses, reflecting a fair degree of consensus regarding their awareness of health policy advocacy strategies for community development.

Hypothesis Four: There is no significant difference in the mean responses of health education officers on the application of health policy advocacy strategies for community development in Anambra State.

Table Six: Summary of t-test analysis of public and private health education officers on health policy advocacy strategies they apply for community development

Variable	N	$\bar{X}$	SD	df	T	Sig. (2-tailed)	Decision
Public	135	3.18	0.80	232	1.02	0.31	No Sig.
Private	99	3.01	0.87				

Two-Sample Statistics

The results in Table Six indicate the summary of the t-test analysis of public and private health education officers on health policy advocacy strategies they apply for community development. The results reveal that the calculated independent t-test was 1.02 with a p-value of 0.31. Based on this, the null hypothesis was retained and the alternative hypothesis not retained, since the p-value was greater than the stipulated level of significances. Thus, there is no significant difference in the mean responses of public-owned and private-owned health education officers on health policy advocacy strategies they apply for community development.

Discussion of the Findings

Study findings in Table Five show that public and private health-education officers in Anambra State generally acknowledged that they apply health-policy advocacy strategies for community development as reported by aggregate means of 3.18 (public) and 3.01 (private). In Table Six, the inferential testing showed no statistically significant difference between the two groups ($p = 0.31$ at $\alpha = 0.05$). These results suggest that both categories of officers demonstrate a moderate-to-high level of application of health policy advocacy strategies, with only marginal differences in mean scores that are not statistically meaningful. The convergence of responses points to a shared understanding and practice of advocacy roles, likely informed by similar professional training, exposure to uniform policy directives, and donor-supported programmes that promote cross-sector engagement in health advocacy. It also implies that both public and private officers perceive advocacy; through tools such as policy briefs, media campaigns, coalition building, and stakeholder meetings as integral to their professional practice and community development mandates. In agreement with the findings of the present study, Okedo-Alex, Akamike, Olisaekee, Okeke and Uneke (2021) documented the use of structured advocacy strategies, such as coalitions and capacity-building efforts, to increase domestic funding for health policy and systems research in Nigeria, supporting the idea that advocacy is a routine strategy among health actors. Equally, Resnick, Blei and Mates (2022) showed how advocacy organizations have influenced nutrition policy in Nigeria, demonstrating that organized policy advocacy is an active and effective mechanism for systemic change across sectors. Obi, Okeke and Nwosu (2024) also found that collaborations and networks within Nigerian communities sustained healthcare access and utilization, highlighting the role of community-based advocacy and cross-sector partnerships in community development. These studies align with the present finding that both public and private health-education officers engage in advocacy activities as part of their work.

In disagreement with the findings of this study, Lattof, Ezeanolue and Chukwu (2023) reported that the private sector in Nigeria remains fragmented and inadequately engaged in system-level policy processes, particularly in maternal and newborn health. This divergence suggests that while individual officers may perceive themselves as applying advocacy strategies, institutional-level private-sector participation in health policy formulation is inconsistent. Likely reasons for this disagreement include differences in units of analysis, sampling frames, measurement methods, and contextual factors such as sectoral fragmentation and limited coordination in the private sector. These nuances highlight that while parity in self-reported advocacy practice across public and private officers is credible, actual influence and systemic integration may still differ, hence, highlighting the need for future research to incorporate mixed-methods designs that capture both individual practices and institutional-level advocacy impacts.

Research Question Four and Hypothesis Four

Research Question Four: What are the strategies of media campaigns that health education officers apply for community development in Anambra State?

Table Seven: Mean Responses on the Application of Media Campaigns Strategies for Community Development

		Public = 135			Private = 99		
S/N	**Items Descriptions**	**X**	**SD**	**Remarks**	**X**	**SD**	**Remarks**
11	Using street live performances to educate the community on health issues.	2.89	0.98	HE	3.10	0.78	Agree
12	Developing mobile websites that connect community members to local health services.	2.54	0.85	HE	2.96	0.86	Agree
13	Distributing easy-to-understand flyers at community centers to provide health information to those without digital access.	3.46	0.69	HE	3.09	0.72	Agree
14	Organizing community fitness events to promote physical activity, with coverage on social media.	3.02	0.89	HE	2.96	0.79	Agree
15	Using targeted online ads to reach specific segments of the community with personalized health messages.	2.51	1.04	HE	2.92	0.91	Agree
16	Creating engaging videos that demonstrate healthy practices shared at community events.	2.52	1.04	HE	2.92	0.95	Agree
17	Developing public service announcements for media houses that emphasize the importance of healthy habits.	2.60	0.92	HE	2.91	0.84	Agree
18	Hosting live Q&A sessions with health experts to provide valuable information that address community questions.	3.08	0.67	HE	3.05	0.83	Agree
19	Partnering with local health professionals to share expert advice.	3.13	0.75	HE	3.18	0.99	Agree
20	Leverage platforms like Facebook to encourage healthy behaviours in the community.	2.88	0.91	HE	2.92	0.79	Agree
	Average	**2.86**	**0.87**	**HE**	**3.00**	**0.85**	**Agree**

The results in Table Seven, with an aggregate mean score of 2.86 and 3.00 respectively against the benchmark mean of 2.50 on a 4.0 scale, indicate that health education officers generally agree that they apply media campaigns for community development in Anambra State. The standard deviation of 0.87 and 0.85 respectively, being relatively low, reflects a considerable level of homogeneity in health education officers' responses, implying a reasonable level of consensus in their responses.

Unizik Journal of Educational Research, Science and Vocational Studies (UJERSVOCS)
Volume 4 (1); January-April, 2026; https://unilaws.org/ujervs
E-ISSN (Online): 1595-6199 ISSN (Print): 1595-6202

Hypothesis Four: There is no significant difference in the mean responses of health education officers on the application of media campaigns strategies for community development in Anambra State.

Table Eight: Summary of t-test analysis of public-owned and private-owned health education officers on media campaigns strategies they apply for community development

Variable	N	$\bar{X}$	SD	df	T	Sig. (2-tailed)	Decision
Public	135	2.86	0.87	232	1.15	0.253	No Sig.
Private	99	3.00	0.85				

Two-Sample Statistics

The results in Table Eight reveal that the calculated independent t-test was 1.15 with a p-value of 0.253. Since the p-value (0.253) is greater than 0.05 significant level, the null hypothesis was retained while the alternative hypothesis was not retained. Thus, there is no significant difference in the mean responses of public and private health education officers on media campaigns strategies they apply for community development in Anambra State.

Discussion of the Findings

The results in Table Seven and Eight indicate that public and private health-education officers in Anambra State generally consented that they apply media-campaign strategies for community development (aggregate means = 2.86 (public) and 3.00 (private) and inferential testing showed no statistically significant difference between the two groups ($p = 0.253$ at $\alpha = 0.05$). The convergence of mean scores and the non-significant p-value strongly indicate that both public and private health-education officers perceive themselves as applying media-campaign strategies at relatively similar levels. This interpretation suggests that media platforms such as radio, television, social media, and community engagement broadcasts are widely recognized across both sectors as valid and necessary vehicles for health communication and community development. Such alignment may reflect shared exposure to national and donor-driven campaigns, as well as harmonized training programmes aimed at strengthening health promotion capacity. For instance, national media messaging during the COVID-19 pandemic created a common professional culture around media engagement, encouraging uniform adoption among health educators regardless of sector. However, the mean values (2.86 and 3.00) sit close to the midpoint of the scale, suggesting that while respondents affirm usage, the depth and frequency of application may be moderate rather than intensive. The non-significant difference ($p = 0.253$) also warrants careful reading: it shows that statistical evidence of divergence was not established, but it does not necessarily prove that public and private officers employ media with equal intensity, quality, or resource backing. Recent empirical studies align with the above finding by reinforcing the evidence that media campaigns are not only widely applied but also effective in Nigeria. Evans et al. (2023) found through a large quasi-experimental study that social-media campaigns significantly improved vaccination uptake and shaped positive health norms across Nigerian states, demonstrating that both public and private health stakeholders actively use media channels. Similarly, Talabi, Oyedeji, Adelabu, Sanusi, Adaja, Talabi, Bello, Lamidi and Alade (2022) reported that residents in selected Nigerian states widely consumed radio campaign messages and linked them to improved COVID-19 preventive behaviour, affirming the central role of traditional broadcast media in health communication. Adeoye, Odeh, Nwala, Edet, Raji, Ahmadu, Songo, Balogun, Idogho and Anyanti (2023) also established that an omni-media campaign during COVID-19 lockdowns enabled continuity of contraceptive access through measurable online procurement, underscoring the effectiveness of multi-channel outreach. In contrast, Udenze and Temple's (2023) presented a nuanced disagreement; their qualitative study of public and

private hospitals in Abuja revealed that private hospitals were more professional and active in their social-media usage, while public hospitals lagged behind. The likely reasons for this divergence could be as a result of differences in research design, focus, and measurement emphasis. Additionally, resource allocation and organizational mandates often give private hospitals a marketing edge, whereas individual officers in both sectors may perceive their personal use of media as broadly comparable. Taken together, these findings confirmed that while media campaigns are broadly embraced across sectors in Nigeria deeper exploration of quality, intensity, and institutional capacity is necessary to avoid overgeneralization and to design evidence-driven interventions.

Conclusion

The findings of the study revealed that health education officers in Anambra State exhibit strong awareness and effective application of diverse health promotion strategies, notably policy advocacy and media campaigns as essential tools for advancing community development. The findings indicate that these officers actively utilize advocacy to influence health policies and employ media platforms to disseminate vital health information Importantly, the findings revealed that both public and private health education officers demonstrate comparable levels of awareness and application of these strategies, with no statistically significant differences in their mean responses. This convergence highlights a unified commitment across sectors toward improving population health, fostering sustainable community development, and achieving equitable health outcomes. However, the study concluded that health education officers play a critical role as agents of change in bridging gaps between policy and practice; which reinforces the foundation for resilient and inclusive health systems in Anambra State.

Recommendations

Based on the findings of this study, the following recommendations were made:

1. Health administrators should strengthen policy frameworks and provide sustained institutional support that enhances health education officers' capacity to apply strategies such as policy advocacy, media campaigns, community engagement, and service integration, ensuring coordinated efforts that improve community health outcomes across Anambra State.
2. School administrators should incorporate structured health promotion programs into school curricula and extracurricular activities, creating platforms for collaboration between teachers, health officers, and students in order to build a culture of health awareness and community responsibility within the educational system.
3. Health education officers should continually update their professional knowledge and practical skills through workshops, seminars, and inter-professional collaborations, thereby reinforcing their ability to effectively advocate for policies, conduct impactful media campaigns, mobilize communities, and integrate health services for sustainable development.
4. Students should actively participate in health promotion initiatives, leveraging peer education, social media platforms, and school-based projects to spread accurate health information, cultivate healthy lifestyles, and contribute to broader community development goals.
5. Parents should support health promotion strategies by reinforcing healthy behaviors at home, collaborating with schools and health officers during community campaigns, and serving as role models in adopting practices that enhance family and neighborhood well-being.

6. The community should embrace inclusive participation in health initiatives by providing local resources, engaging in collaborative dialogues with health education officers, and sustaining collective action that fosters healthier environments and improves the overall quality of life in Anambra State.

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