

Assessment of the implementation of health education in primary health care facilities, Kavango, East Region, Namibia

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Abstract

Background. Primary Health Care (PHC) facilities are critical in preventing, detecting, and managing sickness and injury, thereby lowering morbidity and mortality. This is easily accomplished through health education, which is one of the most effective disease prevention methods.

Objective. The goal of this study is to evaluate the implementation of the health education technique in PHC facilities in the Kavango East Region.

Materials and Methods. A quantitative method was used in conjunction with a descriptive cross-sectional design to evaluate

the implementation of health education in PHC facilities in the Kavango East Region.

Results. The outcomes show that 76% of patients who visit health facilities did not receive health education about their condition, and those who did receive health education know six times more about how to prevent the conditions they are suffering from than those who did not. The study also found that 49.14% of patients got information that was irrelevant to their conditions. These results indicate a statistically significant relationship (2.32 OR 0.93 at 95% CI) between patients who did not receive health education and frequent visits to the PHC facility with the same complaints.

Conclusion. There is a lack of health education implementation in PHC facilities, with patients not getting or being provided with relevant health education to empower them to take care of their own health. The emphasis of PHC centers is on curative services rather than preventative and rehabilitation services. PHC facilities must improve health education as a critical approach to health promotion and disease prevention. This will allow patients to take appropriate preventive measures, resulting in fewer trips to PHC facilities.

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Informed consent: The purpose and procedures of this study were explained to all the participants, who gave informed consent before data were collected.

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Introduction

In 1977, The World Health Assembly recognized that the main goal of the World Health Organization (WHO) should be to ensure that all people achieve a level of health that permits them to lead socially and economically productive lives. The Alma Ata conference (1978) defined Primary Health Care (PHC) as the key to achieve health for all by the year 2000. In order to provide a basis for understanding primary health, a definition of PHC was established at the National Forum on Health in 1997.^{1,2} Primary Health Care is understood to be “the care provided at the first level of contact with the health care system, the point at which health services are mobilized and coordinated to promote health, prevent illness, care for common illness, and manage health problems”.^{3,4}

PHC is the area of the health care system most suited to offering primary prevention and health promotion activities as it is easily accessible, provides continuity of care, and is used by a large proportion of the population. Primary Prevention and Health Promotion activities include initiatives to maintain or increase the level of wellness and to reduce risk factors associated with distinct diseases through the promotion of lifestyle changes (e.g., healthy eating, physical activity, or smoking cessation) and prevention of physical and mental disease such as cardiovascular diseases or depression.⁵ PHC professionals have many opportunities to promote healthy behaviors in patients with effective interventions.⁶

The core functions of the PHC Directorate in Namibia are guided by the WHO/Primary Health Care approach and the Declaration of Alma Ata of 1978. The Declaration emphasizes four pillars as reflected in the Namibian PHC House. These are: health promotion, disease prevention, curative and rehabilitative

services.⁷ Health promotion is one of the four principles of primary healthcare that would save more lives of people if implemented at all primary healthcare entry points. Health promotion measures are often targeted at a number of priority diseases – both communicable and non-communicable. The Millennium Development Goals had identified certain key health issues, the improvement of which was recognized as critical to development. These issues include maternal and child health, malaria, tuberculosis and HIV, and other determinants of health.⁸ Health promotion has a holistic approach to promoting health intervention to stimulate the health and well-being of society, *i.e.*, proper nutrition and physical activities, preventing diseases, identification and maintaining the health of persons suffering from chronic illnesses.⁹ Emphasis on the prevention of diseases and health promotion services provides an opportunity for demanding and establishing health promotion services in hospitals. Therefore, because of their central role in providing health services in the community and their interaction with different categories of patients, staff and organizations have great potential to influence health promotion services and provide these services.¹⁰

One of the primary functions of front-liners in all PHC facilities is to equip the community/society with the necessary knowledge and skills to become self-reliant in terms of disease prevention and health promotion. The Ministry of Health and Social Services (MOHSS) has embarked upon a series of training on health education since independence.¹¹ Despite the efforts by MOHSS, still PHC facilities are overcrowded daily by patients visiting PHC facilities for various preventable diseases ranging from simple Upper Respiratory Tract Infections to Sexual Transmitted Infections. Furthermore, the MOHSS' health information system is still recording cases of such preventable diseases in the country monthly.⁷ In the absence of effective implementation of health promotion services at PHC facilities, the country may experience a high incidence of preventable diseases, outbreaks of communicable diseases, high outpatient turnover, and increased staff workload. Therefore, there is clear evidence that the implementation of PHC strategies such as health education needs to be assessed.

The aim of this was to assess the implementation of the health education strategies in Primary Health Care facilities in Kavango, East Region.

Materials and Methods

Ethical clearance and informed consent

The research proposal was approved by the Ethics and Research Committee of the University of Namibia. Permission to conduct the research was obtained from the Ministry of Health and Social Services. The purpose and procedures of this study were explained to all the participants, who gave informed consent before data were collected.

Study population and study sample

A descriptive cross-sectional design to assess the implementation of health education in Primary Health facilities in Rundu, Kavango East. The population of this study was all patients and guardians of all children with preventable health conditions visiting the PHC facilities seeking curative services. A total sample of 368 was obtained and a stratified disproportionation fraction was used.

Research instrument

The researchers and trained student nurses collected the data by administering a structured questionnaire to participants. The

study was voluntary, whereby the content of the questionnaire was explained to participants before they gave permission to participate. The questionnaire was translated in orukwangari, the most spoken language in Kavango East, for participants that do not speak English. The questionnaire assesses whether patients that are treated in the PHC facilities are given health education, the content, and how it was given. The questionnaire was divided into three sections: section A contained demographic data (communicable/non-communicable); section B contained content of health education given and section C asked what types of health promotion/ education materials (*e.g.*, pamphlets, posters, cards) were given during health visits.

Statistics

Data were analyzed using Epi info, version 7, in which simple logistic regression was used to show the relationship between the provision of health education and health outcome.

Results

The quantitative results of this study focused on demographic data and assessment of the implementation of health education at PHC facilities in Kavango East region.

Demographic profile

A total number of 313 participants participated in this study from a sample size of 368 using the structured questionnaire, making a response rate of 85%.

The number of patients who visited PHC facilities in the Kavango East region (n=313) (Figure 1). Most of the participants (n=80, 25.72%) were females aged between 21-25 years. And few (n=16, 5.14%) males aged 26-30 years participated in the study.

Statistics on health education

$$\text{Odd ratio (OD)} = \frac{\text{Receiving health education}}{\text{Prevent disease condition}} = \frac{140 \times 83}{45 \times 42} = 6.15$$

From Table 1, the findings indicate that OR is 6.15 (OR 3.73 < 6.15 < 10.14). At the same time, a Chi-square is 54.48% with a P-value <0.01. This indicates that patients who received health education knew how to prevent the conditions they were suffering, six times more than those who did not receive health education.

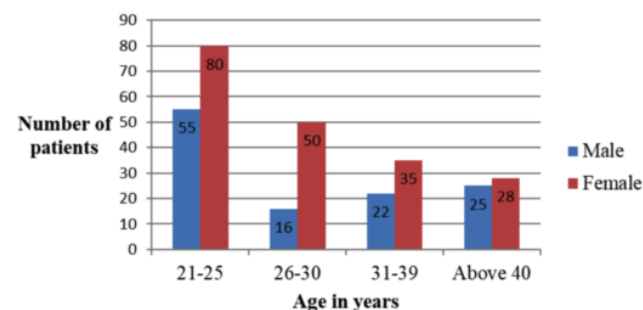


Figure. 1 Demographic information (n=313).

Table 2 indicates that n=57, 49.14% of participants who received health education regarding their medical conditions, the information was not relevant to their conditions. However, almost the same n=59, 50.86% of patients indicated that the health education given was relevant.

	Point Estimate	95% Confidence Interval	
		Lower	Upper
Odds Ratio (OR)	1.4681	0.9277	2.3232 (†)

From Table 3, the findings ($2.32 < OR < 0.93$ at 95% confidence level) show that there is a statistically significant association between patients who were not given information regarding their medical condition and the patients who come back to the health facility with the same complains as the previous one.

Discussion

Most participants were female (62%) compared to their male counterparts (38%). In general, women are more likely to visit health facilities the doctor than men. These findings relate well with Berkowitz,¹² whereby 84% of female patients in his study visited the general practitioner than male counterparts, 66% in Canada. Similarly, in USA, 80% of males visited health facilities in relation to 89.5% of females.¹² These finding does not represent statistical significance on why women are visiting health facilities very often, but it is believed that, generally, the population of

females outnumbers males, and females are more likely to visit health facilities than their male counterparts because women are exposed to a wide variety of health services than men. For example, females may visit, health facilities to seek medical attention as well other services *i.e.*, antenatal services, annual breast/cervical examinations, antenatal, peri and postnatal care visits, and many more.

Impact of the health education given at the primary health care facilities

Health education is one of the strategic actions in the health sector that aims to promote good health practices among communities. It is part of the comprehensive healthcare strategy developed by the primary health division in the MOHSS in Namibia. This study revealed that 76% of the patients that visited PHC facilities in the Kavango East region, Rundu district, did not receive health education regarding their conditions, and yet, 76% did not know how to prevent the diseases they are suffering from. It is expected that any patient who receives health education on any condition must possess some insight on how to prevent that condition, in order to prevent that particular patient from returning back to the same or different health facility for the same condition. If all patients receive health education on conditions that they are suffering from, they should be able to prevent such conditions and improve their health. The main responsibility of healthcare workers is to improve public health and motivate patients to take care of their own health through health education.¹³ The practice of primary health care workers cannot be effective without proper implementation of health education.¹⁴ Therefore, healthcare workers (HCWs) must play a role of a health educators and are expected

Table 1. Impact of the health education given at the primary health care facilities (n=310).

	Do you know how to prevent the condition you are suffering from after received health education?		Total
	No (%)	Yes (%)	
Have you received health education regarding your condition?			
No	140 (76)	45 (24)	185
Yes	42 (34)	83 (66)	125
Total	182 (59)	128 (41)	310

The P-value is set at 0.01, at 95% confidence interval.

Table 2. Relevance of health education given to patients at primary health care facilities in Kavango East (n=313).

	Is the health education received relevant?		Total (%)
	Yes (%)	No (%)	
Level of education of patients			
Primary education	9 (7.76)	11 (9.48)	20 (17.24)
Secondary education	36 (31.03)	25 (21.55)	61 (52.57)
Tertiary education	14 (12.07)	21 (18.10)	35 (30.17)
Total	59 (50.86)	57 (49.14)	116 (100)

Table 3. Number of patients that were treated with the same condition within 12 months.

	Outcome (Treated for the same condition)		Total
	Yes	No	
Exposure (Information given to patient)			
Yes	75	50	125
No	92	94	186
Total	167	144	311

to act as a source of information and create an expectation that HCWs possess current and relevant information related to both communicable and non-communicable diseases.¹⁵

Relevance of health education

The findings of this study revealed that 49.14% of patients who visited health facilities received information that was not relevant to their condition. Although 50.86% of patients received relevant information, the percentage of patients who received irrelevant information is worrisome. Of course, it is important to provide general information that aims at improving the general well-being of a person but then health workers should also pay attention to the current problem as this will prevent the patient from repeatedly seeking health care services for the same condition. The findings indicated challenges regarding the provision of health education, whereby patients are receiving general health information rather than receiving focused information based on their current conditions. The findings agree with the study conducted in South Africa by Visagie and Schneider,¹⁶ whereby the care in the setting was not client-centered, and individual users were not enabled to allow them to manage their conditions. The result of this study gives an indication that the services offered are more curative services rather than preventative and rehabilitative. Some scholars have investigated the effect of health education on the prevention and control of respiratory infectious diseases in school students. His study found that the awareness of respiratory knowledge and the formation rate of healthy behavior of primary and high school students in the intervention group were significantly improved after the health education.^{17,18} This underscores the benefits of health education in changing the health behaviors of the community toward disease prevention. Patients who receive information regarding their medical condition are more likely not to come back to the health facility with the same complaints, simply because they are well-informed on how to change their lifestyle and prevent the same illness. This may reduce the financial burden on the state as well as individual patients, as this will minimize hospital visits for preventive ailments.

Patients tend to come back with the same health problems because they are not well informed regarding immunization, communicable diseases control, environmental health, nutrition, school health services, first aid services, drug education, accident prevention and emergency, services, and aid family life education. Therefore, health education needs to be strengthened to minimize the higher volume of patients coming to health facilities and eventually reduce nurses' workload.

Limitation

The only limitation of the study was the sample size; according to the sample size calculations, 368 respondents were supposed to participate in the study, but the researchers managed to collect data from 313 participants, which was 85%.

Conclusions

The study concluded that health education as one of the principles of primary health care services is not implemented successfully. The fewer patients that receive health education are unable to utilize the information received from health workers to take care of their own health. No community health education programs provide information to community members to make an informed decision on communicable disease prevention. Health workers at the facilities are overwhelmed with a lot of work and focused more on curative than health education and diseases prevention. Our rec-

ommendations are that MOHSS should ensure that health education is a strengthened part of PHC services through ongoing in-service training of health educators for effective PHC services in Namibia; health education should be provided for the community members, regardless of how busy the health facilities are, so as to the community members to have rights to health and preventing communicable diseases; the information provided to the community should also focus on the current health conditions that the patients are suffering from.

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