A synopsis of the field of health education in Malawi

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Health education can be defined as "any combination of learning experiences designed to facilitate voluntary actions conducive to health"[1]. Health education is therefore a planned activity, it is not haphazardly done. There are goals and means. Planning is the best predictor of success and "planning mistakes is the best predictor of failure"[2] . Health education is subsumed under the broader term "health promotion" which itself is said to be "a combination of educational and environmental supports for actions and conditions of living conducive to health". [1] This definition is broader and encompasses social, economic, political and environmental factors that come into play in influencing health behaviour.

The field of health education is said to have been primarily a practice-based discipline throughout its history. Its origins can be traced to three traditions defined by the settings in which they operated. These settings were schools, communities and hospitals. One theme that has characterised the development of the field has been the search for an identity. School health education for example "Struggled for a professional identity separate from physical education"[3]. More recently within the last two decades health educators have attempted to borrow, develop and apply social and behavioural theories to guide practice. Freudenberg et al. point out that four trends have changed the practice of public health in recent years. First the distinctions among chronic, infectious and "social" diseases have become blurred. Health is now seen in a more holistic perspective rather than in categories each requiring a different focus; they all relate to one another. The second change that has impacted public health is the gap in health status between the rich and the poor. Third, the increased multiethnic environments in which health education practitioners work in the west. This has meant that the increased plethora of cultural values related to health has led to the recognition of the need to appreciate variety in approach to dealing with health education related issues [4].

History of health education in Malawi

The origins of health education in Malawi are grounded in efforts to address the practical problem of sanitation[5] . The colonial government in 1933 passed a Native Authorities Ordinance giving the traditional chiefs the mandate to order hygiene and sanitary measures on their people. The chiefs imposed the construction of pit latrines on the people who dug without using them. No explanation or rationale behind the orders were ever given to the people. The same thing is reported to have also happened in Botswana[6] . Since this approach did not involve consultation with the people, the latrines were associated with colonial oppression and not seen as a means of improving health. Bomba cites the Nyasaland Medical Department of 1948 as lamenting: "latrines tend to be regarded as objects to show rather than conveniences to use"[3] . After Malawi gained independence in 1964, government removed the legislative approach and instead introduced an educational approach with maximum community participation. Three education strategies were adopted, the first being education on germ theory, the second, promotion of pit latrine usage as a status symbol and the third, bush clearance.

In 1964, Malawi Government came up with the first of its Five year plans (1964-1969) which focussed on the development of health manpower. Not much thought was given to health education. The first health educator was trained in 1973. Another was trained in 1981[7] . In 1982 in line with the developing ethos of primary health care, a mobile health education unit was established in Malawi. This comprised the production of materials and a reservoir of visual aids. Outreach took place in the form of vans going into rural areas with personnel performing a variety of health education activities [5].

A focus on primary health care is the philosophy that underpins the Malawian health services delivery system. Chowa[8] asserts that health education in Malawi cannot be carried out in isolation from other health programmes. Health education is therefore "a support service which catalyses other components so that action is taken by individuals, families and communities… behaviour change is the end product"[9]. Currently the Malawi Government information, education and communication activities are guided by health education strategies. It is believed that increased public awareness "facilitates involvement and participation, and promote activities which will foster health and encourage people to want to be healthy, know how to stay healthy and do what they can individually or collectively to maintain health and seek help when needed" [7]. Because of material and financial resource limitations, government has had to focus on activities that directly impact vulnerable groups especially women and children [6] .

Health education in Malawi is co-ordinated by the government and is based at a central level. Under the Ministry of Health and Population there is a Health Education and Social Mobilisation unit. Its aim is to "strengthen the health education component of health services so that it is capable of promoting health behaviour which will make positive maximum impact on the major health problems of the country" . The main focus of these activities is at the community level. Ultimately all health care delivery systems of all programmes, be they immunisation, targeting specific diseases or dealing with an outbreak, are aimed at the community. The function of health education activities in Malawi is the synthesis and translation of the various health messages "into meaningful packages" in the areas of health targeting the vulnerable groups . In terms of the goals and overall objectives of health education, Chowa sees no difference between Malawi and industrial countries.

The current health education field

Health education plays a key role in a variety of non-governmental organisation (NGO) activities in developing countries including Malawi. These activities range from child survival, reproductive health, nutrition, safe motherhood,

and diarrhoea to AIDS prevention programmes . More recently there has been an "ecological" slant to health education placing it in a wider context to include facets of a person's environment, such as social support systems and community factors as well as public policy. Robertson & Minkler describe this wider approach as a revolution for the field. They refer to it as a new health promotion movement and list four characteristics:

1. A broadening of the definition of health to embrace social and economic environments that influence health.
2. A move from individual emphases on intervention to encompassing wider social and political strategies.
3. The concept of empowerment has been included as central to health education intervention.
4. Community participation as part of the intervention in which the community is involved in the identification and planning of health interventions.

There are several current approaches to health education. Consequently inherent tensions exist between them. The different approaches are grounded in theoretical and underlying philosophical assumptions. Stetson & Davis (echoed by Robertson & Minkler) list three main health education approaches. Firstly, conventional health education, which emphasises knowledge acquisition. Secondly, health communication, which seeks to modify human behaviour and environmental factors. The objective is to market changes in health-related practices and subsequently, health status. This includes the social marketing approach, which attempts to influence a socially beneficial idea or the use of certain products such as condoms. The key method of delivery is through strong persuasive messages or communication [14]. Also under this approach fall the models of behaviour change. The third approach is health education for empowerment which aims at empowering the target population.

Health education in the school setting

Settings are channels for reaching defined populations. The most common settings are schools, the workplace and medical care facilities[15]. Vast numbers of health education interventions have been conducted in institutional settings. The World Health Organisation (WHO) asserts that schools are "one of the most organised and powerful systems in society to influence the health and well being of those who come into contact with it"[16]. In developing countries, the focus is on contagious infectious diseases [17].

Despite advances in child survival, the threats to health experienced by school-aged children can retard most of these advances[18]. Parasitic infections, malnourishment and other diseases mediated by poor sanitation, lack of access to safe water remain prevalent among school children [19]. Schools are the primary institutions that exist to socialise children [20]. Since the formative period occurs during the school years, health-promoting schools are seen as being strategically placed to address the numerous health challenges in the world. Such schools can co-ordinate the delivery of both education and health services and in so doing can provide the arena for improvements in mankind globally[21]. Over one billion students can be reached world-wide, and through them their communities and immediate families. Schools are thus the "developing world's broadest and deepest channel for putting information at the disposal of its citizens"[22]. However, the resources required to take advantage of this are not in place. Reality lags behind the potential. There is usually a shortage of money, time and qualified personnel[23]. In Malawi, lack of resources includes teachers, classrooms, safe water, books and desks.

The educational system in Malawi operates on three levels: primary, secondary and tertiary. Primary education lasts for eight years at the end of which pupils sit for a primary school leaving certificate national examination. Places at secondary school are limited and very competitive [24]. In 2008 for example, 77,000 primary school pupils sat the primary school leaving examinations and competed for 10,000 secondary places. There is also a high dropout rate. Hence most Malawians do not go past primary school. Primary schools therefore are the most strategic place to reach with health education messages.

Teachers play an important role in the dissemination of school health education[25]. Stage theories of innovations point to the importance of targeting teachers. Green[26]argues that models from mainstream health services cannot be imposed wholesale on school health as this can lead to "misplaced emphasis" (p.793). Schools are neither medical institutions nor public health agencies[27]. Their primary role in society is to provide education and academic development[28]. Although schools can influence predispositions to health behaviour (increasing knowledge, shifting attitudes), they are dependent on community health promotion interventions for the reinforcing and enabling of behaviours. The community is therefore crucial[29]. There is greater chance of success if interventions are simultaneously implemented through schools and their communities[30].School based delivery of interventions is assumed to be cost-effective given the ready accessibility of school children[31].

The most effective ways of disseminating health information among school children has been the use of peer education. As a concept however, peer education has no clear-cut theory accompanying it. It is "a method in search of a theory rather than the application of theory to practice"[32]. The concept has been applied in smoking reduction exercises and substance misuse in the west and is currently being used for HIV transmission control in Africa[33]. The rationale for the employment of the peer education concept includes cost-effectiveness, the credibility of peers as a source of information, the empowering of those involved, the positive role models, the use of already existing networks of sharing information and the ability to reach a wide range of people[34].One peer education philosophy is the Child-to-Child approach[35]. This was established in the U.K in 1978 and is now used in health education programmes in over 70 countries around the world. The main thrust is children being able to take responsibility for themselves and their families and contributing to their communities. The philosophy behind it is guided by the notion of the empowerment of children. Children are therefore to be seen as partners in promoting health.

The design, delivery and effectiveness of health education interventions will be increased if they are guided by theory[36]. In addressing health issues pertaining to young children, recognition of the developmental stages or epochs needs to be made[37]. These epochs may have ramifications for the reception of the message and methods of health education delivery. Epochs are associated with influencers of the child. From ages 7 to 11 for example (when Malawian children begin primary education), wider contacts with peers are made and other adults (teachers) now enter the child's spectrum of influence[38]. An ecological approach is therefore required since there is a complex set of interactions between the child and his or her family, school and the wider community. Many school programmes lack systematic monitoring or evaluation. Measurement of immediate changes such as knowledge as well as more long term changes such as health status need to be made[39]. The most efficient ways of organising delivery need to be evaluated in the school setting.

A primary objective of school health education delivery – whether as a specific curriculum-based subject on its own or as part of a community-wide intervention targeting a specific disease – is to encourage the adoption of health conducive behaviour.

Barriers to effective health education

What factors hinder health education? Hubley[40]argues that there are four overlapping factors at play. These are first, failures in the planning process of the health education intervention. Hence the objectives may not be appropriately selected.

Second, communication failure in reaching the intended audience to the extent that the message may be presented in a culturally unacceptable way. Third, organizational failure in the delivery of health education services. This could be compounded by the weak status of the specialist health educator. Fourth, failure in the evaluation process and the translation of research findings into decision making. It is the recognition and addressing of each of these factors in the course of intervention that will ensure an effective health education campaign.

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Poems

My Heart

My heart is no bigger than my fist,

It works harder than my wrist,

It takes three things at least,

To keep it healthy,

If you want to become wealthy,

So here is what you do,

Exercise enough,

To keep it tough,

Eat good food,

You should be in a better mood,

Don't smoke,

It may cause you to choke!

Smoke Rap

Smokens bad

It ain't cool

Cigarettes can get you kicked out of school

'You ain't cool if you smoke

Smoken makes you look like a dope.

'Your skins looks old

Your breath smells bad

Your lungs turn black

like a big black bat

'You can't breathe

Your lungs can't work,

You gasp, you yelp, you're deeeeeeeead

'So you tell me

Whad do ya do

If some dude says

you wanta smokem?

'Just keep this little rap

in your mind and say no

No, No, No, No, No