

Health Education Practice in Libya; Professional Opinions

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ABSTRACT

The aim of this study is to assess the perceptions of Libyan health professionals of their role in the provision of health education to the general public. It is also to identify barriers to effective health education and to suggest actions for a more effective role. A closed-end questionnaire was distributed to 500 health professionals in five Libyan localities. Participants were requested to answer questions covering the responsibilities, importance and effectiveness of the existing role of health professionals in health education. Participants were also asked to indicate their perceptions of various barriers to the delivery of effective health education. A list of related suggested solutions for improving the practice was also presented. Nearly two thirds out of 500 health professionals responded to the questionnaire. A large majority perceived that they are responsible for providing health education and almost all (98.9%) considered this role very important or important. The effectiveness of their existing role was assessed differently. Participants perceived that lack of educational aids and materials and low priority for health education were the main barriers that should be overcome in order to improve services.

Keywords: *health, professionals, education and promotion, Libya*

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Introduction

The Alma-Ata Declaration for Primary Health Care and the Ottawa Charter for Health Promotion have both recognized the need for the reorientation of health services towards promoting health (World Health Organization, 1978, 1986). The Mexico Framework for Countrywide Plans of Action has identified the process of reorientation as one component of the mechanisms for action (World Health Organization, 2000). The World Health Organization (WHO) has advocated that the role of the health sector must move increasingly in a health promotion direction beyond its responsibility for merely providing clinical and curative services (1986). The role of health professionals (HPs) represents a major contribution to community health promotion and education. HPs are assumed by the WHO to provide an important and effective role because of their high contact rates with individuals and the perceived credibility of HPs among the general public. Health education (HE) is the communication of knowledge and provision of experience to the general public, the development of attitudes and skills and the adoption of appropriate behaviors in order to maintain public health (World Health Organization, 1988). A variety of terms have been used in the literature to cover the educational activities of HPs in health care services. These include HE, health promotion, health advice, patient education, client education and patient counseling.

In Libya, the 'Health for All' strategy has been established, featuring universal access for the Libyan population, to primary health care services, including HE (General People's Secretariat, 1995; General Secretariat for Health and Environment, 2007). However, the authors believe that the education component in the role of Libyan HPs' remains neglected, as it does in many other countries around the world. Recent studies by the authors have revealed that Libyan HPs do not represent an important source for HE (Elfituri, Elmahaishi & MacDonald, 1999; Elfituri, Elmahaishi, MacDonald & Sherif, 2006). To the best of the authors' knowledge, the present study is the first in the country to assess Libyan HPs' perceptions of their responsibility to provide HE. Another objective was to obtain the HPs' opinions on the importance and effectiveness of their existing role in HE.

Subjects and Methods

A closed-ended questionnaire was designed, using a similar format to that utilised in previous studies (Bernstein, Rieber, Stolz, Shapiro & Connors, 2004; Calman, Cant, Williams & Killoran, 1994; Copple & Davis, 1998; Coulter & Schofield, 1991; Hubley, 1986; Imperial Cancer Research Fund, 1995; Rahman, 2000; Tapper-Jones, Smail, Pill & Harvard, 1990; Teutsch, 2003; Williams, Bucks & Whitfield, 1989, Wood, Whitfield & Bailey, 1989). It targeted 500 HPs of both genders from different backgrounds and in different fields of health service. Ethical approval for the study was obtained from the Libyan National Committee for Health Education, General Secretariat for Health and Environment. The questionnaire was distributed personally by the authors and some colleagues during May and June, 2007. A simple random sampling method was used to collect data. This subset of the population (sample) was chosen to be representative of the population with respect to the variables being studied. Study participants were provided with details about the study and informed consent was obtained accordingly. Distribution involved health facilities at five major populated regions within Libya, Tripoli, Misurata, Gherian, Benghazi and Sebha (n = 100 for each region). Participants were requested to tick the perceived correct answer; how they see the responsibility of HPs for HE, to what degree HE by HPs is important and how they assess the effectiveness of the existing role of HPs in HE. Participants were also asked to tick their degree of agreement with each of a list of barriers to the delivery of effective HE by HPs. All the barriers to HPs' role in HE indicated in the reviewed literature were presented in the questionnaire (Bernstein, Rieber, Stolz, Shapiro & Connors, 2004; Calman, Cant, Williams & Killoran, 1994; Copple & Davis, 1998; Coulter & Schofield, 1991; Hubley, 1986; Imperial Cancer Research Fund, 1995; Rahman, 2000; Tapper-Jones, Smail, Pill & Harvard, 1990; Teutsch, 2003; Williams, Bucks & Whitfield, 1989, Wood, Whitfield & Bailey, 1989) A list of related possible suggested solutions for improving HPs' role in HE was also presented in order to determine the degree of agreement with each solution. Using a Likert scale for measuring attitudes (Likert, 1932), five degrees of agreement were presented for each point; strongly agree, agree, uncertain, disagree, and strongly disagree. The degrees of agreement were translated into ordinal measurement scales; +2, +1, 0, -1 and -2 respectively.

A pilot study was carried out involving 50 subjects. Sample size was calculated from the pilot study, according to the equation in Pearson and

Turton (1993). The questionnaires were answered anonymously and confidentiality was assured. Completed questionnaires were individually collected and the resulting data were statistically analyzed using SPSS 10.0.

Results

Out of the 500 questionnaires distributed, 300 were completed and returned, a response rate of 60%. About 60% were males (n = 178). Most of the participants (43%, n = 130) were physicians. About three quarters of the participants (73.7%) had a B. Sc. degree or equivalent or higher (n = 130). More than half of the participants (53.3%, n = 160) were working in the field of curative medicine. Table 1 shows the

Table 1: Distribution and Characteristics of the Participants

Parameters	No.	%
<i>Gender</i>		
Male	178	59.3
Female	122	40.7
<i>Profession</i>		
Physician	130	43.3
Dentist	22	7.3
Pharmacist	32	10.7
Nurse	21	7.0
Midwife	3	1.0
Health visitor	26	8.7
Dietician	2	0.7
Community health technician	17	5.7
Health administrator	17	5.7
Others	30	10.0
<i>Qualification</i>		
PhD or equivalent	24	8.0
MSc or equivalent	25	8.3
BSc or equivalent	172	57.3
Intermediate Diploma	63	21.0
Secondary school degree	4	1.3
Primary school degree	12	4.0
<i>Field of work</i>		
Curative medicine	160	53.3
Preventive medicine	68	22.7
Others	72	24.0

N = 300

distribution of the participants according to their gender, profession, qualification and field of work. Most of the study participants (86.3%, n = 259) perceived that HE is an integral part of the role of HPs while a small group (n = 21) perceived that HE is a limited responsibility for HPs (Table 1). Table 2 demonstrates the view of the participants on the responsibility of HPs for delivering HE. Thus, 76% of the participants (n = 228) considered HPs' role in HE as very important and 23.0% (n = 69) believed that it is important. Table 3 shows the importance of HE by HPs as perceived by the participants. According to Table 4, more than half of the participants assessed the existing role of Libyan HPs in HE as having little effect or as not effective (41.0% and 12.0% respectively, n = 159). On the other hand, less than half of the participants considered this role to be very effective (24.7%) or effective (19.3%), total n = 132.

Table 2: Responsibility of Health Professionals for Health Education

Responsibility	No. (n = 300)	%
Yes, it is an integral part of HP's role	259	86.3
A limited responsibility	21	7.1
Only the responsibility of HPs working at the preventive services	5	1.7
Only for "at risk groups"	4	1.3
No, it is not their responsibility	2	0.7
Uncertain	9	3.0

Table 3: The Importance of Health Education by Health Professionals

Importance	No. (n = 300)	%
Very important	228	76.0
Important	69	23.0
Of a little importance	1	0.3
Not important	2	0.7
Uncertain	0	0.0

Table 4: Effectiveness of Health Professionals' Role in Health Education in Libya

Effectiveness	No. (n = 300)	%
Very effective	74	24.7
Effective	58	19.3
Of a little effectiveness	123	41.0
Not effective	36	12.0
Uncertain	9	3.0

Table 4 indicates how participants assessed the effectiveness of the existing role of HPs in HE in Libya.

The rank order of barriers for delivering effective HE by HPs as perceived by the respondents is shown in Table 5. The top three barriers were the lack of educational aids and materials, the low priority held for HE in health services and the lack of rooms and related facilities for conducting group HE. The rank order of solutions to improve HPs' role in HE as suggested by the participants is shown in Table 6. The provision of educational aids and materials was the primary suggested solution.

Table 5: Rank Order of Barriers to Health Professionals' Role in Health Education

No.	Barrier	Mean \pm SD
1	There is a lack of educational aids and materials.	1.4(0.80)
2	HE is held to be of lower priority than is curative medicine in health services and by policy makers.	1.2(0.90)
3	Health services lack rooms and related facilities for conducting group HE.	1.2(0.98)
4	HPs lack communication skills.	1.1(0.87)
5	Factors such as family, commercial advertising, culture and traditional beliefs have a negative influence on HE.	1.1(0.92)
6	Education and training of HPs are carried out at the curative medicine services (little knowledge of HE).	0.8(0.97)
7	HPs are not invited to participate in the community activities.	0.7(0.97)
8	Some HPs see HE as too trivial a job for them to do, or as merely the job of those working in the preventive health services.	0.6(1.21)
9	There is information contradiction between different HPs.	0.3(1.02)
10	Some HPs are not interested in cooperating & participating in community activities.	0.3(1.08)
11	Not enough time to practice HE	0.3(0.07)
12	HE is of no or little interest to the customer.	0.3(1.10)
13	The presence of other people at the same place (e.g. the pharmacy) hinders discussions on private matters.	0.2(1.10)
14	Some HPs fear upsetting people.	0.2(1.11)
15	The language that HPs use is difficult to understand.	0.1(1.18)

Discussion

Increasingly, HE has been recognized as an essential element in the responsibilities of health and medical professionals'. The HPs who participated in the present study were generally positive in terms of

Table 6: Rank Order of Suggested Solutions

No.	Suggested solutions	Mean +SD
1	HPs should be provided with educational aids and materials.	1.6(0.50)
2	Support of policy makers needs to be improved.	1.5(0.62)
3	Enhancing the role of mobile HE groups is important.	1.5(0.57)
4	Continuous education on techniques of HE should be provided for HPs.	1.5(0.53)
5	Provision of suitable rooms and related facilities for conducting group HE should be facilitated.	1.5(0.63)
6	Communication skills should be taught at medical and health schools.	1.4(6.10)
7	HE should be among the HPs postgraduate specialties.	1.3(0.74)
8	A significant proportion of education and training in the medical and health schools should be based in the primary health care services.	1.3(0.77)

recognizing their responsibility for HE. Most of them (about 85%) considered it as an integral part of their role. Nearly all of the participants saw HPs' role in HE as very important or as important (76.0% and 23.0% respectively, Table 3). However, less than half of the participants (44.0%) assessed the existing Libyan HPs role in HE as very effective or effective.

Previous studies found that HPs held strongly positive attitudes to preventive care and health promotion and suggested that their role as health educators should be further supported (Coulter & Schofield, 1991; Wood, Whitfield & Bailey, 1989). They represent an influential source of health information for the general public who approves of their role as health educators (Wood, Whitfield & Bailey, 1989). Another previous study has shown that 95% of general practitioners (GPs) agreed that patient education was important and 61% placed doctors' advice among the top three most effective methods of communicating health advice (Tapper-Jones, Smail, Pill & Harvard, 1990).

On the other hand, some HPs have too narrow a concept of health and what is meant by health promotion and HE (Ewles & Simnett, 2003; World Health Organization, 2003). Accordingly, these professionals may tend to limit their responsibility for health promotion and education (World Health Organization, 2003; Blinkhorn, 2002). A number of studies have revealed that some HPs do not acknowledge that changing behavior affects risk factors or are even pessimistic about giving life-style education to clients (Imperial Cancer Research Fund, 1995; 25Calnan,

1991). Two previous studies in Libya have revealed that health officials as well as the general public assessed the effectiveness of HPs' role in HE at a relatively low level (Elfituri, Elmahaishi & MacDonald, 1999; Elfituri, Elmahaishi, MacDonald & Sherif, 2006). Smoking intervention programs based on HPs have resulted in a significant reduction in smoking (International Union for Health Promotion and Education, 1999, World Health Organization, 2005). The majority of patients considered that their chances of success were greater if clinicians administered the smoking intervention programs (World Health Organization, 2005). GPs' patient education has demonstrated success with many other health problems (International Union for Health Promotion and Education, 1999).

The rank order of the perceived main barriers to HPs' role in HE in the present study was the lack of educational aids and materials, the low priority held for HE in health services and by policy makers, the lack of rooms and related facilities for conducting group HE in the health services, the lack of communication skills among HPs and the negative influence of factors such as family, commercial advertising, culture and traditional beliefs on HE. Resource constraints may also hinder HPs from achieving their potential in health promotion. There may be staff shortages and work overload, leading to less time available for long term health promotion work (Ewles & Simnett, 2003; World Health Organization, 2003). Difficulties facing HPs' role in HE may be organizational, attitudinal or due to deficiencies in knowledge or communication skills (Bernstein, Rieber, Stolz, Shapiro & Connors, 2004; Tapper-Jones, Smail, Pill & Harvard, 1990; Teutsch, 2003).

About 90% of the GPs who participated in a previous study had encountered practical difficulties involving poor clinician-patient communication. More than three quarters of the participants indicated lack of time as a barrier to providing more health advice for their patients and 54% said that time constraints were a major difficulty in their practices (Tapper-Jones, Smail, Pill & Harvard, 1990). Rahman (2000) reported that the communication between clinician and patient is frequently poor and ineffective. It is the most common cause of complaint from patients or their relatives (Myerscough, Donald, Speirs, Wrate, Currie & Doyle, 1992).

Other previous studies have identified a number of obstacles such as lack of time (Calnan, Cant, Williams & Killoran, 1994), lack of financial incentives, lack of computerized registers (Calnan, 1991) fear of upsetting people (Williams, Bucks & Whitfield, 1989) and administrative burdens (Calnan, Cant, Williams & Killoran, 1994), communication distraction, difference in backgrounds, perceptions and values as well as the use of

complicated language (Hubley, 1986). Coulter and Schofield (1991) found that reported barriers to carrying out health promotion activities by HPs were ranked as follows: lack of time, patient's lack of interest in lifestyle advice, lack of financial incentive, lack of interest on the part of the doctor, too few practice staff, inadequate records and registers, inadequate premises, and lack of computers. The rank order of barriers in another study (Copple & Davis, 1998) was as follows: lack of resources, lack of time, poor interest from patients and the reluctance of patients to help themselves.

Study participants put the first three barriers to HPs' role in HE on the shoulders of the health authorities. For instance, it was observed that rooms that are designed for HE activities in some health centers in Libya were used by the centers' managers as administrative offices. Sufficient funding and support from relevant personnel and availability of resources and training were identified as barriers to more hospital based health promotion activities (Blinkhorn, 2002). Most hospitals surveyed in Australia recognized the importance of patient education, but support was based on individual efforts resulting from initiatives taken in specialty areas rather than reflecting overall hospital policy (Degeling, Salkeld, Dowsett & Fahey, 1990). In Canada, 37% of hospitals had health promotion policies, while 21% stated that health promotion was not part of their role (Bartlett & Jonkers, 1990). Similar observations have been reported in France (Aujoulat, Le Faou, Sandrin-Berthon, Martin & Deccache, 2001).

With all the modern advances, however, the hospital has become the natural workshop of the clinician. The value of primary health care, which could have kept many people out of the hospital, has been more and more ignored and the result has been the neglect of their health (Blinkhorn, 2004). Furthermore, we can argue that medical schools disease-orient their students, and, at best, they risk-factor-orient them. The schools concentrate on clinical sciences and conduct their training programs focused on curative medicine services. "Public health, health promotion, disease prevention, preventive health, and HE" are terms which do not receive much attention within the medical schools' curricula. Primary health care centers and maternal and child health units are not often the sites for training medical students. For instance, medical students know little about 'Teaching Primary Health Care Centers', but usually know a lot about 'Teaching Hospitals'. The authors have never heard about training a medical student at a 'Maternal and Child Health Centre' in Libya.

Many of the world's medical schools prepare clinicians not to care for the health of the people but to engage in a medical practice that is blind to anything but disease and the technology that deals with pathology. More than a quarter of previously surveyed GPs had had no health promotion training. Of those who had training, only 37% had received it through medical education (Killoran, Calnan, Cant, Williams & Pacemaker, 1993). Thus, the existing situation represents the dominance of treatment over preventive medicine. The clinicians stress action for the patient who already has disease, rather than action to prevent people getting diseases in the first place. The GPs approached the work of general practice in a way which is likely to inhibit them from putting their knowledge of HE and prevention into practice. They were largely disease-oriented, took a relatively narrow view of HE, and felt so constrained by circumstances as to respond to the problem presented only (Blinkhorn, 2002).

Moreover, HPs may still be under-utilized in performing a community-based HE role outside their clinical practice, despite their willingness to participate (Blinkhorn, 2002). It is assumed that the lack of confidence due to inadequate training in and information on health promotion is the main barrier to community activities. Most HPs have neither the time nor the specialized skills to work as community organizers. Their primary community development role, at the best, is to facilitate rather than to initiate.

Conclusions

About 85% of the Libyan HPs participated in this study perceived that they are responsible for delivering HE. Furthermore, almost all (98.9%) considered this role as a very important or important. The effectiveness of their existing role was assessed differently. Study participants perceived that the lack of educational aids and materials and the low held priority for HE were the main barriers. They primarily suggested overcoming these barriers in order to improve the service. The authors suggest that the national health authority list HE among its priority programs. It is recommended to provide support to health facilities, in order to conduct a more successful HPs' HE. Medical schools may need to consider equipping students with the required knowledge and skills, towards a more effective HE practice.

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A Questionnaire on Health Professionals' Role in Health Education

- Name: (You may omit this if you choose) _____

• Tick only in the appropriate box:

- Gender:

•Male •Female

- Profession:

•Physician, specialty: _____ •Dentist •Pharmacist

•Nurse •Midwife •Health visitor •Dietitian

•An other, Please specify _____

- Qualification:

•PhD or equivalent •MSc or equivalent
•BSc or equivalent •Intermediate Diploma
•Secondary school •Primary school or lower.

- Field of work:

•Curative medicine •Preventive medicine
•Any other, specify _____

- In your view, do health professionals have a responsibility for health education?

- Yes, it is an integral part of health professionals role.
- Theoretically yes, but not practical.
- A limited responsibility.
- Only the responsibility of preventive health professionals.
- Only for "at risk groups".
- No, it is not their responsibility at all.
- Uncertain.

- How do you consider the importance of health education by health professionals?

- Very important •Important •Of a little importance
- Not important •Uncertain.

- How you assess the effectiveness of the existing role of health professionals in health education in Libya?

- Very important •Important •Of a little importance
- Not important •Uncertain.

• Tick only in front the degree of agreement you feel with respect to the following barriers and reasons for delivering effective health education by health professionals:

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- 1- Not enough time to practice health education.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 2- Lack of communication skills.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 3- Education & training of health professionals are carried out at the curative medicine services (Little knowledge of health education).
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 4- The language that health professionals use is difficult to understand.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 5- Health education is held to be of lower priority than is curative medicine in health services and by policy makers.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 6- Some professionals see health education as too trivial a job for them to do, or as merely the job of those working in the preventive health services.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 7- Lack of educational aids & materials.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 8- Lack of rooms & related facilities for conducting group health education at the health services.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 9- Negative influence of other factors, eg.: family, commercial advertizing, culture & traditional beliefs.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 10- Health education is of no or little interest to the recipient .
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 11- Fear of upsetting people.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 12- The presence of other people at the same place (eg. the pharmacy) hinders discussions on private matters.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 13- Health professionals are not invited to participate at community activities.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree
- 14- Some health professionals are not interested in cooperating & participating in community activities.
• Strongly agree • Agree •Uncertain •Disagree •Strongly disagree

15- Information contradiction between different professionals.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

Others you may suggest:

• Tick only in front to indicate of the degree of agreement you perceive with respect to each of the following suggested solutions for improving health professionals health education:

1- A signification proportion of education & training in the medical & health schools should be based in the primary health care services.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

2- Communication skills should be included within the teaching programmers for medical & health sciences students.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

3- Continuing education on techniques of health education should be provided for the different health professionals.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

4- A number of health professionals should be specialized in the field of health education.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

5- Health professionals should be provided with education aids & materials.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

6- Provision of suitable rooms & related facilities for conducting group health education should be available.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

7- Support of policy makers needs to be improved.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

8- Enhancing the role of mobilized health education groups is important.

• Strongly agree • Agree • Uncertain • Disagree • Strongly disagree

Others you may suggest:

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