Workshops on healthy lifestyle to adolescents

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National strategies are currently being implemented across the UK to deal with the rapid decline in lifestyle with special focus on the areas of smoking, drug and alcohol abuse, and sexually transmitted infections. The responsibility for this in the UK lies with NHS health promotion teams. In South Africa, although health promotion is a directorate within the Social Sector Cluster within the Primary Health Care, there is a lack of experienced health promotion specialist to deliver such targets. Both the UK and Africa are lagging behind in terms of reporting on their findings and experiences. The objective of the current study was to deliver workshops on healthy lifestyle to adolescents at schools and colleges in the West Midlands region of the UK. This would also be of interest to first and second generation African immigrants in the UK. The design of the questionnaires was based on our intuitive knowledge of pathophysiology and health. The bias to our questionnaire included gender and culture responses. Following agreement, the schools subsequently approached parents to secure their consent for participation in the workshops. A tick-box design questionnaire of five elements from selected schools incorporated strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree ratings. Responses and measurements were compared using ANOVA incorporating multivariate and Chi-square statistical tests (SPSS 14.0 for Windows-XP, SPSS Headquarters, Chicago, Illinois). A confidence of 95% was agreed. The results of the current study indicated that interest and understanding were significantly (p<0.05) high and this was not gender specific. The use of medical images was shown to capture the audience by significantly (p<0.05) enhancing understanding. This successful approach should enlighten UK and immigrant Africans about the dangers of frivolous and unhealthy lifestyles. The success of the workshops was evident in the schools and colleges inviting us for subsequent talks.

References

Health and social care curricula – future perspectives for learner experience in Europe and Africa

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Sir,

The health and social care sector is dynamic in nature, and the delivery of a curriculum that meets the needs of the educational establishment, governing bodies, students and the future employers is essential. Interprofessional education at an early stage of integrative student learning usually results in favourable satisfaction amongst students and faculty as well as significant effect on attitudes toward interprofessional teamwork and education. Indeed, interprofessional learning is one solution for students embarking on nursing programmes. Within this context, internet-based environments have been used in a variety of ways including as a forum for communication between the university faculty, students, and preceptors at clinical sites; didactic lectures from expert clinicians to students assigned to distant clinical sites; small group problem-based-learning modules designed to enhance students analytical skills; and conversion of traditional face-to-face lectures to asynchronous learning modules. Recognized advantages include improved communications between the college faculty and the students and clinical preceptors; enhanced access to a national network of clinical experts in specialized techniques; opportunities for student distant clinical rotations with continued didactic course work; and improved continuity and consistency of clinical experiences between students through implementation of asynchronous learning modules.

In the current article, we propose that the successful health and social care curriculum should be interprofessional, multidimensional, needs-led and evidence-based. It is important when interprofessional learning is articulated into the curriculum that it is not merely a formal exercise, but fully integrated into, and meets the practice demands of the various health professions. The introduction
of problem-based learning, multimedia tools and the integration of the basic clinical sciences is also essential. However, with students in some of the health related programmes attending placements for 50% of the time they are enrolled on the academic programme, and with the restriction in time and staffing issues, there is a tendency to dilute the delivery of the basic sciences of physiology, psychology and sociology in the curriculum. This impacts negatively on the students’ learning experience and may have deleterious effects in terms of clinical practice. It is therefore vital that the curriculum is structured in such a way to allow sufficient time for delivery of the basic sciences as stand alone topics, with effective integration into practice units. This allows students to deepen their knowledge and appreciate the relevance of these sciences within their clinical practice.

The move away from didactic lecturing and the utilisation of the virtual learning environment (VLE) is vital for the delivery of high quality teaching to students. VLE is a valuable methodology for the creative implementation of interprofessional learning amongst health professionals. With continuous professional development a necessity for health professional, and with many enrolling on part time programmes, VLE becomes a valuable tool for communication and for flexible methods of teaching and learning. It is a liberating tool that allows peer discussions and student staff discussions. VLE has an added benefit to staff in terms of freeing up some time to pursue their research interests.

A study in South Africa using WebCT, a web-based virtual learning environment (VLE) and Interactive TV (ITV) resulted in a scoring that was highly valued by students and lecturers participating in distance-learning programmes and students rated courses using both technologies as moderately interactive. This study, however, was conducted in a country with access to financial resources, and it would be impossible to detect similarities in third-world countries and due to deficiencies of infrastructure, power cuts and computerised facilities. Therefore didactic teaching is much the norm in these countries. A recent paper in Zimbabwe does, however, express suggestions should be taken on board by faculty administrators. A study in Nigeria utilised a three-day didactic and laboratory course with emphasis on the initial assessment and treatment of patients, with favourable knowledge-acquisition amongst physicians, suggesting a useful addition to academic medical schools in developing countries. Further didactic methods can be promulgated via workshops in distant-learning curricula.

It is also important to complement the future curriculum with effective student support mechanisms. We suggest that this can take the form of conference-style induction and fresher’s events, development days, personal tutor support and peer-assisted student support. This aids students to adjust quickly to university life, feel less isolated, improve study habits and prepare better for course work. We suggest that funding in African institutions through promotion of external collaboration through joint ventures (e.g. medical schools and pharmaceutical companies); sponsorship from the WHO; external links with industry, schools, government departments and institutions; and utilising an apportionment of student fees for VLE development, will all assist in overcoming financial and logistic hurdles in universities in poorer countries.

References