CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The rural dwellers of Nigeria especially in Anambra State have many health-related problems that militate against their successful contributions towards the development of the State and the country at large. The problems could be seen in the areas of economic, social, cultural and political levels, which could be eradicated or minimized through functional literacy education programmes.

Functional literacy is considered an important factor in promoting personal and professional development. It is seen as a means to a better quality of life. This is because it has the potential to fight ignorance, poverty and backwardness which are obstacles to self-fulfilment of an individual. According to Anyanwu (1992), literacy is seen as a part of the process of which ignorant or illiterate persons become aware of their personal inadequacies and learn to do something about improving it. In the process, it becomes a means of achieving political, economic, social and cultural upliftment and knowledge of human rights. This will enable the people who acquire functional literacy skills to make their world a better place to live in.
Literacy is aimed at giving recipients access to information through both print and electronic media and equipping them with knowledge or information that will enable them cope with work and family responsibilities, change the image they have of themselves thereby raising the quality of their lives. An illiterate society is thus plagued by ignorance, diseases, high level of dependency, high poverty rate, malnutrition, underdevelopment and other social ills (Okonkwo, 2005). Illiteracy is therefore considered a threat to the progress and well-being of humanity. Hence, Bash (2001) opined that the problems of illiteracy are so great that its eradication is seen as the common goal of all nations and has been a major concern to educationists, academicians, economic planners, development experts as well as various governments of the world. During the 1980s, United Nations Development Programme (UNDP) (1980) reported that there was a renewed onslaught against the scourge of illiteracy. This culminated in the International Literacy Year in 1990 and the World Conference on Education for All (EFA) held in Thailand in 1990 co-sponsored by UNDP, United Nations Educational, Scientific and Cultural Organisation (UNESCO), United Nations International Children’s Education Fund (UNICEF) and the World Bank. The rationale behind these efforts stem from the understanding or belief that promoting literacy and eradicating illiteracy will have positive consequences on adult learners, their immediate communities, and the
nation at large. There is the strong conviction that literacy can provide knowledge about health, family planning, population education civil education among others.

Oyedeji (1982) viewed literacy as the skills of transmitting and receiving messages in an intellectual manner in the written form. He pointed out further that literacy includes the possession of the skill of numeracy, reading and writing. These are skills actually lacking among the rural dwellers. They could not therefore be of much assistance to themselves in improving their preventive health practices and poor environmental conditions without engaging in meaningful functional literacy education.

Apart from the acquisition of literacy education for the purposes of reading, writing and arithmetic, United Nations Educational, Scientific, and Cultural Organisation (UNESCO, 1965) came up with more functional literacy education that was integrated with basic and vocational skills such as crafts, commerce, agriculture, preventive health practices among others to address the problems of illiteracy and make people more functional to themselves and to the society.

In Anambra State, functional literacy education, which this study focuses on, was established with a view to improving the health of the rural dwellers through preventive health practices.
Beasley and Warin (2009) emphasised that functional literacy is a method used to teach people how to read well enough to function in a complex society. They went further to say that functional illiteracy is a term used to describe reading and writing skills that are inadequate to manage daily living and employment tasks that require reading skills beyond a basic level. Functional illiteracy is contrasted with illiteracy in the strict sense, meaning the inability to read or write simple sentences in any language.

Realising the potency of functional literacy education, Nigeria like other nations of the World, has made frantic efforts at mass literacy campaigns. Since 1940 to date, Omoruyi (1998) said that, Nigeria has experimented with several adult literacy or interventions. These efforts resulted in the promulgation of the National Policy on Education (NPE) in 1978, revised severally in 1981, 1989, 2004 etc. The Mass literacy education campaign of 1982, the policy of the Each One Teach One (EOTO) or Fund the Teaching of One (FTTO), the establishment of the National Centre for Adult Literacy in Kaduna, (State Agencies for Mass Literacy, Adult and Non-Formal Education).

The literacy efforts in Nigeria were essentially aimed at fighting the scourge of illiteracy and reducing if not eliminating the identified high rate of illiteracy, disease, poverty, hunger, exploitation, poor political will, apathy or indifference, high death rates resulting from poor medical
health information and facilities. As part of government efforts aimed at eliminating illiteracy, the policy of literacy for all by the year 2000 was also popularised. In line with global events, the policy of universalizing basic education was also embraced by the government to ensure that the numbers of illiterate adults were reduced.

There is no doubt, therefore, that efforts have been made to embrace literacy in a bid to promote a literate society. It is expected that the large scale promotion of literacy will manifest in a better quality of life for the people in terms of improvement in the areas of social, economic, health, cultural and political lives of the people.

These efforts will only be possible through appropriate preventive health practices by the people concerned as the basic indicators of socio-economic status of any nation are the literacy rate and health of its people. This is also applicable to Nigeria and Anambra State in particular.

**Preventive Healthcare Practices include:**

i. **Prophylaxis:** This means any medical or public health procedure whose purpose is to prevent, rather than treat or cure a disease. In general terms, prophylactic measures are divided between primary prophylaxis (to prevent the development of a disease) and secondary prophylaxis (whereby the disease has already developed and the patient is protected against the worsening of his condition)
Some examples of prophylaxis include:

- Influenza vaccines are prophylactic.
- Antibiotics are sometimes used prophylactically: For example, during the 2001 anthrax attacks scare in the United States, patients believed to be exposed were given ciprofloxacin.
- Antimalarials such as chloroquine are used both in treatment and as prophylaxis by visitors to countries where malaria is endemic to prevent the development of the parasitic *Plasmodium*, which causes malaria.
- Condoms are sometimes referred to as “prophylactics” because of their use to prevent pregnancy as well as the transmission of sexually transmitted infections.
- Daily and moderate physical exercise in various forms can be called prophylactic because it can maintain or improve one’s health.
- Cycling for transport appears to be very significant in improving health by reducing risk of heart diseases, various cancers, muscular and skeletal diseases, and overall mortality.
- Professional cleaning of the teeth is dental prophylaxis, among others.

ii. Immunisation

iii. Preventive Treatment (acupuncture, massage, chiropractic)
iv. Eating balanced diet
v. Proper Ventilation
vi. Washing of hands after using the toilet
vii. Washing of hands before and after eating (Wikipedia, 2010)
viii. Water therapy: water is also prophylactic. Oyedeji (2006) emphasized that:

a. Water prevents clogging of arteries in the heart and the brain
b. Water can prevent glaucoma and can make the eyes shine
c. Water dilutes the blood and prevents it from clotting during circulation
d. Water helps one to lose weight
e. Water reduces incidence of morning sickness in pregnancy
f. Water helps to prevent memory loss, which comes with ageing
g. Water helps to reduce addictive urges for caffeine, alcohol, drugs etc.

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**Source:** Adopted from Oyedeji (2006), How to Use Water, Fruits & Vegetables for Healthy Ageing & Longevity

In Nigeria today, health and literacy, practically and regrettably are privileges for the minority who can afford these vital commodities. With regards to good preventive healthcare practices, all that is necessary is astuteness in resource allocation. “Prevention is better than cure” is one wise saying that could be wisely applied for a more healthy Nigerian society.

Westberg and Jason (1996) highlighted that, in the United States of America and other developed countries, premature deaths and disability results mainly from chronic diseases such as heart diseases, stroke, cancer, injury, emphysema, chronic obstructive pulmonary diseases, and arthritis. Many of these illnesses have been characterised as resulting largely from “accumulated, multiple indiscretions” and linked to habitual and sometimes harmful ways of living. It follows that considerable
morbidity and premature mortality could be reduced if individuals practiced certain preventive health behaviours.

**Preventive Health Behaviours**

Kasl and Cobb (1966) identified three types of health behaviours as follows: preventive health behaviour, illness behaviour, and sick-role behaviour. Preventive health behaviour is “any activity undertaken by an individual who believes himself to be healthy for the purpose of preventing or detecting illness in an asymptomatic state.” Illness behaviour and sick-role behaviour, on the other hand, are concepts that encompass behaviours that occur in response to specific symptoms or illness. These behaviours are aimed at minimizing the effects of specific symptoms of illnesses.

Preventive health behaviour generally follows from a belief that such behaviour will benefit health. An obvious example is quitting smoking to reduce the chances of early morbidity and mortality. It does not follow, of course, that all beliefs on which preventive behaviours are based are well founded, nor that the resulting behaviours will have the desired outcome. Much preventive behaviours have never been demonstrated to be effective but prevention is better than cure.
In line with these trends, the Federal Government as well as the State Governments of Nigeria have on different occasions, set up adult literacy education to improve the quality of life of rural dwellers of the country in order to reduce illiteracy and effect changes in their lifestyle. Central to this endeavour was the establishment of some major at the inception of the development processes from the grassroots. These according to Akinpelu (1992) include: Mass Literacy Education Programme (1982), Better Life Programme for Rural Women (BLP) (1985), the National Directorate of Employment (NDE) (1985), the Directorate of Food, Roads, and Rural Infrastructure (DFRRI) (1986), and the Directorate for Mass Mobilization for Social and Economic Recovery (MAMSER) (1987). The Governments that came to power after the establishment of these did not extend them to the rural areas and the rural dwellers were left to suffer the setback.

To further corroborate the above assertions, Egenti (2005) stresses that, “Right from the colonial era, rural developments have received minimal attention.” Rural development as she puts it, means, “A series of qualitative and quantitative changes occurring among a living rural population and whose converging effects indicate in time, a rise in the standard of living and favourable changes in the way of life of the people concerned.” Anyanwu, (1992) noted that the neglect of the rural areas in the country by governments helped to accentuate the problems of the
rural dwellers, resulting in the growing incidents of epidemic diseases, unemployment, inflation etc.

Adewale (1990) and Uwakah (1989) in their studies observed some of these problems militating against the rural dwellers as: high illiteracy, diseases, poverty, hunger, exploitation, poor political will, poor implementation strategies, and deaths resulting from poor medical health facilities among others.

In Anambra State, malaria, typhoid fever, dysentery, measles and other ailments are prevalent among women and children in the rural areas. Majority of the pregnant women in the State patronise traditional herbalists. As if these problems are not enough, rural dwellers in the State have no access to modern health facilities. Where they exist at all, they do not have the financial wherewithal to patronise hospitals or buy drugs from patent medicine stores. These are the health problems facing the rural dwellers of Anambra State and majority of these rural people are illiterate and semi-literate adults. Consequently, Nigerian Government at different times had tried to combat all these problems by implementing different literacy education in order to curb illiteracy but the efforts have not yielded desired results. As the United Nations’ Educational, Scientific, and Cultural Organisation (UNESCO, 2004) puts it, “Illiteracy impedes development.” Jegede (1996) stressed that,
"There is a need to understand the problem of illiteracy in a country. Illiteracy has fundamental impact on the development process of any nation. Before any nation can talk of meaningful development in the present age, with astronomical technological advancement, a minimum of sixty percent literacy level must be achieved.”

He said further that, development cannot and should not, be conceived in terms of the number of sky-scrappers or fanciful cars available in the country, but the number of men and women in the country who have enough awareness to understand the workings of these indices of modernisation. Oduaran (1991) stressed that in Nigeria, many areas are noted for lack of electricity and other necessary amenities like good pipe-borne water and hospitals, while some lack adult literacy education centres. Such areas he says are devoid of means of transportation and are characterised by lack of access to media information, poor access roads, over-crowded environments, lack of family planning etc.

Ejimugha (2006) noted that many Nigerian adults live in the rural areas and are often unable to migrate to the cities. He expresses the view that most tropical diseases, especially malaria, tetanus, measles, tuberculosis, dysentery and meningitis are endemic in the rural areas to which the illiterate adults and semi-literates are confined. Enuku (2005) stated that the realisation of education for all by the year 2000 has remained elusive
in spite of several mass literacy campaigns in Nigeria. According to them, 21st Century literacy is seen as the foundation of sustainable human development. With literacy rate of 57% and 43% for men and women respectively, Nigeria is in a very weak position to compete in the global market. If all things being equal, it then means that Local Government Areas in the country have a large number of illiterates since more than 75% of the total population live in the rural areas (Adewale, 1996) and since Anambra State is a kind of microcosm of the whole, Nigeria, it will also have a large chunk of its population as illiterates despite the people’s efforts in the development of industries. Illiteracy is commonly seen as an enemy, an evil that keeps people in perpetual darkness. So, it can be said that illiteracy subjects people to superstition and prevents them from accepting innovations and change. Illiterates are therefore hardly capable of meeting the demands of the changing world. There is a need to fight illiteracy through functional literacy education programmes.

In the year 2007 - 2009, the United Nations International Children’s Education Fund (UNICEF) sponsored functional literacy education programmes in Anambra State in order to bring about changes in preventive health practices of the rural dwellers of the State. The programmes, which was designed to address illiteracy and health problems among the rural dwellers of Anambra State dwells on functional literacy education programmes. The functional literacy programmes was
to provide the acquisition of modern health knowledge and practices. It is also concerned with the environment and component of personal hygiene for the rural dwellers of the State.

The main objective of the functional literacy education was to integrate functional literacy education with the health components as the participants learn literacy skills. Through functional literacy education, it is expected that the participants will acquire positive changes in attitudes and behaviour, which will enable them to improve on their health status. The functional literacy component is employed to motivate the participants to learn more about the personal hygiene and environmental cleanliness to promote a healthy living.

Ajala (2001) opined that ideal health is not just mere freedom from diseases but the realization of the physical, mental, and spiritual well being of the individual. “Health”, as they say, “is wealth.” No nation can progress economically, educationally, socially and in other ways under poor health conditions. A high level of good health among the people is required for progress to take place. It might also not be possible to maintain good health until a high level of literacy education is attained among the rural dwellers.
1.2 Statement of the Problem

Thus, it becomes rather germane that functional literacy education organised for the rural dwellers of Anambra State be examined to assess how far the health needs of the people were met.

The study therefore, was motivated by a desire to examine the impact of functional literacy education programmes on the preventive health practices of the rural dwellers of Anambra State who participated in the programmes.

Successive governments in the country have put up some health-related, functional literacy education at different times in order to improve the health of the rural dwellers in Nigeria. All efforts made by Nigerian governments and Non-Governmental Organizations to combat and solve these problems of poor health conditions of rural dwellers through Functional Literacy have not yielded the desired results. For instance, in the rural areas of Nigeria, most people:

- lack the information on how to prepare the Oral Re-hydration Therapy (ORT) against stooling/vomiting in babies and children;
- have poor knowledge of prevention of diseases;
- lack the knowledge on how to purify unclean water;
- do not know how to provide good and proper nutrition;
- lack the knowledge of better child welfare facilities and;
lack the knowledge of how to keep the environment clean among others.

All these characterize the problems of rural communities in Nigeria and Anambra State in particular.

The central problem is whether the health of the rural dwellers of Anambra state has been improved through participation in functional literacy education programmes. Are facilities and instructional materials available and effectively used? Do they have required trained instructors?

1.3 Purpose of the Study

The purpose of this study is to examine the impact of functional literacy education on the preventive health practices of the rural dwellers in Anambra State. Based on this purpose, this study sought to:

1. Determine whether rural dwellers’ participation in functional literacy education programme has significantly influenced their personal preventive health practices or not;

2. Ascertain if the home preventive health practices of the rural dwellers has been affected by their participation in functional literacy education programme or not;

3. Determine whether rural dwellers’ participation in functional literacy education programme has significantly influenced their environmental preventive health practices or not;
4. Examine if there is a significant relationship between the physical facilities and materials available for the functional literacy education programmes and the participants’ assessment of the programmes or not;

5. Find out if there is a significant relationship between the quality of facilitators at the programmes centers and the rural dwellers’ attitude to participation in the functional literacy education programmes or not; and

6. Determine whether the rural dwellers’ attitude to participation in functional literacy education is significantly influenced by their assessment of the programme or not.

1.4 Research Questions

The following research questions were raised to guide this study.

1. Is participation in functional literacy education enhancing the personal preventive health practices of the rural dwellers?

2. Are the home preventive health practices of the rural dwellers improved by their participation in functional literacy education programmes?

3. Is participation in functional literacy education programme boosting the environmental health practices of the rural dwellers?

4. Are there enough physical facilities and materials resources for the functional literacy education programmes?
5. Are the facilitators at the functional literacy education programme centers qualitative?

6. What is the attitude of the rural dwellers to participation in functional literacy education programmes?

7. What is the rural participants’ assessment of the functional literacy education programmes?

1.5 Research Hypotheses

The following hypotheses were stated for testing in this study.

1. Rural dwellers’ participation in functional literacy education programme is not significantly influence their personal preventive health practices.

2. The home preventive health practices of rural dwellers is not significantly affected by their participation in functional literacy education programmes.

3. Rural dwellers’ participation in functional literacy education programme is not significantly influence their environmental preventive health practices.

4. There is no significant relationship between the physical facilities and materials available for the functional literacy education programmes and the rural participants’ assessment of the programmes.
5. There is no significant relationship between the quality of facilitators at the programme centers and the rural dwellers’ attitude to participation in functional literacy education programmes.

6. The attitude of rural dwellers’ to participation in the functional literacy education is not significantly influenced by their assessment of the programme.

1.6 Theoretical Framework
The study focuses on three theories formulated by some eminent scholars on the factors, which affect the learning of adults in functional literacy education programmes:

(i) Motivation Theories by Maslow (1954) and Rubenson (1977)
(ii) Participation Theories by Mcgivney (1990) and Courtney (1991)
(iii) Evaluation Theories by Aderinoye (2004) and Stufflebeam (1971)

(i) MOTIVATION THEORIES
Asiedu and Obe (1981), highlighted that motivation is very significant for people to bring out their best in learning activities, they have to be motivated and in doing this, the adults will participate effectively. Adeosun (1985) supported the view that motivation refers to drive and efforts to satisfy a need. He buttressed the point further that motivation may be regarded as Needs-Wants-Satisfaction chain reaction; connecting felt needs that result in wants or goals that individuals aim to achieve.
The assertion shows that adults are moved to participate in any learning activity which they know that will satisfy their basic needs because adults have wealth of experiences unlike children that have no decision of their own. Therefore for adults to participate meaningfully in any learning activity, all those factors that will motivate them to learn have to be packaged in the programmes.

**HUMANISTIC THEORY**

Humanistic theory is one of the theories of motivation. The theory shows that human beings are driven to achieve their maximum potentials and will always do so unless obstacles are placed in their ways. These obstacles include hunger, thirst, financial problems, safety issues, or anything else that takes our focus away from maximum psychological growth. This is also in line with Maslow’s (1954) Hierarchy of Needs.
Okenimkpe (2003) pointed that, Maslow believes that self-actualisation could not be achieved by children and that activities or interests, which have intrinsic values (good for their own sake) are more likely to bring about self-actualisation than activities and interest, which have extrinsic values (sought because of the benefits which they give).

This is also in line with Knowles’ (1980) categorization of the adults’ characteristics which supports that adults are internally motivated.
Rubenson (1977) portrays this view further when he said that education like work is an achievement-oriented activity, which means that people who want to get ahead will put efforts into personal achievement. He suggested that motivation emerges from interaction of two factors: expectancy and valence. “Expectancy” consists of two components:

(i) The expectation of personal success in the educational activity and;

(ii) The expectation that being successful in the activity will have positive consequences.

“Valence” refers to the sum of positive or negative values that people assign to learning activities. For example, participation in education can lead to high pay. It can also make one see less of the family or spend less time in social activities. These factors above will either positively help or negatively affect one’s participation in the .

The study drew inspiration from the theories in the sense that adult education must have focus in order to address the problems facing adults in the rural areas of Nigeria for them to participate in functional literacy education but where their expectations were not met, they will not participate.
(ii) PARTICIPATION THEORIES

McGivney (1990) provided a very useful summary of some of the best known theories. The first is the one she calls *Needs Hierarchy Theory*. She argues that participation depends upon the extent to which a person has been able to meet a range of primary and secondary needs. She portrays this further with Abraham Maslow’s (1954) Hierarchy of Needs. It states that as basic primary needs of people are met, such as if one’s economic and social position improves then, higher needs are activated and the balance between negative and positive forces shifts. When this happens, people are more prepared to take part in educational activities. This view was also in line with Miller’s *Force-Field Theory*(1967). The assumption is that since adults mature and acquire wealth of experience, they are more concerned with achieving a status for themselves and desire for self-fulfilment, their participation in will focus on their survival needs, safety needs, esteem needs and self-actualisation as shown in the diagram above. At this point, Miller’s Force-Field analysis looks at factors that affect the participation of adult in the programme within the environment. *Force-Field Theory* by Miller (1967) explains why socio-economic status (class) linked to participation in adult education. He sees positive and negative forces and their relative strength that affect adult’s participation in educational programmes.
SOCIAL PARTICIPATION: Courtney (1991) developed this theory. He argues that significant learning often takes place in organisational settings such as schools, community groups, etc. He stresses further that in order to seek motivation for learning, people must seek for those factors, which motivate people to join or be part of organisations or for reasons why organisations compel as well as encourage forms of voluntary participation. He says, if learning is a discreitional act i.e. a function of leisure time, then, it becomes imperative to distribute life’s activities over the days/weeks/years to understand why people participate or not. Courtney finally said that, it is very important that learning involves socialisation or integration of the individual within the larger whole. Therefore, reasons for learning might be sought in the function played by education in giving or denying the individual access to social roles and rewards.
Another relevant model to be employed in this work is that of Cross –

**THE CHAIN OF RESPONSE MODEL:**

![Chain of Response Model Diagram]

**Fig. 2: Chain of Response Model**

**Source:** Adopted from Cross (1981)

The theory was propounded by Cross in 1981. She takes various elements from the theories described above and moulds them into a seven-stage process. It begins with the individual and ends with external factors. It is called the “Chain of Response” model because each of the stages are seen as links in a chain; each stage influences another. The more positive the learner’s experience at each stage, the more likely he/she is to reach the last stage, which confirms McGivney’s (1993) decision to participate.

According to Cross, motivation alone cannot make one to participate in an educational as emphasised by Miller (1967), Rubenson (1977), Asiedu (1985), but participation of an adult in any educational activities depends on the other factors that affect adults’ learning such as:
Having seen the various theories and models as regards factors, either positively or negatively affects participation of adults in functional literacy education, these models provide very vital information to government at all levels, executors and planners of adult literacy education, and the participants. It gives them the opportunity to adopt the correct models that positively influence the adult participants in the programme and the policies concerning adult literacy education in the country to reflect their positive participation and address their individual needs and the needs of the society.

(iii) **EVALUATION THEORIES**
Aderinoye (2004) emphasized that in literacy education, evaluation could be regarded as a process of assessing the contents, the knowledge gained and the impact of the on the learners. He stressed further that evaluation is a process of scientific methodology with specific objectives. This process, according to him, consists of investigation, collection of data, measurement, analysis and interpretation of results for the purpose of decision-making and further improvement of the programmes.
Evaluation must therefore be systematically built into the entire program in order to yield the most useful results as it will serve as a tool for a comprehensive assessment of the programmes.

Fig. 3: THE EVALUATION THEORY

Source: Adapted from Aderinoye (2004) Literacy Education in Nigeria

The Evaluation Chart which was adapted into the study provided feedback for this work. This was shown after the reviewing of the study, it provides feedback for planning also to implementation of any ideas from the findings as illustrated in the second arrows inserted by researcher.

Bhola (1994) said that evaluation examines and judges the worth, quality, significance, amount, degree or condition of something.
Obashoro (2004) emphasizes “the importance of the impact of evaluation on learning events, the learners, the administrators and the facility.” The evaluation tasks vary from one level to the other.

**Level 1:**
The first level assesses the learners’ reaction to the educational experience. The evaluation can be administered by anyone either immediately after completion or during the learning process. Variables that can be appraised could be teachers’, facilities’, or learners’ beliefs or feelings concerning the educational programme, its effectiveness, materials delivering, presentation and delivery methodologies. The important variables at this level are teachers’ personality and dynamics. The data collection can be interview, questionnaire with some form of scale such as the Linkert Scale or Yes or No.

**Level 2:**
At this level, the variables to be assessed are: what has been learnt, attaining of learning objectives’ changes in skills, knowledge and attitudes. Data gathered from this level will be used to improve the educational programme. The evaluator may use a pre-test, post-test and control group design.

**Level 3:**
The Kirk Patrick level 3 measures the extent to which learners can apply what they have learnt to real-life situations. This is a measurement of the
relevance of what is learnt to the learners every day challenges. The focus is on behavioural change, applicability of learning to work. This level entails evaluation of training and its impact on real-life situations (Obashoro, 2004). This level is most relevant when these are needed to show evidence of effectiveness of the educational programme.

**Level 4:**
At this level, the aim is to measure how successful the programme has been. It is used to establish the relationship between the organization and the intervention programme. Information at this level can be obtained through basic analytical ability and drawing logical conclusions.

Obashoro (2004) sees levels 1, 2, and 3 as improvement-oriented while level 4 is effectiveness-oriented. She recommends that a variety of techniques should be employed and evaluation questions should be comprehensive to achieve evaluation result.

In this study, the CIPP model provided by Stufflebeam (1971) is to be utilised. It highlights four basic tasks in the evaluation processes, which are:

(i) C \(\rightarrow\) Context evaluation
(ii) I \(\rightarrow\) Input evaluation
(iii) P \(\rightarrow\) Process evaluation
(iv) P \(\rightarrow\) Product evaluation
‘C’ tries to find out the necessary thing to be done before setting up of a project or programme?

‘I’ tries to find out whether those things have been done?

‘P’ which stands for ‘Process’, is asking how the task is to be carried out?

‘P’ which stands for ‘Product’, is asking if the task succeeded or not?

Context evaluation assesses needs of the people, their problems, opportunities, and outcome of the in order to help the users and decision-makers to judge goals.

Input evaluation assesses alternative approaches, action-plans, staffing, and budgets to achieve the set goals.

Product evaluation deals with implementation or plans i.e. how the task were carried out, which enable the personnel perform their responsibilities to maximise performance. It looks at the outcome of the organisation or programme both intending and unintended, both short-term and long-term outcomes in order to achieve the best outcome.
THE CHART OF THE CIPP MODEL

Source: Adopted from Stufflebeam (1971)

THE INTERPRETATION OF THE VALUES’ COMPONENT

The chart highlights the CIPP model’s basic elements in three concentric circles, which shows the importance of defined values. The inner circle portrays the core values that will be identified and used at any given evaluations. The wheel surrounding the values is divided into four evaluative foci that associate with any programme or plan, actions, and outcomes.

The outer wheel shows the type of evaluation that serves each of the evaluation foci, which are context, input, process, and product evaluation. Each of the two-directional arrows represents a give-and-take relationship between a particular foci and a type of evaluation. The goal-setting task...
raises questions for a context evaluation, which in turn provides information for validating or improving goals. Planning improvement efforts generate questions for an input evaluation, which correspondingly provides judgements of plans and direction for strengthening plans. Programme actions bring up questions for a process evaluation, which in turn provides judgements of activities plus feedback for strengthening staff performance. Accomplishments, lack of accomplishments, and side effects command the attention of product evaluations, which ultimately issue judgements of outcomes and identify needs for achieving better results.

These relationships are made functional by grouping evaluation in core values, referenced in the schemes inner circle. Evaluation root term value refers to any of a range of ideals held by a society, group, or individual. The CIPP model calls for the evaluator and clients to identify and clarify the values that will guide specific evaluations.

The CIPP model demands that the goals and objectives of the research have to be clearly defined. It looks at the organisational structure of the programmes, purpose, and design planning techniques of the programmes. It also takes into consideration various units as regards their functions and performance and lastly, the outcome of the programme. In the final analysis, decision-makers use the information
provided by evaluation, for further research work. The CIPP model has all the potentials that are required in evaluation in any organisational set-up and therefore, very suitable to apply in this study.

THE PROPOSED CONCEPTUAL FRAMEWORK FOR EVALUATING THE IMPACT OF FUNCTIONAL LITERACY EDUCATION PROGRAMMES ON THE PREVENTIVE HEALTH PRACTICES OF THE RURAL DWELLERS OF ANAMBRA STATE, NIGERIA

![Diagram of Input-Process-Output-Feedback Model (IPOF)](image)

Fig. 5: INPUT-PROCESS-OUTPUT-FEEDBACK MODEL (IPOF)

*Source:* Developed by the Researcher (2011)

To determine the impact of functional literacy education on the preventive health practices of the rural dwellers would be based on Input-Process-Output-Feedback Model of evaluation using Stufflebeam ideas as shown in the above diagram. The context as used in Stufflebeam model corresponds to the primer in this study used by the participants in the functional literacy education programmes. The input refers to the functional literacy education and preventive health practices imparted in
the lives of the participants in order to have a desirable change in attitude and behaviour. Process refers to the management of the functional literacy education and the output refers to the result that comes from the functional literacy education in terms of changes in attitude and behaviour after exposing the participants to functional literacy health education. Feedback in this study is the participants whose attitudes and behaviours have not changed and come back into the system again.

This diagram simply illustrates as Stufflebeam et al (1971) CIPP model emphasises that for any organisational set-up to achieve its optimal goals, the organisation must follow all the set down rules and regulations as explained in the CIPP model of evaluation.

In the same vein, Stufflebeam context is used to mean the main course of the programme in this study, which is the primer used by the participants. The input as used by Stufflebeam et al refers to functional literacy education programmes, which is imparted in the lives of the participants to imbibe in order to improve their health. The process refers to the procedure followed by the management or organisers of the functional literacy education programmes including financial, material, and human aspects in order to realise the best of the programmes and finally, the product as used by Stufflebeam is used in this study as
output, which is the changes in the attitude and behaviour of the participants as a result of exposing them to functional literacy health education programmes.

**TABLE 2**
**THE RESEARCHER’S CONCEPTUAL FRAMEWORK OF EVALUATION**

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>C</td>
<td>Context</td>
<td>Curriculum</td>
</tr>
<tr>
<td>I</td>
<td>Input</td>
<td>Functional Literacy Health Education</td>
</tr>
<tr>
<td>P</td>
<td>Process</td>
<td>Management strategies</td>
</tr>
<tr>
<td>P</td>
<td>Product</td>
<td>Changes in attitude and behaviour of the participants in living healthy lives</td>
</tr>
</tbody>
</table>

*Source:* Developed by the Researcher (2011)

In general, the evaluation chart (Input-Process-Output-Feedback Model, IPOF) as highlighted above points to the fact that for the participants in functional literacy education programme to achieve the best outcomes, all the necessary amenities including human and material resources must be put in place.

There must be a well-defined curriculum for the course. The functional literacy health education programmes, which is the input in the programmes, must be well packaged to address the health-related problems of the participants. The management of the programmes will see to all the processes in terms of method of teaching the adults, financial availability, quality personnel etc. in order to achieve the desired goals and objectives. Finally, if the functional literacy education given to
the participants produced a very good result as a product or output, this will be shown when there is a change in attitude and behaviour of the participants more than as they were before registering in the e.g. the functional literacy education they have acquired will make them to inculcate the good habit of personal hygiene, which includes keeping their environment clean, eating balanced diet, boiling their drinking water, avoiding stagnant water around their surroundings to avoid mosquito breeding sites in order to deescalate the menace of mosquito bites that result in malaria, and other sicknesses associated with lack of knowledge of personal hygiene and environmental sanitation. They will be able to write their names, read inscription on drugs, read road signs among others.

The participants whose life-styles have not changed with these practices would go back into the system as a feedback. The system continues in a clock-wise direction until all the participants achieve the required life-style that will improve their health status for personal and national development.

THE LINK BETWEEN MOTIVATION, PARTICPATION AND EVALUATION IN THIS STUDY
The link between motivation, participation and evaluation in this study is that the three theories enable the participants to take part in educational activities. Motivation is very important because in any sphere of human
endeavour being it education, business even at home, motivation is needed even a business man or woman who knows what he is doing, wakes up early in the morning everyday to cross-check how his business is going, if he discovers that his business is not doing well, he has to find out the cause of it and tries to amend those short-cuts in order to maximise his profits. The motivation in this study should be seen in the content of the whereby the content of the programme has to be packaged in such a way that the needs of the adults must be well defined. When this is done, the adults automatically will be motivated to take part in the. The taken part of adults in the learning process means participation. This simply means that it is only when the adults are motivated that they engage in the programmes and this leads into evaluation of the programmes in which adults engaged in. It then means that the have to be evaluated either at the beginning, middle or at the end of it in order to assess how far the are meeting up with the set aims and objectives of the programmes. As a matter of fact, the three theories work together in a cyclic direction that without each of them in the programme, the organiser of the programmes cannot meet with its set aims and objectives. Motivation, Participation and Evaluation concepts are dovetailed or interwoven. This, in essence means that the three concepts are working together to boost adults learning. For example, motivation –
whether extrinsic or intrinsic - is very necessary as it serves as a drive that makes an adult to participate in learning at any given programme. Hence, when an adult sees that the programme will enable him to satisfy his personal needs in future, he will be moved to enrol and participate in the programme because as an adult he/she will have self-confidence of himself, he wants to engage in activities that will give him maximum benefits in return.

1.7 Significance of the Study
The significance of the study lies in the contribution it makes in the following areas:

a. It will equip the neo-literate population of Anambra State rural dwellers with the skills (both cognitive and occupational) necessary for living healthier and productive lives.

b. It will assist the policy-makers and instructors to have a deeper insight into more practical methods of organising functional literacy education.

c. It will also be of great benefit to government at all levels, because it will assist the Ministry of Education in having a deeper knowledge and understanding concerning the importance of improving the health of the rural dwellers in the Nigerian communities through literacy education, especially, in Anambra state.
d. This research will be a good reference material - a blueprint for the governments in the country more especially, the Anambra State Government will utilize it in identifying and solving the health problems of the rural dwellers of the state. The Anambra State Ministry of Health, no doubt, will find this work a great treasure, and will use it as a guide to fine-tune whatever solution(s) it has put in place to remedy the health problems of the state, particularly in the rural areas.

e. The rural inhabitants of the state will derive special benefits from the work. This is because the work will serve as a mechanism of change in the health practices of the people of Anambra State in general and the rural inhabitants in particular. As a result of this study, participants in the functional literacy education who initially do not know how to read, write or to compute, will be able to, not only read or write, but will have a change of attitudes towards their health conditions in the positive direction.

f. The researcher, scholars and even adult education experts would gain much from the recommendations of this study and its findings. For instance, they would see this work as a reference material in their future findings on academic work. Generally, this
work will create a new body of knowledge in functional literacy education and health practices in Anambra State.

1.8 Scope of the Study
The conceptual scope of the study covers the impact of functional literacy education on the preventive health practices of the rural dwellers of Anambra State. The functional literacy education integrated with preventive health practices was designed only to teach the rural dwellers of the state the skills of reading and writing that will enable them acquire personal hygiene, environmental sanitation, good nutrition among others that will improve their standard of living.

The study is limited to rural dwellers of Anambra State, Nigeria. The vast majority of rural dwellers of Anambra State are illiterate peasant farmers, petty-traders and artisans who lack the skills of reading, writing and proper health practices, the situation, which debars them from performing their expected societal and individual roles.

It is the belief of this researcher that functional literacy education can enhance good preventive healthcare practices. On the basis of this, the study examines the impact of functional literacy education on the preventive health practices of the rural dwellers of Anambra State.
1.9 Delimitation

Rural dwellers spread all over Nigeria, but the study was limited to the rural dwellers in the twenty One Local Government Areas of Anambra State. It would have been appreciated if the study covered the whole of the Country but due to time constraint, scarce availability of finance, the twenty one Local Government Areas of Anambra State was considered to provide an adequate population for the research work.

1.10 Operational Definition of Terms

The following terms are defined contextually:

1. **Literacy Education:** This refers to the process of acquiring the skills of reading, writing, and computing with the aim of applying these skills to solve life’s many problems. Therefore, literacy of any type are designed to enrich or enhance the quality of life of its recipients.

2. **Health Education:** This refers to the process of teaching and intimating adults with the health tips in order to prevent or reduce the incidence of preventable diseases and sicknesses through literacy.

3. **Functional Literacy:** It is a method used to teach people how to read well enough to acquire special skills to enable them function in a complex society.
4. **Traditional Literacy**: It is the method of acquiring the general skills of reading, writing and numeracy using traditional methods with a view to finding them useful at some future date. It is not linked to present or on-going activity or task of the learner and hence one single primer readers may be used for all adult learners irrespective of their learning needs.

5. **Preventive Health Practices**: Preventive health practices refer to the measures taken to prevent diseases (or injuries) rather than curing them or treating their symptoms.

6. **Mass Literacy Campaign**: This refers to an effort made by the governmental or the Non-Governmental agencies towards dissemination of information regarding the importance of education or literacy to the generality of the citizens, especially the illiterate rural dwellers. The campaign may not be on how to read or write, but on particular information that will help the people live a good life.

7. **Literacy**: This refers to a series of educational activities specifically designed for a group of learners to accomplish some stated objectives within a given period of time.

8. **Rural Dwellers**: Rural dwellers in this study refer to people who live in the remote areas of the State such as villages, hamlets, huts etc.
9. **Semi-Urban Dwellers:** This term refers to those who live in communities, which are neither urban (developed) communities nor rural (undeveloped) communities. Those who live in semi-urban communities are those who do not have most of the amenities found in the urban cities, but do not live in total conditions as the rural dwellers.

10. **Neo–Literate Population:** This term refers to human beings who have just acquired the skills of reading and writing a required examination.
CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

Related literature was reviewed under the following sub-headings:

- Concept of Literacy
- The Beginning of Literacy Education in Nigeria
- Kinds of Literacy Education
- Levels of Literacy Education
- Characteristics of Functional Literacy
- Advantages of Functional Literacy
- Benefits of Traditional Literacy
- Values of Traditional Literacy to the Community
- Importance of Literacy to the Development of the Society
- Concept of Rural Health Education, which include:
  - Environmental Sanitation
  - Immunization
  - Breast-Feeding
  - Traditional Belief versus Health Education
- Concept of preventive healthcare practices
- Preventive healthcare policy in Nigeria
- Participation Theory
  (i) Congruence Theory
(ii) Life Transition Theory
(iii) Reference Group Theory
- Culture of the Ibos
- Empirical Review

2.1 CONCEPT OF LITERACY

“Literacy” as a concept is often misunderstood and misused. To some people, literacy means ability to read and write one’s name; to some others, it is a means of communicating effectively in the written words while some people refer to literacy as a means of human liberation.

What is Literacy?

Sullivan (1993) believes that “literacy develops the ability to communicate through the medium of the abstract symbols of scripts.” Laubauch and Mujahid (1992) defined illiteracy as “the inability to write a simple message in any language.” In support of what Sullivan said, Laubauch and Mujahid, in Murphy (1997), referred to literacy as “the ability both to read and write at least a simple message; illiteracy, conversely is the lack of such ability.”

To Freire (1973), literacy goes beyond the ability to read and write. He strongly believes in conscientization. Therefore, Freire stated that “Learning to read and write ought to be an opportunity for men to know what the word really means ... speaking the word is not at the same time associated with the right expression, or creating and recreating, or
deciding and choosing and ultimately participating in society’s historical process.” Freire by definition sees literacy as a means of human liberation. He conceives literacy not as an end in itself, but as a means to an end. In other words, Freire (1973) sees literacy as a powerful tool for achieving religious, political, modernising and economic purposes. In his own definition, Gudschinsky (1993) stated that “A person is literate who in a language that he speaks can read and understand everything he would have understood if it had been spoken to him; and can write, so that it can be read, anything he can say.” Gudschinsky, therefore, emphasizes understanding instead of rote learning and memorisation. This implies that the learner’s reading ability should go beyond the books used in the process of learning to read.

Okedara (1981) sees literacy “as the extension of the spoken language.” According to him, literacy emanates from society’s forms of communication. Thus, it could be said that literacy is a basic communication skill that enables one to extend the range of one’s contact well beyond one’s immediate environment. He further opined that: “Literacy... designates the ability to communicate through the medium of the abstract symbols of scripts.” In ordinary language, literacy is the ability to read and write. The majority of the countries of the world regard people’s ability to read and write as a measure of the literacy level for census purposes.
Akinpelu (1981) tried to provide a solution to the above problems by saying that “being able to recognise a simple word or being able to read means that one can follow words across a passage ... Being literate means that one can bring one’s knowledge and experience to bear on what passes before you.” This definition portrays the fact that the degree of understanding in any reading dictates whether or not one is adequately or inadequately literate.

Cipolla (1989) (cited in Adewale, 2002) in her own definition, tried to differentiate between illiterates, semi-literates and the literate in order to bring out a clear definition of literacy. She said: “Illiteracy may be employed to denote a person who is unable to read a text whether printed or in manuscript. In differentiating the three concepts, illiteracy, literacy, and semi-literacy, she claims that, “between the totally illiterate and the literate, there is an intermediate army of semi-literate people. These begin with those who can read but cannot write, comprising people who can read and write only a little and those who can hardly write anything besides their names and signatures. Unless such people are aided to become completely literate in the functional sense, it is possible for them to go back to illiteracy.

In general, literacy is the ability to read, write and compute in a language which one uses. Philips (1970) said that “Literacy is the capacity to read
and write.” He argued further that motivation, while important and is necessary, is not a sufficient condition for becoming literate. “The literate,” according to him, “can be led to the fountain of knowledge but cannot be forced to drink if he does not want to.”

Anyanwu (1980) said that “Literacy is to help human beings to emerge from the darkness of ignorance.” It is an inspiring task indeed, he noted. To stamp out illiteracy in our age according to him, is a moral duty. It is one of the foundations of true peace i.e. a peace based on the freedom and dignity of man.

The Director-General of UNESCO (2002) threw more light on the meaning of literacy education. He says that “a person is literate when he has acquired the essential knowledge and skills which enables him to engage in all those activities in which literacy is required for effective functioning in his group and community. His attainment of reading, writing and arithmetic should be such that could enable him to continue to use the skills towards his own and community development and above all, participate in the life of his community.

In the Nigeria Blue-Print (1990), literacy is defined as “the ability to exercise the basic skills of reading and writing at least in the mother tongue and to calculate numbers for everyday use.”
Bown and Tomori (1979) said: “Literacy education is the process in which people seek to improve themselves or their society by increasing their skills, their knowledge and their sensitiveness.”

UNESCO (2002), in this regard defines a literate person as “an individual who possesses the ability to communicate by using written words,” while one who does not possess this ability is considered to be illiterate. It thus follows that any person who does not have the ability to read, write and compute figures is an illiterate. In ordinary language, literacy is the ability to read and write. The majority of the countries of the world regard people’s ability to read and write as a measure of the literacy level for census purposes.

Asaolu (2000) and Ayodele (2001) (as cited in Oyinloye, 2005) pointed out that “Literacy brings about civilization, which is a prerequisite for development in all facets of life such as science, technology, politics, commerce and agriculture etc. They stressed further that literacy is a catalyst for learning, which enables the individual to function effectively in the society where one puts the experiences acquired into use. This means that society is the theatre where one demonstrates his wits or stupidity when it comes to problem solving. It is also a place where we can make contributions, which will lead to positive development in all ramifications.
According to a World Population Data Sheet (2003) in one hundred and twenty-seven countries, the following comparative data show various forms of relationship between literacy and development.

**TABLE 3: PERCENTAGE OF LITERATE POPULATION – 15 YEARS OF AGE AND OVER**

<table>
<thead>
<tr>
<th>Region</th>
<th>Lowest in any Country</th>
<th>Highest in any Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>1%</td>
<td>55%</td>
</tr>
<tr>
<td>Asia</td>
<td>1%</td>
<td>99%</td>
</tr>
<tr>
<td>North America</td>
<td>97%</td>
<td>99%</td>
</tr>
<tr>
<td>South and Middle America</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Europe</td>
<td>55%</td>
<td>99%</td>
</tr>
<tr>
<td>Oceania (Australia and New Zealand)</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>U.S.S.R.</td>
<td>98%</td>
<td>99%</td>
</tr>
</tbody>
</table>


UNESCO (1990) is one of the foremost champions of universal literacy worldwide. It highlighted the need for universal literacy worldwide in its editorial in its magazine *The UNESCO Courier* of July, 1990, pointing out that one billion people in the world today are unable to read and write – 963 million adults and 37 million school-age children. Akinpelu (1992) asserted that the illiteracy rate in Nigeria may even be worse. He noted that illiteracy rate in the country has been variously estimated at 56% to
70% of the population of 88.5 million people (1965 census). He estimated it at an average of about 60 million illiterates in Nigeria. He said further that there was a high degree of correlation between illiteracy and economic poverty and between illiteracy and political underdevelopment or instability.

Akinpelu (1992) also cited Lourie (1989) who compared the figures of illiteracy and poverty globally and had this to say: “A glance at some statistics other than those for illiteracy reveals that one billion human beings live below poverty line; one-and-half billion people lack medical facilities and one billion people live in unsanitary conditions.” It is difficult not to recognize that the map of the world’s illiteracy coincides with that of the world’s poverty. According to him, this shocking and disheartening fact applies primarily to the developing countries. Malcolm Knowles (cited in Akinpelu, 1992) went into greater details. He pointed out that “Globally, the nine countries which the United Nations Educational, Scientific and Cultural Organization (UNESCO) identified as accounting for 75.2% of the world’s illiteracy – India, China, Pakistan, Bangladesh, Nigeria, Indonesia, Brazil, Egypt and the Islamic Republic of Iran - are all, except Brazil, among the poorest countries in the world.” (Classification by the World Bank, 2002)
The data above, highlights that illiteracy rate is high in Africa, Asia and South America. On the other hand, most of the advanced countries of the world are found in North America, Europe, Oceania and U.S.S.R. where the percentage of illiteracy is very low. Our world of today is a world of letters. So, Fafunwa (1974) noted that “Ability to read and write at least the vernacular is an essential ingredient.” The inability to read, write and count imposes a considerable strain on the citizen. It is also through the art of reading and writing that citizenship education is imparted. Every adult needs to know what his rights and obligations are as a citizen.

Popoola (2001) highlighted that, the national efforts to launch mass literacy education campaign on the 8th of September, 1982 was designed to eliminate illiteracy in Nigeria by the year 1992. He explained that after the launching of the programme, it became impossible to achieve the policy objectives within the targeted period. The problems that made this achievement impossible he emphasised are: The size of the national population estimated at over 100 million people, absence of a formidable base upon which to establish a viable policy and a strategy of implementation, inadequate or lack of planning and supervisory bodies, absence of proper operational structure and machinery to supervise, arrange follow-up, coordinate and adjust programmes, insufficient number of personnel in all aspects of educational planning and
administration, and lack of a systematic data gathering, analysis, and evaluation.

He further observed that the Universal Primary Education (UPE) scheme was launched in 1976 to provide the opportunity for education at all levels in the country but contrary to its objective, it did not provide for all multi-faceted needs of education in the country. He pointed out that despite all the past efforts, more than half of the national population do not have the basic skill of reading, writing, and computation that are required for productive existence.

Fadare and Abu (2004) recounted that despite the efforts by the various tiers of government and individuals in Nigeria, literacy rate is currently estimated to be about 52 percent. In this regard, United Nations Development Programme UNDP (1997) noted that only 40% of households in Nigeria had any education at all, 12% had only primary education, 14% had up to secondary education while 5% had post-secondary education. They explained that the data from the Federal Ministry of Education Statistics (2003) shows that only 14.1 million children of school age are enrolled in primary school out of 21 million children in that category. This poor enrolment figure invariably associates with poor health of Nigerians; hence, literacy is one of the major determinants of the health status (Fadare and Abu, 2004). Moreover
“majority of Nigerian rural communities and semi-urban dwellers lack knowledge of balanced nutrition and hygiene as a result of which the populace is easily affected by diseases associated with lack of knowledge of balanced diet and sound hygiene.” (Nwankwo, 2005)

The foregoing paragraphs have reviewed a large variety of the definitions of literacy, which have been formulated by many thinkers and writers. Two dimensions of meaning emerge from the ideas:

1. literacy is the technical ability to read, write and compute;
2. it is also the acquisition of the social disposition of a sound character make-up. Literacy must achieve a harmonious integration of both elements in order for them to be regarded as being adequately successful.

From the foregoing views of what literacy does, it is clear that literacy is very important in the development of any society therefore, the fundamental objectives of mass literacy education is to wipe out illiteracy in the country to achieve human development and the improvement of the health of the people.

2.2 THE BEGINNING OF ADULT LITERACY EDUCATION IN NIGERIA

Fafunwa (1974) asserts that adult literacy education was brought into Africa by two well-known religions – the Christian religion and the Islamic religion. According to Fafunwa (1974), they started to teach their
converts the rudiments of how to read and write and at least to compute little church proceedings. This could be referred to as rote (literal or imitation) learning since education did not go beyond the knowledge that would enable their converts to be able to read their Holy Books, do interpretations and document some religious events. He stated further that one of the early pioneers in adult literacy education in Nigeria was Chadwick, the District Officer in Udi division in Eastern Nigeria. He stated also that Chadwick organised literacy classes on market days, with the assistance of the local teachers. He also involved village heads and leaders in community projects and organised inter-village competitions in order to stimulate greater community activities. Chadwick’s enthusiasm was partly responsible for his success in Udi. According to Fafunwa, hundreds of adults became literate though not in what is technically defined as functional literacy.

Fafunwa (1974) pointed further that adult literacy education at that time was based on reading, writing and arithmetic (the 3 R’s) alone and had little retention attribute and little social or practical value although some adults, according to him, learnt how to read and write through that means and the literacy levels of certain communities, such as Southern Ghana, were appreciably raised. The major disadvantage of that approach was that teaching the 3 R’s alone (i.e. reading, writing, and
arithmetic), with no other type of knowledge to accompany or follow it provided only narrow education.

Regarding this matter, Bown (1857), (as cited in Ajayi, 1979), stated that their designs and hope in regards to Africa are not simply to bring as many individuals as possible to the knowledge of Christ; they desire to establish the gospel in the hearts and minds and social life of the people, so that truth and righteousness will remain and flourish among them without the instrumentality of foreign missionaries, and that to achieve this goal, civilization must be incorporated into this set goal. To establish the gospel among any people, he noted, they must have the Bible, and therefore, must have the art to make them or the money to buy them. They must need the Bible and this implies instruction.

Akinde and Omolewa (1981) have stated that modern mass literacy in Nigeria, which involves the adult population started with the Christian missionaries in the fifteenth century and that the aim of the organisers was to make the adherents of the Christian religion literate enough to be able to understand the Holy Bible. These writers have pointed out that literacy education was more prevalent in the Southern part of Nigeria, especially in Lagos. In the northern part of Nigeria, according to them, literacy influenced by the Islamic religion was popular. Algbomia (1998)
also has pointed out that in Kano in Northern Nigeria, Moslem traders and teachers introduced the art of reading and writing in Arabic.

The first rural literacy education in Anambra State according to Uzodike (1991), was introduced by the then Church Missionary Society of Nigeria (CMS) in 1857 at Onitsha, Obosi and later to Nnewi and was conducted within their church premises. The, as he emphasised were short-lived owing to the fact that, the did not meet with the needs of the people. He cited further that later in 1887, the Roman Catholic Mission (RCM) under Rev. Father Lutz established theirs in the portion of land given to him at Onitsha by Bishop Ajayi Crowther with the aim of only teaching the people how to read and write. The also were without any accompanying functional literacy skills and the were later closed down. The subsequent adult literacy were established in different years but none of them survived because the were only based on the 3 R’s. This effort was an impetus, according to him, for Anambra State Government to launch its own mass literacy education in 1986 to uplift the education and well-being of the people.

The various Local Governments in the State, in the same vein, realising the importance of adult literacy education, launched their own in 1987, an action which brought about the setting up of many adult literacy education centres in the area.
2.3 KINDS OF LITERACY EDUCATION

There are two main kinds of literacy:

(i) Traditional Literacy
(ii) Functional Literacy

(i) Traditional/Conventional Literacy:

The term, traditional literacy, gained currency with the introduction of the concept of functional literacy with which it often contrasted. It is the old or original method of teaching and learning; how to read and write. It is the method which the new concept of functional literacy has been seeking to replace.

The literacy is also seen as more of a social and cultural activity than a stimulator of economic productivity. Quite often, the acquisition of the skills by adult is one for prestige or to stop being described as illiterate and not so much because it is immediately useful to the work at hand.

Adewale et al (2002) stressed further that traditional literacy “aims at imparting sufficient proficiency in reading, writing, and elementary arithmetic, however, the traditional literacy is non-intensive in its character and tends towards literacy for its own sale.”
(ii) Functional Literacy:

This came into use in 1965 when UNESCO adopted it as its new way of attacking illiteracy. The word ‘functional’ gives the impression of something very useful such that it makes the idea of functional literacy most welcome. Egenti (2005) opined that functional literacy education is “that aspect of education which enables an individual to perform his role in the society. For functional literacy to meet these aims, it must be selective, intensive, global, integrated, and tailor-made as further explained:

- Selective: offered to those who can benefit most from literacy, and once literate, contribute most to national development; i.e. workers in important sectors of the economy;
- Intensive: concentrated over a short period, so that what is learned is immediately used;
- Global: aimed at educating the whole person, not just at imparting isolated knowledge and skills;
- Integrated: combining literacy with other knowledge and skills in one organic programme balancing practical and theoretical learning; ideally provided at work during working hours;
- Tailor-made: designed individually for selectively small groups; elaborated on the spot with the participation of all concerned.
According to Adewale et al (2002), a person may be regarded as being literate when he has acquired the necessary skills for activities, which require literacy. They cited Jeffries (1967) that, “the importance of functional literacy is the ability to read a simple instruction leaflet in his own or some other familiar language, also write a legible letter, keep records of money transactions.

Literacy is important to a recipient when the basic skills that are required are used for solving day-to-day problems whether personal or social in nature. They referred to Stitch (1972) as saying that “a person who has the reading skills sufficient to perform a job is considered functionally literate.”

**TABLE 4:**

**DIFFERENCES BETWEEN TRADITIONAL LITERACY AND FUNCTIONAL LITERACY EDUCATION**

<table>
<thead>
<tr>
<th></th>
<th>Traditional Literacy</th>
<th>Functional Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Aim</td>
<td>Teaching elementary/rudimentary 3 R’s in a short time to make as many literates as possible</td>
<td>Teaching the three components L-T-S (L: 3 R’s; T: technical/vocational; S: socio-cultural) to selected occupational groups.</td>
</tr>
<tr>
<td>(ii) Approach</td>
<td>Mass approach bringing about mass campaigns for mass production</td>
<td>Selective approach; selection of economic sector, area, occupational group and interested learners.</td>
</tr>
<tr>
<td>(iii) Level standard</td>
<td>Very low level of attainment generally producing temporary literacy</td>
<td>Qualified standard, enabling students to retain it (permanent literacy) and to make direct use of it.</td>
</tr>
<tr>
<td>(iv) Content of teaching</td>
<td>One component only (literacy), sometimes only the 2 R’s, is often themeless, and/or not deliberately programmed.</td>
<td>Three components (L-T-S): L, literacy (3 R’s); T: vocational knowledge and skill; S: social content (civics, hygiene, socio-economic organisation, etc.). The three components are often integrated.</td>
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<tr>
<td>(v) Duration</td>
<td>One component 3 – 4 months 40 – 60 teaching hours</td>
<td>Two integrated components (socio-cultural 9 – 12 months 120 – 200 teaching hours. Three integrated components (work-oriented 18 – 24 months 300 – 400 teaching hours including practical lessons.</td>
</tr>
<tr>
<td>(vi) Baseline Surveys and Benchmarks</td>
<td>As the content is restricted and very general, and not directly related to felt needs and interests, surveys and benchmarks seem to be unnecessary.</td>
<td>As the content is defined and planned to reach a certain target, and as it is selected, it is tailor-made to needs and interest. Benchmarks are required to measure final results, in literacy achievements, vocational knowledge and skills, and social change (attitudes, educational interest etc.)</td>
</tr>
<tr>
<td>(vii) Evaluation</td>
<td>Evaluation is normally made at the end of the course only; final examination consists of writing a short letter.</td>
<td>Evaluation is required and carried out during preparation, implementation and at the final stage. There are certain areas of change to be evaluated, social, economic impact etc.</td>
</tr>
<tr>
<td>(viii) Value</td>
<td>The value is of temporary</td>
<td>It is expected to have a</td>
</tr>
</tbody>
</table>
Aderinoye (2004) discussed other types of literacy which include:

(i) Cultural Literacy:- Cultural literacy is radical. It means pride in the learners’ culture. It means active enjoyment of culture and active participation in the cultural activities of the society. It means the continuous rebirth of indigenous culture in the lives of the people. It is highly advocated by Paulo Freire, the Brazilian-born adult educator, who strongly advocates for cultural transformation of the society through literacy and literacy through conscientization.

(ii) Civic Literacy:- Civic literacy is literacy for good citizenship. Citizenship involves both duties and rights. Some civic literacy emphasize duties and peoples’ rights, while at a deeper level, civic literacy means a shared understanding of the approach to life of a group of people.

(iii) Women Literacy:- Women literacy is literacy for the women-folk. It leads to the empowerment of women. It emphasizes women’s duties and rights.

**Source:** Adewale et al (2002)
Critical Literacy:- This is what Paulo Freire (1973) referred to as education for critical consciousness. The purpose is to empower the people, to help them reclaim their rights, culture and civilization. It aims to make people masters of their destiny. Critical literacy enables people to become critical of what they see, of what they hear, of what they get, and of what they are asked to give. In other words, they become critical of the social, political and economic relationships in which they function. Critical literacy is embedded in political education. Critical literacy wants people to do something with the literacy skills they have just acquired.

Emenanjo (2000) brought out some clarifications of literacy education as micro and macro-literacy. Micro-literacy according to him referred to both minimal or basic literacy and functional literacy derivable from basic education. He stresses that micro-literacy is concerned with acquisition and use of the seven language skills which include:

(i) Listening
(ii) Understanding
(iii) Speaking
(iv) Reading
(v) Writing
(vi) Translation; and
(vii) Numeracy in whatever is the language or languages of the culture of the state or nation.
Macro-literacy on the other hand he notes is synonymous with overall or total education. He says that macro-literacy is designed to establish permanent literacy and to produce the literate person. Macro-literacy builds on permanent literacy and produces the educated person.

Micro-literacy establishes the skills for permanent literacy. It also empowers or endows its recipient with those far-reaching skills associated with science. Macro-literacy he asserts, grows from micro-literacy. It builds on the self-sustaining skills of permanent literacy and the enduring scientific culture thrown up by micro-literacy.

Micro-literacy equates to education that is holistic, integrative and development-oriented. It encompasses basic literacy acquired from basic education i.e. pre-primary, primary and the first three years of secondary education.

Mass literacy for adolescents and adults acquired from adult vocational and long-life education; women’s education and the education of under-privileged and the marginalized such as the nomads, migrant, fishermen, and physically handicapped. It also encompasses advanced literacy acquired from tertiary education.

He buttresses further that the above illustrations were captured by the definition of literacy given at the (1975) International Symposium for
Literacy, which was held in Iran. The declaration considered literacy not just as the process of learning the skills of reading, writing, and arithmetic, but a contribution to the liberation of man and his full development.

Nyerere (1976) threw more light to the above assertion when he said that: “The purpose of education is the liberation of man from the restraints and limitations of ignorance and dependency.”

It is no wonder he said that there is very strong correlation between macro-literacy and development. According to him, all the countries that have 80% - 90% literacy are advanced and developed while all the countries that have 60% are under-developed. “The less literate, the less educated.”

He said that these lacking macro-literacy or education are dangerous to society because they can hardly separate between good from evil; and making a rational judgement a difficult task for them. They are ignorant and superstition-personified. These, he emphasised cannot understand and cultivate democracy. For them, education has no multiplier effects. He concluded his assertion by emphasising that the crucial difference between micro-literacy and macro-literacy is that, the latter is steeped in heavy doses of ideology. Macro-literacy is largely responsible for the gap
that exists between the developed or technologically advanced, and the developing or technologically disadvantaged countries.

2.4 LEVELS OF LITERACY EDUCATION

(i) Post-literate:
This term applies to a stage of education into which a new literate enters on the acquisition of literacy skills. It is a stage of a follow-up education for the neo-literate in which he is now able to use the skills to study some other subjects. He can, for example, begin to read books, magazines or newspapers, or more importantly start from new studies to pass examinations.

Post-literacy can also refer to the content of study being undertaken by the new literates. Hence, we talk of post-literacy materials or post-literacy curriculum, which refers to any or all studies beyond initial or basic literacy.

(ii) Pre-literate:
This refers to the state in which a society or group of people was before the introduction of literacy. This group could not be termed to be illiterate because it would assume that the literacy skills were in existence or had been introduced but they have not acquired the skills. Pre-literate is not used to describe individual persons but a term that is applicable to
societies where its literacy skills are not in use at all because they have not been introduced.

(iii) **Neo-literate:**
This term refers to human beings. It applies to persons or group of persons, which have just acquired the skills of reading and writing by passing the required examination and being certified literate. The neo (new)-literate stands the risk of losing his newly acquired skills to become a neo-literate if he does not have the opportunity of putting the new skills into use. This happens frequently in the rural areas where follow-up materials and writing opportunities are minimal, and hence, the new skills are not frequently practiced to make them permanent.

### 2.5 CHARACTERISTICS OF FUNCTIONAL LITERACY

Omolewa (1986) said that functional literacy is a type of literacy linked or integrated with economic, technical, vocational, occupational or job skills and acquired in the context of such skills. UNESCO’s (1990) emphasis was on the economic and income-earning skills, and hence its original full name was Work-Oriented Adult Functional Literacy (WAOFL). This narrow interpretation of functionality in economic or occupational terms only gave way to a broader interpretation in terms of social, political and cultural skills, in addition to the economic skills. The core of all of them is to use the knowledge of those skills as the content of the primers and
follow-up readers for the adult learner. Thus, he can acquire the occupational or social skills simultaneously with reading and writing skills.

Functional literacy is selective in approach i.e. it is targeted at selected groups whose needs for the skills therefore, serve as incentive-motivation for their acquisition of the skills. Such groups be they economic, political, social would usually be homogenous having identical needs and learning to read to improve their functional skills.

Functional literacy is intensive, by this, it is meant that literacy effort is concentrated on the vocabulary and knowledge of the particular functional skills and that intensity of concentration makes the acquisition of the literacy skills faster while traditional literacy is extensive and diffuse in coverage, functional literacy uses words relevant to the skill as the vocabulary to be mastered.

It is more of a method of teaching literacy that promises high motivation for the learner that facilitates the acquisition of the skills that ensures retention and permanence of the skills, and that more immediately promotes individuals and national development.

### 2.6 ADVANTAGES OF FUNCTIONAL LITERACY

Functional literacy is an essential trigger of economic development. It trains various groups to improve their working efficiency and to increase
their productivity. The rapid increase in technical growth requires that the labour force be constantly trained and upgraded in all occupational areas and at all levels (Oyitso et al, 2005). They cited Nwangwu (1999) that “In most mobilisation literature for literacy, prospective learners have been told that learning to read and write would make them better mothers, better business men, better artisans and this will later on translate into a better quality of life.

Functional literacy is the motivation that provides the learner, in that the content of his learning is relevant and useful to him. The learner increases his ability to solve his problems as he learns to read and write along the learning of new economic or social skills. Another advantage is that there is better opportunity for the retention and permanency of the newly acquired skills so long as the neo-literate continues in the occupational skill or social role and reading materials if these are available for his use.

Again, the linkage of work-skill with literacy skills makes the later promoter of economic or social development. In the process of acquiring reading and writing skills, the economic potentiality of the learner is simultaneously being developed. Hence, there is the claim that functional literacy is at least correlated, if not actually causative of economic development and social change.
2.7 BENEFITS OF TRADITIONAL LITERACY:

1. To the individual: It produces changes in the individuals. These changes, according to Adewale et al (2002) are:

(a) Cognitive:
Literacy makes the individual more enlightened, prevents ignorance, and endows useful economic and political awareness as a result of the literate person being able to store information and knowledge. For example, a farmer (especially now that the government is finding it difficult to provide the communities with agric-officers) can retrieve information stored in writing, read the information and follow the instruction.

(b) Affective:
Learning has its own reward. Learning is a sort of discipline through which subject the individual can achieve psychological transformation. Learning helps learners to mix and integrate, to be able to move away from the restrictions of tradition and to make one more adventurous. It helps one in acquiring new values and appreciating other people. It makes one more open and creates in a person a demand for more information. This kind of literacy is very important to a nation that wants to grow and develop.

(c) Psychomotor:
Adewale et al (2002) have emphasised that psychomotor changes occur in the manual domain. Ability to read and write one’s letter leads to
greater confidence and ability to maintain privacy. It promotes worthwhile skills such as in applying fertilizer, application of drugs and insecticides. The authors have also cited various authors who have carried out some researches on the values of literacy, namely, Okedara (1981), Durojaiye and Fortes.

Okedara emphasizes the building of confidence. According to him, the individual no longer feels inferior. Durojaiye finds from the survey of cotton growers in Oyo State that literacy increases the productivity of workers. For his own part, Fortes asserts that: Puerto Rico: the 50\textsuperscript{th} stage of America

(i) literate parents are more likely to send their children to school  
(ii) children from literate parents are more likely to stay in school and complete their studies, and  
(iii) such children are more likely to do better at school than the children from illiterate homes.

2.8 VALUES OF TRADITIONAL LITERACY TO THE COMMUNITY

(i) It is a fundamental human right.  
(ii) It is an instrument for social development and change.  
(iii) It liberates the mind from dependency.  
(iv) It creates conditions for freedom from the contradictions in the society.
(v) It allows the understanding of causes of some illnesses and untimely deaths.

(vi) It increases knowledge and the ability to screen and evaluate new information.

(vii) It increases disposition to adopt improved agricultural practices, a condition that may be one of the reasons why rice yields in Sri Lanka are very high.

(viii) Literacy is also a catalyst for political and ideological changes.

They also highlighted the conditions under which people become literate. These factors include:

(i) the degree of urbanization;

(ii) a high level of commercialisation;

(iii) prosperity i.e. a relatively high level of income per capital;

(iv) a culture or generation that supports literacy activities;

(v) a secular and egalitarian society that is open in nature, and

(vi) The supply or production of a large number of trained teachers.

Benefits of literacy education according to Aderi (1979); Mace (1992); Oduaran (1991), Berteisen (1965), (as cited in Ejiofor, 2000) include:

(i) Improvement of health of the people.

(ii) More understanding of government policies and by the people and co-operation in implementing them.
(iii) Stimulation of demand for vocational training and technical education.

(iv) It raises the productivity of the literate.

According to him, a nation where the illiterate level is at an all-time high cannot be said to be fully developed at least, in human resources. The geography of illiteracy, he says is a geography of underdevelopment, and the geography of literacy is a geography of development.

Omolewa (1981), addressing the issue of empowerment through literacy says: “Literacy enables people to control their physical and psychological environment. It should help to conserve and exploit the natural resources of the earth so as to raise the standard of the people.” Literacy, he also says, helps to bring out the best from people in order for them to achieve a healthy physical, mental and spiritual condition of life. Literacy education and its multiplicity of related activities help to improve the quality of life at the grassroots especially of the rural dwellers who are mostly the beneficiaries of literacy promotion.

He states further that literacy, properly introduced and planted in the culture of the people, can elevate the circumstances of the people. According to him, it is well known that literate people are often healthier and that a healthy community will reduce its expenses on health-care. Literacy also can provide the means of becoming better informed in the
history, culture, religion, and politics of a people. Literacy therefore, can be an effective instrument for assisting a people even to recognise the causes of poverty and the indicators for measuring poverty. He remarks: “Poverty of ideas can be as serious as poverty in resources and clothing.”

Omolewa (1994) further highlights the benefits of literacy education by saying that literacy education hinges on the expectations of improved life for the poverty-stricken masses in villages and rural communities. Literacy enhances the quality of life and improves the standard of living of the people. Through literacy education, the illiterates have access to land, water, labour, skills, business enterprises, money and to funds.

Batiwala (1994) buttresses the conviction about the benefits of literacy by saying that “through literacy education, people have access to intellectual resources, including gaining knowledge of the existing situation of the rural populace and gaining access to information and ideas.” He states further that literacy offers the enabling strategy for grassroots improvement, educationally, physiologically and psychologically. He asserts that through literacy, rural dwellers have access to facilities, resources and to conditions that improve their status, thereby crushing their powerlessness.

Persepolis (1999) identified literacy not just as the process of learning the skills of reading, writing and arithmetic but also as a contribution to the
liberation of man and to his full development. He argued that literacy is inseparable from participation; hence, the illiterates should not be the object but the subject of the process where he becomes the literate.

The primary aim of literacy programme according to him is not simply to provide people with the skills to cope with the written word in everyday life, but to enable them to gain greater freedom to make choices, to have a better grasp of real life, to enhance personal dignity and to have other sources of knowledge.

He stated further that literacy has been defined in so many ways, from reading the word to reading the world. He said that literacy could be defined in the instrumental terms of the ability to read and write in the mother tongue or in a national language where this is required by cultural and political realities. Numeracy – the ability to deal with numbers at a primary level is considered part of literacy. (Literacy Campaign in India, New Delhi, APH Publishing Corporation 1999)

UNESCO (2002) estimates that there are around 1,000 million adults (aged over 15 years) illiterates in the world and that over 95% of these are in the developing world. In India for example, while percentage of literacy increases every decade, the total number of illiterates have also been increasing. The percentage of illiterate women is put at 61.1% as against 36.6% of men. According to UNESCO declaration, the situation is
much worse in rural India where literacy rate is 22.95% in contrast to urban literacy rate of 51.40%. A UNESCO survey of 20 countries of Asia and the Pacific region shows that India with an illiterate population of 56.5% in the 15 plus age group is better off than only four others – Pakistan, Afghanistan, Bangladesh and Nepal.

“Literacy instruction must enable illiterates left behind by the course of events and producing too little, to become socially and economically integrated in a new world order where scientific and technology progress calls for ever more knowledge and specialisation.”

The health of the state must be balanced by a concern for the health of its people. Citizens must be taught critical consciousness so that they can engage in the creation and renewal of social and political structures through genuine participation. (Indian Journal of Adult Education, 1997, 58(2))

Ampene (1986) also highlights the fruits of literacy. According to him, “the usefulness of literacy cannot be denied. The new literate, if properly instructed and made aware that literacy is a tool for liberation and enriched living, gain confidence and dignity.”

Bhola (1983) insists: “Without literacy, development only limps on one leg.” He therefore, sees literacy as “a veritable tool for all forms of development efforts including poverty alleviation.”
Jones (1991) sees literacy as a vehicle for community development. He cites the current emphasis in Western countries on the functions of adult literacy education and asserts that literacy largely lies at the two ends of a spectrum, i.e., literacy for vocational purposes and literacy for self-development. Okenimkpe (1996) stresses the point that literacy education helps people to obtain and keep jobs and to understand their surroundings and culture. Bhola (1983) and Ampene (1986) have stressed that without literacy, development limps on one leg. Therefore, these writers see literacy as a veritable tool for all forms of development, including health development.

All the above views highlight the fact that no meaningful advancement can be attained in human endeavours without literacy education and, indeed, education in general.

Adewale (1990) noted that more than 75% of Nigerians live and work in the rural areas; hence there is a need for effective rural literacy education programmes. Literacy education programmes need to be organised to improve the health of the people. There is now a need to review adult literacy education programmes in Anambra State in order to find out why these have not improved the health and general welfare of the people. What have been the objectives of rural literacy programmes in Anambra State? Who have been responsible for implementing such programmes
and what arrangements did these organisers make towards continuity of the programmes?

UNESCO (2005) expresses the view that literacy will enable the individual “... to extend the range of his mental processes and gain the knowledge which makes the world around him intelligible and manageable.” This means that literacy education serves as an instrument for gaining an understanding of one’s environment and doing something about the world around one. The International Symposium for Literacy in 1995, in Nyerere (1994) considered literacy to be not just the process of learning the skills of reading, writing, and arithmetic but a contribution to the liberation of man and to his full development.

Through literacy education programmes, the peasant farmers in rural communities of Anambra State will imbibe the new methods of agriculture as a better alternative to their old traditional practice and learn to apply insecticides and fertilizers to their crops and even gain the knowledge of obtaining loans from the banks to enable them embark on commercial agriculture instead of relying on the inadequately old methods of farming. Through this means, they will be able to produce higher quantities of foodstuff of higher quality for the people living in the area and beyond. In support of this, Nyerere (1976) expressed the view that liberation of man is a function of literacy education. He said: “The
purpose of education is the liberation of man from the restraints and limitations of ignorance and dependency.”

He further asserts that, when adults acquire literacy education skills, they become conscious of their importance in the transformation of the communities to which they belong. They thereby, liberate themselves from superstitions, ignorance and diseases. They attend hospitals when ill and can read a prescription on medicines labels and apply the medicine correctly. A literate person reads about the dangers of drug abuse and alcoholism. He can more effectively take part in decision-making actions in his community, as well as in community development. All the above assertions of the late Nyerere, President of Tanzania summarize the facts about the value of literacy i.e. that illiterate rural dwellers (and, indeed, urban dwellers) need literacy education in their lives for maximum development of their potentials.

Through literacy education, industrialists and entrepreneurs in Anambra State will acquire more knowledge about the importance of creating health-working conditions for their workers to avoid health hazards in industries. Such dangers from machine hazards like accidental amputation or chopping off of fingers or hands of the illiterate workers in the firms would be reduced. Appropriate care should be taken concerning
where to site their industries so that the wastes from the industries would not create dangers to man and the environment.

The illiterate rural dwellers through literacy education will imbibe the habits of eating well balanced diets to improve their health. They would also learn the skills of observing hygienic habits, such as regularly taking baths, wearing neat clothes, keeping their environment clean, warming their foods when necessary and internalising the values of a balanced diet.

Through literacy education, the women will inculcate the habits of breast-feeding their babies correctly and adopting family planning practices where necessary, applying immunizations, understanding Extended Programme on Immunization (EPI), and the Oral Rehydration Therapy (ORT) to improve their health since, in popular parlance, “prevention is better than cure.” The rural market women, the majority of whom are illiterate, will improve their health by making sure that they do not expose whatever raw foods they sell in the market to flies.

Indeed, governments should not toy with the issue of developing rural adult education. A literacy education programme should be a “number one” rural development project. Adewale (1996) stressed that as many as 70% of national populations world-wide live in the rural area and, for the
reason that the majority of the populations of countries depend on the primary productive efforts of the rural populace, it is compelling that rural areas should be developed. A key to development is education, which includes adult literacy education, as highlighted by Madumere (2006). An adult literacy education programme therefore, is a “must” for rural dwellers, and this is true of rural dwellers in Anambra State.

Jegede (1989) (as cited in Adewale, 1990) shows that illiteracy has its consequences both in the traditional society and the modern times. He noted that lack of writing skills made it impossible for our forefathers to document our historical facts. The health of our traditional people suffered untold miseries because once an inventor of a particular medicine dies the ideas of such facts end up. Illiteracy is sort of hindrance to development. Fakori (2003) pointed out that, “The illiterate is more static, more tradition-bound and more conservative. Literacy education has taken place to correct these anomalies.

Anyanwu (1992) was of the view that literacy is to help human beings to emerge from the darkness of ignorance. Therefore, to be a functional member of the society, and be able to contribute to the growth and development of the society, it is imperative for the individual to be permanently literate. Adult literacy education programmes therefore, is the answer. The primary aim of establishing this within the rural areas of
Anambra State is with the hope of promoting and maintaining the health of the rural populace. Those literacy as a matter of fact entrusted with the responsibility of ensuring that people are freed from the bonds of these crippling diseases rampant in our rural communities in agreement with UNESCO’s (1990) declaration of “health for all” by the year 2000 seems to be living up to its expectations.

2.9 RELEVANCE OF LITERACY TO THE DEVELOPMENT OF THE SOCIETY

Illiteracy has been regarded as an enemy, an evil, which keeps people in perpetual darkness. Illiteracy keeps people in superstition and prevents them from accepting of innovations and change. Illiterates are therefore incapable of meeting the demands of the changing world. There is a need therefore to fight against illiteracy.

Various world bodies, countries and even individuals, have often expressed the need for literacy education. UNESCO (1990) held the view that “literacy would enable an individual to extend the range of his mental processes and gain the knowledge which makes the world around him intelligible and manageable.” This implies that literacy education serves as an instrument for gaining an understanding of one’s environment and doing something about the world around him/her.
When adults acquire literacy skills, they become conscious of their importance in the transformation of the community to which they belong. They liberate themselves from superstitions ignorance and avoidable diseases. They attend hospitals when ill and can easily read a prescription on medicine labels and apply the medicine correctly. A literate man reads about the dangers of drug abuse and alcoholism. He can take more effective part in decision-making exercises in his community as well as community development. As Bown (1993) opined, “Literacy can change the whole outlook of women as regards their ability to use new techniques in innovations so vital in the process of development.”

Illiterate women, kept away from the main stream of change, are likely to act as a deterrent to change in a society. Therefore, literacy education is very necessary for women as well. A literate mother knows how to keep a tidy home to prevent common diseases. She understands the importance of good quality food for the family.

Fafunwa (1990) explained the importance of literacy in this way: “It is surprising that the leading nations are the reading nations; reading nations are winning nations, and those who read, lead the world.” Macro-literacy or good balanced education leads not only to self-fulfilment and self-actualisation in life of the individual but also to the overall advancement or development of society in terms of:
(i) the conquest of poverty;
(ii) the eradication of illiteracy;
(iii) the enthronement of a scientific culture;
(iv) the enthronement of women and gender equality, and
(v) the popularisation, availability and access to qualitative education that knows no boundaries in terms of gender, sex, race, ethnicity, physical disability, religion and ideology.

The development and maintenance of infrastructure in the rural and the urban areas, good all-weather roads, efficient transportation, constant electricity, safe potable water, telephone are dependent on literacy. The International Adult Literacy Survey (IALS, 1998) says: “Literacy means more than knowing how to read and write or calculate and involves understanding and being able to use the information required to function effectively.” It went further to highlight some important implications associated with literacy:

(i) Literacy is a crucial target. As the second International Adult Literacy Survey (IALS) puts it, “while most people can read, the real question is whether the reading-writing skills meet the challenges of living and working in today’s society.” As the demand of society changes, so do the necessary literacy skills required to function in it change.
(ii) Literacy involves comprehension and understanding, not only of the written word, but also of the spoken word. Literacy, for example, is a key factor in the ability to understand and to be able to act upon verbal directions from health professionals, e.g., doctors, pharmacists, physiotherapists and others.

(iii) Literacy skills enhance flexibility. They enable people to deal with change and unfamiliar contexts. As we shall see later in this work, these factors are all closely related to health.

2.10 CONCEPT OF RURAL HEALTH EDUCATION

It has been a common saying that “prevention is better than cure” prevention denotes all measures taken to avoid diseases or infections. Health is not just a state of absence of diseases but encompasses all measures that work against the proliferation of a disease. In the words of Adi (2005), good health is a God-given gift for which we should be thankful and which our responsibility is to maintain. Diocles (1990) maintained: “Prevention is better than cure”. He claimed that Modern knowledge, especially literacy education measures, have taught us how to prevent many diseases, and if this knowledge were generally applied to our everyday life, the health of the community or rural areas would be final. He warned that one’s health is his most precious possession and that how it appears precious dependent on the individual’s ability to maintain his or her health.
Lucas (2003) said that “In African as in all other parts of the world, it is
the desire of man to prevent, limit and control diseases, disability and
death, and thereby to acquire and maintain good health, prevention is
worth hundred the word fold the value of the most effective medicine
ever in existence.”

Through preventive health education, people are informed about good
health habits capable of promoting and maintain healthy living. People
are informed about environmental sanitation, nutrition, malnutrition and
under-nourishment, cleanliness and personal and community hygiene.
Mothers are educated about breast feeding, the oral dehydration therapy,
immunisation and all that is necessary for the promotion and
maintenance of healthy living and avoidance of disease infections.

Gordel (1994) stressed that “the health situation of people in developing
countries is essentially characterised by three factors:-

a. More than 80% of all deaths are caused by:-

- Infectious diseases, such as diarrhoea and respiratory
diseases;
- Communicable diseases, such as intestinal worms, which
  affect at least 50 million people;
- Illness in connection with pregnancies, deliveries and their
  consequences (mortality which is ten or fifteen times higher
  than in industrialised countries), and
Diseases caused by malnutrition and under-nourishment, which can also be assumed to contribute substantially to the high child mortality in the Third World Countries.

b. The diseases listed above mainly occur among the rural populace and among slum dwellers.

c. Most of these diseases could be reduced or even completely prevented through preventive health education and preventive medicine without extensive and costly medical services and without highly specialised medical personnel.

According to Galli (2004), “the goal of preventive health education is to provide information that individuals can use to enhance their health status.” Thus, Fueli (2002) declared that knowledge of when and how to use medical, dental and other services is invaluable for human well-being but millions of people are victims of ignorance in matters relating to self-care and the use of these services. To him, “health superstition, hopelessness and recklessness must be replaced by knowledge through functional literacy education .”

Green (2001) made it clear that “preventive health practices can be effective in reducing care cost because its primary emphasis is on the prevention of diseases and disability rather than on treatment.”
Galli (2004), in the distinction he made between a health-informed and a health-education” individual explained that “an individual who is informed about preventive health is aware of the consequences of specific health practices; the individual knows the appropriate health behaviour towards which to strive and those that are inappropriate. Despite this knowledge, the informed individual may engage in an unsound course of action that may invariably put his health in jeopardy. In contrast, the person who is educated about health is not only well-informed, but uses this information in daily life, resulting in higher levels of well-being.”

The former Anambra State Commissioner for Health, E. Onwudiwe in The National Mirror of Thursday 12th of September, (1992), argued: “Preventive Health education is part and parcel of what used to be called ‘preventable.” The patients are capable of preventing himself or herself from contracting some of the illnesses. Through preventive health education, which he/she acquires, it would be possible for society to reduce the incidence of certain communicable diseases by teaching the people how to live a healthy life.

In recognition of the concrete values inherent in preventive health education, Ennis (2003) said "Over 300 insurance companies under the auspices of the Health Insurance Association of America have given their support to preventive health education. These insurance companies have
important stake in effective Preventive Health Education for a number of reasons:-

a) Preventive health education has the function to improve the environment in which the rural adults live. Health Education must operate by helping to ease the medical pressures of cost inflation and the overuse and misuse of medical care services and facilities.

b) Preventive health education has a very real potential for cost savings at least over a period of time by encouraging positive health behaviour and prevention and thus reducing medical care expenditure.

c) It can generate community interest, support and participation in more effective adult health.

d) Of utmost importance, preventive health education can enhance the well-being of the participants.”

However, it has been noted that in Nigeria today emphasis is placed on diseases treatment in isolation of their prevention. Expressing his view on the present healthcare situation, Galli (2004) commented: “Today, the healthcare industry focuses on the treatment of illness. The healthcare facilities, such as hospitals, health maintenance organisations, local health centres and clinics are equipped to re-establish health after the onset of illness. That is, we wait for illness to occur, so that we may pay to have it treated. This may appear to be a logical sequence of events,
but closer scrutiny reveals that this is not only a major weakness in our health-care system, but also the primary contributor to the causes of many deaths. It is taken that, because the undeveloped nations are restricted in their activities by meagre resources, their governments channel the little fund they have to areas that are likely to yield immediate revenue, postponing action on those that do not give immediate or direct revenue, such as adult literacy education.”

On this ground, Laoye (2003) advised that, “The time spent by patients in the out-patient health institutions should be used positively, with health centres delivering a strong health education message to the ‘captive’ audience. No one can overemphasise the importance of producing pragmatic and functional health education for the prevention of ... diseases in view of the fact that most of the Third World countries have limited human, financial and material resources available for the healthcare delivery.” He stated that, with well-organised functional literacy health education, the number of patients attending out-patient departments should inevitably be reduced and, in the longer term, morbidity and mortality rates ought to be considerably reduced.

Further, he suggested that a separate unit be created specifically for health education. Thus, he declared that to facilitate an effective organisation of health education in the out-patient department, there
should be a unit specifically responsible for the day-to-day planning and execution of health education and activities for the benefit of the patients. At the head of the unit will be a health-sister with the appropriate training in the principles, practice and methodology of adult health education.

Expressing the same belief, Jumar (1990) said: “To ensure better health for all, elementary health education is a necessity for any community development programme.”

Nwamoh (2001) highlighted that health education is so important that he advocated the use of audio-visual materials in Nigerian health institutions. He made it known that “although the main objective of a health institution is to treat a patient, yet, during his/her course of treatment, the patient needs some enlightenment either on his/her illness or on general healthcare. These patients need audio-visual aids to understand better what they are being taught. We should remember that the country’s (Nigeria’s) level of illiteracy is still high and that only visual impression, combined with careful demonstration, can help impart meaningful knowledge into patients ....” In Tanzania, mass health education turned discussion of health matters into a popular fare in many rural areas. According to Hall (1991), adults from 15 and above were enrolled and hundreds of thousands of homes were involved in changes in healthcare practices as a result of the increased awareness.
Preventive actions can reduce, but not eliminate the chances of acquiring a disease or illness. The strength of the cause and effect relationship between certain behaviour and the health problems one is trying to prevent will be determined by the impact, which the behaviour will have on reducing the risk. This impact is measured in terms of attributable risk. Attributable risk is a measure of the chance of acquiring a disease if the risk factors for it are eliminated or prevented. Most people are aware that if you smoke you have an increased risk of getting lung cancer. Data indicate that almost 90 percent of lung cancer cases in male and 79 percent in females can be attributed to smoking, according to Office of Smoking and Health (Wikipedia, 2010). Some people who do not smoke get lung cancer, of course, but the number is small. Similarly, wearing a seat belt reduces the chance of dying in an automobile crash, yet it does not guarantee that the individual involved will not be seriously hurt.

Akoma (2005) Firmly assets that: “The first step towards achieving good health by the year 2000, as declared by UNESCO (1990) as it concerns Nigeria, is balancing curative medicine with preventive medicine (an operation), which will be realised through preventive literacy education” He lamented over the situation of preventive measures in practice in Nigeria today and thus complained that in Nigeria, emphasis is on curative medicine to the neglect of preventive and we tend to forget the
old wise saying that “prevention is better than cure.” This is particularly true when the building of specialist hospitals is en vogue in this country; we continue to neglect the fact that prevention is not only better than cure but cheaper as well. Government, Akoma maintains, have only established medical schools in the universities to train curative medical personnel without integrating preventive medicines into adult education.

*The National Mirror* (April, 2004) also expressed concern over this situation and complained “Apart from curing diseases, the use of preventive measures has been grossly neglected. Environmental sanitation and immunisation against diseases had been grossly neglected. Environmental sanitation and immunisation against contagious diseases, like measles, whooping cough and tuberculosis which harass Nigeria rural dwellers have not been taken seriously.”

On his own part regarding prevention, Udoh (2002) has stated that to boost body immunity, all Nigerians should immunize, take good food, take protein diets, avoid overcrowding, avoid smoking and should report all cases of tuberculosis, asthma, pneumonia or bronchitis to the nearest centre.”

In view of this, Galli (2004) made it known that “one measure that can help reduce the increasing cost of healthcare delivery (while stressing
emphasis on health) is to make preventive health education one of the major in functional literacy education.

Smolenskey et al (2001) embraced preventive health education with all commitment and declared that preventive health practices as being fundamental to the application of all other control measures. According to him, preventive health education involves “dissemination of appropriate and feasible information, communication and intrinsic motivation.” He, however, regretted that too often local and official health agencies assume that they merely must provide vaccines or medical services; they neglect adequate planning and preparation, necessary to launch a community education programme through functional literacy education. In his view, “parents and children must be continuously and emphatically informed the need for protection from diseases. Preventive health practice is very necessary to help prevent most diseases.” According to him, the following diseases can be prevented through education:

**TABLE 5: DISEASES AND WAYS OF PREVENTING THEM**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Prevention through education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typhoid Fever</td>
<td>Personal Hygiene</td>
</tr>
<tr>
<td>Bacillary Dysentery</td>
<td>Personal Hygiene</td>
</tr>
<tr>
<td>Infectious Hepatitis</td>
<td>Personal Hygiene</td>
</tr>
<tr>
<td>Disease caused by Salmonella</td>
<td>Keeping food under moderate</td>
</tr>
<tr>
<td></td>
<td>temperature</td>
</tr>
<tr>
<td>Disease</td>
<td>Prevention</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>Immunisation</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>Eliminating mosquito breeding areas</td>
</tr>
<tr>
<td>Trichinosis</td>
<td>Cooking of pork</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Eliminating promiscuity</td>
</tr>
<tr>
<td>Rabies</td>
<td>Immunising dogs</td>
</tr>
</tbody>
</table>


According to Ositelu (2002) “... ignorance on health matters among illiterates is widespread and should be discouraged. To lose one’s life through not bothering to look after it is tantamount to suicide.”

According to Godman (1998), many infants die in the first year of their lives as a result of uninformed care. He made it clear that backwardness in health matters is often due to peoples knowing insufficiently about them. Thus, one should be well informed on the elementary rules of hygiene to secure the necessary cooperation to promote health for all by the year 2000. However, year 2000 has come and gone and no miracles have occurred. All hands must be on deck to improve preventive healthcare practices for all.

Anyanwu (1981) stressed the importance of health-based adult education, and pointed out that through preventive health education, people learn how important health is for real happiness and permanent prosperity. Thus, preventive health practices leads to a happy life. It equips them against the attack of common diseases. Hence, by learning
how to prevent or cure diseases, people are able to get the maximum benefits from medical services and hygienic habits.

Lucas (2003) outlined five main areas in which the use of the health science in Functional Literacy is indicated. The areas consist of:-

1. Normal structure and function of the human body
2. Care of pregnant women
3. Child-care
4. Health and human environment, and
5. Nutrition and Health

Illustrating the care of pregnant women, he made it known that “this programme...can be effectively combined with the ante-natal clinic programme so that a pregnant woman may acquire literacy as a bonus during care at the ante-natal clinic”. He explained that at the end of course, the participants should be able to:-

i. describe the process of conception, growth of the foetus in the womb, and delivery of the baby;

ii. list measures that the pregnant women can take to project their health and that of their unborn baby, and

iii. list dangerous signs, which may indicate that something is going wrong or that she needs to go to the hospital.

Also, in the area of nutrition, he maintained that: “at the end of the course, the participants should be able to:-
i. List the main elements of a balanced diet and present local foods which contain these nutrients;

ii. List the requirements of special groups, especially pregnant, women and children, and

iii. Describe common signs of malnutrition.

In the words of Anyanwu (1992), the most elementary urge in man is to remain alive. Merely to exist would mean to a human being merely to function biologically. Some important values of education as identified by Anyanwu, includes:

1. Preventive health care practices teach the people how to dig good wells in areas where there is no pipe-born water supply.

2. From health education people learn that drinking impure water from holes or stagnant pools causes dysentery, guinea worm and other disease and that boiling and filtering water before drinking help to eliminate water-borne diseases.

3. Preventive health education for the maintenance of good health also teaches against bathing in stagnate pools, as doing that is a ready means of the spread of schistosomiasis.

4. Preventive health education brings home to the masses the significant fact that the ordinary housefly is one of the most dangerous poisons to health.
5. Preventive health education teaches people that good and sufficient food is necessary for good health.

Anyanwu (1992) stated further “Preventive health education for the maintenance of good health teaches people to appreciate the fact that good health, as an attractive aspect of happy life, cannot be purchased from the shop or market, people can, on the other hand, by their own efforts, do much to ensure their enjoyment of good health even without spending money for it.”

Anyanwu (1992) stressed that present, the World Health Organisation (WHO) and the United Nations International Children’s Fund (UNICEF), after a series of researches, have been advocating breast-feeding, immunisation, the oral rehydration therapy (ORT) and reduction of the infant mortality rate. All these can only be made known to the people through appropriate adult-based literacy health education.

2.10.1 ENVIRONMENTAL SANITATION

Environmental sanitation according to the World Health Organisation (2000) “is the control of all those factors in man’s physical environment which exercise or may exercise a deleterious social well-being.”

Anyanwu (1981) made it clear that: “Dirty surroundings attract diseases which, in turn, lead to death. Thus, while a clean surrounding makes for good health and happiness, a dirty environment will invite flies, fleas, bedbugs, cockroaches and other insects which play the unwholesome role of spreading diseases.” He further pointed out certain responsibilities that are of utmost importance to the department of health. Among them include:
Departments of health teaches the masses, particularly in rural areas, to build proper conveniences, which may not pollute the water in well or allow flies to contact any faecal matter and carry it to food.

- They always try to prevent the very bad practice of defecating in open places.
- They undertake the construction of public conveniences at suitable places in towns, at market places and gates of cities.
- They arrange to dispose of waste matter, which if allowed to accumulate, may lead to fly breeding.

Other sound environmental practices that will impact on good preventive health care practices include understanding proper disposal of garbage so that refuse like nylon and other non-biodegradable material do not block the drainage system and cause havoc on the environment.

Bakare (2010) in a research finding had noted that the improper disposal of nylon bags and pure water sachets had led to the blockage of the drainage system and caused terrible floods that resulted in the decimation of lives and property after heavy rains. Other skills learnt include practising the 3Rs (reuse, reduce and recycle), and maintaining good oral and personal hygiene.

2.10.2 IMMUNIZATION

In the field of Preventive Healthcare Practices, mobile clinic and medical fieldwork units are essential assets for functional literacy health education. These units involve the mobile doctor and mass immunization workers. These units ensure adequate diagnostic and immunization services among rural dwellers. Immunization however, is vital for disease control. According to Mohith and Beyene (2000), “It is estimated that in the Region (of Africa), the six target diseases which could well be
prevented by immunization kill about one million children annually of the
15 million who are born, while leaving many with serious infirmities such
as cerebral lesions, paralysis, chronic pulmonary infections, deafness,
blindness and retarded physical and mental growth.” It is on the grounds
to prevent the above mentioned diseases that some on immunization
exercise were carried out in immunization against typhoid fever, malaria,
tetanus, measles in the Local Government of the state selected for the
study.

2.10.3  BREAST-FEEDING
The World Health Organization (WHO, 2000) in collaboration with the
United Nations Children’s Fund (UNICEF, 2001) has been advocating for
the promotion of breast-feeding as opposed to infant formula.

The World Health Organization further explained: “Like water for plants,
the mother’s milk is the source of life for young children. ...Breast-feeding
not only helps in physical growth but gives also a feeling of security and
love to the baby. This has a nutritious effect on the child’s mental
development. Breast-feeding is really a very complete nutritional tool
because it is helpful to the mother.

2.10.4  TRADITIONAL BELIEFS VERSUS HEALTH
EDUCATION
Okediji and Aboyade (2005) opined that, “...no culture, irrespective of its
degree of simplicity or complexity functions without a range of
knowledge, beliefs, customs, attitudes, and practices pertaining to disease, health, medicine, and sanitation.”

According to Jenkins et al (2006), among the Sebei people in Kenya for instance, the following are their beliefs about certain illnesses and their causes:

**TABLE 6:**
**ILLNESSES WITH THEIR CORRESPONDING ASSUMED CAUSES**

<table>
<thead>
<tr>
<th>Causes and categories of disease</th>
<th>Associated illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancestor spirit</td>
<td>Eye and ear illness</td>
</tr>
<tr>
<td>Spells of wizards</td>
<td>General weakness</td>
</tr>
<tr>
<td>Rainbow from above</td>
<td>Miscarriages, children illness</td>
</tr>
<tr>
<td>Wrong doing, evil eye</td>
<td>Fever, stomach pains</td>
</tr>
<tr>
<td>Killing a man</td>
<td>Madness</td>
</tr>
<tr>
<td>Hereditary clan diseases</td>
<td>Epilepsy, skin lesions, swellings and sores</td>
</tr>
<tr>
<td>Common everyday complaints</td>
<td>Colds, malaria, eye disease, swellings.</td>
</tr>
</tbody>
</table>

*Source: Jerkins et al (2006) In Ecology of Food and Nutrition*

**CONCEPT OF PREVENTIVE HEALTHCARE PRACTICES**

The concept of primary health care (PHC) including preventive health care practices was formulated by 134 countries that met at the conference in Russia on 12th September, 1978, organised under the auspices of the World Heath Organisation (WHO) and the United Nations International Children’s Education Fund (UNICEF).
World Health Organisation WHO (1987) emphasised that preventive health care practices mean essential health care based on practical, scientific, sound and social acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation in the spirit of self reliance and self determination. Primary healthcare forms an integral part of the Nigerian Social and Economic Development. It is the first level contact of the individual and community in the national health system, thus bringing health care as close as possible to where people live and work and contributes the first element of a continuing health care process (Akinsola, 1993).

In the same vein, World Health Organisation (WHO) 1987 specified the aims and objectives of preventive healthcare Practices as follows:

1. To make health services accessible and available to everyone wherever they live or work.

2. To tackle the health problems causing the highest mortality and morbidity rates at a cost that the community can afford.

3. To ensure that whatever technology is used must be within the ability of the community to use effectively.

4. To ensure that in implementing health, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance.
PREVENTIVE HEALTHCARE POLICY IN NIGERIA

The National Primary Healthcare/Preventive Health Practices was launched by the Military Administration of President Ibrahim Babangida in 1988. The scheme emphasized collaborative effort of the three tiers of government, which should be more adapted to Nigeria’s socio-economic and cultural context. It should be people-oriented in that it strives to develop local capabilities, initiatives and to promote preventive health care awareness and self-directed learning and practices.

This was aimed at increasing the proportion of the population receiving healthcare from 25% to 60. The Basic Health Service Scheme policy which was incorporated into the Development Plan had the following objectives.

a. To initiate the provision of adequate and effective health facilities and care for the entire population;

b. To correct the imbalance between preventive and curative care;

c. To provide the infrastructures for all preventive health such as control of communicable diseases, family health, environmental health, nutrition and others.

d. To establish a health care system best adapted to the local conditions and to the level of health technology in the country.

The goal of the preventive health policy is to bring about a comprehensive healthcare system based on Preventive Healthcare that is
promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social well-being, and enjoyment of life.

In the 1999 Constitution of the Federal Republic of Nigeria, health is on the concurrent legislative list; by implication, the three tiers of government are vested with the responsibilities to promote health. The integrated approach is supposed to encourage active horizontal relationships between people and their local services as opposed to the traditional vertical relationship. In addition, fundamental to the preventive healthcare system is the realisation that the major killer diseases in rural communities in the Third World are preventable and that the majority of victims of these diseases are adults and children under the age of five. Therefore, preventive healthcare (PHC) system encourages countries to shift their national healthcare strategy from urban to rural areas where childhood killer diseases most severely affect children living in rural areas or locations.

HEALTH-RELATED PROBLEMS OF RURAL DWELLERS OF NIGERIA
Rural dwellers of Nigeria including those from Anambra State have many health-related problems that militate against the socio-economic development of the country. Available reports in printed and electronic
media support the fact. Umeh, recorded in the Daily Sun of Tuesday October 5th, 2010, that paediatrician raised alarm over pneumococcal diseases. He went further to say that the President of Paediatric Association of Nigeria, Dorothy Esangbado estimated that malaria accounted for 20.2 percent of under-five-year-old deaths in Nigeria.

Recently, Ahmed reported in Daily Leadership of 8th December, 2010 that gastroenteritis (stomach ulcer) killed about 100 people in Kebbi State, which is termed (stomach flu) caused by eating of contaminated foods. He reported further that 20 people were killed in Argungu Local Government Area of the State. According to Ahmed, the diseases were reported in many villages of the Local Government resulting from gastroenteritis, meningitis causing excessive vomiting and diarrhoea. The people of Argungu said that, the cause of the outbreak of the diseases was as a result of the use of contaminated water by the rural dwellers of the state. The State Government was urged by the people affected in the rural areas to look into the possibility of providing portable water to the affected communities.

Rural dwellers of Anambra State like other rural areas of the country also suffer from the same problems of poor health. Uchendu (2010) asserts that the diseases of the rural dwellers of Anambra State emanate from poor living habits which include poor environmental sanitation that breeds
diseases such as guinea worm, gastroenteritis, cholera, craw-craw, measles etc. In Njikoka, Anambra west, Idemili north and Ogbaru of Anambra State, Ezikeh recorded in the *National Life* of Tuesday, 16\textsuperscript{th} March, 2010 that measles killed 1000 children of ages 6 – 12. There was a report in the media on the 10\textsuperscript{th} of April, 2010 in the country that cholera and chicken-pox were in the air and warned that people should beware of this, by washing their hands after using the toilet and properly covering their foods.

The poor health habits of Nigeria have reached an alarming rate when compared with the health habits of other developing countries of the world. This was seen in severe inequalities with teeming populations of over 150 million people in Nigeria with an average Life Expectancy of 47 years as declared by United Nations Human Development Index (HDI) of 2001. There were also reports of high rate of communicable and non-communicable diseases. For example, the *National Mirror* of June 4, 2009, reported that about 35,000 mothers die from related complications from communicable diseases such as acquired immunodeficiency syndrome, tuberculosis, measles, cholera each year during child birth.

Children are not left out in the area of poor health. Ezike, in *National Life* of Wednesday, June 10, 2009 highlighted that Nigeria is still one of the four countries of the world that are to eradicate wild polio-virus coupled
with infant mortality rate which was estimated at 75 per 1,000 births (7.5 percent) and under-five mortality rate of 151 per 1,000 (15.1 percent). The causes of these deaths, according to the reports are from common ailments such as malaria, respiratory tract infections, diarrhoea, and anaemia among others. The sickness and diseases that brought untimely deaths to the people of Nigeria would have been prevented if the awareness of preventive healthcare practices was made known to the people.

**KEY HEALTH INDICATORS**

Nearly 15 percent of Nigerian children do not survive up to their fifth birthday. Two leading causes of child mortality are malaria (30 percent), and diarrhoea (20 percent). Malnutrition contributes to 52 percent of deaths of children under five (World Health Report, 2000). For the adult population, as in the rest of Sub-Saharan Africa, cases of malaria are on the increase. The number of deaths from malaria is not known but it is estimated that nearly a million people are seriously ill from the disease each year. Less than half of the population has access to safe water and water borne diseases are widespread.

The spread of Human Immune Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) has now reached an alarming rate and Nigeria is in the epidemic phase of the AIDS pandemic. The reported prevalence of HIV/AIDS has risen from 1.8 percent in 1990 to 4.5 percent in 1995
(World Health Organization, 2000) report a new survey shows a rate of 5.4 percent among women attending antenatal clinics but in some areas this figure is over 20 percent but with the new Federal Government Policy on Health, Human Immune Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) is higher on the agenda. A multi-sectoral approach has been adopted and is coordinated by a National Action Committee on AIDS (NACA) under the control of the presidency. Similar multi-sectoral committees are being planned at both the State and Local Government levels. Only one Nigerian woman in ten practices any form of contraception. Female genital mutilation and other harmful practices are major public health concerns.

There is a growing incidence and prevalence of non-communicable diseases. For example, hypertension is generally estimated at 8-10 percent for rural dwellers and 10-12 percent for urban communities.

The table on page 13 below gives the key health indicators for the country. Whilst not being the worst in Sub-Saharan Africa, they still represent substantial morbidity and mortality, particularly among the poor. For example, the maternal mortality rate varies from 339/100,000 in the South-Western part of the country.
## TABLE 7: KEY HEALTH INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>Male: 49, female: 52yrs</td>
</tr>
<tr>
<td>Infant mortality (per 1000 live births)</td>
<td>81</td>
</tr>
<tr>
<td>Under-five mortality (per 1000 live births)</td>
<td>Male: 154, female: 140</td>
</tr>
<tr>
<td>Maternal mortality: (per 100,000 live birth)</td>
<td>1000</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>5.2</td>
</tr>
<tr>
<td>Contraceptive Prevalence rate</td>
<td>Not available</td>
</tr>
<tr>
<td>Immunization against measles</td>
<td>69% (based on data from 1997)</td>
</tr>
</tbody>
</table>

**Source:** World Health Report (2000)

It could be said that literacy complement good health practices. The truth is that just as health is wealth, knowledge is power. Knowledge or education liberates people from poverty and diseases. On the other hand illiteracy or lack of knowledge actually leads to poverty and poverty leads to both material poverty and health poverty which to a large extent could be averted through preventive health practices. A lot of diseases could be prevented through good health habits. Unfortunately, illiterate rural dwellers of the country are generally prone to preventable common diseases as a result of unwholesome health habits.
Preventive health care delivery is supposed to be a two-legged process. Unfortunately, it stands on one leg in Nigeria. The two legs of health care delivery are curative healthcare delivery and preventive healthcare delivery. Inexplicably, only the former is wildly recognised. Preventive healthcare practices (PHP) must be embraced by all to achieve the desired result of a healthy society. The subsidiary of preventive healthcare practices are preventive healthcare dialogue, preventive healthcare drive, preventive healthcare diet, preventive healthcare database, preventive healthcare dos and don’ts, preventive healthcare debate, preventive healthcare desire, and preventive healthcare development.

Preventive health practices have not been given the much needed attention that it deserves from the various health care givers - government at all levels including Non-Governmental Organisations thereby, causing people’s lack of awareness of the importance of Preventive Healthcare Practices.

Kasl,(1996) highlights that, preventive healthcare practices refer to measures taken to prevent diseases (or injuries) rather than curing them or treating their symptoms. The term contrasts in method with curative and palliative medicine, and in scope with public health methods (which work at the level of population health rather than individual health).
Preventive health practices also means taking a pro-active approach to one’s health rather than the more common re-active approach. Preventive health practices also means to prevent or to reduce the effect of what a person suffers from. If a person is active he would not have suffered it like someone who is hypertensive or has a chronic heart disease. One can also reduce the effect of diabetes, the effect of chronic tract diseases; one can reduce the effect of stroke by doing regular exercises.

**PARTICIPATION THEORY**

**CONGRUENCE MODEL:** This model suggested that people are more likely to participate in educational activities where there is some congruence between their perception of themselves and the nature of the educational programme or environment. Boshier, (1973) says “there is a correlation between the number of years spent at school and the likelihood of taking part in education. One’s perception of himself, nature of environment, number of years in school/college i.e. those who have been to school or college before will likely participate than those who have not.”

**LIFE TRANSITION THEORY:** The view of “transition” has played major roles in the take-off education. Banks (1992) and Shechy (1976) had looked into this theory. They all highlighted that participation in
education projects is frequently linked to changes in life circumstances as changes in job, the break-up of relationships, having children, bereavement, and retirement. So, these factors will either positively or negatively affect adults’ participation in educational and the stakeholders of the adult literacy education should take the above assertions into consideration when planning literacy education for adults.

**REFERENCE GROUP THEORY:** McGivney (1993) also stresses that this theory is based on the assertion that people identify with the social and cultural group to which they belong, which is referred to as the “normative reference group (NRG)” or with another to which they aspire to belong – “comparative reference group (CRG)”. Many studies looked into the extent to which people’s total environment and group membership creates an orientation to involvement in educational projects and .

The three participation theories above highlighted that for an adult to participate in any educational activity there should be a conducive environment for learning. Educational activities should be planned in days, weeks or months in such a way that would give adults the opportunity to participate at will.
CULTURE OF THE IBO PEOPLE

As this study is being carried out in Anambra state which is Iboland, it will be appreciated to have an idea of the culture of the people in that area.

Ibo is one of the ethnic groups in Nigeria. The people are called the Ibos because of the language they speak known as the Igbo Language. The Ibos according to Ogbalu (1988), stretches across the River Niger from West of Agbor to the fringes of the Cross River and running roughly from North of Nsukka Islands to some parts of the Atlantic Coast. The people are of average height, mostly dark in complexion, thickly built with broad nose, curly black hairs and have moderately thick lips. The Ibos are being identified with the Language they speak. Wherever they come together, one hears them speak the Language referred to as Igbo Language. In speaking the Igbo Language, they blend it up with proverbs and idiomatic expressions so that a novice may not understand the depth of the message hence Achebe (1958), asserted that proverbs are the palm oil with which words are eaten (Ilu bu mmanu e ji eri okwu).

Apart from identifying the Ibos with the aforementioned cultures and traditions, the Ibos also belong to many cultural and political organisations such as;

i. kinsmen (umu nna)

ii. Age grade society (out ogbo)
In the cultural aspect, an average Ibo man must belong to a group of his kinsmen where they discuss matters as they affect the members of their families. Another crucial aspect of Ibo cultural group is the age grade society. This takes care of any member of that group for example, if anyone among the members dies or has some problems, it is the responsibility of the group to convey the corpse of the deceased back to his home town as it is forbidden to bury any Ibo person especially the adults outside of the father’s hometown. The Ibos are their brothers’ keeper (Onye a Ghana nwanne ya) Ohakim 2008. The Ibo people also belong to different political organisations especially now that the awareness of the importance of political parties have been made. Through the parties, the members voice out their own opinions and discuss matters as they affect them. They take part in choosing the candidates of their choice. Through this means, they contribute immensely towards the development of themselves, their communities, as well as the nation because Ibos strongly believe that unity is power (igwe bu ike).

In support of this view, Nzimenje (2006), said that the identity of an Ibo man is the Language that he speaks. Apart from the language the ibos speak, they are well known of many other cultures which could be seen in their mode of dressing, the type of foods they eat, their marriage rites and traditions, chieftaincy titles, new yam festival, burial rites and host of
other cultures. We shall only discuss few of these owing to time limit. A prominent of the Ibo culture and tradition is their marriage custom. It is very hard for any Ibo man or woman to marry out of their towns though, the culture is diminishing these days because some of them inter_ marry with other euthenics groups in the country. New yam feastival is also very remarkable culture of the Ibos because it is regarded that new yam is a new blessing from God to His people and as such it has to be celebrated. Therefore, a good merriment has to be done before eating the new yam. It involves eating and drinking where Kinsmen (Umunna)occasionally, bought cows or goats as their hands can reach and congregate, prayed and thank God for giving them the life to see the new yam. Some people do this alone in their families with their family members.

2.11 EMPIRICAL REVIEW

Onanuga (2004) carried out a study titled the effect of literacy on the self-confidence power of women in Oyo State. The researcher used 200 respondents and applied the t-test statistical tool at 0.05 level of significance to analyse the formulated hypotheses. At the end of the exercise, the findings revealed that:

1. There is a significant effect of literacy education programme on the self-confidence power of women in Oyo State; and

2. Functional literacy education has significant effect on the self-confidence power of women, especially in the rural areas of Oyo
State. With these findings, it implies that literacy education programme is effective in the self-confidence power of women. This is because, women, even men in the rural areas who received functional literacy can now have self-confidence as those who are literate.

In another development, Akingbade (2002) hypothesized that “there is no significant relationship between functional literacy objectives and the improvement in the health practices of the participants.”

In carrying out this study, he used 360 respondents (180 men and 180 female) as sample and employed the Pearson Product Moment Correlation Coefficient statistical tool at 0.05 level of significance. The result of the exercise indicates that a relationship exists between the variables (objectives of functional literacy education and improvement in the health practices of the participants). This further means that the health of the rural dwellers who participated in the functional literacy improved by getting involved in the functional literacy organised by the functional literacy education facilitators. This could further suggest that rural dwellers who participated in the literacy on health practices, gained a lot, as the helped them to improve their health conditions. For instance, most of the participants started living healthy lives such as being conscious of cleanliness of their environment and body.
In her study, Udo (2001) postulated a hypothesis that “there is no relationship between facilitators’ level of qualifications and the accomplishment of the objectives of the programme.” Furtherance to the analysis of this hypothesis, the researcher adopted the Pearson Product Moment Correlation Coefficient statistical instrument to determine whether relationship exists between the qualifications of the facilitators of adult literacy education programmes and the accomplishment of the stated goals of the programme. The finding revealed that there is a significant relationship between the qualifications of the functional literacy facilitators and expected objectives of the programmes. This implies that the facilitators of the functional literacy education programmes, especially on health issues, do not possess the requisite qualifications to carry out the effectively, so that the will have positive impact on the people who they are designed for. This is because most times, preventive health education programmes carried out by facilitators of functional literacy education do not achieve the expected objectives because most of the facilitators do not have the knowledge of preventive health practices and therefore, could not dispense the requisite knowledge to create an impact on people.

Adegbite (2000) maintained that the instructional materials used for functional literacy education programmes are not adequate for the
accomplishment of the objectives of the programmes among the rural dwellers as concerning their health needs. He further formulated a hypothesis which stated that “There is no significant relationship between the adequacy of facilities used for the functional literacy education and the achievement of the anticipated objectives of the .” He used 120 respondents and applied Pearson Product Moment Correlation Coefficient to determine if relationship exists between the independent variable (instructional materials) and the dependent variable (expected achievement of the objectives of the programmes).

After carrying out the analysis, the outcome showed that most of the materials used in carrying out functional literacy education do not meet the objectives. This is because some of these materials are obsolete, faulty and cannot be used without electricity such as projectors, audio-visual aids etc., especially in dispersing vital information to the participants of the programmes. He further opined that most facilitators of functional education do not even have good skills or vision in making an improvisation of suitable teaching aids that will assist them in carrying out the programmes. This researcher supports Amaoye’s (2002) assertion which stated that many researchers and programme facilitators lack the effective use of instructional materials in carrying out functional literacy education programmes. This researcher is of the opinion that availability and effective use of instructional materials for adult literacy education
will no doubt go a long way in meeting the objectives of the, particularly in the rural areas of Anambra states.

Similarly, Eke (2004) embarked on a study about functional literacy education. He formulated a hypothesis on the relationship between health habits of participants of functional literacy education on improvement of health practices and the non-participants of the. The researcher selected 400 respondents (200 males and 200 females) as samples for the study, while using the questionnaire to collect necessary data from the respondents, he used Pearson statistical tool to examine whether significant relationship exists between the variables under review.

At the end of the analysis, it was revealed that no relationship exists between participants’ health habits and the non-participants’ health habit. The implication of this is that, participants in functional literacy education programmes on health, developed new habits in handling their health conditions. With their exposure in the programmes, they changed the ways they previously handled their personal health matters; their environmental health also changed, as they began to keep their environment neat, and avoid those things that bring about ill-health prior to their participation in the; whereas, those who did not participate in
the programmes, remained their old selves and wallowed in ill-health as a result of poor personal and environmental hygiene.

This further implied that rural dwellers that participated in functional literacy education organized by functional literacy education practitioners benefited much from the. Not only did they learn the importance of breastfeeding their children, how to keep personal hygiene, they also learnt the proper diet to be taken, read prescription on drugs, how to maintain good healthy living, how to keep the environment clean etc. This researcher is of the opinion that, if more rural dwellers expose themselves to functional literacy education on health, they will never remain the same as regards their health conditions. This researcher believes that health is wealth and as such, individuals living in the rural areas should endeavour to get involved in that concern healthy living if they want to live relative long life.

Akoma (2001) carried out a study on the effect of functional literacy education on child-rearing practices of mothers in Nsude rural communities of Ebonyi State. She stated that mothers in Nsude communities lack the proper practices of rearing children owing to high illiteracy among them. Lack of proper child-rearing practices of women in these areas as she pointed out, brought about high mortality rate among
the children as a result of poor nutrition, lack of sanitation, juvenile
delinquency among others.

She used an ex-post-facto design method for the study to ascertain if the
functional literacy education programme organised for the women in the
rural communities of Nsude has improved the child-rearing practices of
the women.

From the study, the following findings were observed:
(i) Functional literacy helped the women in Nsude rural communities in
rearing their children thus, leading them to acquire the knowledge
of preparing balanced diet for their children
(ii) The women also, cultivated the habit of family planning.
(iii) Mortality rates were reduced through better access to living a
healthy life such as going to hospital when sick and keeping the
environment neat.
(iv) Poor availability of facilities and infrastructure for carrying out
functional literacy education.

The findings from this empirical study will enable the researcher to
compare the exploits garnered by previous studies carried out in the field
of functional literacy education with the present research work. Based on
the findings from the present study, recommendation will be made to
policy-makers and executors of adult literacy education programmes.
CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter presents the framework of the detailed breakdown of how this study was carried out under the following sub-headings: the research design, population of the study, the sample size and sampling technique, the research instruments, validity and reliability of the instruments, procedure for data collection and method of data analysis.

3.1 RESEARCH DESIGN

The descriptive survey research design was adopted for this study. This design was considered appropriate for this study because the researcher’s intention was to study only a sample of the population and use her result or findings to draw inferences on the entire population. In addition, the research was aimed at studying the variables as they exist without being influenced or manipulated in any way; hence, the research describes systematically, the facts, qualities and characteristics of the population as factually and as accurately as possible to answer questions arising from the study.

3.2 STUDY AREA

This study was carried out in Anambra State, which is located at the south-eastern zone of Nigeria. Anambra State, which is also called the
“light of the nation”, was created in the year 1991 with 21 local government areas. It is bounded by Delta State to the West, Imo State to the South, Enugu State to the East and Kogi State to the North. It has a population of about 4,182,032 people. Anambra State is known for its industrial centre and market networks. Though 75% of the aged population is involved in peasant agriculture, the younger generation is popular for their industry and business acumen. Fig. 6 shows the Map of Anambra State with the Local Government Areas.

Fig. 6: MAP OF ANAMBRA STATE SHOWING LOCAL GOVERNMENT AREAS


The State has big markets such as Onitsha Main Market, Nnewi International Market, Awka Market and host of others. Anambra State is the home to more commercial and industrial institutions than most other
States in the federation. Its business positions are major gateways to people from different parts of the world. The influx of the people to the State constitutes high population density with its health-related problems that could only be eradicated when there is a corresponding high level of functional literacy education and high level of improvement in the preventive health practices of the rural dwellers of the State.

The industries help to alleviate the prevailing unemployment rate in the country by employing many workers into the factories. Unfortunately, most of these workers and others who engage in different sectors of the economy live in the rural areas of the state and are mainly the illiterate adults who dabble into some industrial risks such as collisions, fire outbreak or development of some sicknesses due to waste products from the factories and environmental pollutants and because they have no vocal voice to seek for their basic rights, they are neglected by their employers, which at times, result to their death. Anambra State could well be described as made up of both urban and rural areas, but today, the rural areas are fast growing into urban area as its population increases daily. Therefore, well-planned functional literacy education are needed to make life better for the occupants. However, these manufacturing industries and environmental waste in the area have caused damage to the land resulting in poor agricultural production, situation that adversely affects the health of the populace. Obviously,
therefore, functional literacy education programmes should be provided for the people to help them with the situation in which they find themselves.

3.3 POPULATION OF THE STUDY
The target population for this study included all the beneficiaries in the 85 functional literacy education centres in the 21 local government areas in Anambra State with a total of 746 participants (Men and Women), 183 facilitators (Field survey outcome, 2008).

3.4 VARIABLES OF THE STUDY
The dependent variable in this study is rural dwellers’ preventive health practices which were conceptualized to include personal, home and environmental preventive health practices, while the independent variable is functional literacy education programme. The control variables include physical facilities and materials, quality of facilitators, and the attitude of rural dwellers to participation in functional literacy education programme.

3.5 SAMPLES AND SAMPLING TECHNIQUES
The sample for this study was made up of a total of 360 respondents. The hat and draw method was first of all applied to select 30 centres for the study. The participants in the 30 selected centres were further stratified into two groups of those who have experienced some sort of formal education and those who have not experienced any form of formal
education. Out of the participants of these two groups, 300 participants were randomly selected from among those who have had formal education experience in the proportion of 10 participants per centre, whereas 60 participants were randomly selected from among those who have had no formal education experience in the proportion of 2 participants per centre. The 300 participants that had formal education experience were made to answer the questionnaires, whereas the 60 illiterate participants were interviewed in Igbo language and their responses translated into English language by the assistants employed by the researcher.

3.6 RESEARCH INSTRUMENTS

A questionnaire titled: Functional Literacy Education programmes and Rural Dwellers’ Preventive Health Practices Questionnaire (FLEPRDPHPQ) and an interview schedule generated from the main questionnaire and results corroborated the responses from the main instruments were the materials used to generate data for this study (See Appendix A – D).

The questionnaire was divided into two sections of A and B. The section A sought information on relevant demographic characteristics of the respondents, while the section B contained questions on the variables of the study, which include rural dwellers’ personal, home and environmental preventive health practices; participants’ perception of functional literacy education programme, physical facilities and materials,
quality of facilitators, and the attitude of rural dwellers to participation in functional literacy education programmes.

The structured oral interview section was guided by 29 items that focused on the content of the functional training program, the respondent’s perspective on the contribution of level of availability of infrastructure as well as teaching material and the facilitators’ capability have affected their ability to gain from the whole experience. The questions were close ended to ensure uniformity of responses. Their responses were further used to corroborate the responses from the questionnaire. (See Appendix A-D)

3.7 VALIDITY OF RESEARCH INSTRUMENTS

The instruments used in this study were validated through consultation with my supervisors and other experts in the field of Adult education and Health education. Their comments and suggestions in terms of clarity, simplicity, relevance of contents as well as appropriateness of instructions and presentation to the respondents were used to modify the questionnaire items before final production to ensure that it has both content and face validity.

3.8 RELIABILITY OF RESEARCH INSTRUMENTS

In this study, the test re-test method was adopted to determine the reliability of the questionnaire. Accordingly, a pilot study was carried out by the researcher before the main study to determine the instruments’ consistency in measuring in different circumstances, what they were meant to measure. This pilot study was conducted using 40 respondents (for the questionnaire) and 20 respondents (for the interview schedule) at the centres that were not involved in the main study. Two weeks later, a repeat of the exercise was undertaken to obtain a second set of data. The essence is to remove any ambiguities from the instruments and
check the reliability of the various variables in the instrument. The administered questionnaires when retrieved were grouped into two groups of odd and even numbers. The scores of the two groups were correlated using the Pearson Product Moment Correlation Coefficient Method in order to show the level of correlation between the two sets of data generated. The size of the coefficient of correlation was used to determine the reliability status of the instrument.

Table 8: Summary of the Reliability of the Instrument

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Variables</th>
<th>Reliability Co-efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>(FLEPRDPHPQ)</td>
<td>Personal Preventive Health Practices, Home Preventive Health Practices, Environmental Preventive Health Practices, Adequacy of Available Physical Facilities and Material Resources, Quality of Facilitators, Rural Dwellers’ Attitude to Participation in Functional Literacy Education Programme, and Participants’ Perceptual Assessment of the Functional Literacy Education</td>
<td>0.68</td>
</tr>
</tbody>
</table>

The 0.68 obtained made the researcher deem the instrument reliable enough for the study. However, the data that were obtained from the interview schedule were considered non verifiable though reliable as they were obtained directly from the interviewees.

3.9 INSTRUMENT ADMINISTRATION PROCEDURE

To achieve the purpose of this study, a team of three research assistants were engaged after training them for two weeks to help with the data collection. The copies of the instrument (FLEPRDPHPQ) were personally administered to the respondents and retrieved instantly also with the help
of the trained assistants. The trained assistants were selected among Primary School Teachers to help the researcher administered the instrument and collect data also. Before the administration of the instrument, the confidentiality of the respondents was assured by the researcher. The researcher also believed that this method of administration reduce reasonably, the amount of misrepresentation of the instrument. After the completion of the responses, the questionnaires were collected and crosschecked responses to ensure there was no omission. The trained assistants were also fluent in the Igbo language and helped in administering the oral interview as well as in the translation which was used to collect data from the illiterate respondents. In all, it took about five months to carry out the administration exercise.

3.10 DATA SCORING
The scoring of the data generated using the FLEPRDHPQ was done as shown in Table 2.

**Table 9: Scoring of the Data in FLEPRDHPQ**

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
<th>Score</th>
<th>Code</th>
<th>Meaning</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD</td>
<td>Strongly Disagree</td>
<td>1</td>
<td>VLE</td>
<td>Very Low Extent</td>
<td>1</td>
</tr>
<tr>
<td>D</td>
<td>Disagree</td>
<td>2</td>
<td>LE</td>
<td>Low Extent</td>
<td>2</td>
</tr>
<tr>
<td>A</td>
<td>Agree</td>
<td>3</td>
<td>HE</td>
<td>High Extent</td>
<td>3</td>
</tr>
<tr>
<td>SA</td>
<td>Strongly Agree</td>
<td>4</td>
<td>VHE</td>
<td>Very High Extent</td>
<td>4</td>
</tr>
</tbody>
</table>

The interview section was analysed using percentages.
3.11 METHOD OF DATA ANALYSIS

Descriptive and inferential statistics were used for data analysis. Descriptive statistics, such as percentage and mean were used to collate and present the demographic information of the respondents, and also to analyze the generated data to answer the research questions raised in the study. The Pearson Product Moment Correlation Coefficient and the One-way Analysis of Variance (ANOVA) were used to analyze all the hypotheses posited in this study. The analyses of the formulated hypotheses were tested at 0.05 alpha levels. This is to ensure whether relationship exists between the variables involved in the hypotheses (i.e the dependent and independent variables).

3.12 DOCUMENTATION

All the documents used for the study were obtained from primary and secondary sources. The primary sources include interviews while the secondary sources are office records, agencies’ publications, reports, magazines, journals and other relevant textbooks were consulted.
CHAPTER FOUR
DATA ANALYSIS AND RESULTS

4.0 INTRODUCTION
The entire data generated for this study have been statistically analyzed in line with the research questions and hypotheses raised in the study. The results are presented below in three parts. The first part contains the summary of the respondents’ demographic characteristics; the second part contains the answers to the research questions raised in the study; while the third part contains the results of the statistical analysis of the hypotheses posited in the study.

4.1 PRESENTATION OF RESPONDENTS’ BIO-DATA
Table 10: Bio-Data of Students

<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>121</td>
<td>40.3</td>
</tr>
<tr>
<td>Female</td>
<td>179</td>
<td>59.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 - 39</td>
<td>56</td>
<td>18.7</td>
</tr>
<tr>
<td>40 - 49</td>
<td>123</td>
<td>41.0</td>
</tr>
<tr>
<td>50 - 59</td>
<td>93</td>
<td>31.0</td>
</tr>
<tr>
<td>60 and above</td>
<td>28</td>
<td>9.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Background</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary School Dropout</td>
<td>35</td>
<td>11.7</td>
</tr>
<tr>
<td>Completed Primary Education</td>
<td>129</td>
<td>43</td>
</tr>
<tr>
<td>Never go to School</td>
<td>104</td>
<td>34.7</td>
</tr>
<tr>
<td>Completed Secondary Education</td>
<td>32</td>
<td>10.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 1, shows that out of the 300 respondents that were involved in this study, 121(40.3%) were male, while 179(59.7%) were female; 56(18.7%) of the respondents were between 30 and 39 years old, 123(41%) were between the ages of 40 and 49 years, 93(31%) were between 50 and 59 years old, while 28(9.3%) were 60 years old and above; 35(11.7%) of the respondents were primary school dropouts, 129(43%) completed primary education, 104(34.7%) of them did not go to school, while 32(10.6%) completed secondary education.

4.2 ANSWERS TO RESEARCH QUESTIONS

Research Question 1: Is participation in functional literacy education enhancing the personal preventive health practices of the rural participants?
Table 11: Perception of respondents on functional literacy education (FLEP) and rural participants’ personal preventive health practices

<table>
<thead>
<tr>
<th>To what extent has your participation in FLEP made you to start doing the following (PPHP):</th>
<th>VHE</th>
<th>HE</th>
<th>LE</th>
<th>VLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding the eating of red meat or processed meat like gala, hot dog, and sausage?</td>
<td>98</td>
<td>114</td>
<td>57</td>
<td>31</td>
</tr>
<tr>
<td>Eating of cereal instead of refined grain products, such as Semolina, and Semovita?</td>
<td>29</td>
<td>38</td>
<td>132</td>
<td>101</td>
</tr>
<tr>
<td>Avoiding foods that are rich in calories and fat like Fufu, Eba, and Egusi soup?</td>
<td>96</td>
<td>159</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Eating less of high-calorie baked goods like pies, cakes, cookies, sweet rolls and doughnuts?</td>
<td>88</td>
<td>116</td>
<td>63</td>
<td>33</td>
</tr>
<tr>
<td>Avoiding the adding of butter, margarine, oil, sour cream, or mayonnaise to foods when cooking or at table?</td>
<td>30</td>
<td>53</td>
<td>124</td>
<td>93</td>
</tr>
<tr>
<td>Eating less of fried foods?</td>
<td>97</td>
<td>155</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Taking moderate physical exercises like walking, dancing, skating, and leisurely bicycling every morning or evening?</td>
<td>102</td>
<td>131</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>Trying to maintain a healthy weight?</td>
<td>93</td>
<td>148</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>Spending most of my free time being active, instead of watching television?</td>
<td>101</td>
<td>133</td>
<td>36</td>
<td>30</td>
</tr>
<tr>
<td>Abstaining from drinking alcohol?</td>
<td>33</td>
<td>49</td>
<td>125</td>
<td>93</td>
</tr>
<tr>
<td>Brushing your teeth and wash your mouth twice every day?</td>
<td>92</td>
<td>106</td>
<td>61</td>
<td>41</td>
</tr>
<tr>
<td>Taking your bath at least twice every day?</td>
<td>41</td>
<td>63</td>
<td>117</td>
<td>79</td>
</tr>
<tr>
<td>Cutting both your finger and feet nails?</td>
<td>35</td>
<td>77</td>
<td>141</td>
<td>47</td>
</tr>
<tr>
<td>Drinking at least 21/2 cups of fresh vegetable or fruits juice every day?</td>
<td>33</td>
<td>42</td>
<td>136</td>
<td>89</td>
</tr>
</tbody>
</table>
Drinking less of beverages containing caffeine like Lipton, Nescafe and many other types of black teas and coffees?  

<table>
<thead>
<tr>
<th></th>
<th>99</th>
<th>119</th>
<th>54</th>
<th>28</th>
</tr>
</thead>
</table>

Washing and ironing your clothes before wearing?  

<table>
<thead>
<tr>
<th></th>
<th>37</th>
<th>61</th>
<th>121</th>
<th>81</th>
</tr>
</thead>
</table>

Washing your hands with soap immediately after toileting?  

<table>
<thead>
<tr>
<th></th>
<th>83</th>
<th>96</th>
<th>68</th>
<th>53</th>
</tr>
</thead>
</table>

**Total =**  
**Percent =**

<table>
<thead>
<tr>
<th></th>
<th>1,187</th>
<th>1,660</th>
<th>1,348</th>
<th>905</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23.3%</td>
<td>32.6%</td>
<td>26.4%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

**Aggregate Percent =**

<table>
<thead>
<tr>
<th></th>
<th>55.8%</th>
<th>44.2%</th>
</tr>
</thead>
</table>

**Key:**  
**VHE = (Very high extent), HE = (High extent), LE = (Low extent) and VLE = (Very low extent)**  

Table 2, shows that on aggregate, 55.8% of the respondents indicated that their participation in functional literacy education has enhanced their personal preventive health practices to a high extent, while 44.2% of the respondents on the contrary indicated that their personal preventive health practices have to a low extent been enhanced by their participation in functional literacy education. On this note, we infer in relation to research question 1 that participation in functional literacy education is enhancing the personal preventive health practices of the rural participants.

**Research Question 2:** Are the home preventive health practices of the rural dwellers improved by their participation in functional literacy education programmes?
Table 12: Perception of respondents on functional literacy education (FLEP) and rural participants’ home preventive health practices

<table>
<thead>
<tr>
<th>To what extent has your participation in FLEP make you to start doing the following (HPHP):</th>
<th>VHE</th>
<th>HE</th>
<th>LE</th>
<th>VLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring that your house is properly swept every day?</td>
<td>93</td>
<td>128</td>
<td>42</td>
<td>37</td>
</tr>
<tr>
<td>Ensuring that your home toilet is always cleaned up with effective disinfectant?</td>
<td>113</td>
<td>153</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>Making sure that plates used for eating in your house are washed immediately after meal?</td>
<td>81</td>
<td>112</td>
<td>63</td>
<td>44</td>
</tr>
<tr>
<td>Not using dirty containers to store water in the house?</td>
<td>104</td>
<td>131</td>
<td>36</td>
<td>29</td>
</tr>
<tr>
<td>Reminding your children not to litter the house?</td>
<td>85</td>
<td>127</td>
<td>52</td>
<td>36</td>
</tr>
<tr>
<td>Not using firewood to cook in your home?</td>
<td>23</td>
<td>64</td>
<td>126</td>
<td>87</td>
</tr>
<tr>
<td>Encouraging the re-use of used bottles and containers in your house?</td>
<td>48</td>
<td>79</td>
<td>108</td>
<td>65</td>
</tr>
<tr>
<td>Disposing your home generated refuse to appropriate place?</td>
<td>84</td>
<td>125</td>
<td>66</td>
<td>25</td>
</tr>
<tr>
<td>Fumigating or disinfecting your house at intervals?</td>
<td>31</td>
<td>77</td>
<td>121</td>
<td>71</td>
</tr>
<tr>
<td>Discouraging your children from defecating or throwing faeces outside or into the bush instead of into the toilet?</td>
<td>83</td>
<td>135</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>745</td>
<td>1,131</td>
<td>684</td>
<td>440</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>24.8</td>
<td>37.7</td>
<td>22.8</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Aggregate Percent</strong></td>
<td>62.5%</td>
<td>37.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Key: VHE = (Very high extent), HE = (High extent), LE = (Low extent) and VLE = (Very low extent) N =300*

Table 3, shows that on aggregate, 62.5% of the respondents noted that their participation in functional literacy education programmes has improved their home preventive health practices to a high extent, while 37.5% of the respondents on the contrary indicated that their home preventive health practices have to a low extent been improved by their
participation in functional literacy education programmes. Based on this result, we infer in relation to research question 2 that the home preventive health practices of the rural dwellers are being improved by their participation in functional literacy education programmes.

**Research Question 3:** Is participation in functional literacy education programme boosting the environmental preventive health practices of the rural dwellers?

**Table 13: Perception of respondents on functional literacy education (FLEP) and rural participants’ environmental health practices**

<table>
<thead>
<tr>
<th>To what extent has your participation in FLEP made you to start doing the following (EPHP):</th>
<th>VHE</th>
<th>HE</th>
<th>LE</th>
<th>VLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not throwing your waste or refuse in the open?</td>
<td>79</td>
<td>152</td>
<td>48</td>
<td>21</td>
</tr>
<tr>
<td>Burying your waste to form manure?</td>
<td>85</td>
<td>131</td>
<td>57</td>
<td>27</td>
</tr>
<tr>
<td>Not throwing refuse, waste and dirty things into the rain?</td>
<td>91</td>
<td>148</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>Not throwing papers and pure water sachets on the road?</td>
<td>33</td>
<td>66</td>
<td>113</td>
<td>88</td>
</tr>
<tr>
<td>Not burning your bushes again before farm work?</td>
<td>30</td>
<td>52</td>
<td>135</td>
<td>83</td>
</tr>
<tr>
<td>Engaging in environmental sanitation?</td>
<td>86</td>
<td>118</td>
<td>52</td>
<td>44</td>
</tr>
<tr>
<td>Not urinating by the roadside or stool in the open or bush when pressed?</td>
<td>43</td>
<td>61</td>
<td>122</td>
<td>74</td>
</tr>
<tr>
<td>Frowning against people that do things that have negative effect on the health of the people?</td>
<td>77</td>
<td>111</td>
<td>79</td>
<td>33</td>
</tr>
<tr>
<td>Cutting down trees and planting new ones?</td>
<td>33</td>
<td>42</td>
<td>131</td>
<td>94</td>
</tr>
</tbody>
</table>

**Total =** 557 881 769 493  
**Percent =** 20.6 32.6 28.5 18.3

**Aggregate Percent =** 53.3% 46.7%

*Key: VHE = (Very high extent), HE = (High extent), LE = (Low extent) and VLE = (Very low extent) N = 300*
Table 4, shows that on aggregate, 53.3% of the respondents indicated that their participation in functional literacy education has boosted their environmental health practices to a high extent, while 46.7% of the respondents on the contrary indicated that their environmental health practices have to a low extent been boosted by their participation in functional literacy education. Based on this result, we conclude in relation to research question 3 that the environmental health practices of rural dwellers are boosted by their participation in functional literacy education.

**Research Question 4:** Are there enough physical facilities and materials resources for the functional literacy education?

**Table 14: Perception of respondents of the adequacy of the physical facilities and material resources at functional literacy education (FLEP) centres**

<table>
<thead>
<tr>
<th>Physical facilities and materials at the centres (P/M)</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available physical facilities at the centres are inadequate and unconducive for qualitative academic work.</td>
<td>95</td>
<td>152</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>There are inadequate desks and chairs to contain the participants comfortably during lesson sessions.</td>
<td>93</td>
<td>139</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td>The available classrooms are not spacious and properly ventilated for effective teaching and learning.</td>
<td>98</td>
<td>118</td>
<td>49</td>
<td>35</td>
</tr>
<tr>
<td>Facilitators are not provided with separate well equipped office accommodation and facilities.</td>
<td>105</td>
<td>146</td>
<td>27</td>
<td>22</td>
</tr>
</tbody>
</table>
The centres lack relevant instructional materials for effective teaching.  
<table>
<thead>
<tr>
<th></th>
<th>111</th>
<th>141</th>
<th>23</th>
<th>25</th>
</tr>
</thead>
</table>

The centres lack toilet facilities.  
|                        | 98  | 135 | 36  | 31 |

Spoilt chairs and desks are left unrepaired to no definite time.  
|                        | 93  | 148 | 31  | 28 |

**Total =**  
**Percent =**  
| Total | Percent | 693  | 979  | 238 | 190  | 33   | 46.6 | 11.3 | 9.1 |

**Aggregate Percent =**  
| 79.6% | 20.4% |

*Key: SA = (Strongly agree), A = (Agree), D = (Disagree) and SD = (Strongly disagree) N = 300*

Table 5, shows that on aggregate, 79.6% of the respondents that were involved in this study agreed that: the physical facilities and material resources available at the functional literacy education centres are inadequate and unconducive for qualitative academic work, the desks and chairs available at the centres are inadequate to contain the participants comfortably, the available classrooms are not spacious and properly ventilated for effective teaching and learning, the facilitators at the centres are not provided with separate well equipped office accommodation and facilities, there are no relevant instructional materials for effective teaching, and that the centres lack toilet facilities; but 20.4% of the respondents expressed a contrary opinion to the above submissions. In this regard, we infer in relation to research question 4 that the functional literacy education centres in the rural areas lack adequate physical facilities and material resources to function effectively.
Research Question 5: Are the facilitators at the functional literacy education programme centers more effective?

Table 15: Perception of respondents of the quality of facilitators teaching at the functional literacy education (FLEP) centres

<table>
<thead>
<tr>
<th>Quality of Programme Facilitators (FQ)</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the facilitators in my centre are not first degree holders.</td>
<td>79</td>
<td>163</td>
<td>37</td>
<td>21</td>
</tr>
<tr>
<td>Most of the facilitators are not ICT literate</td>
<td>87</td>
<td>135</td>
<td>45</td>
<td>33</td>
</tr>
<tr>
<td>Facilitators do not have adult education qualification in their academic background</td>
<td>83</td>
<td>146</td>
<td>44</td>
<td>27</td>
</tr>
<tr>
<td>Most of the facilitators are not well experienced in their job.</td>
<td>69</td>
<td>121</td>
<td>79</td>
<td>31</td>
</tr>
<tr>
<td>There is high rate of turnover in facilitators’ recruitment disrupting long stay and experience of the facilitators.</td>
<td>44</td>
<td>112</td>
<td>108</td>
<td>36</td>
</tr>
<tr>
<td>The facilitators most times come to class late and unprepared.</td>
<td>89</td>
<td>104</td>
<td>62</td>
<td>45</td>
</tr>
<tr>
<td>The facilitators do not usually give professional answers to participants’ questions.</td>
<td>41</td>
<td>68</td>
<td>122</td>
<td>69</td>
</tr>
<tr>
<td>The courses are always presented to learners in a poorly organized manner by the facilitators.</td>
<td>78</td>
<td>153</td>
<td>43</td>
<td>26</td>
</tr>
<tr>
<td>The facilitators do not show thorough and in-depth knowledge of their courses.</td>
<td>82</td>
<td>114</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>Concerted efforts are not made by facilitators to encourage and enhance learners’ participation.</td>
<td>85</td>
<td>132</td>
<td>44</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total =</strong></td>
<td>737</td>
<td>1,248</td>
<td>640</td>
<td>375</td>
</tr>
<tr>
<td><strong>Percent =</strong></td>
<td>24.6</td>
<td>41.6</td>
<td>21.3</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Aggregate Percent =</strong></td>
<td>66.2%</td>
<td>33.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key: SA = (Strongly agree), A = (Agree), D = (Disagree) and SD = (Strongly disagree)  
N = 300

Table 6, shows that on aggregate, 66.2% of the respondents that participated in this study affirmed that most of the facilitators at the
centres: are not first degree holders, do not have knowledge of ICT, need to improve their academic quality, are not experienced in their jobs, come to class late, do not give professional answers to participants’ questions, do not show possession of in-depth knowledge of what they teach, present their lessons in a poorly organized manner, and do not make concerted effort to encourage and enhance the participation of the rural dwellers in the programme; but 33.8% of the respondents in disagreement expressed a contrary opinion to the above submissions. On this note, we conclude in relation to research question 5 that the facilitators at the functional literacy education centres are of low academic quality.

**Research Question 6:** What is the attitude of the rural dwellers to participation in functional literacy education programmes?

**Table 16: Perception of respondents of the participatory attitude of rural dwellers to functional literacy education (FLEP)**

<table>
<thead>
<tr>
<th>Rural Dwellers’ Participatory Attitude (RDPA)</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do attend tutorials once a while.</td>
<td>96</td>
<td>148</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Most times unavoidable social engagements override my attendance of tutorials.</td>
<td>88</td>
<td>132</td>
<td>55</td>
<td>25</td>
</tr>
<tr>
<td>I do not attend tutorials whenever I have very important engagement to attend.</td>
<td>85</td>
<td>131</td>
<td>51</td>
<td>33</td>
</tr>
<tr>
<td>I attend tutorials only when I see myself free to do so.</td>
<td>91</td>
<td>140</td>
<td>45</td>
<td>24</td>
</tr>
<tr>
<td>I do not attend tutorials regularly because I think I am no longer fit for academic rigors.</td>
<td>78</td>
<td>151</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>I attend tutorials whenever I want to go and cash fun with other adults.</td>
<td>87</td>
<td>115</td>
<td>55</td>
<td>43</td>
</tr>
<tr>
<td>I attend tutorials only when I feel like doing</td>
<td>81</td>
<td>127</td>
<td>52</td>
<td>40</td>
</tr>
</tbody>
</table>
Table 7, shows that on aggregate, 73.8% of the respondents noted that the rural dwellers do attend tutorials: once a while, only when there are no overriding social engagements, whenever they do not have important engagement to attend, when they think they are free to do so, because they consider it irrelevant to their age, whenever they want to cash fun, and whenever they feel like doing so; but 26.2% of the respondents on the contrary were in disagreement with the above submissions. In this regard, we infer in relation to research question 6 that the rural dwellers have poor attitude to participation in the functional literacy education.

**Research Question 7:** What is the rural participants’ assessment of the functional literacy education programmes?

**Table 17: Perception of respondents of the functional literacy education**

<table>
<thead>
<tr>
<th>Assessment of the Functional Literacy Education Programme (AFLEP)</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization and conduction of the programme is not encouraging enough to command rural dwellers’ continuous participation.</td>
<td>82</td>
<td>147</td>
<td>45</td>
<td>26</td>
</tr>
<tr>
<td>I am not satisfied with the quality of tutorials that I get from the programme.</td>
<td>68</td>
<td>122</td>
<td>77</td>
<td>33</td>
</tr>
<tr>
<td>Tutorials are too theoretical and boring</td>
<td>43</td>
<td>143</td>
<td>75</td>
<td>39</td>
</tr>
</tbody>
</table>
without practical demonstration with instructional materials.

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>OA</th>
<th>DA</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>The contents of the subjects taught at tutorials are not in-depth.</td>
<td>78</td>
<td>152</td>
<td>48</td>
<td>22</td>
</tr>
<tr>
<td>The facilitators are not very effective and professional in their teaching.</td>
<td>84</td>
<td>132</td>
<td>55</td>
<td>29</td>
</tr>
<tr>
<td>The programme is not really giving me what I expected to get from it.</td>
<td>90</td>
<td>148</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>The curricula of the subjects do not accommodate enough things that will give participants wider knowledge of different aspects of life.</td>
<td>77</td>
<td>143</td>
<td>44</td>
<td>36</td>
</tr>
</tbody>
</table>

| Total = | 522 | 987 | 377 | 214 |
| Percent = | 34.9 | 47.0 | 18.0 | 10.1 |

| Aggregate Percent = | 71.9% | 28.1% |

Key: SA = (Strongly agree), A = (Agree), D = (Disagree) and SD = (Strongly disagree)  
N = 300

Table 17, shows that on aggregate, 71.9% of the respondents in their assessment of the functional literacy education programmes indicated that: the organization and conduction of the programmes is not encouraging enough to command rural dwellers’ continuous participation, they are not satisfied with the quality of tutorials they get from the programmes, the tutorials are too theoretical and boring without practical demonstration with instructional materials, the contents of the subjects taught are not in-depth, the facilitators are not very effective and professional in their teaching, the programmes are not really giving them what they expected to get from them, and that the curricula of the subjects do not accommodate enough things that will give participants wider knowledge of different aspects of life; but 28.1% of the respondents in disagreement disapproved of the above submissions.
Based on this result, we conclude in relation to research question 7 that the rural dwellers have poor assessment of the functional literacy education programmes.

4.3 TEST OF HYPOTHESES AND RESULTS

**Hypothesis 1:** Rural dwellers’ participation in functional literacy education programme will not be significantly influence their personal preventive health practices.

Table 18: Rural dwellers’ participation in functional literacy education programme and personal preventive health practices

<table>
<thead>
<tr>
<th>Sources of Variation</th>
<th>SS</th>
<th>Df = (k-1) and (N-k)</th>
<th>MS</th>
<th>F-cal.</th>
<th>P-value.</th>
<th>F-critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>223.5</td>
<td>1</td>
<td>223.5</td>
<td>8.53</td>
<td>0.05</td>
<td>6.76</td>
</tr>
<tr>
<td>Within Group (Error)</td>
<td>7837.4</td>
<td>298</td>
<td>26.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8060.9</strong></td>
<td><strong>299</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***α = 5% significance level

Table 18 shows that the calculated f-value of 8.53 is greater than the critical f-value of 6.76 given 1 and 298 degrees of freedom at 5% level of significance. This result approves the rejection of null hypothesis I in acceptance of its alternative, thereby confirming that the rural dwellers’ participation in functional literacy education programme is significantly influencing their personal preventive health practices.
**Hypothesis 2:** The home preventive health practices of rural dwellers will not be significantly affected by their participation in functional literacy education programmes.

**Table 19: Rural dwellers’ participation in functional literacy education programme and home preventive health practices**

<table>
<thead>
<tr>
<th>Sources of Variation</th>
<th>SS</th>
<th>Df = (k-1) and (N-k)</th>
<th>MS</th>
<th>F-cal.</th>
<th>P-value.</th>
<th>F-critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>343.98</td>
<td>1</td>
<td>343.98</td>
<td>11.7</td>
<td>0.05</td>
<td>6.76</td>
</tr>
<tr>
<td>Within Group (Error)</td>
<td>8, 761.2</td>
<td>298</td>
<td>29.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9, 105.18</strong></td>
<td><strong>299</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***α = 5% significance level***

Table 10 shows that the calculated f-value of 11.7 is greater than the critical f-value of 6.76 given 1 and 298 degrees of freedom at 5% level of significance. This result confirms the rejection of null hypothesis 2 in acceptance of its alternative, thereby indicating that the home preventive health practices of the rural dwellers is significantly affected by their participation in functional literacy education programme.

**Hypothesis 3:** Rural dwellers’ participation in functional literacy education programme will not significantly influence their environmental preventive health practices.
Table 20: Rural dwellers’ participation in functional literacy education programme and environmental health practices

<table>
<thead>
<tr>
<th>Sources of Variation</th>
<th>SS</th>
<th>Df = (k-1) and (N-k)</th>
<th>MS</th>
<th>F-cal.</th>
<th>P-value</th>
<th>F-critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>273.99</td>
<td>1</td>
<td>273.99</td>
<td>9.58</td>
<td>0.05</td>
<td>6.76</td>
</tr>
<tr>
<td>Within Group (Error)</td>
<td>8,522.8</td>
<td>298</td>
<td>28.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8060.9</td>
<td>299</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***α = 5% significance level

Table 20 shows that the calculated f-value of 9.58 is greater than the critical f-value of 6.76 given 1 and 298 degrees of freedom at 5% level of significance. This result approves the rejection of null hypothesis 3 in acceptance of its alternative that the rural dwellers’ participation in functional literacy education programme is significantly influencing their environmental health practices.

**Hypothesis 4:** There will be no significant relationship between the availability of physical facilities and materials available for the functional literacy education and the rural participants’ ability to gain from the experience of the.

Table 21: Physical facilities and materials and participants’ assessment of the functional literacy education

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Df=(n-2)</th>
<th>P-value</th>
<th>r-calculated</th>
<th>r-critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants’ Assessment of FLEPs</td>
<td>300</td>
<td>27.3</td>
<td>7.584</td>
<td>298</td>
<td>0.05</td>
<td>0.647</td>
<td>0.1946</td>
</tr>
<tr>
<td>Physical Facilities and Materials</td>
<td>300</td>
<td>12.3</td>
<td>3.359</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 21 shows that the calculated r-value of 0.647 is greater than the critical r-value of 0.1946 given 298 degree of freedom at 5% level of significance. This result approves the rejection of null hypothesis 4 in acceptance of its alternative that there is a significant relationship between the physical facilities and materials available for the functional literacy education and the rural participants’ ability to gain from the experience of the.

**Hypothesis 5:** There will be no significant relationship between the level of qualification of facilitators at the programme centers and the rural dwellers’ attitude to participation in the functional literacy education.

Table 22: Quality of facilitators and rural dwellers’ attitude to participation in the functional literacy education

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Df=(n-2)</th>
<th>P-value</th>
<th>r-calculated</th>
<th>r-critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Dwellers’ Attitude to Participation in FLEP</td>
<td>300</td>
<td>20.55</td>
<td>2.357</td>
<td>298</td>
<td>0.05</td>
<td>0.814</td>
<td>0.1946</td>
</tr>
<tr>
<td>Quality of Facilitators at the FLEP centres</td>
<td>15.44</td>
<td>2.673</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***α = 5% significance level***

Table 22 shows that the calculated r-value of 0.814 is greater than the critical r-value of 0.1946 given 298 degree of freedom at 5% level of
significance. This result confirms the rejection of null hypothesis 5 in acceptance of its alternative that a significant relationship exists between the quality of facilitators at the programme centers and the rural dwellers’ attitude to participation in the functional literacy education programmes.

**Hypothesis 6:** The attitude of rural dwellers’ to participation in the functional literacy education is not significantly influenced by their social responsibilities.

**Table 23: Rural dwellers’ attitude to participation in functional literacy education and their social responsibilities**

<table>
<thead>
<tr>
<th>Sources of Variation</th>
<th>SS</th>
<th>Df = (k-1) and (N-k)</th>
<th>MS</th>
<th>F-cal.</th>
<th>P-value.</th>
<th>F-critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>410</td>
<td>1</td>
<td>410</td>
<td>12.5</td>
<td>0.05</td>
<td>6.76</td>
</tr>
<tr>
<td>Within Group</td>
<td>9,774.4</td>
<td>298</td>
<td>32.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10,184.4</td>
<td>299</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***α = 5% significance level***

Table 23 shows that the calculated f-value of 12.5 is greater than the critical f-value of 6.76 given 1 and 298 degrees of freedom at 5% level of significance. This result supports the rejection of null hypothesis 6 in acceptance of its alternative, thereby confirming that the attitude of rural dwellers’ to participation in the functional literacy education is significantly influenced by their assessment of the programme.
4.4 Summary of the Findings

(1) Functional Literacy education programmes aided improvement in preventive health practices of the participants of functional literacy education programmes in Anambra State. Through their participation in the programmes, they acquired changes in attitudes and behaviour, which make them eat balanced diet, wash their hands before or eating, brush their mounts on a daily basis to avoid tooth decay, keep their surroundings clean etc.

(2) It was discovered that rural dwellers of Anambra State who participated in functional literacy education programmes has enhanced their personal preventive health practices.

(3) It was also noticed that the home preventive health practices of the rural dwellers of the State has improved their participation in functional literacy education programmes hence, they could maintain proper ventilation in their houses, sweep their homes always, cover their foods against flies etc.

(4) It was also discovered that the rural dwellers of Anambra State have poor attitudes of themselves which affect their level of participation in the programmes hence, some of them attend the programmes when they like, when they have no overridden social engagements, some considered the programmes irrelevant to their ages.
There were gross inadequate of facilities and instructional materials for an effective running of the functional literacy education programmes in the centres of the study.

Most of the facilitators of functional literacy education programmes were not trained adult educators.
CHAPTER FIVE
DISCUSSION OF FINDINGS, RECOMMENDATIONS,
SUMMARY AND CONCLUSION

5.0 INTRODUCTION
The study highlights the necessity of functional literacy education on the improvement of the health status of the rural dwellers of Anambra State. It examines the extent the have gone in improving the preventive health practices of the rural dwellers in the area of study.

5.1 DISCUSSION OF FINDINGS
From the study, the following findings were established:
The first research question sought to find if participation in functional literacy education program affected the participants’ personal preventive health practice. Most of the respondents at 55.8% felt that participation has enhanced their personal preventive health care practices as indicated by their avoidance of processed food and in the increase in moderate physical exercises as well as better oral and personal hygiene practices. The corresponding hypotheses had an f-value of 8.53, which is greater than the critical value of 6.76 at 298 degree of freedom and 0.5% level of significance. This translated into the rejection of the null hypothesis which stated that the participation of the rural dwellers in the functional literacy programmes will not significantly affect their personal preventive health care practices. This implies that the respondents’ personal
preventive health care practices were positively affected by their participation in the functional literacy.

The second research question sought to find if participation in functional literacy impacted the lifestyle of the respondents. At 62.5%, majority of the respondents agreed that their participation in functional literacy has impacted positively on their home preventive health care practices as indicated by their increase in better environmental hygiene, like ensuring that the home is swept more than once a day, ensuring that water containers are clean, proper disposal of refuse and frequent fumigation of the house to get rid of pests. A key new skill learnt is to try to recycle materials that are reusable to be more environmentally friendly and to also try to cook outside the house while using firewood.

The second null hypothesis postulated that the home preventive health practices of rural dwellers will not be significantly affected by their participation in functional literacy education. This hypothesis was rejected because the calculated value of 11.7 was greater than the table value of 6.76 at 298 degree of freedom and 0.5% level of significance. This meant that the alternative was accepted which means that the home preventive health care practices of the respondents were significantly affected by their participation in functional literacy.

Research question number three helped to answer the question of whether the participation of the rural dwellers in functional literacy will
affect their environmental health care practices. The perception of the respondents was that at 53.3% agreement, their environmental health care practice is affected by their participation in functional literacy. They agreed that their participation has boosted their paying more attention to indiscriminate refuse disposal, and their understanding that their waste can be turned into manure through careful disposal which can in turn improve their organic farming output. They have also learnt that the hazardous repercussion of indiscriminate throwing of empty water sachets and nylons material into the street can cause them to be blown around and block sewers and the drainage system which can lead to flood, increase in breeding of mosquitoes and other environmental hazards.

The third null hypothesis stated that the rural dweller’s participation in functional literacy will not significantly influence their environmental health care practices. This hypothesis with the calculated value of 9.58 and critical value of 6.76 was rejected and the alternative upheld. This suggests that the participation in functional literacy significantly affected the rural dweller’s environmental health care practices. The finding agrees with a research finding by Bakare (2010) that poor disposal of non-biodegradable materials can be harmful to the environment, causing flood and other environmental degradation which can lead to loss of lives and property. Participation has also helped the respondents improve on environmental cleanliness as well as being more conversant with tree planting, all of which will make them more environmentally friendly.
On the question of adequacy of provision of physical and material facilities at the functional literacy centers, majority of the respondents felt that it was grossly inadequate at 79.6%. This is seen to affect the quality of academic work. The provision of furniture, like desks and chairs were found to be either inadequate or not in good condition. The spaces for the classrooms were also seen to be inadequate and the centers were generally poorly ventilated. This has implication for adult learners who are likely to be affected by the normal progressive deterioration of the senses like sight and hearing. This is coupled with the expected social responsibilities the adults already have which may make them fall asleep in the classroom due to poor ventilation. It will be difficult for qualitative learning to take place under these circumstances and therefore affect their preventive health care practices negatively.

The situation was further exacerbated by the lack of instructional materials and other teaching aids to enrich the teaching learning experience. Also the lack of readily available toilet facilities is detrimental to learning for the adult who is likely to need more frequent bathroom breaks as a result of getting older.

The corresponding hypothesis states that there will be no significant relationship between the availability of physical and material facilities for the functional literacy and the rural participants’ ability to gain from the
experience. At 0.647, the r-calculated is greater than the r-critical of 0.1946 which led to the rejection of the hypothesis. The alternative was therefore upheld which suggests that the level of availability of physical and material facilities significantly affects the adult learner’s ability to learn.

The better the facilities are the more likely that the learners will be able to gain from the experience. This was buttressed by Bakare (2009), whose research finding indicated that the availability of facilities influence learners’ ability to gain from the teaching/learning experience.

Research question 5 sought to find out the effectiveness of the facilitators. The qualification shows that majority of the facilitators were not adult educators. This by itself may not pose as much problems as the facilitators not having the required adult education background to prepare them for helping adults to learn and they may therefore treat the learners like children which will in turn affect their attitude towards learning. This may have precipitated the high turnover rate of the facilitators at the center as reported. This is shown by the figures that 66.2% were not first degree holders. It was also discovered that they were largely not conversant with Information Communication Technology (ICT), or the use of technology generally. All these will invariably affect their ability to best help the adult learners.
The next hypothesis states that there will be no significant relationship between the level of qualification of the facilitators at the functional literacy center and the participants’ attitude towards the programmes. The hypothesis was rejected, which suggests that there is a significant relationship between the level of qualification of the facilitators and the attitude of the learner towards the programmes. This is because the r-calc was 0.814 and greater than the r-critical of 0.1946. If the facilitators do not have the required adult education background, it will ultimately affect the learner’s attitude towards the programmes as they may not understand the best way to handle adult learners without the relevant training.

The sixth research question was to elicit responses on the participants’ attitude towards the programmes and their responses show that they mostly attend the tutorials unless there were other pressing social engagements. They generally had a positive attitude towards attendance and try to be present in most of the classes. Their general assessment of the itself indicates that the majority of the respondents at 71.9% feel that the organization and conduct of the leaves much to be desired which will influence the level of participation in this and subsequent of the same nature unless lessons are learnt from the mistakes of the past. They also add that the method of delivery of the course content was not participatory enough which affects the overall effectiveness of the programmes.
The final hypothesis stated that the rural dwellers’ attitude towards participation in functional literacy education will not significantly affect their assessment of the programmes. The f- calc of 12.5 and a lesser table value of 6.76, 298 degree of freedom at 0.5% level of significance meant that the null hypothesis was also rejected. This implies that the respondent’s attitude towards their participation in the functional literacy significantly affects their assessment of the programmes.

Another offshoot of the study was that it was found that there was a correlation between people who belonged to social groups and Associations and the increase in better environmental practices. It looked like their belonging to a group of like-minded people, which seemed to be a common practice in the area (as everyone belonged to an age grade system, at the very least), boosted their likelihood to participate in functional literacy.

The structured oral interview was guided by 29 key items with individual questions. The items were closed ended and related to the respondents’ participation in the functional literacy education.

The oral interview questions were mostly answered in the positive except for item which was mostly in the negative.

The findings of this study corroborated the findings of some scholars. For example, Nassarawa (2008) agrees that Functional Literacy Education goes beyond Basic Literacy, which simply means ability to read and write,
compute only; but also involves skills-based education that enables dropouts or people out of formal school system to be self-reliant by deploying knowledge they have acquired to tackle their health-cum-socio-economic problems. The study revealed that the objectives of the programmes were geared towards the improvement in the preventive health practices of the participants. In general, it all means that the objectives of the functional literacy education met the needs of the adult participants health-wise.

It was also discovered during the cause of the study that most of the facilitators of the programmes were untrained adult educators and majority of them were retired school teachers who were temporarily engaged while the greatest number of the facilitators were primary school teachers who were in part-time teaching.

The characteristics of adult learners demand that a specialized adult educator should be the facilitator who will apply all the andragogical methods of teaching the adults – the andragogical methods such as discussion method, role-play, seminars, workshops etc. At this point, the facilitators and the adult learners discusses as equals owing to the wealth of experiences acquired by the adults. The principle of pedagogy, which is the method of teaching children, would not be used in teaching the adults because of its rigidity and the teacher dominates the class as the most experienced of all.
The adults’ perception of themselves as well as the views of the society about adults enrolling in literacy education hinders the adult learners in enrolling in the because majority of the participants were of the opinion that the society does not reckon with adult learning.

There was also no effective publicity channel of making the rural populace aware of the importance of the functional literacy education programmes that were being organised in the rural areas of the State.

5.2 IMPLICATIONS OF FINDINGS

The findings of this study have very important implications for functional literacy education practitioners in Nigeria.

1. On the whole, the study found out that functional literacy education have the power to salvage the issues of preventive health practices of adults in rural communities because participants who were in functional literacy education recorded health achievement in contrast to their counterparts in traditional literacy education.

2. The study has shown the need for Government at the Federal and State levels in Nigeria to increase the intake in admission of the candidates for training in adult education in all schools of higher learning as this will provide qualified personnel to handle functional literacy education programmes. The onus is on the Local
Government to sponsor students who are willing to study Adult Education for intake into Federal and State institutions.

3. The study has highlighted the need for facilitators in such to be properly trained as adult educators so that they can be in a better position to help adults to learn.

5.3 RECOMMENDATIONS

The findings of this study portray an urgent need that all literacy education organised in Anambra State should be made functional literacy education to make do for a more efficient productivity rate among adults as a healthy mind is a wealthy mind. This is to consolidate on the gains already recorded to nip retrogression in the bud.

The required educational system is the main gateway through which the health of the Nigerian adults would be improved. On this premise hangs the need for all adult education promoters to seriously orientate the Nigerian society at large leading to the eradication of the old belief that adults are over-aged to learn.

The management of these functional literacy education centres should place premium on the recruitment of qualified adult educators who will facilitate the learning process of the adult learners as well as put into meaningful use instructional materials that are available for adult learning.
It is also very important that the Government at the Federal and State levels in Nigeria should increase the intake in admission of the candidates for training in adult education in all schools of higher learning as this will provide qualified personnel to handle functional literacy education. The Local Government should sponsor students who are willing to study Adult Education for intake into Federal and State institutions.

The organizers should be provided with all the necessary facilities that are required for the smooth running of the programmes. It is also of paramount importance that functional literacy education should be made free to its recipients. This will motivate the adults to enrol in the and create awareness for adults’ massive participation in the programmes.

It will also be very necessary to emphasize that the centres for functional literacy education should be cited closer to the participants’ places of residence as this will also motivate their enrolment in the programmes.

It is also recommended that Government at all levels should direct the political will and funding of functional literacy education in the Local Government Areas in order to make this treasure accessible to as many adults as possible.

Also, the patronage of the by the adults can be given a lift should Government get involved in creating huge channels of publicizing these
to the people of the State and also sensitization should be made on the importance for functional literacy education and not just any other.

Lastly and not the least, the organizers of functional literacy education, well-spirited Nigerians as well as voluntary organizations should contribute their own quota by making sure that the curricula of the are geared towards the improvement of the preventive health practices of the participants of these in general.

5.4 SUGGESTIONS FOR FURTHER RESEARCH

It could be pointed out here that the study cannot be said to be comprehensive enough, but serve as a springboard where more detailed and valuable research work could be focused. The view points that were highlighted in this research work will go a very long way in the improvement of the preventive health practices of adults in the rural communities of Anambra State and the nation at large.

More research work could be done in the following areas to find out:

(i) What content that would constitute the curriculum of functional literacy education programme.

(ii) How functional literacy education would be made more accessible to adults in the rural areas the State.

(iii) The effect of cultural and societal belief on the health of adults in the rural areas of the country.
(iv) How to propagate functional literacy education.
(v) The importance of trained adult educators in teaching of the adult learners.
(vi) The health impairments as regarding the learning capabilities of the adults learners and;
(vii) How to solicit funds to finance functional literacy education amongst others.

5.5 CONTRIBUTIONS OF THE STUDY TO KNOWLEDGE
(i) The study unearthed the unrivalled place of functional literacy education in equipping the neo-literate population of Anambra State rural dwellers with the skills (both cognitive and occupational) necessary for living healthier and productive lives over traditional literacy education.
(ii) The study developed a conceptual model for evaluating the impact of functional literacy education on the preventive health practices of the rural dwellers. The model when adopted by the policy makers will influence the government to provide training in functional literacy education for the masses and the outcome of that will improve the standard of living i.e. better sanitation, better health practices leading to higher quality of life.
(iii) The study has proved that illiterate adults when exposed to appropriate functional literacy education are capable of changing their behaviour pattern.

(iv) The Input-Process-Output-Feedback (IPOF) evaluation model developed by the researcher in this study, if adopted and utilized, will go a very long way in improving the propagation of functional literacy education.

(v) The study has demonstrated that there was a return on investment i.e. the money spent; time, as well as human resources expended on the had proved worthwhile.

(vi) The study overtly pinpoints the weaknesses of functional literacy education in the State and this will subsequently help the planners of the to improve on the future.

5.6 SUMMARY AND CONCLUSION

From the discussions of the findings above, it could be said that functional literacy education organised for the rural dwellers of Anambra State have lived up to their billing in terms of the improvement of the preventive health status of the participants in functional literacy education.
The age-long belief of most people that the education of adults is useless rather, children education should be encouraged is only fit for the bins. This has contributed immensely to the poor health practices of rural dwellers and should be discouraged hence, the representative of the Director-General of UNESCO (2002), in his opening speech to the Regional Conference for the planning and organisation of literacy in Africa once said that, “It is not the children of today who hold the destiny of Africa in their hands, it is the adults.” This assertion simply brings to the front burner the need for functional literacy education to improve the lives of the adults of Africa including Nigeria and the rural dwellers of Anambra State. This will enable the adults carry out the responsibilities of development of the nation that lies in their hands. This calls for an urgent need for a massive campaign in the sensitization of the rural dwellers because if the participants in the functional literacy education showed health achievement, then, there is a greater possibility that new intakes into these will show positive health behaviours thereby providing the society with healthy minds for input into every sector of the economy.
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Mbagwu, I. J. (1984). “Voluntary agencies: A strong factor in adult education delivery in Nigeria”. In *The adult educator: Journal of the Association of Adult Education Students*, University of Ibadan. 2 (12), ...


Nyerere, J. K. (1976). Adult education and development in literacy discussion. In *Journal of the international institute for adult literacy methods* 7(8), ...


OFFICIAL DOCUMENTS/ REPORTS


Dear Respondent,

This questionnaire is for research purpose. It is meant to collect information on the impact of functional literacy education on the preventive health practices of the rural dwellers. Your esteem response will be treated in confidence. Kindly, assist my academic pursuit.

Sincerely yours,

PART ONE – BIOGRAPHIC DATA

**Sex:** Male ( ) Female ( )

**Age:** 30 - 39 years ( ) 40 - 49 years ( ) 50 - 59 years ( )

60 years and above ( )

**Education Background:** Primary School Dropout ( )

Completed Primary Education ( )

Secondary School Dropout ( )

Completed Secondary Education ( )
Appendix B

PART TWO: QUESTIONS

Key: Out of the responses: Very high extent (VHE), High extent (HE), Low extent (LE) Very low extent (VLE) tick into the space of the one that best describes your opinion on each item.

<table>
<thead>
<tr>
<th>V1 PPHP</th>
<th>To what extent has your participation in FLEP made you to start doing the following (PPHP):</th>
<th>VHE</th>
<th>HE</th>
<th>LE</th>
<th>VLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Avoiding the eating red meat or processed meat like gala, hot dog, and sausage?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Eating of cereal instead of refined grain products, such as Semolina, and Semovita?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>Avoiding foods that are rich in calories and fat like Fufu, Eba, and Egusi soup?</td>
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</tr>
<tr>
<td>4.</td>
<td>Eating less of high-calorie baked goods like pies, cakes, cookies, sweet rolls and doughnuts?</td>
<td></td>
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<tr>
<td>5.</td>
<td>Avoiding the adding of butter, margarine, oil, sour cream, or mayonnaise to foods when cooking or at table?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Eating less of fried foods?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7.</td>
<td>Taking moderate physical exercises like walking, dancing, skating, and leisurely bicycling every morning or evening?</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td>Trying to maintain a healthy weight?</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>Spending most of my free time being active, instead of watching television?</td>
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<tr>
<td>10.</td>
<td>Abstaining from drinking alcohol?</td>
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<tr>
<td>11.</td>
<td>Brushing your teeth and wash your mouth twice every day?</td>
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<tr>
<td>12.</td>
<td>Taking your bath at least twice every day?</td>
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<tr>
<td>13.</td>
<td>Cutting both your finger and feet nails?</td>
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<tr>
<td>14.</td>
<td>Drinking at least 2 1/2 cups of fresh vegetable or fruits juice every day?</td>
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<tr>
<td>15.</td>
<td>Drinking less of beverages containing caffeine like Lipton, Nescafe and many other types of black teas and coffees?</td>
<td></td>
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<tr>
<td>16.</td>
<td>Washing and ironing your clothes before wearing?</td>
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<tr>
<td></td>
<td>Question</td>
<td>V2 HPHP</td>
<td>VHE</td>
<td>HE</td>
<td>LE</td>
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<tr>
<td>17.</td>
<td>Washing your hands with soap immediately after toileting?</td>
<td><strong>To what extent has your participation in FLEP make you to start doing the following (HPHP):</strong></td>
<td></td>
<td></td>
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<tr>
<td>18.</td>
<td>Ensuring that your house is properly swept every day?</td>
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<tr>
<td>9.</td>
<td>Ensuring that your home toilet is always cleaned up with effective disinfectant?</td>
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<tr>
<td>20.</td>
<td>Making sure that plates used for eating in your house are washed immediately after meal?</td>
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<tr>
<td>21.</td>
<td>Not using dirty containers to store water in the house?</td>
<td></td>
<td></td>
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<tr>
<td>22.</td>
<td>Reminding your children not to litter the house?</td>
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<tr>
<td>23.</td>
<td>Not using firewood to cook in your home?</td>
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<tr>
<td>24.</td>
<td>Discouraging the re-use of used bottles and containers in your house?</td>
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<tr>
<td>25.</td>
<td>Disposing your home generated refuse to appropriate place?</td>
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<tr>
<td>26.</td>
<td>Fumigating or disinfecting your house at intervals?</td>
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<tr>
<td>27.</td>
<td>Discouraging your children from defecating or throwing faeces outside or into the bush instead of into the toilet?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>V3 EPHP</th>
<th>VHE</th>
<th>HE</th>
<th>LE</th>
<th>VLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.</td>
<td>Not throwing your waste or refuse in the open?</td>
<td><strong>To what extent has your participation in FLEP made you to start doing the following (EPHP):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Burying your waste to form manure?</td>
<td></td>
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<tr>
<td>30.</td>
<td>Not throwing refuse, waste and dirty things into the rain?</td>
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<tr>
<td>31.</td>
<td>Not throwing papers and pure water sachets on the road?</td>
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<tr>
<td>32.</td>
<td>Not burning your bushes again before farm work?</td>
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<tr>
<td>33.</td>
<td>Engaging in environmental sanitation?</td>
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<tr>
<td>34.</td>
<td>Not urinating by the roadside or stool in the open or bush when pressed?</td>
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<tr>
<td>35.</td>
<td>Frowning against people that do things that have negative effect on the health of the people?</td>
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<tr>
<td>36.</td>
<td>Cutting down trees and plant new ones?</td>
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</tbody>
</table>

**Appendix C**

**PART THREE: QUESTIONS**

**Key:** Out of the responses: strongly agree (SA), agree (A), disagree (D) and strongly disagree (SD), tick into the space of the one that best describes your opinion on each item;

<table>
<thead>
<tr>
<th>V4</th>
<th><strong>Physical facilities and materials resources at the centres (P/M)</strong></th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>37.</td>
<td>Available physical facilities at the centres are inadequate and unconducive for qualitative academic work.</td>
<td></td>
<td></td>
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<tr>
<td>38.</td>
<td>There are inadequate desks and chairs to contain the participants comfortably during lesson sessions.</td>
<td></td>
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<tr>
<td>39.</td>
<td>The available classrooms are not spacious and properly ventilated for effective teaching and learning.</td>
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<td></td>
</tr>
<tr>
<td>40.</td>
<td>Facilitators are not provided with separate well equipped office accommodation and facilities.</td>
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<td>41.</td>
<td>The centres lack relevant instructional materials for effective teaching.</td>
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<td>42.</td>
<td>The centres lack toilet facilities.</td>
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<td>43.</td>
<td>Spoilt chairs and desks are left unrepaired to no definite time.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>V5</th>
<th><strong>Quality of Programme Facilitators (FQ)</strong></th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>44.</td>
<td>Most of the facilitators in my centre are not first degree holders.</td>
<td></td>
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<tr>
<td>45.</td>
<td>Most of the facilitators are not ICT literate</td>
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<td>46.</td>
<td>The academic quality of the facilitators needs to be improved for better performance.</td>
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<tr>
<td>47.</td>
<td>Most of the facilitators are not well</td>
<td></td>
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</tbody>
</table>
experienced in their job.

48. There is high rate of turnover in facilitators’ recruitment disrupting long stay and experience of the facilitators.

49. The facilitators most times come to class late and unprepared.

50. The facilitators do not usually give professional answers to participants’ questions.

51. The courses are always presented to learners in a poorly organized manner by the facilitators.

52. The facilitators do not show thorough and in-depth knowledge of their courses.

53. Concerted efforts are not made by facilitators to encourage and enhance learners’ participation.

<table>
<thead>
<tr>
<th>V6</th>
<th>Rural Dwellers’ Attitude to Participation in Functional Literacy Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.</td>
<td>I do attend tutorials once a while.</td>
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<tr>
<td>55.</td>
<td>Most times unavoidable social engagements override my attendance of tutorials.</td>
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<tr>
<td>56.</td>
<td>I do not attend tutorials whenever I have very important engagement to attend.</td>
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<tr>
<td>57.</td>
<td>I attend tutorials only when I see myself free to do so.</td>
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<tr>
<td>58.</td>
<td>I do not attend tutorials regularly because I think I am no longer fit for academic rigors.</td>
</tr>
<tr>
<td>59.</td>
<td>I attend tutorials whenever I want to go and cash fun with other adults.</td>
</tr>
<tr>
<td>60.</td>
<td>I attend tutorials only when I feel like doing so.</td>
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</tbody>
</table>

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<tr>
<th>V7</th>
<th>Assessment of the Functional Literacy Education Programme (PAFLEP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.</td>
<td>The organization and conduction of the programme is not encouraging enough to command learners’ continuous participation.</td>
</tr>
<tr>
<td>62.</td>
<td>I am not satisfied with the quality of tutorials that I get from the programme.</td>
</tr>
<tr>
<td>63.</td>
<td>Tutorials are too theoretical and boring without practical demonstration with instructional materials.</td>
</tr>
</tbody>
</table>
| 64.                                    | The contents of the subjects taught at
tutorials are not in-depth.

65. The facilitators are not very effective and professional in their teaching.

66. The programme is not really giving me what I expected to get from it.

67. The curricula of the subjects do not accommodate enough things that will give participants wider knowledge of different aspects of life.

---

Appendix D

The oral interview schedule

Since you took part in the program, how has your life changed?

**a) Personal preventive health practices:**

1. I try more to avoid eating processed or junk food
   - Yes / / No / /

2. I try to watch my calories intake by reducing starchy foods and taking more fruits
   - Yes / / No / /

3. I try to eat less of fried food
   - Yes / / No / /

4. I try to take in moderate exercises
   - Yes / / No / /

5. I try to avoid too much alcohol
   - Yes / / No / /

6. I take better care of my personal hygiene
   - Yes / / No / /

**b) Home preventive health care**

1. I now sweep the house twice a day
   - Yes / / No / /

2. I clean the house with disinfectant
   - Yes / / No / /
3. I ensure proper disposal of garbage  Yes / /  No / /  
4. I ensure the fumigation of the house and surrounding  Yes / /  
   No / /  
5. I now encourage reusing and recycling practices  Yes / /  No / /  

c) Environmental health practices  
1. I make sure that nylon and other non-biodegradable materials are  
   properly disposed of  Yes / /  No / /  
2. I pay better attention to the use of refuse for manure  Yes / /  
   No / /  
3. I am more invested in the practice of tree planting  Yes / /  No / /  

d) Availability of physical facilities at the functional literacy  
   centre  
1. I have noted that the available furniture is adequate  Yes / /  
   No / /  
2. There are adequate chairs and desks at the centre  Yes / /  No / /  
3. The classrooms are many and spacious  Yes / /  No / /  
4. The classrooms are well ventilated and well lit  Yes / /  No / /  
5. There is adequate provision of toilets  Yes / /  No / /  

e) Qualification of programme facilitators

1. Most of the facilitators are first degree holders  Yes / /  No / /
2. There is a high rate of turnover of facilitators     Yes / /  No / /
3. Most of the facilitators are ICT literate        Yes / /     No / /
4. The facilitators use participatory methods most of the time Yes / /
              No / /
5. The mode of presentation and content are poor Yes / /     No / /

f) Rural dwellers’ attitude towards participation

1. I attend most classes all of the time     Yes / /     No / /
2. I only attend classes when I do not have other engagements
              Yes / / No / /
3. I feel I am gaining a lot from the programme     Yes / /     No / /
4. I do not attend classes regularly as I have other things to do
              Yes / / No / /
5. The classes are rather boring and I don’t learn anything new
              Yes / / No / /

All research questions were answered and hypotheses tested, using the analysis of data obtained from the research questionnaire.
APPENDIX E

ADULT LITERACY EDUCATION ESTABLISHMENTS CONSULTED IN ANAMBRA STATE DURING THE STUDY

1. State Agency for Mass Literacy Education, Awka

2. Anambra State Social Welfare Department, Awka

3. Adult Literacy Education Office, Nnewi

4. Non-Governmental Organizations (NGOs) carrying out Adult Literacy Education, Onitsha

5. Mass Literacy Education Board, Enugu-Ukwu

6. Mass Literacy Education Center, Oraifite

7. Local Governments’ Adult Education Departments
APPENDIX F

THE TWENTY ONE SELECTED LOCAL GOVERNMENT AREAS OF ANAMBRA STATE USED FOR THE STUDY

(i)   Aguata Local Government Area;
(ii)  Anambra East Local Government Area;
(iii) Anambra West Local Government Area;
(iv)  Anaocha Local Government Area;
(v)   Awka North Local Government Area;
(vi)  Awka South Local Government Area;
(vii) Ayamerem Local Government Area;
(viii) Dunukofia Local Government Area;
(ix)  Ekwusigo Local Government Area;
(x)   Idemili North Local Government Area;
(xi)  Idemili South Local Government Area;
(xii) Ihiala Local Government Area;
(xiii) Njikoka Local Government Area;
(xiv) Nnewi North Local Government Area;
(xv)  Nnewi South Local Government Area;
(xvi) Ogbaru Local Government Area;
(xvii) Onitsha North Local Government Area;
(xviii) Onitsha South Local Government Area;
(xix) Orumba North Local Government Area;

(xx) Orumba South Local Government Area and

(xxi) Oyi Local Government Area.