Critical Issues of Training and Health Education in Kenya

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The foregoing study examined why health education is given low priority in several National Health Development programmes and how increased support may be introduced. Relevant experiences were drawn from the reviewed literature on Health Education, and then discussed in the light of health education problems in Kenya to help draw suitable conclusions and recommendations for improving the Kenyan situation. In this paper, health is defined in light of health education and Human Communication Theory among other related issues. Training for health education and strategies and improving health education programmes are also discussed. It emerged that health education needs priority attention through practical support in the areas of resource allocation; management; reorganization of the Division of Health Education in order to introduce effective management capabilities; revival of training for health education officers; review of the training curricula for all health workers so that health education is introduced as a major subject of study; introducing incentives and attractive scheme of service for health education officers; setting performance standards research into health education concepts, training models, educational materials and programme evaluations.

Keywords: issues, training, strategies, health education, kenya, human communication theory

INTRODUCTION

In 1963, Kenya became an independent nation within According to WHO (1946), health is a "state of complete, physical, mental and social well-being and not merely the absence of disease and infirmity". This much quoted statement has subsequently been criticized because it implies a static position of complete well-being which may not be easy to achieve. The idea that health means having the ability to adapt continually to constantly changing demands, expectations and stimuli is more preferable (Ewles & Simnett, 1985, p. 5).

It appears that health is generally accorded low value when compared to the considerable importance accorded to ill-health. The definition of “health” tends to be tied to an “absence of ill-health”. As yet, health cannot be quantified scientifically in the same way as the signs and symptoms of ill-health. Furthermore, it seems that an individual's interpretation of health may be broadly or narrowly related to age, human potential or is merely a reflection of that person's state of well-being at any given moment in their life.

The absence of a clear concept of health, which would include variations according to a multiplicity of factors, is again hampered by the historical fact that healthcare, including health education, is based on a medical model which concerns itself with systematic diagnosis and treatment, and rarely takes the whole person, his/her environment or total needs, into account. Strehlow (1983) observes that education has suffered from similar difficulties as described of health because many people associate the word with unpleasant experiences of childhood and adolescence.

In other words, the "good days" of school life appear to be a myth for the majority of the people and, therefore, they are reluctant to expose themselves to any proposal which might repeat unsatisfactory experiences. In addition, Green et al. (1980) see that health education is a field without a clear articulation of its boundaries, methods and procedures, although its philosophy and intellectual roots are sufficiently understood. Moreover, the same commentator perceives that the training of health educators has been relatively devoid of uniformity or consistent standards.

In the same context, Strehlow (1983) complains that the textbooks for health education are not easy to read or put into practice. However, she sees that the scope of health education is limitless despite being regarded with scepticism by some of its recipients. Rodmell and Watt (1986) argue that although health education is practiced at different levels in different places by different people, it may be regarded as a discipline of its own right.

The focus of health education is mainly outside the curative system of healthcare because it is generally concerned with preventive and promotive health services. This task has generally been conventionally performed by health educators from within an individualistic behavioural framework which manifests itself through a focus on habits, attitudes and values (lifestyles) which affect health. In this way, it is assumed that when individuals are given appropriate health knowledge, they will use it to make informed choices about their health and that of their families. Therefore, it may be stated that health
education strives to help people to make these choices easy choices about health.

In the same way, Macdonald (1988) observes that the concept of individual lifestyles tend to blame the victim when sometimes the cause of the problem is outside the individual. For instance, the socio-economic problems of poverty, although they affect individuals, have their causes emanating from the political system and the community in general. Tones (1991, p. 2) argues that the major influences on health are lifestyle, human biology, health services and environment. The most important of these (arguably) is environment. The role of health education in all this is to achieve the goal of health promotion and 'Health for All' by the year 2000. Tones (1991) concludes that health education would also include consciousness raising about social issues, empowerment of individuals and communities, the appropriate utilization of health services and modifying perceptions about health promotion services. Going back to what we said earlier, that people need to make informed choices about their health, then appropriate approaches and methods to assist them need to be found. In this way, Strehlow (1983, p. 35) proposes five approaches which may be considered. First, the medical approach would involve the promotion of medical intervention to prevent or ameliorate ill-health. Secondly, the behavioural-change approach would concern attitude and behavioural change to encourage the adoption of "healthier" lifestyles. Thirdly, the educational approach would deal with information about causes of ill-health, exploration of values, attitudes and the development of skills required for healthy living. Fourthly, the client-directed approach would involve working with clients' identified health issues, choices and actions. Lastly, the social-change approach embraces political-social action to change the physical-social environment.

In view of the above, it appears that there is no "right" approach to health education and in some situations a combination of approaches may be preferable. In the same way, Green et al. (1980, p. 86) describe twelve health education methods which may be selected singly or in combinations depending on situations. These include lecture, discussions, role-play, mass media, demonstration, community organizing, field trips, modelling, behaviour conditioning, community development, social action and organisational development.

In this context, Naidoo (1986, p. 35) maintains that there is no ideal method for all situations, but recommends that health education needs to be client-centred without being victim-blaming and should focus on the real causes of ill-health. Furthermore, she cautions that the dominant ideology of individualism ignores health as a social construct, assumes existence of free choice and is ineffective without concentrating on social and environmental determinants of health. Because of its use by many health education programmes, a discussion of the Health Belief Model would shed more light on the factors influencing behavioural change. In recent times, this model has been analysed by several commentators in order to determine its usefulness (Rosenstock et al., 1988; Bunton et al., 1991; Ben-Sira, 1991; Macdonald, 1992). It is based on the hypothesis that behaviour depends on the value which an individual places on a particular goal and the individual's estimation of the likelihood that a given action will achieve that goal. In this way, the individual's perception of the severity and his own susceptibility to a particular disease would influence his response to health education, as will his perception of the benefits to be gained by changing behaviour and the obstacles that would need to be overcome for them to adopt this behaviour change. Some emphasis is put on cues to action, that is, the presence or absence of stimuli to change. In addition to these factors, demographic and psychological variables have also been found to influence behaviour change. In other words, being in a place where the problem is endemic reinforces the perceived susceptibility. The need for motivation (incentives) and self-efficacy were also found useful. It is worth noting that the same observations are reinforced by the Social Learning Theory (Social Cognitive Theory) which stipulates that learning results from events (reinforcements) that reduce physiological drives that activate behaviour (ibid, p. 117).

Therefore, in planning programmes, health educators may find it useful to assess educational needs partly in terms of beliefs described in the Health Belief Model and Social Learning Theory. In other words, they may seek to ascertain how many members of the target population are interested in the matters, feel susceptible to serious health problems, and believe that the threat could be reduced by some action at an acceptable cost. In addition, consideration may be taken on the extent to which patients or clients feel competent to carry out the prescribed actions immediately or over a long time with or without incentives.

Another model often referred to is the PRECEDE Model proposed by Green et al. (1980) to draw attention to the necessity of asking what behaviour contributes to each health benefit and what factors influence each health behaviour manifestation that must be considered in a health education plan. In some ways, the Precede Model may be seen as complementary to the Health Belief Model since it deals with factors which influence values and judgments. It may be useful to point out that other researchers have proposed the incorporation of "significant others" in any health education strategy.
(Zimmerman et al., 1989) as a perspective that would be consistent with the primary healthcare approach to health education. All this suggests a move towards life-context health education because at the moment, there is considerable emphasis on health education upon lifestyles rather than life-context.

Bunton et al. (1991, p. 226) observe that focusing on an individual’s health per se may not be the end in itself to be attained by health protective behaviour. Equally, it may be important to consider other life areas, such as family or wider social relations (such as one’s job) which may be more salient and may motivate health protection behaviour. In the same way, Kok et al. (1991) argue that convincing people about the utility of expected behaviour is necessary but it is perhaps more important to teach people the skills (for removing the barriers) that are needed to change their behaviour and to maintain the behaviour change by improving self-efficacy.

In this context, Peterson and Stunkard (1989) show that personal control has a positive correlation with one’s health because belief in one’s competence is closely tied to physical well-being, while a belief that one is helpless may be associated with sentiments concerning morbidity and mortality. In the same way, RUHBC (1989) perceive that changes in behaviour would be difficult to maintain unless and until new behaviour becomes relegated to the routine level as well. It was concluded that change may take place through the community development approach by involving local people in health issues and by encouraging participation.

Furthermore, Selvaggio (1990, p. 17) sees that behavioural change may occur when the messages have roots in community ideology, values, religion, myth, involving opinion leaders and when problem-solving training is done at the village level. Other researchers, like Currie et al. (1991, p. 452) observe that behaviours change singly, although sometimes multiple changes do occur in particular sets of behaviours. Thus, to exhort people to embrace a consistently healthy lifestyle in one grand effort may be an unacceptable and unrealistic challenge, especially if the individual is unsupported by favourable personal, environmental and socioeconomic resources. The European Public Health Committee (1980) concludes that any deeply rooted behaviour may not be changed by a belief campaign, but by a programme sustained over many years. For all the above reasons, it is clear that the crucial factor in health education is the process of communication.

PROCEDURES AND METHODS
The required information for the foregoing study was collected through library searches using liberra circulatory system and on-line catalogue at the University of Bristol. Again, a review of relevant documents from the Ministry of Health in Kenya was made. The design of the study did not require research assistants or a funding agency because it was manageable, using the resources available. No problems were encountered during the research study because due consideration was given to the timing of activities. The conceptual framework found appropriate for the work was that of primary healthcare, health education/health promotion and Human Communication Theory. Data and information collected were analysed using historical methods to assess the problems and their appropriate solutions. It was hypothesized that by identifying the relevant experiences from other countries, useful information would be tapped for improving similar programmes in Kenya and other countries of the world. In this way, this study had its conclusions drawn from the evidence adduced.

In the dissertation, the study problem was conceived through a literature review and from the researcher’s own experience as provincial health education officer in the Eastern Province of the Republic of Kenya, for more than ten years.

RESULTS AND DISCUSSION
Some Strategies for Health Education
Experience has shown that individuals and families generally make the most important health decisions on their own. If these millions of daily decisions are to be made wisely, people need to be equipped with the knowledge and skills necessary to exercise individual and community responsibility. In this context, community health education involves activities which may enable decision-making for adaptation of certain types of behaviour and styles of living beneficial to the health of individuals, families and communities. Sharing the same thoughts, Feurerstein (1982, p. 28) demonstrates that health education attempts to foster activities which lead to a situation where people want to be healthy, know how to achieve good health, do what they can to attain health and know how to seek help when needed.

According to WHO (1988, p. 75), the school system may help to lay the basis for health knowledge and health behaviour in the most formative period of the individual’s life which is childhood and adolescence. Moreover, outside the school system, other forums such as adult education programmes, sectoral seminars, non-governmental organisations, religious institutions and the mass media may be useful. Therefore, health has a direct and indirect link with all processes of teaching and learning that are to be found in different parts of society. It is further suggested by WHO (1988) that health education with individuals and families may be done through counselling because it would be vital for the people to know what they can do through their own efforts to
avoid the causes of ill health. In the same way, the use of group health education, as discussed earlier, would provide the support and encouragement needed to promote and maintain healthy practices through the sharing of experiences and resources. Again, health education with informal groups would be beneficial if based on the common interests of the majority of the people. The importance of group discussions was also underscored by O’Sullivan-Ryan and Kaplun (1981) who found cassette/video-taped discussions and adult education for liberation useful.

It is useful to note that other grass-root participatory projects succeed more when involvement and education for women is encouraged (Bushad, 1986). As we have seen in our previous discussions that health education may contribute in many ways to primary healthcare development, WHO (1983, p. 21) maintains that health education may be useful in helping people to determine their needs, in creating awareness, community organizing for action, the training of health workers, the production of educational materials, and the supervision and evaluation of programmes.

To successfully discharge all these tasks, the European Public Health Committee (1980) argues that if Health Education Units are set in the Ministry of Health, then there would be more advantages of being accepted and also of having access to vital data, than being autonomous agencies outside the Ministry. In addition, the Committee recommends that health education needs to be included in National Health policies, National Development plans for Health, and be supported through manpower and financial resources. In the same way, it may be useful to note that the use of political decrees to support health education has been noticed in USSR (WHO, 1963, p. 9) where health education was made the duty of every health professional, part of cultural activity, obligatory in schools and a mandatory four hours a month devoted to mass health education. In this way, significant success was achieved.

Sutherland (1979, p. 236) argues that if health education is to compete for funding, then it needs to demonstrate the value of its activities in economic terms. He recommends that it would be useful for health educators to choose projects with immediate pay-off in reducing the burden on health and social services, or projects which have short-term benefits in reducing mortality and morbidity rates. Nevertheless, some projects may still need long term implementation before significant changes are noticed.

It is also important to shed some light on the usefulness of mass media as an activity of health education. The effects of mass media are not easily quantifiable in economic terms. However, Ewles and Simnett (1985) perceive that mass media may raise health consciousness (agenda setting), increase knowledge, influence attitude and social change. All the same, mass media may encounter some difficulties due to the high cost involved in message design, dissemination, censorship and lack of feedback. Sharing the same opinion, Cernada (1992) observes that mass media need interpersonal communication with credible sources to stimulate behavioural change. He continues to see that regardless of the media chosen, local leaders should be involved and messages pre-tested for language, cultural sensitivity and effectiveness. Lin (1973) notices that mass media messages of an informative nature seem more effective in inducing change than messages based on emotional appeal (negative messages).

It may be useful to learn from the Mass Media and Health Practices Project in Honduras and Gambia (ICR, 1984) which reported that obstacles could be encountered through inadequate planning, training and orientation of health personnel, information and education on programme performance. However, the lessons learnt were that radio gives the biggest coverage supported by reading materials, plus credible health professionals. In addition, it was found that a comprehensive plan which takes into account existing audience practices and beliefs is crucial for the success of the project. In the same way, the American Public Health Association reported the same observations, but they also argue that radio broadcasts would easily succeed in Africa because they represent the continuation of oral tradition (APHA, 1982). In the same context, Meyer (1980) reveals that health education by radio and television could be more effective if the intersectoral approach is used. For instance, the reorientation of journalists on health matters may improve their scripts.

On the other hand, several commentators observe that folk-media may play a significant part in health education (WHO, 1988; Fehrsen et al., 1979). In this way, folk-media involves dissemination of health messages through poetry, storytelling, songs, theatre, games, puppet, dance, role play, town criers, shows and art amongst others. In addition to what we have already said about communication, Porter (1970) recommends that the Audio-Visual Aids Unit of the Division of Health Education needs to be manned by a professional health education officer. He advises that this unit needs to have sections dealing with loans, maintenance, professional training and consultancy, research and development production, cooperation and liaison with outsiders. The same commentator maintains that all health education officers need to be trained in the use of audio-visual aids as a teaching method. Macdonald (1988) sees
that researchers need to be linked to graphic artists in order to contribute to the design of such materials. The importance of locally made audio-visual aids has also been emphasised.

Research and evaluation of programmes play a central role in developing alternatives for solving the problems as they arise. In this context, Roemer and Aquilar (1988) argue that setting performance standards would be useful for quality healthcare and that corrective action for better quality would involve the improvement of basic training, continuing education and supportive supervision. These commentators observe that indicators of quality in health education may concern the measurement of the percentage of people exposed to health education activities, which, according to a simple test, have understood a specified proportion of the contents and found them acceptable. In many health education projects, a lack of evaluation may be due to inadequate funds but, all the same, continuous evaluation may be useful. Similarly, Engelkes (1990) observes that it may not be easy to evaluate primary healthcare activities because the baseline evaluation of the masses is not easily quantifiable and that other contributory factors may influence the results. It is recommended by the European Public Health Committee (1980) that evaluation at all levels needs to be a "sine qua non" of health education. The same commentator sees the need for monitoring the activities of market forces like advertising, which sometimes promotes the sale of products harmful or potential harmful to health.

Basch (1987) emphasises the value of using focus-group interviews as a qualitative research method for health education studies, planning, formative and summative evaluation. For all these reasons, Earp and Ennett (1991, p. 167) conclude that a single theory is usually insufficient to in-corporate all the variables of interest to the evolving conceptual models of health education.

**Strengthening Training for Health Education**

Training for health education has been recognised by many authorities, including WHO (1983, 1988) which urges all governments to support basic and post-basic training for health education. Therefore, some significant support has been noticed, especially in the areas of drawing policy guidelines on education for primary healthcare in Kenya. Perhaps constant lobbying for more support, particularly in the areas of reviving the training for health education officers and resource allocation, would be beneficial. According to the data available, the training curriculum for health education needs to be competence-based, continuous and dynamic in order to meet the challenges of the day. The case of Kenya shows that the curriculum was last revised in 1985 to include primary healthcare concepts and there is probably a need to constantly review it in order to reflect the changing demands and the actual tasks in the field. The problem of HIV/AIDS is a big challenge for us to look again at the training curricula for health education. It may be important to note that AIDS gives a chance to argue for more mainstream funding of health education activities. However, in Kenya, the tendency to concentrate HIV/AIDS activities at the National AIDS Secretariat denies the Division of Health Education its rightful duty and responsibility to educate Kenyans. The importance of selecting appropriate training staff, and especially those with an interest to teach, was emphasised by several researchers, including Giovanni and Brownlee (1982) and WHO (1979). The case of Kenya may be difficult to handle without improving incentives for the teaching posts. In the same way, the need for preparing teachers for the training posts is recognised by Macdonald (1988) who argues that such reorientations may be done through seminars, workshops and scholarships. It appears that such training would be beneficial if and when funds are available through the continuing education programme or donors. However, on-the-job training would be a partial alternative.

Review of other studies has revealed that the training methods for health education may be reinforced through experiential-training techniques which involve micro-teaching, peer teaching, simulations, grounded theory, practical interviews, critical-incident study, case study, audio-visual aids laboratory and field practice (Mullen & Reynolds, 1973; Porter, 1970; Foley, 1974; Strombeck, 1991; Giovanni & Brownlee, 1982). The case in Kenya may benefit from these suggestions, particularly when the trainers have been appropriately trained and the funding for practical experiences is secured. Incorporating some of the above suggestions into the existing curricula for health education officers in Kenya would be advantageous. The importance of training other health workers (including officers from other sectors) in health education is recognised by other authors who see the need for including health education in their basic curricula or to introduce the post-basic certificates in health education (Ewles & Simnett, 1985; Carlaw, 1988; WHO, 1983). With this in mind, it was again proposed that continuing education programmes would be suitable for training in communication skills and counselling. The use of self-learning materials for continuing education and teacher training was also found helpful (Strombeck, 1991). The Kenyan situation would benefit from these proposals, although there may be constraints due to lack of funds for organizing seminars, producing self-learning materials and negative support from trainers. In spite of this, it appears that the continued support for the training of health education officers and conducting continuing education seminars for all health workers, plus
officers from other sectors, would be a worthwhile alternative. It may be generalised from all the studies so reviewed that health education suffers from inadequate research into the guiding theories and training models. Therefore, there is an increasing need to finance for more research into these areas in order to supplement the existing concepts (Green et al., 1980).

CONCLUSION AND RECOMMENDATIONS
The foregoing study dealt with appropriate ways of strengthening community health education and the training for health education in order to improve on the effectiveness of the National Health Education Programme in Kenya. For this purpose, relevant experiences were drawn from the work of various researchers and discussed in the light of health education problems in Kenya, in order to draw suitable recommendations for improving the Kenyan situation. It was found that although health education encounters several constraints during its implementation, useful experiences can be drawn from other programmes or countries of the world. Some of these experiences may be taken as a whole or be modified to suit individual situations. It is proposed that the involvement of international bodies, like WHO, USAID, UNICEF and others, in support of the National Health Education Programme may yield significant benefits, especially through supporting community health education activities, training for health education and sponsoring sensitization seminars for policy-makers. In addition, the Ministry of Health should practically support preventive and promotive health services through explicit National Health policies and Development Plans which favour health education as an important tool for National Health Development.

There is also a need to reorganize the Division of Health Education through the introduction of management capabilities which would effectively spearhead the specialised activities of the division for the purpose of achieving National Health Education goals and objectives. Furthermore, training for health education officers should be revived and strengthened, through the training of trainers, a regular review of the curriculum, training methods, teaching aids and evaluation procedures. In this way, experiential-training techniques, HIV/AIDS education and management skills would be incorporated into the curriculum. Apart from that, the curricula for all health workers, including doctors, nurses, environmental health officers and other paramedical personnel, should be revised in order to include health education as a major subject of study. Moreover, intersectoral training through the continuing education programme would be advantageous in order to enhance teamwork while implementing community health education activities. In addition, the Ministry of Health should provide incentives and an attractive scheme of service for health education officers in the training department and those doing community health education as a means of boosting morale, performance and retention of personnel in the service. The Ministry should also strengthen the Division of Health Education through adequate resource allocation in order to effectively implement the main health education strategies of training, school health education, mass media, patient health education, production of educational materials, community education and administration of the Division of Health Education. On the other hand, in their normal duties, Health Education Officers need to consider the usefulness of Health Belief Model, principles of health promotion, local beliefs and practices opinion leaders, community health committees/workers, women's groups, informal discussions, personal control, focusing on benefits to the people, receptive target audiences, community development approach, multi-media approach, intersectoral collaboration, production of local educational materials, translation of existing materials into Swahili, use of folk media, preference for both short-term and long-term health education projects.

Furthermore, the National Health Education Programme would be effective if adequate support is given to research and evaluation needs through allocation of funds and skilled manpower. In this way, research into the guiding health education theories, training models and appropriate Audio-Visual aids would be necessary. Again, preference for continuous evaluation as a 'sine qua non' of health education plus the use of focus-group interviews would be beneficial to the programme. Besides that, although it may be helpful to judge health education’s effectiveness through achievement of educational, behavioural and medical outcomes, consideration should be made for setting a standards committee at Headquarters to monitor the performance standards for quality health education services.

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