

Health Education for Primary Health Care Development in Kenya

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This paper discusses appropriate ways to strengthen community health education activities and training for health education in order to improve the effectiveness of the National Health Education programme in Kenya. The study procedure involved drawing of relevant experiences from a review of related literature and discussing in the light of health education problems in Kenya to help make suitable conclusions and recommendations for improving the Kenyan situation. It was revealed that the National Health Education programme in Kenya has many constraints which need priority attention through practical support from the Ministry of Health in the areas of resource allocation, management, reorganization of the Division of Health Education in order to introduce effective management capabilities, revival of training for health education officers; review of the training curricula for all health workers so that health education is introduced as a major subject of study, introducing incentives and attractive scheme of service for health education officers, and setting performance standards concepts, training models, educational materials and programme evaluations. It is also proposed that the Division of Health Education be renamed the Division of Health Promotion, in charge of health promotion activities and Health Promotion Officers

Keywords: health education, health promotion, human communication theory, training; primary healthcare development

INTRODUCTION

In 1963, Kenya became an independent nation within the Commonwealth. The administration of the country is done within a five-tier system of the Provinces, Districts, Divisions, Locations and Sub-locations. All districts are centres of development activities coordinated by District Commissioners. In this way, they support the government policy on District Focus Strategy for Rural Development, which was started in 1983 to decentralize decision-making to the grass-roots level and to turn the districts into centres of planning and implementing projects (Kenya Government, 1983). According to the provisional results of the census of 1989, the Republic of Kenya had a population of 21,397 million and a growth rate of 3.3 4%. It appeared that this was a significant change compared with 1979 when it was 3.8%. The country had a fertility rate of 6.1% and a contraceptive prevalence rate of 27%, plus a life expectancy of 59 years (Central Bureau of Statistics, 1991).

Sindiga (1985, p. 72) attributes Kenya's high demographic change to improved healthcare and the falling mortality rates. The seemingly low prevalence rate of contraceptives is attributed to the side-effects of contraceptives and unresponsive attitudes. The same commentator observes that Kenya's fertility patterns do not clearly fit into the European Demographic Transitional Model, which suggests that the population stabilizes (lowering of births and deaths) as modernisation sets in. He also opines that in Kenya, traditional structures of family life and the values attached to children would sustain high

fertility even as the effects of modernisation lead to lower mortality. In other words, the benefits of modernisation seem to have improved the health status among the poor but are not yet sufficient to lower the fertility rate. He concludes that modern contraception in Kenya appears to have been adopted by a small number of women mainly as an aid to child spacing rather than limiting family size. In most developing countries, Kenya included, the deliberate spacing of births is a completely new idea. In many cases, reasons given for desiring more children are: the need to ensure family survival, to attain social status, the fear of losing children, religious fatalistic beliefs and distrust of contraceptives. Currently, the Ministry of Health does not have specific family planning programmes for the youths who form half of the population (MOH/GTZ, 1988).

Kenya is a multi-cultural country with about fifty indigenous groups, as well as different racial groups of mainly Asians and Europeans. This diversity of culture harbours socio-cultural beliefs which have both positive and negative effects on certain development activities, including health (Barkan & Okumu, 1979). It is useful to note that the concept of community participation is not new in Kenya because the *Harambee* (self-help) movement has been in existence since Independence, raising funds for various projects. On many occasions, these *Harambee* forums have been used for creating awareness about health and other socioeconomic activities. In Kenya, local leaders organize the communities for self-help meetings (*barazas*) where they discuss exhaustively what projects should be

undertaken. When the general consensus has been reached on various aspects of a project, a project committee is then elected democratically, often with a show of hands. Later, all the community members, plus some invited guests, are called to a *Harambee* meeting for funds-raising. Those who cannot afford cash may promise materials or labour (Bennett & Maneno, 1986).

According to the current National Development Plan (1989-93, p. 258) *Harambee* contributions in 1979 were K £9.79 million and increased to K £37.29 million by 1985. However, development through *Harambees* has not been even because of unequal economic power between tribes (ibid, p. 103).

Problems of Health Education in Kenya

The Division of Health Education was established in Nairobi, Kenya, in 1957 as an Audio-Visual Aids Centre. It was a place for designing, production and distribution of educational materials to support disease campaigns in the country. This division was manned by a few expatriate health education officers supported by some subordinate staff (Division of Health Education, 1985). In this way, the Division produced educational materials like booklets, posters, folders, handouts, charts, taped messages, slides, filmstrips, mounted photographs, models and flannel graphs, for free distribution to the target audience. Unfortunately, most materials were produced in English, although in rare circumstances, translation into the common language, Swahili, was done.

Today, the Division has more staff and produces the same materials in a similar manner. Translation into local languages (which are about fifty in number) would be difficult and uneconomical. It is hoped that the materials would be useful if translated into Swahili, the language spoken and read by the majority of the population. Today, the literacy rate in Swahili stands at fifty-four percent (CBS, 1989). However, the materials have been found useful during school health education programmes. In addition to the problem of translations, the production of locally made materials has not been feasible due to the shortage of funds for field trips and technical production.

Currently, the Division of Health Education is charged with the responsibility of conducting health education to all Kenyans in order to prevent and control the causes of ill-health and also to promote good health practices. However, when striving to accomplish these tasks, health education officers are mainly hampered by the constraints of inadequate funds, logistics, lack of support from other health workers, inadequate intersectoral collaboration, low morale due to insufficient promotional opportunities, unsuitable audiovisual aids, lack of evaluation and research skills, an absence of performance standards

and code of ethics (DHE, 1987; MOH, 1987; MOH, 1989). The Division has a staffing strength of 900 members, including technicians, subordinate staff, administrators and professional health education officers (DHE, 1985). They are deployed in various specialised departments like printing, photography, design, workshop, electronics, transport, administration, training and community health education. The production of materials is manned by a few technicians and designers in collaboration with the Head Division of Health Education. Unfortunately, there are no technicians to run the Radio and Television Studios. The organisation of the Division is a five-tier system running from the National Head of the Division, Provincial Health Education Officers, District Health Education Officers, Divisional Health Education Officers and Locational (or project) Health Educational Officers. In recognition of the crucial role played by the Division of Health Education, several National Development Plans reflect the need to support preventive and promotive health services, as was the case with the National Development Plan (1974-79) which stated:

The plan objectives of the Division of Health Education are to get the people to realize that health is a community asset essential to economic growth and social progress, to motivate them to make efforts to contribute to improving their own health, and get their cooperation and participation in public health programmes (p. 502).

During this plan period, a new Division of Health Education was built and the training of health education officers was started. However, no evaluation was done to determine the extent to which the plan objectives were achieved. The current National Development Plan (1989-93) stipulates that:

Currently, curative services take 70% of public spending on health while preventive medicine accounts for less than 5% expenditure allocations in the Ministry of Health. During the plan period, greater emphasis will be placed on preventive and promotive health services (p. 238).

In this context, experiences from many countries of the world, including Kenya, have shown that bridging the gap between curative and preventive health services may not be easy because of the unchanged attitudes of policy makers. Perhaps, the world-wide concept of primary healthcare and the necessary sensitization would improve the situation significantly. It is useful to note that the strategies for health education in Kenya include school health education, patient education, mass media, community health education, production of materials and the training of health education officers (DHE, 1986).

My experience has shown that school health education is constrained by overcrowded curricula and lack of reliable transport. In addition, patient health education is done by other health workers during their routine duties in wards and clinics. Sometimes, difficulties arise due to insufficient skills in communication and counselling. Unfortunately, mass media is not regularly done because of the cost involved and lack of skilled production staff. Despite administrative problems, health education officers are normally preoccupied with the activities for changing attitudes towards health and community organizing for self-help on health through the primary healthcare approach.

To tackle these challenges, the main objectives to guide resources allocation and programme management in the Division are as outlined below:

- a) Planning, implementation, supervision, coordination and evaluation of all health education activities in the country.
- b) The design, production, storage and distribution of educational materials.
- c) The training, deployment and supervision of professional health education officers.
- d) Support of other departments in the training for communication skills and the development of appropriate health education packages.
- e) Coordination and collaboration with non-governmental organisations dealing with health education activities.
- f) Policy development on health education to meet the challenges of uplifting health and welfare of Kenyans.
- g) The research for solutions to various health education problems.

In summary, the Division of Health Education is mainly involved in putting relevant policies into practice so that health education strategies may yield the desired benefits in the country. Therefore, to realize most of the above objectives, the appropriate training of health education officers would be required.

METHODOLOGY

The required information for the foregoing study was collected through analytical design involving library searches using Liberta circulatory system and on-line catalogue at the University of Bristol. Again, a review of relevant documents from the Ministry of Health in Kenya was made. The study did not require research assistants or a funding agency because it was manageable, using the resources available. No problems were encountered during the research study because due consideration was given to the timing of activities. The theoretical framework found appropriate for the work was that of primary healthcare, health education/health promotion and

Human Communication Theory. Data and information collected were analysed using historical methods to assess the problems and their appropriate solutions. It was hypothesized that by identifying the relevant experiences from other countries, useful information would be tapped for improving similar programmes in Kenya and other countries of the world. In this way, this study had its conclusions drawn from the evidence adduced. In the dissertation, the study problem was conceived through a literature review and from the researcher's own experience as Provincial health education officer in the Eastern Province of the Republic of Kenya, for more than ten years.

RESULTS AND DISCUSSION

The Contribution of Health Education to Primary Health Care Development

Several studies (Smith, 1979; Strehlow, 1983; Rodmell & Watt, 1986) have concluded that health education has not been properly understood and therefore it is accorded low priority in development programmes. In this context, the European Public Health Committee (1980) recommends that to improve the situation, Health Education Units need to be set up in the Ministries of Health, and that health education should be given emphasis in National Development plans and policies. The case of Kenya appears to fit this description because the Division of Health Education is set in the Ministry of Health as a Specialised Department, with its policies reflected in National Development plans. Although this idea seems helpful, necessary support, in terms of resources allocation, is given low priority. In the same context, it may be useful to note that some studies (such as Downie *et al.*, 1990) indicate that for health education to be more effective, it should incorporate health promotion strategies in its approaches. This may be a sound argument which would widen the individualistic approach to health education. Although the health promotion approach is utilised in Kenya, and in many other developing countries, some constraints may be encountered because several health problems are rooted in the socioeconomic development of the country, and tackling such social economic problems is often not easy because it involves working in the political sphere. It appears that intensifying health promotion in Kenya may be an important approach, although it needs intersectoral collaboration and political support for its operations. Perhaps emphasizing intersectoral collaboration in all trainings may strengthen teamwork. Furthermore, data collected in the dissertation suggested that health educators may find the Health Belief Model useful in planning health education because it provides the main factors which contribute to behavioural change. Although this Model provides important factors for consideration, some researchers have criticized it for being individualistic, while offering a fixed pattern for behavioural change. It

appears that without alternative models for behavioural change, the Health Belief Model may remain valuable for a long time. In the same context, accumulating evidence (Selvaggio, 1990; Lin, 1973; EPHC, 1980; Zimmerman, 1989; Bunton *et al.*, 1991; Kok *et al.*, 1991; Peterson & Strunkard, 1989; RUHBC, 1989) suggest that behavioural change for improved health would occur when: messages are rooted in the beliefs and practices of the people, opinion leaders are used, emphasis is put on significant other persons, people are taught the skills of how to remove barriers, there is increase personal control, use of the community development approach, there is focus on receptive target audience, there is organization of long-term health education programmes and focus on benefits to individuals, job, family or social relations. It appears that all the above suggestions may be found useful by health education officers while planning, implementing and evaluating their activities. Apart from that, as mentioned earlier, significant achievement may be realised if health education is given the necessary support through resource allocation, in terms of adequate funds, equipment and skilled personnel. Currently, the Division of Health Education is operating below expectations due to these constraints. In the same way, some studies have shown that health education may yield more when appropriate methods and strategies are used. Since there is no single method which would fit all the occasions, a mixture of methods may be a better alternative (Strehlow, 1983).

Sharing the same opinion, Naidoo (1986) maintains that health education needs to be client-centred without apportioning blame and should also aim at tackling the real causes of ill health. Experience from many countries has demonstrated that some causes of ill health may be beyond an individual's control and, therefore, soliciting for government or community involvement would be helpful. The Kenyan situation would benefit from these suggestions, especially in the areas of education for primary healthcare which may need a multi-media approach.

At this juncture, we also note that several researchers have shown that village health committees and community health workers would stimulate health education activities but problems of support, supervision and remuneration may arise. Perhaps enhancing people's participation through involvement in decision-making, implementation, evaluation and the sharing of benefits may be advantageous (Cohen & Uphoff, 1980). Nevertheless, the *Harambee* movement in Kenya is not without problems; nevertheless, its role in development activities, including health, should be recognised. Again, the role of women and women's groups in support of education activities is encouraged because they play a central role in family growth and development

(Burshad, 1986). Indeed health education officers would find women's groups indispensable targets for health education. More findings by this dissertation point to the suggestion that health education may be enhanced through counselling, group discussions, adult education for liberation, cassette and video discussions among others. All these may be profitable strategies, but in some cases, problems may be encountered due to the high cost of cassette/video equipment and the need for technical skills. Availability of this equipment and skilled manpower in the Division of Health Education would go a long way to strengthening health education in Kenya. Although health education for liberation may be advantageous, it will almost inevitably encounter political resistance because it empowers people to see the contributing factors to their ill health which may include the social-political system of their government. Perhaps sensitizing people for self-help on health (*Harambee*) without blaming the government for health problems would be preferable (O'Sullivan-Ryan & Kaplun, 1981).

Another recommended strategy is school health education which provides a receptive audience who have attitude formation at childhood and adolescence (WHO, 1988; Geizary, 1990). Although this strategy could be significantly effective and have a multiplier effect, it may be constrained by overcrowded curricula, lack of transport, educational materials and uncooperative teachers. Perhaps the situation may be improved by seeking policy decisions at the Ministerial level in order to incorporate health education into the training of teachers and the school curricula. Although problems of School health education seem to persist in Kenya, Health education officers may, as resources permit, organize seminars for teachers, distribute educational materials and give health talks to selected schools as the need arises. On production of educational materials, the available data suggest that emphasis needs to be put on locally produced materials, adequately pre-tested, and translated into the relevant languages (Porter, 1970; Macdonald, 1988). For this purpose, the training of health education officers should then adequately prepare them for this responsibility, which may include the management of an Audio-Visual Aids Unit at Headquarters. This proposal would greatly benefit the Kenyan situation when resources are improved; otherwise, translation of the existing materials into Swahili, which is widely read, would be worthwhile. At this juncture, it is important to discuss the effectiveness of mass media (radio and television) as a tool for health education. Several researchers have suggested that mass media may be useful in increasing coverage, setting the agenda for public discussion, increasing knowledge and influencing attitudes. There are also disadvantages because it may be costly, censored and lacking feedback (Ewles & Simnett, 1985). In the same way,

other studies have shown that mass media would be more effective if it uses a credible source, supported by reading materials, opinion leaders, involving intersectoral collaboration and using pre-tested messages, especially of an informative nature (Cernada, 1992; Lin, 1973; ICR, 1974; Meyer, 1980). Although the mass media strategy is inadequately utilised in Kenya special programmes may be made according to demand and the availability of resources. It is sometimes argued that where the local culture is strong, folk media may be useful. In so doing, it may involve incorporating health messages into the local poetry, storytelling, songs, role-play, theatre, games, puppetry, art, dance, town cries and shows among others (WHO, 1988). Experience in Kenya has shown that dances, songs and role-play would be useful, although these take a long time to organize. Depending on how they are organized, some activities have been found to be more entertaining than educational. Therefore, it requires considerable skill on the part of the Health educator to incorporate some entertainment into a programme without losing the essential message. Hopefully, folk media would be a good alternative in some parts of Kenya where cultural activities are strong.

At this point, it is useful to note that the contribution of health education to quality healthcare would be increased if Health education officers discharge their duties effectively according to the set performance standards (Roemer & Aquilar, 1988). Although this suggestion appears helpful, the task of setting up a Performance Standards Committee to oversee compliance through supervision, training and continuing education may be a difficult task because of the changing contexts and cost outlay. Perhaps the incorporation of these standards into the basic and post-basic training of health education officers in Kenya would be beneficial. Accumulating evidence indicates that the role of research and evaluation for health education programmes need to be intensified (Macdonald, 1988; EPHC, 1980; Basch, 1987).

In this way, Sutherland (1979) proposes that:

Success or failure of health education should be judged by whether or not it succeeds in achieving some educational or behavioural objectives such as increase in knowledge or change in lifestyle and not by medical outcomes (p. 245).

For emphasis, the same commentator argues that health education has not been seen to have impact because of being judged in terms of measurable improvements in health status. It may be further contended that the increase in knowledge or changes in lifestyle should be able to contribute significantly to preventive measures which would resultantly lower morbidity and mortality rates. Perhaps, judging health education in all parameters of educational, behavioural and medical outcomes would be more useful.

The study by Basch (1987) demonstrates the appropriateness of focus-group interviews as a qualitative research method for health education research, planning, formative and summative evaluation. Although this method would be found handy by health education officers in Kenya, the results may be invalid for generalization into large projects. In the same context, the European Public Health Committee (1980) recommends that health education may be better evaluated through continuous evaluation and preferably be a 'sine qua non' of health education. This may be an important observation which could indeed widen the sphere of health education. However, constraints may be noticed when technical skills and funds are lacking. In the same way, it may be advantageous to argue that evaluation results, which are not threatening to the system, may be more likely to be put into practical use.

CONCLUSION AND RECOMMENDATIONS

The study dealt with appropriate ways of strengthening community health education and the training for health education in order to improve on the effectiveness of the National Health Education Programme in Kenya. For this purpose, relevant experiences were drawn from the work of various researchers and discussed in the light of health education problems in Kenya, in order to draw suitable recommendations for improving the Kenyan situation. It was found that although health education encounters several constraints during its implementation, useful experiences can be drawn from other programmes or countries of the world. Some of these experiences may be taken as a whole or be modified to suit individual situations. Emanating from the findings of this dissertation, the Health Education Programme in Kenya may therefore benefit from the following recommendations:

- a) Involvement of international bodies like WHO, USAID, UNICEF and others in support of the National Health Education Programme may yield significant benefits, especially through supporting community health education activities, training for health education and sponsoring sensitization seminars for policy-makers.
- b) That the Ministry of Health should practically support preventive and promotive health services through explicit National Health policies and Development Plans which favour health education as an important tool for National Health Development.
- c) There is need to reorganize the Division of Health Education through the introduction of management capabilities which would effectively spearhead the specialised activities of the Division for the purpose of achieving National Health Education goals and objectives.
- d) Training for health education officers should

- be revived and strengthened, through the training of trainers, a regular review of the curriculum, training methods, teaching aids and evaluation procedures. In this way, experiential-training techniques, HIV/AIDS education and management skills would be incorporated into the curriculum. Apart from that, the curricula for all health workers including doctors, nurses, environmental health officers and other paramedical personnel, should be revised to include health education as a major subject of study. In addition, intersectoral training through the continuing education programme would be advantageous in order to enhance teamwork while implementing community health education activities.
- e) The Ministry of Health should provide incentives and an attractive scheme of service for Health Education officers in the training department and those doing Community health education as a means of boosting morale, performance and retention of personnel in the service.
- f) That the Ministry of Health should strengthen the Division of Health Education through adequate resource allocation in order to effectively implement the main health education strategies of training, school health education, mass media, patient health education, production of educational materials, community education and administration of the Division of Health Education.
- g) In their normal duties, Health Education Officers need to consider the usefulness of Health Belief Model, principles of health promotion, local beliefs and practices opinion leaders, community health committees/workers, women's groups, informal discussions, personal control, focusing on benefits to the people, receptive target audiences, community development approach, multi-media approach, intersectoral collaboration, production of local educational materials, translation of existing materials into Swahili, use of folk media, preference for both short-term and long-term health education projects.
- h) That the National Health Education Programme would be effective if adequate support is given to research and evaluation needs through allocation of funds and skilled manpower. In this way, research into the guiding health education theories, training models and appropriate Audio-Visual aids would be necessary. Again, preference for continuous evaluation as a 'sine qua non' of health education plus the use of focus-group interviews would be beneficial to the programme.
- i) Although it may be helpful to judge health education's effectiveness through achievement of educational, behavioural and medical outcomes, consideration should be made for setting a standards committee at Headquarters to monitor the performance standards for quality health education services.
- j) To enhance the image of the Division of Health Education, a new name is proposed to match with the current mainstream of the concept of Health promotion. In this way, the Division should be rightly called the Division of Health Promotion in charge of Health Promotion Activities and Health Promotion Officers.

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