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….creating pathways to *health*

REPORT
HEALTH PROMOTION RESEARCH IN NIGERIA

1. INTRODUCTION

Background

Access to Health and Education are critical determinants to the degree of development of any nation state. According to the Nigerian Demographic and Health Survey (NDHS 2003 and NDHS 2008)[1] it is clear that the education and health systems in Nigeria are performing poorly. Nigeria's overall health system performance was ranked at 187th among the 191 Member States[2] of the United Nations. Three key preventable diseases (Malaria, HIV/AIDS and TB) account for most of the disease burden, with poverty being the root cause. Nigeria as Africa's most populous country and ninth-largest in the world, reports adult literacy at a total of 28% (68% among men and 43% among women)[3]; with 68% of primary school-age children that live in rural areas, accounting for 80% of those who are out of school. Given that the educational level of a child's parent is often related to the child's own participation in schooling, 86% of children out of school have a mother that lacks formal education[4]. Education attainment clearly becomes a greater issue within this context. Moreover examining differences between ethnic groups, it is clear that households where Hausa is the native language, predominantly in the Muslim north, 54% children are out of school compared to where were Yoruba and Igbo is spoken which have higher attendance rates[5].

The Government of Nigeria acknowledges the targets agreed to achieve Education for All (EFA)[6] and the Millennium Development Goals[7]. These goals are without doubt highly unlikely to be achieved given levels of income inequality, low levels of participation and attainment of education, poor access to health care services and information[8]. These issues mitigate against addressing key preventable diseases impacting the most vulnerable and significant 45% of Nigeria's population who are adolescents[9] under the age 15[10].

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1 Nigeria Demographic and Health Survey (NDHS 2003 and NDHS 2008) http://www.measuredhs.com/pubs/pdf/GF15/GF15.pdf

2 WHO's definition of adolescents as those between the age of 10-19 years is the definition that was adopted at the South Asia conference on adolescents in 1998 http://www.un.org.in/Jinit/who.pdf

3 Statistics and monitoring of adult learning and education(4th December 2009) Global UNESCO http://www.unesco.org/uploads/media/conf**in**teavi_ws4-8_uis_hu

4 Children Out of School. Measuring Exclusion from Primary Education. (2005) UNESCO Institute of Statistics. http://www.uis.unesco.org/template/pdf/educgeneral/OOSC_EN_WEB_FINAL.pdf (Accessed: 4th March 2010)

5 Children Out of School. Measuring Exclusion from Primary Education. (2005) UNESCO Institute of Statistics. http://www.uis.unesco.org/template/pdf/educgeneral/OOSC_EN_WEB_FINAL.pdf

6 Education for All (EFA) Dakar Framework for Action. (2000). UNESCO http://www.unesco.org/education/efa/ed_for_all/dakfram_eng.shtml

7 Millennium Development Goals (MDG). (2000) United Nations Development programme. http://www.undp.org/mdg/basics.shtml

8 UNDAF Nigeria (2009-2012) United Nations Development Group http://www.undg.org/docs/10204/UNDAF_Nigeria_2009.pdf

9 WHO's definition of adolescents as those between the age of 10-19 years is the definition that was adopted at the South Asia conference on adolescents in 1998 http://www.un.org.in/Jinit/who.pdf

10 Nigeria Demographic and Health Survey (NDHS 2003 and NDHS 2008) http://www.measuredhs.com/pubs/pdf/GF15/GF15.pdf

The World Health Organization highlights the critical role of 'simple cost effective public health measures' which could avert the length of human life span for those who are 'underweight in children and mothers, unsafe sex, poor access to water, sanitation and hygiene, indoor smoke from solid flues, iron deficiency, high blood pressure, tobacco, alcohol, high cholesterol and obesity'[11] Access to health and education therefore becomes critical, where development of the child from the poorest households who are more likely to be out of school than the rest of the population is critical, underlining the importance of poverty reduction within policies of health and education for all.

To achieve good health (physical, mental and social well-being) through health promotion enables individuals and groups to identify and realise aspirations, satisfy needs and change or cope with the environment that is consistent with complete good health. According to the WHO Ottawa Charter, health promotion aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people achieve their fullest health potential[12]. It is therefore clear that health promotion and education research are critical to Nigeria's overall development.

Justification

It is within this context that the Partnership for Transforming Health Systems (PATHS2) and the 'Education Sector Support Programme in Nigeria' (ESSPIN) projects in Nigeria were established in cooperation with the Federal Ministry of Health (FMoH) and DFID. The over arching goal of these projects being to assist in strengthening the Nigerian governments Health and Education programmes. One key goal of the PATHS 2 project is to 'strengthen capacity of citizens to make informed choices about prevention, treatment and care' (Output 5) with comprehensive programming targeting both in and out-of school youth. This corresponds and ties in with the objective of the ESSPIN which is to enhance 'capacity of primary and junior secondary schools to provide a high quality learning environment developed and sustained' (Output 3).

Critical to the process involved in this report is being mindful of the FMoH policy[13] and strategy for health promotion and ensuring that there is direct synergy with and alignment with actions proposed by the PATHS 2 programme. More critically it is clear from the assessment of In and Out of school youth health programmes already undertaken by YozuMannion for the PATHS 2 project, that there are a number of mapping exercises that are proposed which could well be followed up on as part of the proposed research.

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[11] School Health and Health Promotion. (accessed 4th March 2010) http://www.un.org.in/Jinit/who.pdf

[12] World Health Organization (1986). *Ottawa Charter for Health Promotion. Geneva:* WHO http://www.who.dk/policy/ottawa.htm Accessed: 16th February 2010

[13] Health Promotion Policy for Nigeria (FMOH, February 2006) v http://www.fmh.gov.ng/docs/FMOH_Health_Promotion_Policy.pdf

Objectives

The goal of this study is to essentially review national research efforts for health promotion, with the following objectives:

1. Preparatory review of Health Promotion efforts undertaken by HMIS, NDHS and PRHAA, Ministry of Education, National and State health authorities.
2. A desk review of all national research efforts highlighting nature of qualitative and quantitative data gathered on health promotion.
3. Summarize and provide an overview of existing research in health promotion. Identify the nature of research undertaken and a review of follow up by Government, civil society and private sector.
4. Identifying gaps and areas for further capacity development focusing on nature of existing and other data required for health promotion planning, implementation and monitoring.

2. METHODOLOGY

The study focused on assessing the state of health promotion in Nigeria, reflecting the national scope and not just the status in the four PATHS 2 states (Enugu, Kaduna, Kano and Jigawa). The population of the study included the Federal Ministry of Health (FMoH), State Ministries of Health (SMoH), community based organisations (CBOs) and international development agencies involved in health promotion in Nigeria.

However, the sample adopted for the study, apart from the importance of recognising the role of the public sector (FMoH and SMoHs) was purposively chosen to assure a wide range of health promotion in the country, demonstrating synergies between the FMoH and PATHS programme with clear roles to support government in health education and health promotion, as well as build capacity through ease of access and sharing of experiences in health promotion. Based on the above criteria the following organizations were selected: UNAIDS; UNODC; UNFPA; FHI; SFH; UNESCO; National Primary Health Care Development Agency, WHO and YozuMannion. In addition to these, selected CBOs were equally sampled (see Annex One: List of Organisations).

The study adopted a qualitative research approach. Thus two qualitative methods viz. desk research and the in-depth interviews (IDIs) were utilised in generating data for the study. As part of the desk review all documents published by the FMoH and the above organizations were reviewed with the view to identify both the current status of and gaps in the research on health promotion in Nigeria. In-depth interviews were conducted utilising face-to-face and electronic (internet and telephone) approaches with identified officers in charge of health promotion or behaviour change communications/education officers in the above agencies and CBOs.

The face-to-face interaction took place in the work places of the respondents while the electronic approach allowed the respondents to raise issues in the study in their own convenient time. These ensured that the collection of data for the study did not intervene with or impede the ability of the respondents to discharge their official duties. The analysis was triangulated and focused on establishing current practice, comparison and cross-checking of information with other correlating factors. The interviews were very useful in ascertaining the why and how of the current status and direction of health promotion research in Nigeria.

3. SITUATIONAL ANALYSIS

Generally health promotion in Nigeria is impacted by some of the debilitating challenges which confront the practice of health promotion broadly in other parts of Africa. These challenges include:

- Ambiguous definition of the factors and conditions that influence health promotion
- A poor definition of expected health outcomes
- Lack of health promotion policies, guidelines and their implementation
- Inadequate capacity to develop, implement, monitor and evaluate health promotion programmes
- Inadequate investment in health promotion

- Poor sectoral collaboration and joint programming
- Structural problems linked to political will and a commitment to health promotion programmes
- Lack of addressing the structural drivers of poverty, which in turn mitigate against addressing any meaningful responses to health and well being.

The above challenges have enormous implications for research in health promotion, which in Nigeria is generally limited. The importance of evidence based practice for health promotion cannot be over-emphasised since this is the only way to assure responsiveness to the health needs and requirements of the country. Research assists in assessing the extent to which health outcomes are defined, providing an understanding of the correlating factors and social conditions to be targeted for change or modification through health promotion. Beyond this, research contributes in both agenda setting through informing both policies and guidelines on health promotion,

Thus while there exists a National Health Promotion Policy[14] (2005) and a National Strategic and Implementation Policy on Health Promotion[15] (2007) in Nigeria, the extent to which these documents have impacted on both research and practice of health promotion in the country is doubtful. Without doubt, research in health promotion has been affected by glaring lack of capacity gap among the various stakeholders and practitioners across the country. Based on this context, any health promotion research should aim at enabling a realistic and focused achievement of the aims of health promotion.

Health Promotion research in Nigeria has largely been uncoordinated and unsystematic. The FMoH undertook relatively nascent efforts undertaking a baseline assessment in 2004 and a recent assessment in November 2009 prompted by the need to establish health communication data banks in six centres in Nigeria (Bida, Nnewi, Yola, Zaria, Asaba and Lagos) with the support of UNICEF and the WHO[16]. Apart from the degree of external support provided including from PATHS2[17] , the notion and practice of health promotion as a comprehensive health sector strategy does not yet exist. Therefore the available research is clearly limited, poorly focused and can be characterised as thus:

- The outcomes of this limited research are not widely disseminated and nor is there any measurable stakeholder feedback mechanism. In fact there is a glaring lack of health promotion research dissemination in the public domain.
- Current health promotion research focuses on health education especially on HIV/AIDS and immunization, and predominantly influenced by external funding.

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[14] Health Promotion Policy for Nigeria (FMOH, 31st October 2005) http://www.fmh.gov.ng/docs/FMOH_Health_Promotion_Policy.pdf

[15] Strategic Framework and Implementation Plan for the National Health Promotion Strategy. (FMOH, January 2007)

[16] World Health Organization (1986). *Ottawa Charter for Health Promotion. Geneva:* WHO http://www.who.dk/policy/ottawa.htm Accessed: 16th February 2010

[17] Inception Phase Assessments and Development of Communications Strategies and Plans. Assessment of In-school Health Programmes and Out-of-School Youth Health Programmes. YozuMannion/New Media Networks: 2009 – Work Order 007

- While advocacy and mediation have been utilised consistently in the areas of HIV/AIDS, reproductive health and malaria, there is hardly commensurate research on these approaches and their effectiveness in different contexts.
- There is no form of operational research being undertaken by the FMoH and the SMoHs which lacks technical and resource capabilities to effectively respond to the challenges of health promotion

4. GAP ANALYSIS

In view of the context outlined, health promotion research in Nigeria can seen as lacking in the following ways:

- The lack of a holistic response, which acknowledges the interrelationship between health, education, culture and communication sectors as a means of addressing joint planning and resource allocation towards cooperation that assures meaningful responses.

- Current research is too embedded on quantitative approaches and a priori assumption of positivism as the best orientation thus neglecting or glossing over such reliable qualitative methods like ethnography, personal or life histories and the lived realities of the majority in Nigeria.

- The lack of evidence of health promotion effectiveness in primary health care is clearly a problem which is particularly acute in the following areas:
    - An understanding of vulnerability and those youth most at risk, particularly for youth who drop out of school and for whom access to information and service provision remains a huge challenge.
    - Youth understanding of access to information or knowledge about puberty or sexual health, factors that mitigate against health seeking behaviours and an understanding of their access needs to health care services.
    - Substance misuse is cited as an issue across the country with cocaine and marijuana used as a means of alleviating the frustrations of youth. While this information exists there is no information on how best to prevent substance misuse and access to appropriate service provision.

- There is no health promotion research on the role and effective utilization of the media in health promotion. The consistency with which IEC materials are utilised needs to be seriously reviewed when operating within the context of high levels of illiteracy and a poor understanding of life style choices individuals can make given the poverty the majority experience. This highlights limited information on alternative ways of learning and how best to assure access to information.

- Current health promotion practice demonstrates poor sectoral linkages, collaboration and partnerships even among organizations focusing on similar issues. One would hope that the UN operating as a single entity would lead to better leadership in implementing support to government and its agencies in the health and education sector.

- Equally there do not exist any forums for cooperation, sharing of information and learning among community based organisations, which either the government, international agencies or the UN supports.

- A disempowering lack of community participation in originating or initiating research interest or areas of concern. Community participation must be the cornerstone of any strategy in assuring responsive change particularly among the most vulnerable and disenfranchised.
- No research currently exists towards identifying best practices in health promotion and making these the benchmark of health promotion in the country. Nor does any mechanism exist to disseminate international best practice and lessons learned from international good practice.

- While a good number and quality research exists in the area of health education and even other areas of health promotion in tertiary institutions like the University of Nigeria Nsukka and the University of Ibadan, there is apparently little linkage of such research to the health promotion practice and implementation. Moreover the role of these tertiary institutions in research, monitoring and evaluation and addressing their social responsibility are consistently overlooked as a sustainable solution.

- Health promotion research in Nigeria so far is not cautious or cognitive of the critical difference between health promotion outcomes and health outcomes. Ordinarily and in a crude sense health outcomes imply the consequences or benefits of health care delivery e.g. reduction of mortality rate related to a disease (which may exist in spite of an increment in number of those affected by the disease) but health promotion outcomes exist in the form of control and attitudinal re-orientation groups and individuals adopt in facing a given disease which may affect the number of people affected by the disease and improve attitudes and behaviour towards those affected. Health promotion outcomes can be glimpsed through community members' perception and interpretations of a given health issue which makes the achievement of control possible.

- Responding to the weak research thrust in health promotion in primary health care (PHC) requires increased theory building on one hand and collaboration of health promotion researchers with health promotion practitioners in order to improve practice, along with indicators for measuring health promotion effectiveness.

- Health promotion research in Nigeria needs to move away from the dogmatic devotion to quantitative methods or a reliance on the need for a positivist orientation which

often obscures knowledge of the why and how of health behaviour among community members. Actually the global trend is towards a more qualitative research approach which feeds on both local knowledge, ethnography and lived experience of the people. Therefore, *"consensus is undoubtedly emerging that an over-emphasis on outcome measures and indeed on quantitative data is an outmoded and inappropriate way to measure the effectiveness of health promotion programs and interventions (Macdonald and Davies, 1998: 8)"*[18].

- The lack of technical competencies, staff, adequate financing is a constraint to adequate implementation of health promotion. It is not surprising that health promotion activities cannot be adequately implemented to make high impact on the health of the population.

[18] Macdonald, G and J. Davies (1998). "Reflection and Vision: proving and improving the promotion of health", in G. Macdonald and J. Davies (eds) *Quality, Evidence, and Effectiveness in Health Promotion: striving for certainties.* London: Routledge

5. RECOMMENDATIONS

Health promotion research in Nigeria should principally address the priority health programmes identified by the WHO for the African region. These programmes include Malaria, HIV/AIDS, Tuberculosis, Immunization, Mental Health, the Tobacco Free Initiative and Reproductive Health. Efficacy on any of these programmes can only be lead by enhancing government policy developed on evidence based practice and research on health promotion, which is equally focused on addressing the structural drivers of poverty that contribute to the vulnerabilities many experience. Responsiveness is best assured when focused on targeted responses for the most vulnerable facilitating access, equity and quality health education. Community participation in this process engenders ownership and responsibility, broadly improving overall programme effectiveness and sustainability. Within this framework, health promotion research should aim to develop outcomes which reflect the lived realities of those targeted and seek to promote change and behaviours, establishing reliable mechanisms and indicators to monitor the implementation of health promotion strategies.

In addition to the above over-arching recommendation, the study makes the following specific operational recommendations to YozuMannion in the decision making process for PATHS 2:

1. Identify and establish clear partnerships between the two DFID initiatives – PATHS 2 and ESSPIN, with a view of creating synergies exploring mutual areas of cooperation between the two initiatives.

   Proposed outputs:

   - A forum established for joint meetings at national and state level with a view to cooperate, share information and communication between PATHS 2 and ESSPIN. This output contributes to the mutual objectives of both projects in addressing EFA and the MDG's.
   - Cooperation in partnership with government departments with joint planning among PATHS 2 and ESSPIN projects established.
   - Joint research explored focused on out of school youth and mechanisms that facilitate access to non-formal education. This output contributes to addressing in particular EFA goals 3 and 6 and MDG goals 2 and 6.
   - Joint research explored on models of community learning centres which can cater for out of school youth through the provision of basic and health education, as well as livelihood skills. This output equally contributes to addressing in particular EFA goals 3 and 4 and MDG goals 2 and 6.
   - Joint research that aims to identify the role of faith based institutions such as Islamic schooling, their potential to build inter faith coalitions, and their role in facilitating access to basic education and communicating health messages. This output equally contributes to addressing in particular EFA goals 3 and 4 and MDG's goals 2 and 6. The process potentially secures partnerships, mainstreams non formal education institutions into formal schooling, and engenders a culture that promotes access, equity and quality education for all.

2. Gender gaps are particularly notable in access to education, household decision-making and political representation[19]. Identify the role that gender plays in any health promotion and education responses providing an understanding of responsibilities. This output contributes to addressing in particular EFA goals 2, 3 and 4 and MDG goal 3.

   Proposed outputs:

   - Research commissioned identifying mechanisms to assist young girls and women that enable them to make decisions, with view to informing communication strategies and programme development.
   - Research commissioned on identifying male roles and responsibilities among adolescents and men, with view to informing communication strategies and programme development.
   - Identify potential joint cooperation developed in partnership with UNIFEM, UNFPA, UNAIDS, UNICEF and women's organisations.

3. Empowerment of communities in health promotion as part of the development process, creating greater ownership, promoting a rights based approach and responsiveness.

   Proposed outputs:

   - Data base developed of non-governmental organisations (including faith based organisations) working with adolescents, categorising them on the basis of how they work with: out of school youth, non-formal education, basic education, providing income generating activities, micro credit schemes, livelihood skills, life skills development, peer to peer education, substance misuse, HIV, reproductive health among other health issues. The process should be designed to assess capacity and scope of expertise among non-governmental organisations to undertake the range of identified skills, with recommendations for further training in health promotion.
   - A national and state based NGO forum within the framework of the PATHS 2 and ESSPIN project established.
   - NGOs identified in the four PATHS 2 selected states that could be invited to bid with a view to act as a hub overseeing planning, delivery, management of and reporting on state based actions undertaken among NGOs. Selection of these organisations would be based their legal status, proven track record of practice on similar actions, accountability and transparency of their practice.
   - Potential NGOs identified to manage pilot projects based on pre- determined and agreed criteria for assuring access to health promotion and education, ensuring access and equity particularly among the most vulnerable.
   - Research, monitoring and evaluation skills of NGOs identified, capacity built and mentoring facilities with Universities established, with recommendations for further training.
   - Capacity of NGOs to administer, manage funds, and manage projects, with competencies to M&E and report established, with recommendations for further training.

[19] Combined Welfare Indicator Survey/CWIQ (2006).
http://www.undg.org/docs/10204/UNDAF_Nigeria_2009.pdf

- A hub established in the four PATHS 2 states to oversee an internet network facilitating an E Forum that enables a regular exchange of information between NGOs, providing technical advice and support to enhance capacity. The process should be designed to obtain information about current practice and issues of concern within community settings and provide guidance on setting the research agenda.
- Quarterly meetings organised by the hubs for the purposes of an exchange of information, training and as a means of developing synergies among and between service providers both among state, government and civil society.
- Health promotion training implemented among selected PATHS 2 states, enhancing capacity of NGOs to undertake health promotion interventions by building on their understanding of health promotion theory and practice.

4. Role of Universities including ABU, UNN, Ibadan and Lagos assessed and identified, with view to engendering social responsibility but more importantly building on national and sustainable competencies in research, monitoring and evaluation of any interventions planned, being undertaken or research commissioned.

   Proposed outputs:

   - Requirements for developing formal partnerships with Universities explored with view to engaging cooperation whereby graduate students would provide classes, training, mentoring, documentation, monitor and evaluate the impact of any projects developed within a state.
   - Competencies in assessing issues such as community perceptions and cultural factors that influence health behaviours, potential areas for developing capacity and delivery of health and education messages, particularly through non-formal education within community based settings with recommendations for further training identified.
   - Capacity and training for Universities to develop a curriculum for training on health promotion within the framework of non-formal education – theory and practice assessed, with recommendations for further training.
   - University staff capacity to oversee and provide mentoring facilities to the students and to undertake monitoring and evaluation identified, with recommendations for further training.

5. Evidence demonstrates the limited health promotion research that currently exists in Nigeria, leans towards a quantitative approach. Qualitative research methodologies need to be enhanced enabling health promoters and researchers to undertake local needs assessments, design programmes and plan implementation against the background information about the knowledge, perceptions and attitudes of the people concerned. This needs serious socio-cultural considerations of communities since what works in one may not automatically work in another and perceptions, values and attitudes do change between communities and over time.

   Proposed outputs

   - Ethnographic survey undertaken of health behaviours among social groups in the PATHS 2 with a view of documenting indigenous knowledge, cultural values and practices related to health behaviour.

- Capacity of PATHS 2 staff built on qualitative research in health promotions so as to better enhance their ability to respond to the why and how of health actions at the community level
- TOT of SMoHs and FMoH staff undertaken on qualitative approach to health promotion.

6. There is need for stepping up health promotion research in the areas of family and reproductive health targeting such issues as VVF; ante-natal care; diabetes, cardio-vascular issues etc. especially in terms of communicating those who are located outside the formal sector of the society or are marginal by virtue of a lack of education, economic opportunities or physical/mental challenges to the mainstream of socio-economic contexts in both urban and rural communities in Nigeria.

   Proposed outputs

   - Partnerships with WHO, UNFPA, UNAIDS, UNODC, international NGOs and government identified and potential for joint cooperation or programming developed.
   - Carry out a community level health needs assessment in the four PATHS states with the view of using this to determine health promotion research focus.
   - Awareness created among identified health promotion research hubs (tertiary institutions, NGOs and the public sector) through awareness and sensitization workshops.

7. There is need to build a culture of documenting outcomes and evidence of health promotion research between different sectors and organizations in Nigeria. This is a step towards achieving the desirable goal of multi-sectoral coordination which is seriously lacking.

   Proposed outputs

   - Establish quarterly interactive E forums or state based meetings on health promotion among the relevant organization already identified in this study with a view to disseminate, share and promote cooperation through shared learning exchanges.(Annex One: List of organizations)

8. The role of media and theatre practitioners in both private and public sectors on health promotion. This is especially important given the media's crucial role in health information dissemination.

   Proposed outputs

   - Commission health promotion research on methodologies of communication – how and what, identifying importance of key messages within different community and national settings.
   - Commission research on the impact of peer to peer or community based non formal education vs. mass media approaches designed to promotion health promotion, with a view to identify efficacy and good practice.
   - Identify and assess the role of theatre, drama and community based mechanisms currently operational to communicate health and education messages, with recommendations for further training identified.

- Conduct capacity building workshops for practitioners from the four PATHS 2 states. The FMoH could expand this training with time and availability of funds.
- Using the HIV template mount advocacy for increasing the coverage of health promotion issues in the media with special focus on community needs.

9. Health programme or intervention specific health promotion capacity building for different cadres of public sector workers both at the federal and state levels. Such training should be based on acute awareness of current research trends and best practices globally. Specific health promotion for some under-represented health issues and priority non-communicable diseases should be targeted as well as incorporating methods of targeting those members of society who are marginal or vulnerable.

   Proposed outputs

   - Periodic awareness and capacity building workshops undertaken for different cadres of public sector health workers especially in the states which are the sites of implementation of health programmes, with recommendations for further training identified.
   - Study commissioned and disseminated on health promotion research best practices to broad based stakeholders cutting across the private and public sectors including NGO's and the media
   - Make the inclusion of the needs of the marginal and vulnerable key components of health promotion research and interventions in the four PATHS 2 states

10. Evaluation of health promotion research must be anchored on the three forms of evidence based on scientific and philosophical traditions:
    a) Knowledge associated with health promotion is instrumental in controlling social and physical environments (Park, 1993[20]). Based on: positivism, quantitative, experimental, scientific knowledge.
    b) Interactive understanding of diseases/health issues, lived experiences and solidarity. Based on: constructivist, naturalistic, ethnographic/qualitative knowledge.
    c) Critical reflection and action and raising consciousness regarding causes and means of overcoming them. Based on: materialist, structural and feminist theory.

    Proposed outputs

    - Technical Associates engaged to conduct or lead health promotion research exercises, promoting use of methodological diversity and triangulation in health promotion research
    - PATHS 2 should provide resources to interface with the universities already identified here and independent technical assistance in conducting operational research in health promotion in Nigeria

[20] Park, P (1993). "What is Participatory Research? A theoretical and methodological perspective", in P. Park; M. Brydon-Miller; B. Hall; and T. Jackson (eds) *Voices of Change: participatory research in the United States and Canada.* Toronto: Greenwood Pub.

11. Health promotion research in Nigeria should as much as possible based on evidence rather than promote ideologies, which are rooted in vested interests and values (Seedhouse, 1997[21]).

Proposed outputs:

- Make health promotion efforts evidence-based and reflective of the diversity of values and viewpoints in the country. Sensitization workshops on these should aim on modifying behaviour of health workers and funding agencies to eradicate them of pre-conceived notions, personal bias and universalisms since the Nigerian society is characteristically diverse
- Health promotion research and needs assessment should be made to establish community values and beliefs impacting on health behaviour.

12. A significant population occupies rural Nigeria, vastly different from those within urban dwellings of Abuja and Lagos. Qualitative research approaches offer the possibility of insights into the why and how of health behaviours which is not possible with quantitative or traditional bio-medical approaches.

Proposed outputs:

- Research commissioned utilising quantitative and qualitative approaches identifying the why and how of why certain health behaviours or dispositions occur with rural settings. Assessing issues of access, equity and quality of service provision in health and education would be critical in determining good practice mechanisms for service delivery.

[21] Seedhouse, D (1997). *Health Promotion: Philosophy, Prejudice and Practice.* New York: John Wiley

6. CONCLUSION:

The above recommendations while taking care of the cultural and contextual realities and challenges that Nigeria is confronted with in health promotion research, are also largely in line with the WHO standards on achieving and sustaining health promotion. Thus, according to the WHO the priority interventions in Africa in respect to health promotions include: capacity building, development of plans, incorporation of health promotion components in non-health sectors, and strengthening of priority programmes using health promotion interventions. The recommendations proposed above essentially entails pursuing health promotion through: capacity building; action planning; advocacy and multi-sectoral orientation.

The current status of health promotion in Nigeria requires much support if we are to collectively make any meaningful contribution towards building human and social capital. Influencing health seeking behaviours clearly requires a long term response as part of the development framework addressing the poverty and the broader socio economic circumstances people find themselves in. Piecemeal responses are no longer adequate by merely providing information through media vehicles which invariably have short term impact in the absence of a holistic response. Equally the somewhat misguided strategy of UNDAF Nigeria which emphasises the fostering of societal demand as a mechanism to achieve the MDG's is misplaced, given the disempowered population.

Education and health are ultimately State responsibilities and the support provided by the DFID ESSPIN and PATHS 2 projects, are testimony to the needs of the Government. Clearly the efficacy of these projects needs to be mindful and responsive to priorities that address issues of access, equity and quality in facilitating health and education for all. From the research undertaken it is clear that the priorities should focus on empowering the most unreached and therefore vulnerable if any meaningful responses are to be made.

ANNEX 1: LIST OF ORGANIZATIONS

1. WHO
2. UNFPA
3. Family Health International (FHI)
4. UNICEF
5. Society for Family Health (SFH)
6. UNAIDS
7. UNODC
8. Action Aid International (AAI)
9. National Primary Health Care Development Agency
10. Centre for Public Health and Humanitarian Aid (CEPHA)
11. Global Health Awareness Research Foundation (GHARF)
12. Year of Ultimate Talent Harvest (YOUTH)
13. Life Line Plus Foundation
14. Youth-Child Support Initiative
15. Women Network for Access to Justice
16. Jigawa Advocacy Network
17. Foundation for Social Development of Destitute
18. Federation of Moslem Women in Nigeria (FOMWAN)
19. Community and Health Research Initiative – CHR
20. Masterpiece Health and Development Organization
21. Grassroots Health Organization of Nigeria (GHON)
22. Federal Ministry of Health (FMoH)
23. State Ministries of Health (SMoH)
24. PATHS 2