

MOTHER TONGUE EDUCATION AS A TOOL FOR HEALTH PROMOTION IN SCHOOLS AND COMMUNITIES: ADVANTAGES, BOTTLENECKS AND SOLUTIONS

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Abstract

Mother tongue-based education (MTBE), involving the use of learners' first or predominant community language as a medium of instruction, has important implications for health literacy and health promotion beyond the classroom. This position paper examines its potential to strengthen health promotion in schools and communities in Nigeria and the wider West African context. Drawing on literature on multilingual education, language policy, health communication, and school health, the paper argues that MTBE can improve comprehension of health information, cultural relevance, community engagement, and the adoption of appropriate health practices. However, its effective implementation is constrained by linguistic diversity, inadequate indigenous-language health terminology and instructional materials, limited teacher and health educator preparation, weak policy implementation, and societal preference for dominant international languages. The paper proposes strengthening indigenous-language health resources, capacity building, community participation, multilingual digital technologies, and effective implementation of language policies. MTBE can therefore support more inclusive, culturally responsive, and equitable health promotion.

Keywords: *Mother Tongue Education, Health Promotion, School, Communities*

Introduction

Health and education are two of the most tightly interwoven pillars of human development, and the point at which they intersect most visibly is health literacy: the ability of an individual to obtain, process, and understand basic health information well enough to make appropriate decisions. Health literacy, in turn, depends fundamentally on

comprehension, and comprehension is mediated by language. In a country such as Nigeria, home to an estimated 525 or more indigenous languages (Eberhard et al., 2024), the language in which health messages are delivered whether in the classroom through school health education or in the community through outreach and mobilisation has direct consequences for whether those messages are understood, trusted, and acted upon.

Nigeria formally recognises the importance of indigenous languages in its National Policy on Education, which provides for a trilingual model of instruction involving a child's first language or the Language of the Immediate Community (LIC), one of the three major national languages (Igbo, Yoruba or Hausa), and English (Education Outloud, 2025). Nigeria's National School Health Policy, adopted in 2006, similarly recognises skills-based health education as a core component of a comprehensive school health programme, alongside a healthy school environment, school feeding, and school health services (Federal Ministry of Education [FME], 2006). Yet the two policy domains language-in-education policy and school/community health policy are rarely examined together, even though the success of health education ultimately depends on whether the language of delivery matches the language of comprehension for the intended audience.

Conceptual Clarifications

Mother tongue-based education (MTBE) refers to schooling in which the language learners know and use best, usually the home or community language, serves as the medium of instruction and the language of initial literacy, with regional, national and international languages added progressively (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2025). The term does not require that the language be the mother's: many children grow up with more than one home language, so "mother tongue" is used here as shorthand for the language of greatest familiarity. UNESCO (2025) estimates that about 40% of the world's population lacks access to education in a language they speak or understand fluently, a share that rises to as much as 90% in some low- and middle-income countries. In Nigeria, MTBE is operationalised through the trilingual provision of the National Policy on Education, which combines the Language of the Immediate Community, one of the three major national languages, and English (Federal Republic of Nigeria [FRN], 2013).

Health education refers to planned learning experiences that build people's knowledge, motivation and health literacy so that they can improve their own health, whereas health promotion is the broader process of enabling individuals and communities to gain greater control over their health, combining education with environmental, policy and service-level action (World Health Organization [WHO], 2021a). Health literacy, the capacity to obtain, understand and use health information, is the outcome through which language matters most, because comprehension is a precondition for the decisions that health education seeks to influence (Nutbeam, 2025). The paper therefore treats language as an enabling condition for health education within the wider field of health promotion, not as a health intervention.

School and community health education are the two settings considered here. In schools, the health-promoting school approach integrates health education with the school environment, health services and community partnership (WHO & UNESCO, 2021), and Nigeria's National School Health Policy similarly pairs skills-based health education with a healthy school environment, school health services, school feeding services and school-home-community relationships (FME, 2006). Community health education refers to health promotion delivered outside formal schooling to families, out-of-school youth and adults, typically through outreach workers, community leaders, adult literacy programmes and mass communication. The two settings differ in who is taught and by whom, but both depend on language as the carrier of health information, which is why MTBE is examined here as a vehicle for the skills-based component in schools and for the reach and comprehensibility of community outreach.

Theoretical Framework

Three theoretical perspectives helped to explain why the language of instruction and communication matters for health education and promotion outcomes.

Cummins's Linguistic Interdependence and Threshold Hypotheses

James Cummins's (1979) linguistic interdependence hypothesis proposes that a cognitively and academically beneficial form of bilingualism can be achieved only when a child has developed adequate competence in their

first language; the development of competence in a second language is partly a function of the competence already achieved in the first. His related threshold hypothesis suggests that a bilingual child must attain a threshold level of proficiency in both languages to avoid cognitive disadvantage and to benefit cognitively from bilingualism. Applied to health education, this suggests that a child (or adult learner) who first grasps a health concept securely in their mother tongue is better positioned to transfer and retain that understanding when the same concept is later encountered in English or another second language, rather than being taught the concept for the first time in an imperfectly understood second language.

This psycholinguistic account is complemented by the three-part rationale for mother tongue instruction advanced by Okedara and Okedara (1992, as cited in Akintola & Adetunji, 2020), who describe the mother tongue as psychologically the most automatic medium for understanding facts, educationally the quickest route to learning, and sociologically a marker of community identity. These dimensions map closely onto the mechanisms through which mother tongue delivery is expected to improve health outcomes specifically. The psychological dimension underlies faster and more automatic processing of health messages, the educational dimension underlies the comprehension gains associated with instruction in a familiar language, and the sociological dimension underlies the trust and cultural relevance that mother tongue delivery affords.

The Health Belief Model

The Health Belief Model explains health-related behaviour as a function of an individual's perceived susceptibility to a health problem, perceived severity of that problem, perceived benefits of taking actions, perceived barriers to action, cues to action, and self-efficacy. Each of these components depends on accurate comprehension of health information. Where health messages are delivered in a language the learner or community member does not fully understand, perceptions of susceptibility and severity may be distorted, perceived barriers (including the discomfort of engaging with unfamiliar language) may be inflated, and self-efficacy confidence in one's ability to act may be undermined. Mother tongue delivery, by removing the added burden of linguistic decoding, allows these belief components to be shaped more accurately by the health content itself.

Diffusion of Innovations

Everett Rogers's (1962) diffusion of innovations theory holds that the adoption of new ideas and practices, including health innovations such as immunisation, family planning, or improved hygiene practices, depends heavily on communication channels and the compatibility of the innovation with the values and language of the adopting community. Community engagement approaches promoted by bodies such as the Africa Centres for Disease Control and Prevention (Africa CDC) explicitly emphasise engaging and listening to affected communities in the aftermath of outbreaks such as Ebola, underscoring those channels as central to effective risk communication and community engagement (Africa CDC, 2023). Local language is one of the clearest markers of a communication channel's compatibility with a community's social system, making mother tongue delivery a natural fit with diffusion-based approaches to health promotion. When taken together, these three frameworks provide converging support for the proposition that language of instruction and communication is not incidental to health education outcomes, but a determinant of comprehension, belief formation, and behavioural adoption.

Mother Tongue Education Policy in Nigeria

Nigeria's language-in-education policy has a long and contested history. One of the most influential empirical studies in this field was the Ife Six-Year Primary Project, led by Professor Babatunde Fafunwa at the then University of Ife (now Obafemi Awolowo University) in the 1970s, which found that children taught in their indigenous language for the full six years of primary school learned more effectively than those taught predominantly in English (The Sun, 2022). This finding has continued to shape policy discourse, feeding into the National Policy on Education's trilingual framework: a child's first language or Language of the Immediate Community, one of the three major national languages, and English (Education Outloud, 2025). The relevance for health education is that the early comprehension gains it reported are the mechanism through which later health content would be understood (Section 3.1), although the project measured learning outcomes, not health outcomes.

The Federal Executive Council approved a National Language Policy (2022) making mother tongue instruction compulsory in the early years of

basic education (The Sun, 2022). In November 2025, however, the Federal Government cancelled the policy and declared English the sole medium of instruction from pre-primary to tertiary level, citing high failure rates in national examinations in areas that had implemented mother tongue instruction (Vanguard, 2025; TheCable, 2025). Language and literacy experts disputed the causal claim, noting that the examinations are themselves conducted in English (AllAfrica, 2025; World Education Blog, 2026), and the Fafunwa Educational Foundation attributed the difficulties to weak implementation, inadequate funding and insufficient teacher training rather than to the concept itself (ThisDayLive, 2025).

For health promotion and health education, the reversal has two consequences. First, the school-based pathway is closed for now: skills-based health education under the National School Health Policy must be delivered in English, which removes the comprehension advantage for children who do not yet command it and illustrates the policy–implementation problem discussed in Section 6. Second, the practical opportunity shifts to community and non-formal channels, which are outside the medium-of-instruction rule and where mother tongue delivery of health content is already operating (World Education Blog, 2026), as the next paragraph shows.

Beyond formal schooling, mother tongue-based approaches have already been applied directly to health content in Nigeria. The Mother and Child Education Programme (MCEP), for example, uses an integrated, bilingual (English and mother tongue) approach to literacy and life-skills training for women and children, deliberately incorporating health topics such as HIV/AIDS awareness and prevention, nutrition, and sanitation alongside civic education themes (UNESCO Institute for Lifelong Learning, 2015). This programme demonstrates that mother tongue delivery of health content is not merely theoretical but has already been operationalised, at least at pilot or programme scale, within the Nigerian context providing a template that could plausibly be extended to formal school health education.

Advantages of Mother Tongue Education in School and Community Health Programmes

Four advantages are examined below, each in the same order: the claim, the evidence selected to support it, and an interpretation of what that evidence can and cannot show. The interpretation matters because direct tests of MTBE as a vehicle for health education in Nigeria are scarce. Most available evidence comes from adjacent fields, namely clinical communication, early-grade literacy research and digital health design, so it supports the paper's position that MTBE is a plausible, conditional enabling mechanism for health promotion, not a proven stand-alone intervention.

Comprehension, Health Literacy and Cognitive Foundation

Learning health content in a familiar language improves comprehension of that content, and early instruction in the mother tongue builds the conceptual and literacy foundation on which later, more technical health learning depends. A narrative review of local languages in health service delivery associates the use of patients' own languages with greater satisfaction, adherence and better health outcomes (Babalola et al., 2025). A study documented that indigenous-language health information sources were most strongly related to knowledge of Type 2 diabetes, less strongly to attitudes, and only modestly to sustained behaviour (Adesina & Salawu, 2025). On the educational side, the Ife Six-Year Primary Project (Fafunwa et al., 1989) and later primary-level studies, including one on pollution concepts in Katsina (Musa & Osa-Omoregie, 2020; Sadiq & Yusuf, 2024), link early mother tongue instruction to stronger learning, an outcome consistent with Cummins's (1979) interdependence hypothesis.

The graded pattern in the Nigerian survey is the most informative result, because it indicates that language operates mainly on understanding and much less directly on behaviour. This fits the Health Belief Model: comprehension shapes perceived susceptibility and severity, but perceived barriers and self-efficacy depend on cost, access to services and social support, which language alone cannot change. The educational studies suggest that the benefit accumulates through early learning, yet they measure academic achievement, not health outcomes, so the step from better literacy to better health literacy remains an inference. The evidence is also limited in design. The review concerns clinical encounters rather than

classrooms and draws mostly on studies from high-income countries; the survey is correlational and drawn from university students who will largely have been educated through English; and the Ife project dates from the 1970s. A recent study of 1,272 Indian primary school children adds a further caution: sites with more mother tongue-educated pupils showed better regional-language literacy but weaker English (Vogelzang et al., 2025). Taken together, the evidence supports treating comprehension as a necessary but insufficient condition, which is why this paper pairs MTBE with skills-based, service-linked health education and with an additive bilingual model that protects English competence.

Cultural Relevance and Trust-Building

Health messages delivered in the mother tongue are more likely to be judged credible and acceptable, because language carries the idioms, explanatory frameworks and social relationships through which communities evaluate health advice. Participatory design work in Port Harcourt illustrates this. In co-design workshops with people living with Type 2 diabetes, caregivers and health workers, culturally and linguistically generic digital tools failed to resonate, whereas prototypes that used local languages, familiar dress and locally understood explanations of illness were rated as more trustworthy and relevant (Arueyingho et al., 2025). Diffusion of innovations theory predicts this pattern, since adoption depends on an innovation's compatibility with the values and language of the adopting community (Rogers, 1962). The finding is best read as evidence for cultural and linguistic fit as a package, not for language alone, because the prototypes changed dress and illness explanations together with language and the study cannot separate their effects. Trust, in other words, appears to arise when the language of delivery signals that a message was designed with the community, not merely translated for it. The evidence is thin: a single qualitative study in one city, with participants closely connected to diabetes care, measuring perceived trustworthiness and not uptake or behaviour. The effect may also run in the opposite direction where communities regard indigenous languages as unsuited to scientific discourse (Trudell, 2016), a point taken up in Section 6. For the position of this paper, the implication is practical: the trust advantage depends on co-designing materials with communities, not on translating existing English materials into local languages.

Community Participation and Inclusive Reach

Mother tongue delivery widens who can take part in health programmes, because people ask questions and voice concerns more readily in a language they command, and because oral, pictorial and digital channels in that language can reach people who cannot rely on print literacy in an official language. After the West African Ebola epidemic, Africa CDC and its partners built continental risk communication and community engagement training around listening to affected communities (Africa CDC, 2023), and Chumbow (1990) argued that mobilising rural populations for development requires mother tongue-based communication, since the rural majority are least likely to command an official or foreign language confidently. Digital channels extend the same logic: a scoping review found that language technologies, including chatbots, have been used in several African countries to deliver health information in local languages and counter misinformation (Hu et al., 2025).

The convergence of these sources suggests that the participation advantage lies mainly in removing exclusion: those least served by English-only, text-based communication are often the very rural and low-literacy community members whom community health programmes most need to reach. Because this reach does not require formal schooling, it holds even where school-based MTBE is unavailable, which makes it the strongest argument for the community and non-formal pathway that the paper recommends after the 2025 reversal of the National Language Policy. The evidence, however, is more conceptual than experimental. Africa CDC (2023) documents programme design, Chumbow (1990) offers an argument, and Hu et al. (2025) show that tools exist and are used, not that they change knowledge or behaviour. The advantage is therefore plausible and consistent across sources but not yet demonstrated, and it calls for evaluation studies that compare participation and reach between mother tongue and English-only programmes.

Alignment with Existing Policy Frameworks

Mother tongue delivery of health content does not require a new policy architecture, because it can connect two frameworks that already exist. Nigeria's National Policy on Education provides for instruction in the Language of the Immediate Community in the early years (FRN, 2013),

and the National School Health Policy designates skills-based health education as a core programme component (FME, 2006). Outside schools, the Mother and Child Education Programme (MCEP) already integrates health topics such as HIV/AIDS prevention, nutrition and sanitation into bilingual literacy training for women and children (UNESCO Institute for Lifelong Learning, 2015).

This is an advantage of opportunity, not of demonstrated effect. The alignment exists on paper, but Sections 4 and 6 show that policy provision and classroom practice diverge, and the Federal Government's November 2025 decision to make English the sole medium of instruction has closed the national school pathway for now. What remains available is the community pathway, including non-formal programmes such as the MCEP, which the reversal does not touch. The evidence here is documentary: policy texts and a programme description in a practice database, with no outcome evaluation cited. The paper's position follows from this limitation. Policy alignment is a reason to advocate for reinstatement and to scale proven community programmes, but it cannot by itself be counted as evidence that MTBE improves health.

Taken together, the evidence is strongest, though still correlational, for comprehension and knowledge gains; qualitative and limited for trust; largely conceptual for participation and reach; and documentary for policy fit. None of it directly tests whether mother tongue-based health education changes health behaviour in Nigerian schools or communities. The paper's position is therefore deliberately conditional: MTBE is a plausible enabling condition for health promotion, whose benefits depend on the bottlenecks examined next and on the controlled comparisons recommended in Section 8.

Bottlenecks in Using Mother Tongue Education to Promote Health in School and Community

The Policy–Implementation Gap and Funding Constraints

Bamgbose (2014) demonstrated that African language policies consistently fail at the implementation stage because of weak enforcement mechanisms, inadequate funding, and the enduring prestige of colonial languages. In Nigeria, the FRN (2013) stipulates mother tongue instruction in the first

three years of primary education, yet this provision is routinely disregarded, and UNESCO (2025) confirmed that the gap between multilingual education policy and classroom practice remains one of the most persistent barriers to equitable education globally. Funding sharpens the gap, since developing orthographies, producing materials and training teachers demand substantial and sustained investment (Ouane & Glanz, 2010) that resource-constrained systems often judge prohibitive. The reversal of the National Language Policy in November 2025 (Section 4) shows that political commitment is itself vulnerable. When health education is delivered in a language learners do not fully comprehend, the result is superficial recall rather than genuine health literacy (Nutbeam, 2025).

Linguistic Diversity and the Selection Dilemma

Nigeria's extraordinary linguistic heterogeneity presents a practical bottleneck. In multilingual urban settings, determining which mother tongue should serve as the medium for health instruction becomes politically contentious. Heugh (2021) cautioned that imposing a single indigenous language in a multilingual context may simply replace one form of exclusion with another, particularly for minority language speakers. Ouane and Glanz (2010) noted that this dilemma is compounded in schools where pupils arrive from diverse linguistic backgrounds, making it practically impossible for a teacher to deliver health content in any single indigenous language.

Inadequate Teaching and Learning Materials and Health Terminology

The scarcity of health education materials, including textbooks, pictorial guides, audio-visual aids, and digital resources developed in indigenous languages, remains a severe logistical bottleneck. UNESCO (2025) identified the absence of quality learning materials in local languages as a primary obstacle to multilingual education globally. Fafunwa et al. (1989) demonstrated over three decades ago that when adequate materials are provided in the mother tongue, learning outcomes improve dramatically, yet this finding has not been translated into the systematic production of health-specific educational materials in Nigerian indigenous languages (Bamgbose, 2014). Many languages also lack standardised orthographies and health terminology (Trudell, 2016; Ouane & Glanz, 2010), so even

willing teachers and health workers often have no agreed words for key health concepts.

Shortage of Qualified Bilingual Teachers and Health Educators

Effective mother tongue health education requires teachers who are not only fluent in the indigenous language but also trained in bilingual pedagogy and health content delivery. Heugh (2021) argued that teacher education programmes across Africa remain overwhelmingly oriented towards English-medium instruction, leaving graduates ill-equipped to teach health or any other subject in an indigenous language. This shortage is most acute in rural areas, where the need for mother tongue health education is greatest but qualified bilingual teachers are least available (Ouane & Glanz, 2010).

Negative Language Attitudes and Weak Community Ownership

Deeply internalised negative attitudes towards indigenous languages constitute a formidable psychological bottleneck. Trudell (2016) documented how communities in Africa often perceive their own languages as inadequate for academic or scientific discourse, including health education. This "linguistic inferiority complex" manifests in parental resistance to mother tongue instruction, with many families insisting that their children be educated exclusively in English, and UNESCO (2025) noted that such attitudes, rooted in the colonial legacy, undermine the credibility of health messages delivered in indigenous languages. Attitudes interact with programme design: the WHO (2021b) emphasised that health-promoting schools require active community participation, and when mother tongue health programmes are designed in a top-down manner without meaningful community input, they fail to resonate culturally and are met with apathy (Auld et al., 2020). Five solutions are proposed, each responding to one of the five bottlenecks in Section 6.

Strengthening Policy Frameworks, Enforcement and Funding

UNESCO (2025) recommended that governments enact enforceable legislation mandating the use of indigenous languages in early education and community health communication, with clear monitoring frameworks and accountability mechanisms. Bamgbose (2014) advocated the explicit inclusion of health education as a core component of mother tongue instruction in national curricula. In Nigeria, the FRN (2013) should be

revised to integrate health literacy as a measurable learning outcome of mother tongue instruction, with dedicated funding streams at the federal, state, and local levels that are protected from shifts in political priorities of the kind seen in 2025 (Section 4).

Managing Linguistic Diversity through Local, Flexible Language Choice

Since no single indigenous language can serve every classroom or community, the choice of language for health instruction should be made locally and not imposed nationally; Heugh (2021) cautioned that a single imposed language may simply replace one exclusion with another. This paper proposes three practical steps: mapping the languages of each school catchment or outreach area to decide the medium of instruction; using a major local language as a bridge in mixed classrooms, supported by pictorial and audio materials that can be reproduced cheaply in several languages; and adopting an additive multilingual model in which learners' home languages are used to explain health concepts alongside the language of instruction, in line with UNESCO's (2025) multilingual education guidance. Ouane and Glanz (2010) similarly treat diverse classrooms as a design problem for multilingual education to solve and not as a reason to abandon indigenous languages.

Developing Orthographies, Terminology and Materials, Including Digital Media

For languages lacking standardised writing systems, collaborative efforts between linguists, educators, and community members are essential to develop functional orthographies (Trudell, 2016). Health-specific terminologies should be developed collaboratively by linguists and health professionals to ensure both linguistic accuracy and scientific correctness (Ouane & Glanz, 2010), and UNESCO (2025) recommended national and regional language resource centres dedicated to producing educational materials in local languages. Technology can speed up and cheapen this work: UNESCO (2025) recommended mobile applications, radio broadcasts, podcasts, and social media in indigenous languages, animated videos and gamified apps can make health education more engaging for school children (Auld et al., 2020), and audio and video formats help

document indigenous health knowledge against erosion caused by language shift (Trudell, 2016).

Investing in Teacher and Health Educator Training

Heugh (2021) recommended that teacher education curricula be restructured to include bilingual pedagogy, indigenous language literacy, and culturally responsive health education. Pre-service and in-service training programmes should equip teachers with the skills to deliver health content effectively in the mother tongue. Ouane and Glanz (2010) further proposed recruiting community members fluent in indigenous languages to serve as auxiliary health educators, particularly in rural and underserved areas, an approach the WHO (2021b) endorsed as essential for sustainable health-promoting schools.

Fostering Community Ownership, Attitude Change and Evidence

The WHO (2021b) established that effective health promotion requires enabling communities to take ownership of their health, and Auld et al. (2020) emphasised that health education in schools must be designed as a collaboration between educators, health professionals, and community members. In practice, this means involving parents, traditional leaders, and local health workers in the design, delivery, and evaluation of mother tongue health education programmes, and using storytelling, drama, and song in indigenous languages as vehicles for health communication (Trudell, 2016). Changing attitudes also requires evidence and advocacy. Nutbeam (2025) called for longitudinal studies tracking the health literacy outcomes of children educated in their mother tongues, and UNESCO (2025) stressed that advocacy must target parents, policymakers, and community leaders to present mother tongue education as a scientifically validated approach to learning and health communication, with the International Decade of Indigenous Languages (2022–2032) as a platform.

Conclusion

This paper examined the advantages and bottlenecks of using mother tongue education to promote school and community health education programmes in Nigeria. The evidence reviewed suggests four advantages of mother tongue delivery: it supports comprehension and health literacy, including a cognitive foundation for later and more technical health learning; it builds cultural relevance and trust; it widens community

participation and reach, including to low-literacy populations; and it fits within existing policy frameworks. The strength of this evidence varies, however, and no study reviewed directly tests the effect of mother tongue-based health education on health behaviour in Nigerian schools or communities. These advantages are reinforced by established theoretical frameworks, including Cummins's linguistic interdependence hypothesis, the Health Belief Model, and diffusion of innovations theory, all of which identify language as a determinant of health-related comprehension and behaviour.

At the same time, the paper has shown that Nigeria's extraordinary linguistic diversity, inadequate materials and standardised health terminology in most indigenous languages, chronic shortages of trained bilingual teachers and health workers, weak, underfunded and politically volatile policy implementation, and unfavourable language attitudes combined with weak community ownership constitute five significant bottlenecks. These constraints mean that the advantages of mother tongue education for health promotion, while plausible and partly evidenced, are not being systematically realised in practice.

Recommendations

Based on examinations of various relevant literature and convictions of the authors, they made the following recommendations:

1. Advocacy for the reinstatement of, and thereafter stabilising political and financial commitment to, Nigeria's mother tongue education and school health policies to protect long-term implementation;
2. Investing in community-driven development and standardization of health terminology in major and minority indigenous languages;
3. prioritising multimodal, low-literacy-friendly materials that combine mother tongue narration with pictorial and oral formats.
4. Expanding teacher and community health worker training in indigenous-language health communication;
5. Scaling proven bilingual platforms, such as the Mother and Child Education Programme, that already integrate health content into mother tongue literacy training.

6. Adopting an additive bilingual model that positions mother tongue health education alongside, rather than as a replacement for, English-language competence, in order to address parental and community concerns about educational and career mobility.
7. Further empirical research, particularly controlled comparisons of health knowledge and behaviour outcomes between mother tongue-based and English-only school and community health interventions in the Nigerian context, would strengthen the evidence base for these recommendations.

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