

EDITORIAL

Health education in Africa: 1975–2000

The past 25 years have seen some major developments for institutionalizing health education training, practice and research in Africa. The year 2000 provides a time to reflect on progress, and consider gaps and challenges in organizing and promoting health education in Africa. While much of the focus herein is on the African Regional Health Education Center (ARHEC)¹, which is 25 years old this year, the authors recognize that many organizations have contributed to the development of health education in Africa in the past quarter-century. Hopefully this writing will stimulate others to share their experiences.

Professional training

The need for African-based training in health education was voiced as early as 1969 by the Organization of African Unity (Johnson, 1988). Over the years professional and in-service training in health education has been organized by African and other (e.g. Nigeria, Zimbabwe, Ghana, UK) universities, ministries of health (MOH, e.g. Kenya), international and bilateral agencies (e.g. UNICEF, WHO, USAID), and non-governmental organizations (NGOs, e.g. AMREF). ARHEC was founded in 1975 at the University of Ibadan in Nigeria (Ademuwagun, 1978). Since its inception ARHEC has been linked to many of the major developments in health education in Africa and beyond, and these experiences have enabled its staff to view the gains in health education as a profession and discipline within public health as well as to evaluate critically the shortcomings of health education on the continent.

ARHEC was founded jointly by the World Health Organization (WHO), the Nigerian Federal Ministry of Health and the University of Ibadan, after an extensive review of several potential university sites by a WHO team in 1972. (Parallel development of a training center for the Franco-phone countries was slow and the final result was a post-graduate diploma in public health for physicians based in Benin Republic.) The need for

African-based training in public health generally and health education specifically was advocated for several reasons, primary among which was the need to base professional training in a culturally relevant setting so that graduates would be in a better position to apply their new knowledge and skills more easily when they returned home.

A corollary of this need was the development of culturally appropriate training materials and experiences. Simply basing a training center in an African university would not guarantee that the content of teaching would differ from that obtained in European or American classrooms. Thus, the staff and students were involved in the active generation of new knowledge about the planning, implementation and evaluation of health education in an African context.

Since 1975, ARHEC has trained students from 17 African countries with the assistance of sponsors such as WHO, UNICEF and the West African Health Community. ARHEC was established as a unit in the Department of Preventive and Social Medicine, College of Medicine, in part because the Department had a multidisciplinary base of public health professionals and partly to stimulate the Department to develop other academic post-graduate public health training programmes. Three main teaching programmes evolved at ARHEC, as well as the potential for short in-service training courses.

The Advanced Diploma in Health Education (ADHE) was designed to upgrade the many personnel such as health inspectors, nurses and teachers at state/province and district level who had been functioning as health educators but who had never received formal training (Adeniyi and Brieger, 1981; Brieger *et al.*, 1981). Thus, ARHEC has been a major supplier of front-line health educators in the continent, with over 650 ADHE graduates to date. These efforts have been complimented by similar diploma courses that were subsequently established at Leeds Metropolitan University in the UK and in Zimbabwe.

The second major programme and, from the academic and professional point of view, the center-

piece of ARHEC's mission was the Master of Public Health (MPH Health Education) course (Adeniyi and Brieger, 1978). Since ARHEC aimed at contributing to the growth of culturally relevant health education practice and research in Africa, a 2-year programme that combined academic study, field work and research was adopted. To date, over 230 students have enrolled in the MPH programme. Finally, a PhD programme started on a small scale in the 1980s and has produced 10 graduates.

The founding sponsors of ARHEC hoped that its graduates would initiate the development of similar training centers in other African universities, but this has not materialized. In the meantime, due to political instability in Nigeria, ARHEC has not been fulfilling its continent-wide training responsibilities. The most recent non-Nigerian to be enrolled at ARHEC began his MPH in 1995. Political instability in Nigeria was reflected in numerous strikes by students as well as academic and non-academic staff of universities as well as the general workforce. By the year 2000, the University of Ibadan itself had lost two full academic sessions. This unstable political and academic situation meant that students often had to be enrolled for an extra year, which was not satisfactory for sponsors or employers of health educators-in-training. Those who could obtain the funds have sought training outside Africa.

In-service training

Pioneering efforts in health education human resource development preceded 1975. WHO's regional public health training center in Lome, Togo was active in providing in-service training in health education for Francophone African countries. The Danfa Project in Ghana, funded by USAID and implemented by the University of California at Los Angeles, innovated in the training of community-level health educators around the issues of family planning and endemic diseases (Ward *et al.*, 1988). With the advent of the primary health care (PHC) concept in 1978, the need for health education training was accelerated.

The US Centers for Disease Control (CDC; now Centers for Disease Control and Prevention) played

a major role in strengthening health education services during this 25-year period. In 1981, CDC became the lead implementing partner for the USAID African Child Survival Initiative—Combating Childhood Communicable Diseases programme (ACSI-CCCD), which focused on childhood immunization, and control of diarrheal diseases and malaria. CCCD drew on the health education resources of CDC's International Health Programs Office and the Academy for Educational Development in Washington to strengthen health education services in 13 African countries. ARHEC played a key role in CCCD as consultants and trainers.

A partnership among CDC, ARHEC and the Department of Health Behaviour and Health Education at the University of North Carolina (UNC) School of Public Health in Chapel Hill developed a unique interdisciplinary training–consultation model (Oladepo *et al.*, 1991). The workshops brought together teams of health educators and programme managers of other service units for 4 weeks to develop actual health education plans for implementation on return to the worksite. Two follow-up consultation visits to the trainees were conducted by joint ARHEC–CDC–UNC teams at 3- and 6-month intervals. The teams met with the trainees and MOH officials to learn how the plans were progressing and provided consultation to enable the health educators to implement their plans. CDC teamed up with ARHEC and Tulane University's School of Public Health to initiate this training–consultation model for Francophone countries. The workshops were based within the School of Public Health, University of Kinshasa in the former Zaire. The CCCD programme resulted in a variety of health education training modules and guidelines (CDC, 1986, 1993a,b; Berney and Olukoya, 1993). Currently there are no in-service training programmes with a similar continental perspective.

A positive development has been the expansion of health education to the district level. For example, a country-based training model was developed by UNICEF Uganda which involved ARHEC and ARHEC graduates in the Uganda

MOH in developing, delivering and evaluating a training programme for health educators to staff each of the more than 30 districts in the country. At ARHEC, more ADHE applications are being received from health workers who are based in local government health departments, as opposed to state and national agencies. Another growth area for health education training observed in Nigeria is increasing independence of health education from physical education in faculties of education, thus creating a new pool of first degree holding health educators.

Health education resource development

The first textbook on health education developed in Africa was published by the African Medical and Research Foundation (AMREF) (Scotney, 1976). Five over-riding themes for health education practice in rural Africa were drawn from experiences in several countries over many years and included:

1. People are different and need to be approached in different ways.
2. Health education must change with changes in services and changes in health problems.
3. Developments in psychology, sociology and related sciences—the behavioral sciences—have provided new foundations for skillful health education.
4. All health education efforts need to be carefully planned and the results measured.
5. Just as health services depend on team efforts, so a team effort is required for health education.

AMREF continues to use these principles in implementing community health and education programmes throughout the region (<http://www.amref.org>).

During its third academic session, ARHEC was contacted by the Health Education Unit (HEU) of the WHO Headquarters to develop a manual on health education practice. Although the manual was meant for worldwide use, it was expected that ARHEC would draw on its field experiences to write a book that would have practical value to health educators in Africa and other developing countries. The book went through two field-tested

drafts and finally emerged under the title *Education for Health: A Manual for Health Education in Primary Health Care* in 1988 (WHO, 1988). It has been translated into several languages. In addition, the active involvement of ARHEC staff in guinea worm eradication research and programming led to the development of several training and programme guidelines (Brieger and Rosensweig, 1988; Silverfine *et al.*, 1991; Brieger, 1992), which were used by US Peace Corps Volunteers and health staff in endemic countries throughout sub-Saharan Africa.

Carlaw and Ward (Carlaw and Ward, 1988) also contributed to health education material and professional development through the publication of *Primary Health Care: The African Experience*, a second volume in their series of case studies on community health education. This volume contained 17 chapters that describe the planning, implementation and evaluation of community health education and training programmes in 10 Anglophone and Francophone countries. These provide a valuable guide to the health education practitioner.

Development of Internet tools for health education in Africa has begun. The African Region of WHO has developed an on-line health information package (ARFOPAC) 'to enable people cope with basic health problems', according to Dr Ebrahim M. Samba, the Regional Director (<http://whoafr.org/dcp/afropac/>). Dr Samba further stated, in the spirit of self-reliance which undergirds primary health care that, 'I firmly believe in the use of information as one of the tools for promoting health. I have no doubt that, if properly used and widely disseminated, this publication can set off a movement for better health through self-help'.

While the foregoing provide valuable context-relevant examples of health education practice needed in the training and support of health educators on the continent, such resources are not universally accessible. Purchase of books by health educators in Africa is often inhibited by high prices, problems of currency exchange and out-of-print status. Even though Internet access is rapidly increasing in Africa, basic telecommunications infrastructure is still problematic in most countries.

Health education practice

The essential role of health education in PHC, and following from this the importance of health education services in health ministries and departments, has been clearly recognized (WHO, 1978; Federal Health Education Unit, 1981; Carlaw and Ward, 1988; Egwu, 1989–90; Dehne and Hubley, 1993). Johnson (Johnson, 1988) described the unique challenges facing health education in Africa in the 1978 Alma Ata Declaration on Primary Health Care. He explained that, 'In Africa, health education has promoted the non-formal participatory approach to community-based health program development, characterized by a process that enables, encourages, supports, and facilitates but does not impose'. This participatory approach lies at the heart of Alma Ata, but is not easy to implement since:

Many health professionals, administrators, and political decision makers are comfortable with centrally determined priorities and solutions. Some appear to feel insecure with the community control emphasis promoted by the health education and primary health care approaches, and react with strong advocacy and marketing techniques to maintain the centrist position.

The role of health education in PHC was well articulated at the First All Africa Conference on Health Education, which was held in Lagos from 31 August to 5 September 1981, and was attended by nearly 400 delegates from 33 African countries and several international and donor agencies (Federal Health Education Unit, 1981). Organizers included the Health Education of the Nigeria Federal Ministry of Health, WHO, International Union for Health Education and ARHEC through the Department of Preventive and Social Medicine. The conference speakers addressed six major themes concerning health education practice and development:

- (1) Health education in the context of health care delivery with special reference to primary health care.

- (2) Policy, organization and administration of health education services.
- (3) Health education human resource development and training.
- (4) Promotion of health education through international cooperation.
- (5) Communication and media technology in health education.
- (6) School health education.

Of the dozen recommendations that were developed in the closing sessions of the conference, two were essential to the growth and development of health education services on the continent:

6. The conference recommends that Governments should set up health education service units where these do not already exist, and to strengthen those that exist, giving them respectable ranks in the administrative hierarchy and the means to make them able to reach the people.
7. The conference recommends that in order to ensure proper leadership in Health Education, Health Education Units should be staffed by well-qualified Health Educators. The provision of such personnel is contingent on the continuous training of health educators of different cadres in appropriate educational institutions.

The reality on the ground has been reflected at various points in time and in various countries, e.g. Egwu (Egwu, 1989–90) observed 9 years after the All Africa Conference that the Nigerian Federal Health Education Division (FHED) 'appears to lack dynamism, innovation, and leadership'. Furthermore, 'the FHED does not initiate its own programs...only play(ing) a supportive 'service' role in other nongovernmental and voluntary agency programs, on an *ad hoc* basis'. As in many countries, activities of the FHED to this day are primarily a response to donor support instead of local initiative and grantsmanship.

Lack of programming initiative may in part be traced to the effect of selective primary health care on limiting the focus and scope of health education programming to specific health technologies that were priority concerns of health professionals and

donor agencies. This resulted in a behavioristic or atomistic approach to health education wherein the emphasis was on changing specific health-related behaviors rather than improving health and the quality of life in a community through the full participation, including priority setting, of the people themselves (Brieger, 1996). Thus, for example, one saw the divergence of guinea worm eradication away from developmental efforts such as community involvement in improving water supplies, to education and information efforts that stressed adoption of specific individual behaviors such as filtering drinking water (Brieger *et al.*, 1997).

Dehne and Hubley (Dehne and Hubley, 1993) identified other problems that affect the function of health education services using the HEU in the Zimbabwe MOH as a case study. Location of the unit within the larger Maternal and Child Health Services was found to limit its interaction with other service units and programmes. This limited the coordinating function of the HEU across various departments and agencies. Despite increased opportunities for health education training, staff of the Nigerian Federal Ministry of Health observed that, 'Few health educators carry out well planned programmes with demonstrable outcomes', which was attributed in part to 'the low status accorded health education by health policy makers' (FMOHSS and USAID, 1992). A vicious circle of poor performance, scant attention by policy makers, paltry allocation of resources and poor performance due to inadequate resources was thus identified. Green and Kreuter (Green and Kreuter, 1999) termed this the 'poverty cycle of health education'.

The consultation component of the ACSI-CCCD-sponsored training-consultation interventions provided further insight into why health education units met difficulty in delivering quality services. Not only were HEUs often placed at the bottom of the MOH organizational chart [as also observed by Dehne and Hubley (Dehne and Hubley, 1993)], they were staffed by people with diploma level training (health inspectors) or university degrees in non-health fields. Within the MOH

setting, non-physicians have generally found it difficult to gain recognition and make progress even with the addition of a diploma in health education. Schemes of service are often lacking that would enable health educators to advance within their own professional cadre.

Even with the afore-mentioned barriers to health education practice, there are many positive developments. The CCCD project emphasized the use of formative research, especially using qualitative methods, in planning and evaluating health education programmes (Glik *et al.*, 1986-87, 1989; Cutts *et al.*, 1990; Eng *et al.*, 1990, 1991; Brieger *et al.*, 1996-97). CCCD projects also stressed the need to work with existing resources and begin health education realistically at points in the health system where contact with clients already existed, i.e. in a front-line clinic setting (Naimoli *et al.*, 1996).

Another positive development has been the African Programme for Onchocerciasis Control (APOC), which was established in late 1995. APOC has adopted as its main strategy community directed distribution of ivermectin (CDTI) (UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, 1996; Amazigo *et al.*, 1998). CDTI involves training district and front-line health staff to undertake health education and community organization to enable communities to plan and implement their own village-level distribution programmes using the supplies of the drug ivermectin donated by the manufacturer. Health educators in Africa have played a major role in training, monitoring and material development to ensure the success of CDTI in 17 endemic countries.

Professional identity

The All African Conference of 1981 set the stage for the development of professional identity for health educators in Africa. The Conference recommended that:

In order to be able to continue this laudable job which the Federal Government of Nigeria and other supporting organizations have begun, the conference exhorts National Governments to support the All Africa International Union for

Health Education, Zonal and National Associations for Health Education, morally, financially and materially. The conference holds that with the strong support of National Governments, Africa's health educators will always be able to meet to discuss and find answers to those common problems that continue to hold back her people's development efforts.

Unfortunately, the first conference was, to-date, the last.

During the Conference, the Africa Chapter of the then International Union for Health Education (IUHE) was formed with an Anglophone President and a Francophone Vice-President. Five Zonal Directors were nominated. An ARHEC staff member was selected as Secretary to the body. Prior to the conference, ARHEC organized an alumni meeting. The upcoming Conference enabled graduates from other African countries to piggy-back their sponsorship and attend both events. The need for an alumni association was aired. Neither the African Chapter of the IUHE nor the ARHEC Alumni Association survived these good intentions.

Efforts were subsequently made to form sub-regional groupings, e.g. in eastern and southern Africa and in a few Nigerian states. A recent inter-country consultative meeting held in Nairobi considered reviving efforts to establish a professional association. It was recommended that the International Union for Health Promotion and Education (IUHPE; formerly IUHE), 'formally establish as IUHPE Regional Office for Africa, in close collaboration with WHO, based at the African Medical and Research Foundation' (International Union for Health Promotion and Education, 1999).

Professional and alumni associations require major resources, and these usually come from membership fees and contributions. The near subsistence salaries earned by civil servants and university personnel in most African countries provide little spare funds for investing in professional development. Even so, it is not reasonable to expect a donor to provide all the support needed to launch and sustain such bodies. Some level of member investment is needed to demonstrate commitment and ensure sustainability.

Research

The past 25 years has produced a wealth of health education research in professional journals and books. A major concern is the ability of this research to influence health education practice and policy is the question of access (FMOHSS and USAID, 1992). Few school or health department libraries in Africa, let alone individual health education professionals, can afford to subscribe to journals. Student dissertations and theses, if not developed into articles, are available only in university libraries. Identifying a timely and inexpensive means for sharing and disseminating health education research findings within Africa remains a challenge for health education into the next 25 years.

A fair amount of health education research in Africa has been published. A review of two health education journals, *Health Education Research* (HER) and *International Quarterly of Community Health Education* (IQCHE), provided an overview. IQCHE started publishing in 1981 and has completed 18 volumes. HER, which began in 1986, is in its 15th volume. During this period 122 articles concerning Africa were published in the two journals. Most (88.4%) had at least one Africa-based author. Over half (52.7%) were based on studies and programmes in Nigeria. Zimbabwe accounted for eight articles, South Africa for seven and Egypt for six. The largest number of articles (46.4%) could be classified as formative, baseline or survey research concerning health behaviors and antecedent factors. Many (27.7%) tested and/or evaluated a health education intervention. Some (20.5%) were programmatic, being either a case study of a health education programme or lessons/guidelines learned from a programme. Finally, a few (5.4%) could be classified as commentaries about health education issues and practice.

MPH students at ARHEC did fulfill their role in conducting health education research. Due to the relative short time available to conduct their projects in the second year, many students opted to carry out surveys that examined the social, cultural and cognitive factors associated with key

health behaviors such as health care seeking during illness such as malaria and diarrhea, alcohol consumption, participation in immunization programmes, and utilization of family planning commodities. Others were evaluative in nature and looked at the effect of existing educational programmes such as those promoting oral rehydration therapy and road safety. A fair number conducted intervention or quasi-experimental projects that shed light on appropriate health education methods in an African setting. One project determined that volunteer village health workers were able to influence knowledge about guinea worm transmission and community action to construct wells, protect ponds and filter water (Akpovi *et al.*, 1981). Another student designed a training programme that increased patent medicine vendor knowledge of appropriate management practices for common illnesses including malaria, diarrhea and sexually transmitted infections (Oshiname and Brieger, 1992). A student with a nursing background designed a model patient education programme for post-surgical pain management and demonstrated that educational methods could reduce consumption of pain-killing drugs (Edem *et al.*, 1985).

The ACSI-CCCD project of USAID sponsored a review of field and research reports in 1992, to learn about the 'efficacy of health education in Nigeria' (FMOHSS and USAID, 1992). A total of 23 studies and projects that took place between 1980 and 1992 were reviewed. In the introduction of the document, the then Deputy Director of the Department of Primary Health Care and Disease Control, Federal Ministry of Health and Social Services noted that, 'It is the task of health educators to demonstrate in a convincing manner that health education provides unique services'. The document identified studies in the fields of community health education, patient health education, school health education and health education in the work place. The team that compiled the report concluded that while, 'The reviewed articles and reports have clearly shown that health education works in different settings...(there is also a) dearth of intervention and evaluation studies'.

A specific contribution to health education

research made by ARHEC was the role of local knowledge, including indigenous organization (Brieger *et al.*, 1987-88; Brieger and Kendall, 1996), to a social-cultural understanding of tropical disease transmission and control. The issue of guinea worm disease (dracunculiasis) was a primary example of how health education helped define the social-cultural context of disease transmission and control. The importance of a multi-strategy approach was demonstrated (Brieger *et al.*, 1991). As well as the need to account for local explanatory models of health and illness in designing public health interventions (Ramakrishna *et al.*, 1985-86; Brieger and Kendall, 1992; Brieger *et al.*, 1996).

Conclusions

The past 25 years of health education in Africa has experienced the growth of indigenous health education service, training and research programmes and activities. Research in Africa and by Africans has provided a basis for developing culturally relevant principles of practice for training and service. In 1988, Adeniyi observed that Africa was witnessing considerable changes brought about by population movement, industrialization and new patterns of life resulting from the cultivation of Western life-styles by increasing numbers of Africans. Such changes were predicted to impact on emphasis and direction in health education. In fact, Africans now suffer from a deadly mix of infectious and non-communicable diseases. What was not foreseen in 1988 was the extent of economic recession arising from structural adjustment programmes, the political instability and civic unrest resulting from ethnic strife and militarism, the devastating consequences of HIV/AIDS, and the resurgence of diseases like tuberculosis and malaria. The economic impact of tropical diseases is only recently being given full attention and can be seen as a major component of the ongoing economic crisis in Africa. In this crisis environment, it is not surprising that resources for public health and health education have declined.

Today at the dawn of the 21st Century, the situation of health education practice in Africa is far from encouraging, in spite of at least 25

years of concerted inter-agency effort to develop a science base and human and financial resources. During the recent years of political instability in many countries, official development assistance has come to favor the private, commercial, NGO and not-for-profit sectors over MOHs for planning and implementing health education programmes. To the extent that health education programmes do not rely on a functioning public health care system, development assistance does not need to flow through the public sector, and yet training and research, in particular, are largely public sector activities since most African universities are run by governments.

A positive unforeseen factor has been changes in health education technology. There is growing, though uneven access to computers and the Internet. This is leading to an increasing likelihood that health education resource materials will be acquired and shared through this medium rather than through more expensive print (books and journals) and travel (conferences) sources. A sound and less expensive investment for carrying health education into the next quarter century may be providing HEUs and university training programmes with Internet access so that they can share among themselves, and continue to develop and evolve an African base of knowledge for health education practice. This will open up a world of Internet distance education and publishing to African health educators and enable health educators throughout the world to learn from Africa.

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Note

1. As of July 2000, the National Universities Commission of the Nigerian Federal Government gave ARHEC full Departmental status within the University of Ibadan to become the Department of Health Promotion and Education.

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