An Assessment of Health Education carried out for Mothers at Health Units

A Case study of two units in Busia District

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October 2004

Acknowledgements

This study would not have been possible without the support of District officials in Busia District. Special thanks go to the Deputy Director District Health Services and the Chief Administrative Officer who made the preparatory work smooth. Special thanks also go to Mr. Mayende the Ag. District Health Educator for his time and for all the prior arrangements and support during the research process which enabled the research to go ahead smoothly. Special thanks go to Masafu Health Centre Staff namely, Mr. Mangeni, Ms. Mulongoti, Ms. Namugaya, Mr.Sanya and Mr. Ochen and others who shared their experiences with health education at the unit level freely and allowed the researchers to sit in their health education sessions. Special thanks also go to Mr. Baraza the In-Charge at Lumino Health Centre and his staff at the health unit who spared the time to be interviewed and also allowed the research team to sit in and observe their health education sessions. Special thanks also go to the many mothers who agreed to be interviewed as they left the units sometimes having waited for several hours. Without their cooperation this study would not have been complete. Special thanks also go to Ms Twebaze and Mr Mutumba from CHDC for all their administrative support and to Ms Kabayoro for her secretarial support.

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1. Introduction

1.1. Background to the study

The importance of education for the health of individuals and their children is a well-established principle of development policy. Public health research throughout Africa has demonstrated that people who have been to school are better users of health services including family planning and that their children are healthier and more likely to survive (Caldwell, 1997). The introduction of Universal Primary Education in many African countries including Uganda is partly in recognition of this fact. This however is a long-term intervention that seeks to get all children of school going age into school. For the shorter term, the question remains what can be done to reduce the high child mortality among children born to mothers with no schooling in developing countries? What lessons can we draw from the way schooled mothers care for their children and use health services that could help unschooled mothers to care for the children better and to use health services more effectively to the benefit of their children? How can health workers at health units be made more sensitive to the needs of unschooled mothers, and how can health education be used to promote more effective use of health services especially by unschooled mothers? These and many others were the questions, which prompted this research project.

In 'Facts For Life' produced by UNICEF, WHO and UNESCO (1993) ten key behaviours for improvement of child health are identified, these include:
Health behaviours, which was defined as actions that healthy people undertake to keep themselves or others healthy and prevent disease. Examples of these were hygiene practices, tooth brushing, taking anti malaria drugs, reduction of health damaging behaviours such as smoking, bottle-feeding, excessive alcohol consumption and accidents. These behaviours may be based on decisions or are done regularly and have become habits or routines.
Utilisation behaviours, which was defined as utilization of health services such as antenatal, child health, immunization, family planning and screening programmes.

Illness behaviours, which included recognition of early symptoms and prompt self-referral for treatment, such as oral rehydration.
Compliance behaviours, which included following a course of prescribed drugs.
Rehabilitation behaviours, which included what people, need to do after serious illness to prevent further disability.
*Community action***,** these were defined as actions by individuals and groups to change and improve their surroundings to meet special needs**.**

The assumption made here is that if parents of young children especially mothers were to adopt these behaviours their children's health and survival would greatly improved. This study was predicated on the observation that health education carried out at health units could help mothers with young children adopt behaviours such as attending, antenatal care, immunization sessions for themselves and for their children, family planning and screening programmes. It could also equip mothers with abilities to recognise early symptoms and prompt mothers to take their children for treatment, prepare and administer oral rehydration and to follow courses of prescribed drugs.

1.2 Statement of the Problem

Busia District has a high Infant Mortality Rate of 138/1000 live births and a high Under Five Mortality Rate of 152/1000. The Total Fertility Rate is 7.1 and the Maternal Mortality Rate is 504/100,000 live births (District Health Plan 2003/2004). A study carried out in Busia district in 1997, revealed that many children in the district were born and brought up in an environment of poverty, food shortage, poor sanitation and unprotected water sources as a result many of them were ill often and suffered malnutrition. The study showed however that children born to mothers who have been to school were less likely to die of these conditions, this could have been because schooled mothers used preventive services for themselves and for their children more but many of the dangers to children's lives in the district such as malaria and acute respiratory infections could not be avoided by immunisation. This suggested that children of mothers who have been to school may have survived these diseases because their mothers were

better able to, recognise early symptoms, take their children for treatment, prepare and administer oral rehydration correctly, follow courses of prescribed drugs and seek help effectively at health units (Katahoire, 1998).

This study was premised on the assumption that health education if effectively carried out at health units could contribute to improved child health and survival by equipping mothers with the necessary knowledge, skills, attitudes and confidence to recognise early symptoms, prompt referral for treatment, prepare and administer oral rehydration as an emergency measure, follow courses of prescribed drugs and to seek help at health units effectively. As a starting point this study sought to examine health education practices at selected health units in Busia districts and how they could be improved.

1.3 Objectives of the Study

More specifically the study sought to establish:

1. The nature of health education activities currently taking place within selected health units and the approaches and methods used during health education sessions

2. Health workers background training and their perceptions on the role of health education at unit level

3. Perceived differences by health workers of mothers who come to the health units

4. Mothers' perceptions of the health education they received at the health units

1.4 Literature Review

The ability to recognise early symptoms, prompt referral for treatment, prepare and administer oral rehydration, follow courses of prescribed drugs and seek help effectively

requires among other things a certain level of self confidence on the part of the mother, a supportive environment both at home and at the health unit and certain knowledge, skills and attitudes. In-depth interviews with mothers and health workers carried out in 1997 revealed that schooled mothers were more effective users of health services. When they took their children to health units they expected more than just treatment, they asked questions about the nature of the problem that their children were suffering from, the diagnosis and the treatment their children were being given. They sought information about the whole process and tried to understand the problem better. When given the opportunity they asked questions and sought clarifications.

Mothers who had not been to school however tended to keep quite, very rarely did they ask questions or seek clarifications not because they were not concerned about what was happening to their children but because in most cases they did not have the self confidence that it took to ask a health worker questions relating to nature of the problem, diagnosis and the treatment their children were being given. In most cases unschooled mothers responded to questions asked but asked no questions nor sought clarifications. They seemed to be unsure as to whom to ask, how to ask and when to ask and in most cases they ended up keeping quiet. Some admitted that they feared to ask. This had consequences for the way these mothers managed their children's conditions at home once they left the unit because some of them had difficulty recalling instructions given regarding how they should manage their children's illness and how the drugs should be administered (Katahoire, 1998).

In a study on "Quality of Out Patient Care" carried out in both Tororo and Busia districts in 1996 it was observed that poor communication between patients and health workers was a major problem, an observation later corroborated by Twebaze (1999). In the six health units where the study was conducted the consultations on average lasted 3-4 minutes and this was attributed to such factors as limited physical facilities, the inadequate number of trained health workers available at the units and the amount of time the health workers had available to attend to patients at the units. Users of these units during exit interviews observed that some of the health workers were short-tempered,

irritable and had no patience with patients who could not explain their problems quickly or who had difficulty in explaining what it was they were suffering from. This instilled in patients and mothers who brought their young children, feelings of resentment, fear and frustration. Nearly two thirds (62%) of the exiting patients reported that the health workers had not asked any additional questions beyond the minimal "What is the problem" and more than half of them said they were not told their diagnosis and only 37% had fully understood the dosage that had been prescribed for them. (Nshakira et al (1996). This suggests that many mothers left health units without vital information relating to how to manage their children's health problems which was detrimental to their children's health.

The Ministry of Health recognises some of these problems. In the justification for wanting to introduce a Diploma Course in Health Education it was stipulated that:

Health workers who provide basic health care especially in the rural areas are the backbone of the health care system. They need efficient and appropriate health education training to deliver effective health care to rural populations. There is a need therefore to prepare every health worker in the art and science of health education so that they can incorporate health education in their daily work (MoH et al 1994:11)

It was further observed that:

The quality of health education services presently given in the field leaves a lot to be desired. In fact very few health workers understand the role of health education in their work e.g. counselling patients on matters related to their ill health. For those who do, they limit themselves only to information giving and their methodology leaves a lot to be desired…There is need to train health educators who will be equipped with knowledge and skills in health education in order to provide good quality care (MoH et at 1994:11).

So the Ministry perceives health education as an important component of health promotion. According to the WHO Policy Statement on Health Promotion

Information and education provide the informed base for making choices. They are necessary and core components of health promotion, which aims at increasing knowledge and disseminating information relating to health. This should include: the public perceptions and experiences of health and how it might be sought; knowledge from epidemiology, social and other sciences on the patterns of health and disease and factors

affecting them; and descriptions of the total environment in which health and health choices are shaped (WHO).

The main aim of health education is to try and influence behaviour. While health education is recognised as a key strategy in Primary Health Care for maintaining and improving people's health (MoH 1999, Marcia 1998, Robottom and Coluhoum 1992) over the years there has been a lot of debate over the success of health education and promotion practices aimed at changing the health behaviours of individuals. A lot of emphasis in health education seems to be placed on content rather than on the process of communicating information.

2. Design of the Fieldwork

Fieldwork was carried out at two health units in Busia district and four main strategies were adopted during data collection, these were:

Documents Review. Various documents were reviewed to try and understanding whether there are any written policies relating to health education and how it is perceived at the district level as a strategy. Among the documents reviewed was, *the proposed Curriculum for the Diploma Course on Health Education, Annual Work plan for Community based activities for Sub Counties in Samia Bugwe South Health Sub District For the year 2003/2004, Busia District Health Work Plan 2003/2004.*

In-depth interviews were held with district officials to try and understand their experiences with health education, how it has evolved over time, changes that have taken place, the challenges they face in this area and plans that they have for the future. An attempt was made to gauge what they perceived as the future of health education and health educators in the district.

Observations: since this study was specifically interested in health education organized for mothers with young children, so observations were carried out of health education sessions organized during antenatal and immunization clinics. A total of ten-health education sessions were observed in all some of them were at health units the others were

at outreach centers. In as much as possible the researchers tried to ensure that they did not interrupt any session. They just sat in them and observed how they were organized, the sitting arrangement, the preparedness of the educator, how the session was structured, the number of mothers and fathers in attendance, the sessions duration, the topics covered and how they were covered, availability of time for asking questions and seeking clarification. The body language of the mothers, did they communicate understanding e.g. nodding, responding verbally etc. What kinds of materials did the staff use and what kinds of examples did they give, Was the session evaluated by the educator at the end, were the learners asked to give feedback after the sessions

In depth interviews were also carried out with staff members involved in health education to try and establish the nature of health education activities taking place, their perceptions regarding the role of health education in service delivery, the percentage of their time devoted to health education, their perceptions regarding the kind of training they received i.e. did they feel adequately prepared to carry out health education, their perceptions regarding their clientele, were there any noticeable differences between the different mothers who brought their children for care, how did they as staff address these differences if at all and to what extent was this an issue that they took into consideration when planning and implementing health education session. What kinds of challenges did they encounter during the process of health education and how did they address them, was there an inbuilt evaluation in the sessions, how was feedback sought and given after the session, what did they perceive as the future of health education, how would they like to see health education programmes organized in future.

Exit interviews were conducted with mothers exiting the health center. These were conducted specifically with mothers who had been attending antenatal care who had brought their children for immunization or postnatal care. The purpose of these exit interviews was to establish, what new information mothers may have acquired from the sessions, how this kind of information could be applied to situations at home and how they intended to use it. Whether they had any questions that they would have liked to ask or clarifications that they would have liked to seek. Here the interviewer probed for

reasons why they had not done so, was there any additional information that they would like to have as mothers of small children which they did not find readily accessible, whom did they share the information they got from the health unit with, were there any difficulties in putting into practice what was learnt at the health units and did they have any suggestions as to how health education carried out at the health units could be improved in future.

3. Findings

This section discusses the findings from the research. As previously stated, this study explored the nature of health education activities taking place in two selected health units in Busia district. The study explored the approaches and methods used during health education, the background training of the health workers, health workers perceptions regarding the role of health education at unit level, their perceived differences between mothers who come to the health units and mothers' perceptions regarding the health education they received at the health units.

3.1 The nature of health education activities carried out at health units.

3.1.1 Organisation of health education at the district level

According to the Busia District Health Plan (2003/2004) health education sessions are routine activities carried out at every antenatal clinic, postnatal, immunisation outreach clinics, daily for inpatients and at least once a week in the outpatients department. The plan further states that health education is an integral part of all preventive services. Being an integral part of the preventive services suggests that an educational component is planned and implemented systematically as part and parcel of the immunisation, antenatal or postnatal services this however as is discussed later is not always the case.

One of the Clinical Officers at Masafu who was a member of the District Health Education Team explained that at the district level, there were a number of programmes, which had a health education component these included the malaria programme,

HIV/AIDS programme, Trypanosomiasis programme, Functional Adult Literacy programme, Bilharzias programme and the T.B programme. While there was no separate budget line for health education activities as a whole there was some budgetary allocations for conducting film shows on EPI, HIV and Reproductive Health and for community sensitisation meetings.

The Clinical Officer reported that he was involved in most of these health education activities and the strategy that they adopted at district level was that of working through key persons such as Heads of Department at the District level, District Community Based Organisations and Community Leaders. These key people were sensitised through workshops so that they could in turn serve as advocates for health education messages by passing them on to those with whom they worked and lived. At the sub-county level, the district health education team targeted those engaged in the implementation of development programmes. These included Sub County Chiefs and Local Councillors. They also targeted extension workers working in the areas of Agriculture, Fisheries, Veterinary, Environment/Forestry, Community Development and health. The District Team also trained teams at Sub County level who included Parish Development Committees, Community Based Distribution Agents and Community Volunteers who included vaccinators and community mobilisers to further spread the health messages at the community and household level.

Health education activities at the district level were reported to include:

Sensitisation meetings at all levels i.e. District, S/county and community.
Training workshops and seminars for Heads of Departments etc
Open Radio Talk Show on the local Radio i.e. Rock Mambo and Open Gate in the Local language.
Dissemination of IEC materials like posters, pamphlets, leaflets. Brochures, banners and drama and dance
Celebration of important days like World Health Day, World Aids Day, women's Day, Valentine's Day, Girl-Child Day, etc.

3.1.2 Organisation of health education at unit level

Health workers interviewed during the course of this study reported that in the health units, health education activities were routinely carried out as part of the preventive health services, which included family planning, antenatal and immunisation. Observations carried out during the course of the study however, revealed that, while there were several health education activities taking place in the health units they were not routinely organised. It was noted that health education activities at unit level were not planned and implemented as separate activities they were more of an add on when time allowed and where staff was available. In the process health education at the health units ended up being marginalized.

Health education seemed not to be perceived as part and parcel of the curative services provided by the units. For example when mothers brought their children to the outpatient clinic, the clinical officers did not always perceive this as an opportunity for a one on one health education session. Health education was perceived by most of the health workers as a group activity. Some of the health workers interviewed observed that the lack of adequate supervision of health education by the District Health officials contributed to the marginalisation of health education activities within the district. They pointed out that there was no substantive District Health Educator and as a result there was no central planning, support supervision and evaluation of health education activities.

It was evident from the interviews and observations made during this study that health education sessions were not routinely organised. According to the health staff immunisation and antenatal care were both carried out twice a week and immunisation outreaches were also carried out twice a week. Mothers who were interviewed during the exit interviews confirmed this as did some of the health workers interviewed. The health workers explained that it was not always possible to organise health education sessions because mothers arrived one at a time and this made it difficult for them to be addressed as a group. It was also explained that sometimes the mothers came late and wanted to

leave quickly. The other reason given was the shortage of qualified health staff in the health units. Most times there was only one health worker working on many mothers. One of the health workers explained that it was not possible for the midwife to carry out health education and do all the other tasks such as weighing the mothers, taking their history and filling out their cards.

In one of the health units it was report that health education was carried out at immunization outreaches twice a week on Tuesdays and Thursdays when the unit staff went out for immunization. The session was reportedly carried out prior to the actual immunisation. Different people organized the health education sessions. At one of the health units the health education sessions during immunization were organised by the midwife, at another health unit the vaccinators were responsible for the health education during immunisation. During outreaches, people were first mobilised by community mobilisers a day before and on that very day.

That is where the clinical officer was supposed to educate them as individual mothers. Interestingly enough most of the health workers did not consider one on one discussion with individual mothers as opportunities for health education. Their definition of health education was the group sessions they organised. One of the health workers explained that they often waited to see if the number of mothers was large enough before they started the health education session.

A Clinical Officer at Masafu Health Centre explained however that there has been no deliberate effort or clear-cut organization of health education activities at the unit level. Most of the health education activities carried out were attached to specific programmes. He explained that at the Health Centre for example, he was the VCT Coordinator and as a Coordinator he was involved in advocacy and community mobilization. This included sensitisation of communities and training of drama and youth groups on HIV/AIDS. He was also responsible for coordination and linking up with NGOs like 'Friends of Christ Revival Mission' (FOC-REV) an NGO, which works in the area of HIV/AIDS and with an active component of Home-Care, support for orphans and Psycho-social counselling

and Post-Test Clubs. Another programme where he was involved in health education was the Malaria Control Programme. This he explained had two dimensions; at the unit he was involved in training other health workers in the management of severe and complicated malaria. The second dimension was that through health education they advocated for mosquito nets and supply of IPT – Intermittent Preservative Treatment. At community level, he was involved in the training of Parish Development Committees (PDC) in Community Integrated Management of Childhood Illnesses. They trained 4 people per PDC in five sub counties.

One of the clinical officers explained that when he wants to educate pregnant mothers, he communicates health education messages that he would like to reach the mothers through the midwives at the health unit. They in turn train the TBAs who have more access to these mothers. He reported that he hardly conducts health education sessions directly with the target population. He perceived his role as a health educator as one of training others. He explained for example that he was involved in conducting health education sessions with different community leaders who were in turn expected to pass on the messages to their community members. This was done at the District level.

So at health unit level, although heath education sessions for mothers were supposed to be organised regularly in reality health education was carried out when mothers turn up in large numbers. A Midwife at one of the health units explained that mothers were taught as a group and not as individuals due to lack of time. Another health workers explained that health education was supposed to be done on a daily basis when mothers brought their children for immunization or when they came for antenatal and postnatal care, however due to lack of manpower it was not carried out as regularly as it should. It was further explained that in most cases health education was carried out when the staff had time and that mothers were educated as individuals when they were referred to the outpatients department.

3.1.3 Content covered during health education sessions organised for mothers

Interviews with health workers and observation sessions carried out during the fieldwork revealed that content covered during health education sessions included family planning, pregnancy, nutrition and hygiene. It was evident in most of the health education sessions observed that there was minimal preparation for the session by the health workers and that none of the content was covered in sufficient detail. The content covered in most cases did not seem to have been prepared in advance. The majority of health workers just gave brief talks. During the antenatal sessions mothers were given information relating to preparing for delivery, family planning, HIV/AIDS, other STDs and VCT. Mothers who come for immunization were taught about the importance of immunization, type of immunisable diseases and how to take care of the after effects of immunization.

In the majority of cases the health education sessions observed were unstructured and did not focus on any particular topic, several different topics sometimes unrelated were touched upon during the brief talks. For example during a health education session for expectant mothers, the midwife talked about HIV/AIDS, family planning and the need for frequent visits by pregnant mothers to the health units for check ups. The session lasted about 45 minutes. The midwife did not have any notes nor did she discuss any of the topics in detail. She presented the information very fast and did not allow for questions since she seemed to be in a hurry. Immediately after her talk she began taking the mothers blood pressure, weight and filling in their cards before they left.

In another session that lasted approximately 55 minutes also for expectant mothers, the midwife had prepared some notes on a piece of paper, which she referred to a few times she also had some learning aids, which she used. During the session she talked about reproductive health focusing on family planning, antenatal care and child care as well as STDs/ HIV and AIDS. Though the midwife was knowledgeable about most of the topics she covered, the topics were too many to be discussed in such a short time. She gave very brief information on each one of them and at one stage she mixed them up.

Many of the sessions observed were brief and touched on several different topics. Sometimes the topics presented were related at other times they were not. One of the

health workers explained that there was no problem with presenting different topics together because the problems were related. The presentations however did not always bring out the relationship between the different topics presented, thus making it difficult for the mothers to see the relationship. Most of the presentations did not help the mothers to systematically develop their knowledge base on any particular topic mainly because of the way the information was presented. Many of the talks were structure as a one off lecture and at no time did any of the health workers begin by referring to previous talks or end by saying next time we will discuss this or that topic or we will continue with this topic. None of the health workers at the beginning of the sessions tried to assess what the mothers already knew about the topic they were about to discuss. When the exiting mothers were asked what new information they had acquired from the health education sessions they had attended several of them said they had learnt nothing new and that a lot of what was said had been said in previous health education sessions.

3.1.4 Methods and approaches used during health education

Most of the health education sessions observed lasted between 30 minutes and one hour. It was clear from the different health education sessions observed that there was no agreed upon methods or approach. The main teaching method adopted by the health workers was the lecture method, which usually took the form a brief talk and in some cases some question and answer sessions followed though not often. While a few of the health education sessions observed were somewhat structured, several of them were unstructured. Some of the health workers took the health education sessions that they conducted seriously, they came prepared with notes, charts and other teaching aids but the majority of health workers talked off the cuff.

A health education session observed at one of the immunisation outreach post revealed that the health workers had come prepared to give the session, it was structured and the presentations were coherent. The session was divided into two parts. The first part was conducted by one of the Vaccinator and a Health Assistant conducted the second part. The Vaccinator's education session focused on immunization. He adopted a question and answer approach. He kept asking questions relating to immunisation and immunisable

diseases and the mothers responded to the questions asked. Later the vaccinator got out an immunisation card and referred to it while teaching. He explained the diseases that they immunised children against and the process of immunization. Mothers were then given an opportunity to ask questions and seek clarification.

The second part of the session was about hygiene, nutrition and weighing children to monitor their growth. The Health Assistant who conducted this session used 'Growth Promotion Counselling Charts.' The first chart explained how mothers should prepare porridge for their children using groundnuts, eggs, millet, sorghum, maize flour, Soya bean and honey. He asked them questions, which they responded to. The second chart described the process of preparing porridge; it showed a picture of a mother feeding a baby on porridge and a smiling health child at the bottom. The third chart was about "Tips on protecting illness in children". He then emphasized the importance of having a clean home and washing hands with soap and water before preparing food and before feeding children. The Health Assistant asked the mothers the basic sanitation facilities a home should have and they mentioned the bathroom drying rack, kitchen and refuse disposal/rubbish pit! Chart four was about energy giving foods and foods that boost a child's immunity. It showed a mother with 2 healthy looking babies. Mothers were given time to ask questions and seek for clarification.

In the majority of cases however, the health education sessions were unstructured. For example in one of the health education sessions organised for both expectant mothers and mothers who had brought their children for immunisation the vaccinator began by showing the mothers an immunization card, an injection and syringe. In each case he asked them what they were. He then went on to explain that the injection and syringe were used only once. He then explained to mothers how they were used and allowed 3 of them to touch them and examine them. He then showed them a box where the used syringes were disposed of. He then went on to explain to the mothers what an immunisation card was for and how the one for a child who had completed immunization looked like. He then ended the session and began immunising the mothers and children. It was evident from the mothers interviewed as they left that they had understood very little

of what was explained. What most of them could remember was that the needles used by the health workers were not recycled but were thrown away immediately after use.

It was observed in a few cases that when expectant mothers came to attend the antenatal clinics one of the midwives spent some time with the individual mothers taking their history, weighing them and filling out their cards and books and asking them whether they were experiencing any problems, they did during this time give mothers some medical advice based on the problems that the individual mothers were experiencing and sometimes some additional information was also given. These sessions however, were not perceived by the health workers as opportunities for health education. If the health workers perceived these individual sessions as opportunities for health education they would utilise them to give more detailed information to the mothers. This kind of information would probably be more meaningful to the mother concerned than the more general health education sessions organised during antenatal, especially because it would be information about a specific problem being experienced.

For example in one of the individual sessions observed the mother when asked if she was experiencing any problems she responded that she sometimes experienced some dizzy spells. The midwife then examined her eyes and gave what were presumably iron tablets and told her to take them twice a day and that was it. The midwife did not make use of this opportunity to explain to the mother what she suspected the problem to be, the possible causes and consequences of iron deficiency during pregnancy nor did she stress the importance of taking the tablets regularly. There were many other such missed opportunities for one on one health education.

One of the Health Assistants interviewed explained that he carried out what he called follow up health education sessions during his home visits. He explained that when he got to the homes he asked the mothers for their own immunisation cards and for the immunisation cards of their children, to find out whether their children were fully immunized or partially immunized then he advised them accordingly. Those whose children were only partially immunized he advised to go to the nearest outreach post.

From the card, he also looked at the growth monitoring curve to see whether the children were malnourished, He then advised on the type of foods to give to the children and older siblings who may be malnourished. During these home visits, he also asked mothers about whether they knew about family planning and what they knew. If in the home the children were not properly spaced, he spoke to the mother about the advantages of child spacing. He explained that he also checked for latrines, if they were none then he spoke to the men in the home because they were the ones responsible for the construction of latrines. He also made follow up visits to see the completed structures and checked for refuse pits, drying racks, bath shelters, kitchens and their general condition. He then advised the mothers on what to do depending on the situation found in the home.

3.2 Background training of health workers involved in health education and their perceptions of its role

3.2.1 Health workers background training

In-depth interviews with health unit staff revealed that most of them were engaged from time to time in health education activities. Those interviewed included the Clinical Officers, Midwives, Health Assistant, Dental Officer, Enrolled Nurses and Vaccinators. The midwives for example reported that they organised health education sessions for expectant mothers as part of antenatal and postnatal care that they provided. The vaccinators were involved in health education sessions organised during immunisation sessions and the Health Assistant participated in the health education sessions organised in the community during outreach immunisation sessions.

The majority of the health workers reported that they had not been trained in health education. One of the Clinical Officers and Dental Officer at one of the health centres reported that they had been trained in health education. The Clinical Officer held a Diploma in Clinical Medicine and Community Health and had undergone one year training in health education organised by Ministry of Health in Jinja. He explained that during the health education training they had covered Health education principles, which included communication, planning, monitoring and evaluation of programmes, group and

community dynamics, personnel management and institutional management, community diagnosis, community surveys, communicable diseases, behaviour and behaviour Model systems, IEC and material development. He had also received additional training in HIV/AIDS counselling organised by the Ministry of Health in Kampala and training in Palliative Care organised by Mildmay International and had also done some short-term training in ENT and malaria. He felt that although they had spent a year in training, there was need for more in-depth coverage of topics like, health planning, health policies, proposal write-ups, communication models and ideal communication strategies in different situations and IEC material development. The Dental Officer had also undergone the one-year training in health education.

The Health Assistant reported that he was trained at the School of Hygiene in Mbale after completing his senior four and was posted to the health unit in 2001 as a Health Assistant. He had not received any special training in health education apart from the basic training he received at Mbale School of Hygiene. He had attended some workshops since then. These included a workshop on Nutrition in Early Childhood Development, which last about four weeks, a workshop on communication and counselling skills at the District for one week and he had also attended training for cold chain maintenance in Entebbe for 2 weeks. He perceived health education as an integral part of his work, which involved improving community health. He explained that his work involved creating awareness among community members of the prevailing health situations in their communities. He felt however that the training he received was not sufficient, for the kind of work he was doing in health education. He felt he needed more training to get well versed with the changing conditions in communities. He felt that health education would have greater impact if there were trained manpower. He observed that the nursing aids that met with the mothers regularly have no training in health education. He explained that there were very few trained health personnel at the health centres. He felt that the health education conducted at the unit played an important role.

Due to health education during immunization, we have taken long without seeing cases of polio around. I visit the children's ward often, and there is also a reduction in the cases of

measles. The mortality rate has also reduced, even the morbidity rate. If there was enough manpower, health education would improve and have greater impact. Now with the assistance from the government, communities have access to safe water.

The midwives at both health units visited were also actively involved in health education. One of the enrolled midwives reported that she was trained at Masaka School of Midwifery and had been working as a midwife for 23 years. Although she was not trained in health education, she had learnt about it in Primary Health Care and this is what helped her. She explained that the topics relating to antenatal and postnatal care that she talked to the mothers about she had covered during her midwifery training. She felt however that she needed further training in how to teach these women.

She observed that health education helped the mothers to know the use of health services at the unit. She observed however that there is no one supervising health education or helping them to plan it but they were managing somehow. She felt that they could carry out the health education sessions better if there were health educators especially from the district to help them to plan and if they had more trained staff on the ground. She explained that sometimes the trained health educators helped to advise them but they were also busy in other departments. She suggested the need for additional staff and more training in health education in the form of refresher courses. She observed that ever since she started working, she has not got a chance to go for further training.

Vaccinators at both Masafu and Lumino health units were involved in health education especially during immunisation sessions. The vaccinators at Masafu explained that the Clinical Officers had trained them for 3 months at the Health Unit. An interview with one of them who had worked with the unit for 4 years revealed that he had been oriented on how to carry out health education by the enrolled midwife and the Vaccinator in charge of UNEPI. His orientation had focused on how to welcome mothers once they arrived, how to relate with them and how to prepare the venue for health education and immunisation.

At Lumino health centre one of the vaccinator interviewed reported that he had been trained by the Red Cross in Primary Health Care in 1989. He had been working at Lumino health Unit for 12 years. He was not trained in health education but had received training in Community Based Health Care. He explained that during this training he learnt the approaches of working with communities and that some of these have been useful to him because he learnt how to work with people.

An Enrolled Nurse at Lumino Health Centre who had been trained at Gulu Nursing Training School had been working with the unit for 16 years. She explained that she too did not have any special training in health education but perceived it as important. She explained that at the unit they used health education to create awareness among the people especially patients about the cause of disease and measures that can be taken.

3.2.2 Health workers perceptions of the role of health education at health unit level

One of the clinical officers explained that he perceived health education as an empowering process and as a means to networking. He explained however that at the health unit he did more clinical work than health education because his appointment letter stipulated that he was deployed at the unit as a Clinical Officer. He explained that 30% of his time was spent on health education at the district level, while the other 70% of his time was spent doing clinical work at the health unit. It was interesting to note that he perceived health education as a separate set of activities organised separately elsewhere and not as an integral part of his clinical work. This perception seemed to partly arise from the fact that the health education training that he had undergone was conducted separately and not as an integral part of his Clinical Medicine and Community Health training.

A Dental Officer who had also undergone the one year training in health education, perceived health education as a vehicle to all other health activities in the health unit and the community. He felt that all public health problems required health education and that there was no way one could talk of only treatment without providing information. He

explained that health education should be used to alley fears and misconceptions give facts and encourage people to use the services available at the health unit more.

A health Assistant based at one of the health centres observed that health education is not something readily appreciated by many people because it has got long-term benefits as compared to curative services and therefore that means it is budgetary allocations are always over looked implying health education could be done routinely and by anybody, which was not the case. He explained that: *when it comes to mothers specifically, mobilising them is not easy because not all mothers come in health facilities. Because you are using other people to deliver the messages, it is difficult to evaluate the messages and therefore the impact of the messages.*

One of the midwives explained that she perceived health education as a very important part of her work. She explained that when mothers came to the health unit they taught them and counselled them on various health issues like how to care for their pregnancy and the need to visit the health unit for check ups and also about the importance of bringing their children for immunisation. She explained that:

Health education as we practice it is very important for motivating and encouraging mothers to come to the health unit for check up. We encourage them to come back during the heath education sessions.

She observed however that some mothers did not want to come for antenatal at the unit and that some come from very far and this prevented them from coming frequently. She also observed that culturally, husbands do not bring their children for immunisation and don't even come with their wives when they are coming for antenatal. She further observed that sometimes mothers came in a hurry and did not want to wait to be examined so they just left and that when children are immunized and they suffer side effects this scares away some of the mothers. Some mothers get very angry and blame the vaccinator. So all these issues have to be explained to the mothers during health education sessions organised before the actual immunisation.

One of the vaccinators felt that the health education sessions helped to create awareness among the mothers about some of the common diseases, their causes and what could be done to prevent them. He explained that they used health education sessions to create understanding and awareness among the mothers of their role as mothers. Most importantly health education had helped them to pass information on to mothers that encouraged them and other people to use the available services at the health units such as immunization, antenatal, and family planning services. Another vaccinator explained that health education has been instrumental in increasing the number of mothers using health services at the unit. An Enrolled Nurse at Lumino Health Centre explained that health education played an important role of creating awareness and passing on information to the people on the services available at health unit and their use.

Most of the health workers observed that health education was playing a positive role because, the mothers who came to the unit continued coming back and this was because they had learnt why they should do so. One of the health workers reported that there was an increase in the use of immunisation and family planning services. She felt however that there was a need to improve the way health education was being carried out. She observed that:

First of all there is limited planning for it right from the district. There is no specific person who seems to be responsible for health education. And even at the unit level, those who conduct health education are not professionally trained. They just pass on information…for about one and a half years now there is no district health educator. So nobody coordinates and supervises health education. I have not seen any form of evaluation of health education at the district level or even at the unit level. Also the Ministry of Health proposed that the district produces its local IEC but this is not done.

Another health worker observed that the impact of health education, was being felt in the rising numbers of mothers attending the immunisation sessions at both the unit level and at outreach centres. He explained that the out reaches have reduced the distances that

mothers had to travel to come to the health centre. He suggested that the district should help them to plan and to conduct health education and if possible a centre should be established for training health workers in health education methods. He further suggested that each sub county and health unit could use its Poverty Alleviation Funds to make a contribution towards the establishment of such a centre. He felt that even if the training was a short one it would be better than no training at all.

3.3 Health workers' perceptions of differences between mothers

Health workers were asked whether there were any differences between the mothers who came to the health units and whether during their health education sessions they took these observed differences into consideration. The majority of health workers reported that the mothers who came to the health units were mostly mothers of childbearing age and most of them had not gone beyond primary seven. They further observed that most were rural women engaged in subsistence farming and that they came from the surrounding villages. It was noted however that some traveled longer distances to come to Masafu health unit because it provided more services than the smaller health units. It was also explained that mothers who had several young children tended to come more frequently to the health units than others.

3.3.1. Differences between young and older mothers and schooled and unschooled mothers

In explaining the differences between the mothers who brought their children to the two health units health workers observed that there were differences between younger and older mothers. The young mothers were said to be shy and fearful while the older mothers were said to be more experienced and to have more self-confidence. As one health worker explained

Older mothers with several children are braver and sometimes they challenge us. The young mothers (especially) first time mothers tend to be fearful and timid. They don't ask questions and often look down when you are talking to them. Most of them are very young girls of less than 18 years and are very worried. The mature mothers are more

confident and courageous. They tend to support the young mothers during health education by encouraging them to try to look after their children.

One of the midwives observed that:

Most of these mothers are young newly married or unmarried girls who conceive while still at school or home. These young mothers tend to be shy and timid, they fear to speak and only do so if asked questions and in some cases, they just keep quiet. The same applies to uneducated mothers. They fear to speak and cannot read cards or even posters. The uneducated mothers are slow to understand even very simple information like how to prepare ORS and how to give a child medicine/tablets. In most cases, such mothers are seen or heard asking for information from fellow mothers even if all of them are attending the same session. The uneducated mothers cannot ask any questions especially if they are with others in a group. The also can't read and write and so you cannot even rely much on the IEC materials that may be there.

Another health workers observed that unschooled mothers were fearful and did not speak when she or the vaccinator were around, they only spoke when asked a question about their cards.

They tend to learn slowly but they come earliest to the health unit. Unschooled mothers are complicated because they don't learn easily and you have to repeat the same thing again and again yet there is always no time. These mothers tend to ask for information from others who have been asking and answering questions during the health education session. They will not ask for extra information from us. Those who have been to school are the ones who are talkative, free and always want extra information during the health education session. However, they don't want us to help the uneducated (others) in terms of understanding the message or guidance because they feel it is a waste of their time to repeat.

Another health worker observed that:

Those who have been to school are free and can speak openly while those who have not tend to be shy and fearful. Young mothers also fear to talk and find out more information yet they do not know much about pregnancy and children. When you ask them questions they either don't know or will refuse to talk. The schooled mothers talk freely and will ask you to explain things. The schooled mothers can understand you when you explain and don't waste your time but with the unschooled, you have to repeat the same thing.

One of the midwives observed that:

Mothers with some level of education come to the unit without being forced they also seem to pick faster what you are teaching and they respond to the questions correctly whereas those who are illiterate cannot even tell the type of vaccines and even where they are administered. An educated mother for example, can judge and know that when a child is crying, one breastfeeds her which an illiterate mother will not do. She explained however that although there are some differences between the mothers they are not handled differently. *As a health educator, I bring myself down to the level of the ones with no or low levels of education so that we can communicate with one another*. She further observed that:

It is easier to relay messages to mothers with some education as compared to illiterate ones. Those that stop in early primary, start producing in their early teens around 15 years. For mothers who reached secondary level, they always attend antenatal and finish the schedule, they also follow the prescriptions and First Aid care at home for their children such that they don't bring their children with severe complicated cases. If one is educated she perceives better and follows instructions better. Some mothers who are not educated can't read the cards and so even if you educate them and inform them on when the next immunization will take place, they are not able to read the cards. So they may not come. They tend to rely on memory or other mothers for information. Most of their husbands seem not to help.

Although there were these perceived differences between mothers with schooling and those with none, in health education sessions they were not handled differently as one of the health workers explained:

You just talk to them as a group and keep repeating things. But because you don't have much time, you can't separate them. This is how the unit works and I think it is the same even in big hospitals".

She observed that all mothers who came were handled as a group.

The practice here is that all mothers who come are treated the same way because there is limited time to attend to them as individuals. We are very few yet the mothers want to go away – without having to be delayed. The only thing we do to cater for uneducated mothers is to use local language while dealing with all the mothers.

Another health worker explained that one of her greatest challenges was that of talking to many people, she felt that she lacked communication skills and need training to help her conduct health education sessions better.

3.4 Mothers' perceptions of the health education they received at the health units.

Exiting mothers were asked about the health education that they had received at the health unit. Mothers were asked about what they were taught, whether they found it useful in caring for their children and with whom they shared the information they got from the health unit.

3.4.1 Perceptions regarding the organisation of the sessions

Several of the mothers interviewed explained that they had come late and had found the health education sessions already in progress or finished, while others reported that there had been no education session organised. For example an 18-year-old mother who had 10 years of schooling explained that this was her first time to come for antenatal care. She had managed to register and get a card. She explained however that no health education session was organised for them and that this was probably because there was a shortage of health workers at the unit.

I arrived at 8.00 a.m. but I am leaving after 3.00 p.m., there is need for more health staff. There were many mothers and no health education session took place.

A thirty-six years old mother with fifteen years of schooling had brought her child for immunisation she reported that sometimes the midwives and vaccinators talked to them before immunising their children but sometimes due to shortage of time and staff they did not. An interview with a twenty four year old mother who was a primary school teacher revealed that she too had brought her baby for immunization. She explained that on that particular day there had been no health education session organised, but that she had attended others in the past, she observed that:

They tell us a few things to do but you can't really call it health education. Health education should be more detailed and things are made very clear. But these people just mention a few things which, in most cases we already know. Today we were taught why

we should immunize, the effects, etc. I knew most of these things that were talked about. Being a teacher, I feel more informed than even these people who were talking to us. You can even see from how they talk that, some of them don't seem to be very well versed with the concept of immunization.

A twenty four year old mother with seven years of schooling who had also brought her child for immunisation observed that:

They rarely carry out health education. When one comes for immunization sometimes, they just do immunization and then we go away. Even when we come for antenatal, they just check your stomach and tell you to go away without any health education. Today we have been taught how to care for and feed our children. We have been taught about immunization that children are immunized against tetanus, measles, polio, whopping cough.

She observed however that she as an individual had learnt nothing new this was the same information they were taught in the past. A twenty nine year old mother with no schooling who had brought her seventh child for immunisation claimed she could not remember what they were taught. Another mother aged twenty-years with three years of schooling who had brought her second child for immunisation reported that:

We were taught about proper feeding of children and how to care for them. I have forgotten the rest I came late.

Several of the mothers when asked what information they had learnt during the health education sessions claimed that they had learnt nothing new. Others claimed that they could not remember what was talked about but there were also those who explained that they had acquired new information during the health education sessions.

3.4.2 Information acquired during health education

A mother who had nine years of schooling reported that she regularly brought her children for immunization and that the one she had brought was her eighth. She explained that sometimes when she came the health workers organised health education sessions for the mothers and they taught them how to feed their children. She explained that:

Today we were taught how to mix Soya bean in maize porridge. They also told us to get immunized during pregnancy. We were taught to feed well after we have delivered. We have been taught how to feed our children well by mixing millet, sorghum, maize, Soya bean and eggs. Feeding children on breast milk and maintaining hygiene in homes.

Another explained that through the health education sessions she had learnt

Maintaining hygiene and proper sanitation in the kitchen and toilet, having a rubbish pit and drying rack. Another mother explained that: *we are told how to care for our children and ourselves during pregnancy. Why we must be immunized during pregnancy, types of immunisable diseases and what one needs to do when a child develops side effects after immunisation. These sessions have helped me to be more alert at home*.

A forty-year-old mother with five years of schooling had brought her child for immunisation. This was her ninth child. She explained that she usually brought her children to the health unit for immunization. She explained that:

We are taught how to care for our children at home and how to care for ourselves while pregnant. We were taught to go for antenatal check-ups to find out whether the foetus is alive. We are taught to take our children for treatment when they are sick and we are taught about feeding children on sorghum/millet porridge mixed with Soya, milk, groundnuts and paw paws.

She explained that although a lot of what she was taught she already knew she was going to improve on the way she was feeding her children and to try and keep her home cleaner. A twenty seven year old mother with seven years of schooling had brought her forth child for immunisation. She reported that she regularly brought her children for immunisation at the unit. She explained that:

We are taught that even if one has delivered from the village, she should take the child for immunization. Even when a child is sick, they should be taken for immunization since the purpose of immunization is to prevent such diseases. We were taught about the signs or symptoms of measles, T.B, Polio, tetanus. We were told not to give birth on the ground if one delivers from the village. We were told to have a clean cloth/cotton wool and sheets, clean threads to tie the umbilical cord, razor blade just before one gives birth. Today we were taught to keep the immunization days i.e. not to come before or after and how to prevent ourselves from getting infected with diseases and how to maintain cleanliness in homes. I also learnt how to prepare porridge mixed with eggs. I have chicken at home therefore I will add eggs in my children's porridge. I wanted to ask a

question about my child who was given an injection called "after birth" but it disappeared and left no scar, which puzzles me, but there was no time

Another mother when asked what new information she had learnt she responded that:

I have learnt about proper feeding of children i.e. giving the child porridge mixed with milk, eggs, and sorghum. I am going to buy sorghum and eggs, pound the groundnuts mix them with cow's milk because we have a cow, and then feed the children.

A thirty-year-old mother had come for antenatal care for her 7th pregnancy. She had five years of schooling. When asked if she had attended a health education session she explained that:

I have been taught about proper feeding of a child on milk, food and porridge mixed with Soya beans. The importance of using a mosquito net for the baby's bed. Washing bed sheets and the blanket used by the children. Preparing myself for delivery by buying baby clothes, baby shoals. Using Family Planning by agreeing with my husband i.e. if he consents I will go ahead and use Family Planning so that we can have a number of children we can look after. Bringing children for immunization.

A twenty two year old mother with five years of schooling explained that:

I was taught about caring for children in April after giving birth to this child. Today we were taught about how to feed our children. They told us that a child should be breast feed until he is 6 months after that the baby should start feeding on other foods. They need to be immunised against measles, polio, T.B. I have forgotten the rest.

When asked if she had learnt anything new she observed that:

I did not know that immunization goes on until 6 years, I though that immunization is completed when the child is 9 months. I will make sure that the child completes all the dozes in immunization and I will also try to improve on the way I have been feeding my children.

A twenty six year old primary school teacher had brought her fourth child for immunisation. She reported that:

When I was pregnant I was told that I should be prepared with bed sheets, cotton wool and cloths for the baby. We are taught to feed properly on foods that contain iron,

vitamins, proteins, etc so that one can push the baby. So when I was pregnant, I used to feed well.

It was evident from the exit interviews that there were some mothers who acquired new information which they perceived to be useful and which they planned to put into practice.

3.4.3 Sharing of information acquired

When asked with whom they shared the information they got from the health unit one of the mothers explained that she shared it with her husband and children. Another mother explained that:

A few times when we meet with other women in groups, health issues arise and you find yourself talking about something you know. But this is not to say that I specifically plan to do that.

An interview with an eighteen-year-old mother who had eight years of schooling revealed that she had come to attend the antenatal clinic. She explained that she had attended the health education session, organised by the midwife. She explained that:

During the session we were told what to do when we are pregnant and also after giving birth, but it was just a short talk not a proper lesson

She explained that she always shared the information that she got from the unit with other people in the home and her friends. When she returned home from the unit those at home usually asked her what had happened at the unit so she always narrated what happened at the unit.

3.4.4 Additional information mothers would have liked to be given during health education

Some of the mothers interviewed explained that there was additional information that they would have liked to get in the health education sessions. One of the mothers explained that being a new mother she would have liked to know more about the dangers of immunizing a child who has another illness.

I wanted someone to clarify this point and alley my fears but the health workers seemed to have no time.

Another mother observed that:

We have never been taught anything about how to care for ourselves once we have delivered.

Another mother observed that:

These health workers sometimes confuse us, when I used to come for antenatal, they never talked about what we should bring when we come for delivery, now that I have already delivered I hear them talking about what we should bring together with how we are supposed to look after our children. Why don't they talk about one thing at a time?

Others observed that the different topics were not covered in sufficient detail. One mother remarked that she had hoped that on her return visit the health worker would continue from where they left off, instead they just repeated what they had covered in the previous session. She felt that there was a need for the health workers to cover individual topics exhaustively so that they would go home with complete information on a topic instead of touching many different topics but none of them in detail.

3.5 Challenges experienced by health workers in conducting health education

During the interviews with the health workers they were asked about the kinds of challenges that they experienced in carrying out health education at the units. One of the health workers explained that "due to time and staff constraints we have to try and fit everything in". One of the vaccinators observed that:

One of our major challenges is that very many mothers attended. Another is that we have to be slow when teaching yet you have to perform other tasks after the session as well such as immunisation or antenatal services for all these mothers. I need formal training in nursing and health education and in how to handle mothers

He observed that there was no planning for health education at the unit level and that the unit did not have any special person in charge of health education. He noted that the health workers who were trained in health education did not work as health educators at the health unit. He explained that when they went for training in health education on their return they were deployed in their original positions. As a result there was no supervision of health education activities. He felt that if a substantive District Health Educator was appointed and if the funding for health education were increased it would have a bright future.

Health staff at one of the health units observed that although some of their colleagues had been trained in health education they were not actively involved in health education at the unit level. It was explained that their role was not clear and their training had not been felt at the unit level. Other health workers observed however that, on a few occasions those trained gave them guidance on how to carry out health education. It was felt by most health workers that health education activities need to be expanded to reach out to the communities, and that there was a need to making health education a priority in terms of planning, facilitation, transport and learning materials. It was also felt that the district should appoint a substantive district health educator to supervise health education activities within the district.

According to the Ag. District Health Educator ideally the planning for health education is supposed to be done at the district level in conjunction with the health unit. However, this was not the case. Individual departments at the health units organized and planned their own health education. It was reported that the trained health educators sometimes (though rarely) helped to orient the various heads of department on how to plan and conduct health education. He observed that during the course of his work in health education he met several challenges. The first challenge was his deployment and appointment. He was officially deployed as a Clinical Officer and not as a health educator yet he was expected to fulfil both roles. He felt that he was torn between clinical and health education work. Another challenge was that in order to carry out health education at the community level they needed audio radio equipment, transport and fuel

but these were lacking. He observed that health education was allocated very limited funds at the district level.

3.6 Conclusions and Recommendations

This study was predicated on the general assumption that health education sessions carried out at health units could help mothers with young children adopt behaviours such as attending antenatal care, immunization sessions for themselves and for their children, family planning and screening programs. It was also assumed that health education at the health unit level could equip mothers with abilities to recognize early symptoms and prompt mothers to take their children for treatment, prepare and administer oral rehydration and to follow courses of prescribed drugs.

In-depth interviews with health unit staff revealed that while most of them were engaged from time to time in health education activities, the majority had received no training in health education. At the health units health education was perceived to be part of the preventive health activities but was not necessarily perceived to be part of the curative services provided by these units. In most cases it was more of an add on activity where time allowed and where staff was available, as a result health education was a marginal activity. The majority of health workers did not consider the one on one discussions they held with individual mothers as opportunities for health education, their definition of health education was that it is an organised group session.

The health education sessions observed during the course of this study were brief, several of them were unstructured and did not focus on any particular topic. Several different topics sometimes unrelated were touched upon during a single session. Even in cases where the talk focussed on just one topic like immunisation the approaches adopted by the health workers were sometimes haphazard thus making it difficult for the mothers to follow the presentation. The relationship between the different topics presented, was not always explained thus making it difficult for the mothers to see the relationship. There

seemed to be no agreed upon structure or approach to health education activities carried out at the health centres.

Most of the presentations were not structured in a way that could enable the mothers to systematically develop their knowledge base on any particular topic. The talks were structure as one off lectures and at no time did any of the health workers begin by referring to previous talks or end by saying next time we will discuss this or that topic or we will continue with this topic. None of the health workers tried to assess what the mothers already knew about the topic they were about to discuss. When the exiting mothers were asked what new information they had acquired from the health education sessions they had attended many of them who came to the health units regularly said they had learnt nothing new and that a lot of what was taught had been taught in previous health education sessions.

There is a need to strengthen health education activities currently taking place at the unit level by training all health unit staff in health education. While health education seems to some extent to be perceived as a specialised area, there are no posts for health educators at the unit level. At the same time nearly all health unit staff engaged in preventive health activities are expected to carry out some form of health education yet they are not trained to do so. This suggests that health education needs to be mainstreamed into all training programs for health workers instead of seeking to make it into a specialisation. By so doing hopefully all health workers in future will perceive themselves as health educators in addition to being clinicians which is not the case at the moment.

While the suggested curriculum for the health education diploma covers a wide range of topics, there is very little emphasis on methods and approaches for educating adults. This is rather unfortunate given that this is already a major weakness in the health education activities currently taking place. There is need to think through how best to organise meaningful sessions even when there is limited time and staff. Health staff need to also think through how best they can help mothers learn in a systematic way. Problem based learning maybe one approach. It was also evident that there was need for more

participatory approaches instead of straight talks with time for questions and answers. It was interesting to note that most health workers reported that young mothers and unschooled mothers tend to be shy and withdrawn, but in most cases there were handled in mush the same way as the others. It would be important that health workers are taught how to handle mothers with individual differences so that they too could benefit fully from these sessions instead of being left alone.

Curriculum changes are not always easy to implement and sometimes take a long time, so in-service training may need to be considered for health workers who are already in service. At the moment health education is tagged to particular programs and is not perceived as part and parcel of health care delivery. There is need to reconceptualise the role of health education in service delivery and reorient staff to the idea that they should perceive themselves as educators in addition to health service providers.

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