

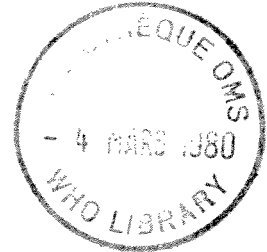


SELF-CARE ORIENTED HEALTH EDUCATION

INDEXED

FROM THE PERSPECTIVE OF
THE WHO ROLE

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It is a fundamental principle of social philosophy that one should not withdraw from individuals and commit to the community what they can accomplish by their own enterprise and industry. So, too, it is an injustice and at the same time a grave evil and a disturbance of right order to transfer to the larger and higher collectivity functions which can be performed and provided by the lesser and subordinate bodies. Inasmuch as every social activity should, by its very nature, prove a help to the members of the body social, it should never destroy or absorb them.

"The Concept of Subsidiarity"
Pope Pius XI
Quadragesimo Anno
1931

I. Introduction

A careful psycho-history is required to sort out all the misconceptions and maladaptive responses that have enmeshed health education for the last several decades. It must be sufficient here to say only that new conditions of social demand for health education suggest a plan for health education that responds to the public interest. To understand and act in those socially determined directions will compel setting aside many previously held beliefs about health and health education. The next several pages elaborate on this theme as background to some proposals for self-care oriented health education. Finally, I have presented some strategic recommendations. While many if not all of these ideas were discussed with Health Education and the wider membership of Division of Family Health, and official documents stimulated my thinking, I am solely responsible for this product.

II. Limitations of the Professional Health Model

We have become accustomed to a construction of social development which places specialized agencies of help where it is easy to distinguish between providers of a service and consumers of service. Providers, it is believed, possess the knowledge and technology to

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know what is right and to do what is best. Consumers, on the other hand, possess the problem and precious little else. Hopefully, they will be motivated to seek a solution from, or with the help of, providers.¹ Health services fit this essentially industrial model. They engage in market research (needs assessment), product testing (pilot demonstrations), advertising (health education) and profit analysis (cost-benefit, cost-effectiveness, agency growth). At the ideological level, the fit of health services in the industrial model is even more striking, with the belief in health as a product which can be "delivered". It is not surprising, therefore, that health education is expected to produce results which are sought by the professional operator and which are manageable within a professional system of social control. Health educators have been put to work on recruiting clients (screening), reducing "delay" in seeking professional care (early detection), and improving compliance with medical recommendations (patient education). "Resistance" of individuals to modify personal behaviour or communities to accept a new model of health care has been viewed as a negative reaction and not as a positive indicator of personal and social independence.

During the last decade we have become more aware of the limitations of the "professional construction" of health and health care. The contribution of medical care to health status was appraised as insufficient to continue policies supporting expansion of medical resources as a cost-effective solution.^{2,3,4,5} Furthermore, evidence of the negative consequences of existing professional care^{6,7} and the lack of attention to rigorous evaluation of technical interventions⁸ forces a general reassessment of the professional role in health care. Professional activities in health promotion and disease prevention also have undergone a fresh appraisal of their effectiveness⁹ and potential side-effects.^{10, 11} We can conclude from these studies and critiques that there are some shortcomings of health care and of professionally oriented health education that go beyond problems of technology or deficiencies in personal resources: the assumptions and perspectives of both are not in step with world society's demand for wider development of the lay health resource, greater self-determination and more effective lay control over personal and communal health destinies.

III. The Social Model of Health

How can we characterize the non-professional construction of health and the role of health care? There are many dimensions to this question and most certainly the answer will vary between nations and among cultural subgroups. Generalizing is a dangerous game, but some broad aspects can be described without implying universality. In any case, it is a starting point for discussion of what might become a new beginning for health education policy, programme and practice. There follows here a brief listing of some of the salient features of the social model of health. They are not presented in any special order of importance.

1. Health is not life's highest goal. Happiness is. The contribution of health to happiness is not a dose-response relationship. Achieving happiness is more obviously linked to a secure supply of life's basic necessities for personal and social growth. Health "norms" need to be more broadly defined and deviance from "norms" must be decriminalized. Not only should deviance from the health norm not be considered a flaw, particularly in the case of chronic disease, but as a sign of change and an opportunity for growth.¹²

*Implication for health education:

Accepting the fact that life involves a "risk-mix," health education must abandon its paternalistic tradition of efforts to prevent disease (and the final insult, death) and focus on reducing those factors which restrict options in personal and social action in risk selection. Ignorance of risks (their source and control) is certainly a major concern of health education, but so also must be the structural (political, economic, environmental) realities. People want to make risk choices, not dedicate themselves to achieving a no-risk status.¹³ Risk itself must remain the creative choice of the individual as a responsible social being and within those social limits be able to pursue their risk preferences. The debate (social control versus personal control in health and safety) is a crucial one;¹⁴ a debate which can help redress the balance and sensitize health practitioners to hear what society wants their input to be.

2. Self-reliance is an expression of growth and human dignity. In its own right it satisfies the need for identity, fulfillment, and optimizing the human potential as a constructive social resource. This appears to be relevant regardless of the overall political perspective of a community. It is not so much a matter of mistrust of the health establishment or disappointment with its effectiveness (although these contribute), but a more positive sense that increasing lay competence in primary health care is the most effective, safest, most available, most acceptable, and more economical way of meeting health needs. Most of the usual barriers to health care are avoided, i.e., accessibility, and social distance between professional and consumer. Moreover, there are corollary benefits such as the potential reduction of iatrogenic effects of professional care, particularly dependency. The social control by a monopolistic and monolithic medical care system also is reduced while at the same time enhancing the health care contributions of the community's natural care-giving resources of family, extended family, friendship networks, mutual aid groups, religious organizations and in some situations, the entire tribe or village.¹⁵

The non-professional construction of health and health care defines self-care as the first level and most pervasive form of primary care.¹⁶ All levels of professional primary care are ancillary and supportive; in effect, residual and supplementary. This belief is reflected in the profoundest terms of actual behaviour, with an estimated 65 to 85 percent of all health care being self- or family provided.^{17,18,19,20} Self-care constitutes a mix of folk, non-allopathic, and allopathic technology and appears to encompass activities related to health promotion, disease prevention, illness and injury treatment, chronic disease management, and rehabilitation. The family functions as a health care unit with an elaborate system of beliefs and procedures. It is also a health information gathering and interpreting system which links the family to external support systems and contributes to the protection of individual members as they use external (particularly professional) care-giving resources.²¹ Without the primary care frontline resource of self-care, or even a modest erosion of its current contribution, there would be disastrous effects on the professional care-giving system. At the same time, a modest increase in public competence in health has the clear potential for a powerful improvement in health indicators as well as substantial economic benefits.^{22,23}

Self-care is certainly not the exclusive practice of industrialized societies nor is its further development only appropriate for countries with high literacy rates and high standards of living. On the contrary, self-care is the dominant mode of health care for most of the world's rural people in developing countries. It is the essential ingredient in health care that needs to be complemented by necessary professional and technical resources. The task is to appreciate and strengthen beneficial self-care practices, encourage the replacement of inappropriate ones, and back-ups self-care with accessible (and acceptable) professional care. Raising the level of lay health competence is also the best way to maximize the benefits of scarce and costly professional resources.

When it comes to health care, people of both the developing and developed worlds share a state of powerlessness. Professional health care, with few national exceptions,^{24,25} has been elitist, exclusory, and mystifying. The public demand for access, however, is powerful and in the EURO and AMRO Regions of WHO there is the evidence of a growing market for health texts, both allopathic and non-allopathic, covering a vast array of topics, media concentration on health, lay-oriented medical care protocols, and self-care education programmes. Mutual aid (self-help) groups have, within the last decades, burgeoned, with the United States becoming perhaps the first major industrialized nation where mutual aid groups provide the dominant modality for chronic disease and disability management. Mutual aid groups are voluntary, small (usually 10 or so members) groups of people who came together to provide mutual support for problems they hold in common. Alcoholics Anonymous and groups formed by parents of mentally retarded children are early examples. There are now groups formed around such problems as stuttering, post-mastectomy, single-parents, and obesity. Members help each other in coping with their problem both at the personal and social level. The groups are usually formed and governed by the members themselves with health professionals in advisory roles. Membership is freely sought by individuals, but professionals increasingly encourage patients to join a mutual aid group. It is estimated that 500,000 mutual aid

groups are in operation in the United States, representing at least 5 million members.²⁶ Again, it must be emphasized that the movement toward self-reliance in health, as exemplified by the mutual aid group, is not necessarily a negative response to professional care or merely filling a vacuum of professional services. They are for their members a preferred strategy in health, used in conjunction with professional care, but offering benefits which may be unique to the situation of self service.²⁷

As chronic diseases begin to dominate the morbidity patterns in the developing world as they now do in the industrialized nations, people who may perceive their role as limited in curative disease, in contrast, see their role in carative disease management as practical and appropriate. The development of purpose built medical support technology for home use (e.g. hemophilia, renal dialysis) add to the feasibility of self-management of chronic disease. In a similar way, the historical role of families in health monitoring is being facilitated by technology and methods successfully adapted to home use.^{28,29,30,31}

*Implication for health education:

One cannot fail to be impressed by the magnitude, pervasiveness, and utility of lay self-care world wide and with the current new lay initiatives in self-care and mutual aid in the industrialized nations.^{32,33} In a sense it appears that the public have taken health care into their own hands and in some areas of the world are actively persuing increased access to health knowledge, skills, and technology. The natural process of diffusion of innovation is at work. Development in self-care is occurring apace because people are highly motivated in their own self-interest. This presents a powerful opportunity for a response by health education specialists geared to "going with the flow" of public interest. Specifically, health education's role is to help expedite the process of knowledge, skill, and technology transfer from the professional to the lay component of the health care system, just as the professional care sector is now concerned with facilitating the flow of technology to its practitioners. Several actions are required here and health educators must function as a team with clinical epidemiologists and others, including legislators and legal scholars. Clinical epidemiologists must help determine which medical skills are efficacious and safe; legal resources are needed to modify or create new legislation which allows the appropriate technical transfer to take place.³⁴

Health education specialists, again working in a team, have a clear responsibility to ensure that contact with the professional care system has a minimum negative effect on the patient's integrity; that avoidable iatrogenic effects are controlled. Health education has a special interest in minimizing patient dependency be it in the form of information deprivation, failures to teach self-management skills, or more subtle methods of patient control via fear arousal.³⁵ Patient education approaches must be revised so that they are as patient empowering as possible,³⁶ seeking to activate the patient not only as a participant in self-care but also as a crucial contributor to self-healing, including self-control in psycho-physiological processes (e.g. biofeedback, techniques of conscious control of involuntary processes like heartbeat).

Both health and health care are social phenomena which influence, and are influenced by, their social, physical, and economic contexts. These influences can be pathogenic³⁷ or they can be preventive³⁸ or they can contribute to health care.³⁹ Health education has a major role along with other public health specialists in all three aspects of social impact. With regard to social pathogenesis, health education acts to inform the public of the complicity of environmental stressors in diseases and may assist in the formation of community action groups. The emphasis in these activities is to clarify the multifactorial nature of community health problems, placing personal factors into a perspective along with social factors. Regarding the preventive contributions of the social environment, health education can implement strategies based on our knowledge of the importance of social relations as a source specific-protection e.g., friendships and membership in community groups. In some instances these efforts could be directed at social policies like public housing to ensure that communication links between residents are effective in controlling social isolation.

The third aspect of the social construction of health, i.e., the provision of health care includes a vast array of non-professional resources: the individual family, extended family, friendship network, mutual aid groups, commune (tribe or village), religious and work organizations among others. Health education plays a facilitating or linking role within the arena of non-professional community health resources and between those resources and professional health care resources, be they "traditional" or "scientific" professional health resources. Suspicion, territorial rivalries, fear of loss of patient control, or simple ignorance of the availability and suitability of non-professional resources may thwart cross-referrals by health workers with the patient losing out. On the other hand, lay health groups may resist linkage with professional health workers out of concern for potential co-optation. This is a poorly understood area for health education practice. Health education specialists to work effectively on the matter of linking non-professional with professional resources (allopathic and traditional) will have to first acknowledge their own biases historically rooted in their professional training.

Finally, at the community level, health education can assist in making purposeful self-care education programmes available to all sectors of the population.⁴⁰ It is necessary to raise a caution, however. Self-care education, to fit ideologically with the concept of "empowerment," must develop from the interest and preferences of lay people who are self-motivated to seek self-care skills. They must determine the "curriculum" within the reasonable guidelines of the time and effect investments they wish to make and the utility of the skill itself (e.g., frequency with which the skill would be used). Where this has been the approach, it is found that people seek skills which are easily and quickly learned and which will be used a good deal. Clients also must decide on evaluation criteria. What do they propose as evidence that the educator's have met their (client's) needs? These may overlap only partially with professional outcome criteria. Self-care education also must take care not to wash out existing health care practices or to be condescending toward them. The aim is to build confidence in competence by supplementing existing practices with new skills, allowing substitutions to take place as the clients decide on the relative merit of old and new practices.

3. The non-professional or social construction of health and health care is not bound to believe in, much less adhere to, one dominant medical culture. In any given society one might expect to find several health belief and practice systems functioning, with people moving comfortably from one to the other as the circumstances of their health (and perceptions about it) warrant. Competition and conflict between these health strategies occur primarily among professional practitioners whose status or economic welfare may be at stake. The almost constant tension occasionally breaks out in open warfare, the most recent examples being the importation of western allopathic medicine into African villages and the importation of "Eastern healing methods" into the United States and Europe. A resurgence of public interest in naturopathy, homeopathy, charismatic healing, and chiropractic medicine has mobilized resistance and counteractions by allopathic medicine. Many diverse non-allopathic health care ideologies have been lumped together as the holistic health movement and are often characterized by "official medicine" as fads or actually a symptomatic response to pervasive social alienation, narcissistic and self-serving.⁴¹

Whatever else can be said about the present rise in the visibility of public attraction to "alternative" health methods, the message is clear: health is a complex whole and that efforts to intervene successfully also must be whole or integrated. World-wide, citizens also are becoming less interested in labels than in the right to access to alternatives and to move freely across professional borders without guilt. The contributions of different health care perspectives are all possible within a holistic view of health.⁴²

*Implication for health education:

Health education practice can no longer restrict its repertoire of values and beliefs to the dominant western allopathic culture of medicine. There should be an appreciation that all medical cultures are "alternatives." In this sense, the choice and mix of choices should reflect the needs and preferences of the populations being served. The planning strategies and certainly the criteria and methods of evaluation also must reflect the special circumstances of both allopathic and non-allopathic interventions.

With regard to the non-allopathic world of health, it is a legitimate concern of health education to assist in bridging the conceptual gaps between allopathic and "alternative" health care practitioners. This could involve work on a system for comparative analyses of practices; organizing a library of comparative health cultures; designing a patient medical record which accommodates differing perspectives on patient problems; and facilitating training exchanges among diverse practitioner groups.

The preceding three aspects of the social construction of health (i.e., health is not the dominant value in life; self-reliance is an expression of growth and human dignity; there is more than one medical culture) suggest several themes for planning changes in health education practice. The need for placing health education in the framework of a social construction of health is apparent for both the developing and industrialized world. Both possess rich and pervasive non-professional health resources; in both worlds the benefits of scientific health skills can be demystified and made available to lay people; and in both situations, the professional system of health care has much to learn in how best to preserve the lay resource, how to incorporate some of its methods in professional care, and how to strengthen the lay care resource as a legitimate and powerful component of the total health system. As far as health care is concerned, the third world shares with the industrialized world the limitations and liabilities of a monolithic health development strategy which pins most of its hopes on the professional resource to achieve health care equity, "that will permit them to lead a socially and economically productive life." To arrive at a realistic and equitable distribution and use of scientific medical resources requires that all nations respond to their potential for self-reliance within the resource of the people themselves. By enhancing the public competence in health we enhance the availability, reduce the danger of, and extend the benefits of our professional resources.

IV. Some Research and Programme Proposals for Health Education

1. Research

In contrast with our knowledge of the world of professional health care, very little is known about lay self-care, the contributions of family to health care, the social network as a health care resource, and specific social organizations in health such as the mutual aid group or "healing ministries" of religion. We know these resources exist (by definition of common experience), but we are not able to describe with any precision the nature of these activities, their origins, social/cultural determinants, or effectiveness (or the criteria of effectiveness applied by the users of these resources). Furthermore, there are serious deficiencies in methodology which severely limit the validity of data on lay health care behaviour, not the least being the virtual neglect of "grounded theory" or phenomenological approaches.^{43,44} The shortcomings of health education research in this regard have been traced through WHO Expert Committee and Task Force reports since 1953. An excellent review of the "state of the art" in health education produced in 1978 makes explicit the need for a more focused commitment to cultural and social research in health.⁴⁵ This review also identifies examples of research in several regions, research which is going in a productive

direction but where there is a frank admission of inadequacy of both methods and coverage. The report emphasizes that health education (research and practice) "should not follow a stereotype." But it is clear that a powerful influence on health education research may come from experimentalists with a behavioural modification orientation. This has resulted in structuring health education research within the confines of professional values, professional definitions of "relevant" health behaviour, and, of course, professional judgements with regard to "success." It is also clear that economic models and cost-accounting concerns have favoured evaluation in terms of short-term gains, often more in the interest of the health system than in the interest of the people. This is not to denigrate the utility of programme cost analysis, but to insist that the educational effort in the first place enhances the self-initiative of the client to grow in wider skills of health and in power to determine personal and social destinies. Health education must shake off its deadening paternalism and health education research is a key to this. There is already in place a priority commitment to this "empowering" perspective in health education research as the first point of emphasis in the Health Education Medium Term Plan, i.e., "to encourage people, vulnerable groups ... to take leadership in their own health and health of their children ..."46 The question is, can we do it with existing research resources both in terms of their quality and quantity?

Clearly there is no point in "throwing good money after bad" in persuing a course of "more of the same." A revision in the present research agenda of health education in the direction of raising the public competence in health may mean -- probably does mean -- searching out new principal investigators from the ranks of phenomenological sociology⁴⁷ and from the ranks of health professionals and experienced lay persons who have initiated or given technical support to new forms of health education which are fundamentally empowering of people⁴⁸ e.g., mutual aid and self-help groups.

The most efficient way to get at those new resources is to tap into existing (or forming) networks of investigators and self-care/self-help oriented practitioners. Several international symposia and congresses recently held or being planned can help in identifying these networks.⁴⁹ Some of these networks are more formally constituted e.g., Self-Help and Mutual Aid International, (a newly formed association of self-help organizations) while others are essentially correspondence networks. An important first step is to compile an inventory of research and practice resources world-wide with special efforts in third world countries. Such an inventory could become the basis for convening principal investigators interested in national and cross-national research on the contribution of non-professional social resources to health care -- the lay side of the primary health care dyad. In such an activity it is clear that HED must seek co-sponsorship with all relevant units of the Division of Family Health as well as the Division of Health Manpower Development, where interest cross-overs are obvious.

Cross-national research on the non-professional health care resources of individuals, families, networks, mutual aid, and the community itself are not likely to be fully useful until some systematic lexicon of concepts and practices can be developed. Health Education can provide leadership in clearing communication among researchers and health planners to ensure the necessary distinctions between and among non-professional health resources. There is a need to understand variations in concept (e.g., self-care, cover-care, self-help, mutual aid) and in goals (e.g., support, therapy, education, advocacy, protection) and in methods (e.g., advice and consultation, direct service, networking, community action) and in outcomes (e.g., cure, care, self-actualization, social cohesion, community change).

Health education research in the lay resource in primary care also will require a working reference bank of theoretical, research, and practice literature linked to existing information systems (e.g., MEDLARS). The emphasis should be on the working nature of this reference library as a central resource in facilitating global development of scholar and practitioner networks. It also could serve the needs of planners in their efforts to account for the lay health care resource as an element of the health service system. A full-time documentalist

should be assisted by short term consultants with special knowledge of various aspects of the collection (e.g., family styles in monitoring members health status, differential health care functions of extended families and friends, forming mutual aid groups). This is another important activity for joint support of FHE and HMD with HED as the linking factor.

It is not feasible here to lay out an elaborate research menu. The essential element of health education research is important to emphasize; namely, the scope, function, benefits, limitations, and potential of the lay health resource -- individual, family, social networks. This represents a major reorientation of research strategies, and new cooperative ventures within the Family Health Division and between FHE and other Headquarters divisions.

2. Training

A recent FHE in-house discussion paper provides a cogent yet comprehensive agenda for research and training on the determinants and consequences of family health and on the role of the family in health care. A careful reading of this document reveals both the need for substantial technical reorientation of scholars given the changes in the concept of family, and its social significance; and the need to overcome implicit professional biases which tend to construct the research problems in a way which downgrade family self-care as secondary to professional interventions.⁵⁰

It is clear that training of health professionals including health education specialists in family health must start with the assumption that the family is the primary health and health care resource. This will require changes in ideological values at considerable variance from those training institutions now committed to the orthodox perspective of health care as being synonymous with medical care; and health resources as being synonymous with professional resources. Thus, sensitization of trainers to their previous professional biases must be purposefully undertaken. A key item for an initial meeting of health education specialists would be to examine the limits and constraints imposed by their ideological biases. Closely linked to this would be a second concern: to identify necessary innovations in curriculum which would elucidate the family as a health and health care producing resource.

Health education (and its supportive research) have followed a largely allopathic set of beliefs to the virtual exclusion of alternative health viewpoints on cause, prevention, cure, and care. This has severely restricted communication with a substantial proportion of the world community and also has limited public access to options in health development. Some compensation for shortcomings in the preparation of health education specialists, like other allopathically trained health professionals, must be encouraged. The aim is not to convert but to sensitize health workers in order (at the very least) that they may appreciate the complementary potential of allopathic and non-allopathic approaches. One of the problems which could be avoided is the tendency for allopathic practitioners to attempt to wash away established native beliefs and replace them with scientific ways of coping. Respect for endogenous health practices can earn respect for scientific practices. HED could play an important role in opening dialogue between disparate health belief systems through the mechanism of regional meetings leading toward an international "ecumenical" congress called to address liberalizing the curricula of health professions to include knowledge of the "community's medicine."

3. Practice

New goals for health education practice have been both implicitly and explicitly put forward in this report. The central point is the shift from behaviour modification and victim-blaming approaches to education designed to enhance personal and social competence in health. Health education's role is to become more enabling and less controlling; more respectful of the powerful lay resource in health (self-reliance) and less medicalizing; and more focused on changes in counterproductive professional attitudes and practices and less

fixated on client failures. And finally, health education practice will be giving more attention to the control of complicit, environmental stressors -- physical, social, and economic.

While the venue of health education practice may be the home, school, community, or workplace, the perspective and approach remain to empower people in defining problems, making decisions in their own and communal interest, and in carrying out effective health actions. The methods appropriate to empowerment and the nurturance of self-reliance rely heavily on using the natural and available resources of community development i.e., Freirian education, diffusion processes, and social networking. Health education specialists should be (although still too few are) adept at (1) identifying the potential for applying these approaches in the general scheme of public health practice; (2) assisting all health professionals orient their efforts in ways to reduce dependency and optimize self-reliance skills; and, (3) drawing out client determined criteria of effectiveness. To make any appreciable difference, health education specialists must work through others -- "contact point" health professionals and the lay community itself. In essence, health education is a consultative, advisory, facilitating, and advocacy practice. It is social activism without social control.

Bringing health education into full compliance with the goals set forth at Alma-Ata⁵¹ will certainly force reconsideration of the usefulness of established procedures for influencing global practices. In the context of primary health care, nurturing the public's health competence and mobilizing the non-professional health care resources must become both the ideological and practical priority of health education. It is not a forced choice brought about by a shortage of health professionals, but rather, it is a preferred choice which carries benefits which exceed those of a professional alternative even if one were feasible. Given that this is agreed, health education must be seen as the core discipline, the ideological and strategic centre of programme development in WHO as it addresses its mission in primary health care as a vehicle to achieve health for all by the year 2000.

Headquarters HED must be a useful, indeed indispensable, resource for information sharing, and a world reference bank on all aspects of the non-professional social resource in health as noted in the body of this report. A corollary service of the reference bank would be the regular availability of annotated research and practice briefs.

Headquarters' commitments to development of the lay health resources falls heavily on the health education unit as the nexus in the process, most immediately as this development relates to the Family Health Division. The present staff in health education, strongly supportive of reorientation of health education's role, must now be expanded to include specialists in lay self-care; mutual aid and self-help organization; community development from the standpoint of non-professional care giving resources and their networking; community organizing for social action regarding environmental stressors (physical and social); reference bank development and information services; and coordination of in-house advisory services in all aspects of enhancing the non-professional resource in health.

Resolutions and declarations notwithstanding, little progress toward the goal can be expected without adapting some WHO operating protocols to accommodate new opportunities for extending the benefits of primary health care. Some examples may serve to illustrate this.

1. If the expert committee mechanism is to be effective in the area of primary health care, it must include as "experts" those who are closest to the process; namely representatives of so-called "consumers" who are in point of fact "providers" -- self providers -- of primary health care. While this is a declared principal for grass roots health planning, it must now be extended to include global health planning bodies as well.
2. Cooperative WHO relations with other world bodies have been largely with agencies with professional and governmental constituents. WHO stimulation and encouragement of non-professional (usually non-governmental) networks in primary health care is needed (e.g. mutual aid groups). A precedent was set for this approach at the WHO/UNICEF meeting on Infant

Feeding (Geneva, October, 1979) where consumer groups (non-governmental) were full voting participants.

3. WHO in general must broaden its council of expertise to include non-allopathic health care scholars and practitioners.

V. Conclusions

One can most certainly anticipate broad debate and legitimate concern for the implications of moving toward recognition and support of lay resources in health and health care, especially health care. Who structure, modus operandi, and theoretical and technical commitments represent a powerful tradition of important contributions to world health. This has been true as a result of WHO's sensitivity to changing world priorities and the emergence of new options for intervention. Recent rediscovery of the importance of the lay health resource and, at the same time, awareness of the limited potential of "business as usual" centered on the medical model call once again for a reappraisal of WHO strategy. The Alma Ata conference was the harbinger of this reappraisal. There is little doubt now that world demand for equity in life above the minimum level of existence means moving away from elitist models with their limited access, costly maintenance, and weak cost-benefit and cost-effective ratios. The proposed change to a lay construction of health and health care is already in progress in both the developing and industrial world. It is the result of informal and pragmatic public experience. The appeal of moving with the flow of a broad based social movement in health will show in the growth of new service opportunities for WHO in general, and HED in particular, and in the satisfaction derived from their more focused contribution to world health.

The directions for redevelopment of health education proposed in this report require both reallocation of existing resources and the encumbering of new funds. Since health education prevades virtually all Headquarters programmes, it is essential that a mechanism be established to identify health education aspects of all programmes in a systematic and continuous way. This could take the form of a mandatory "Educational Impact Statement" attached to all planning memoranda, including Medium Term Programmes. The statement would specify programme implications for the public affected, particularly their roles in decision-making and self-care. Further, the flow of collaboration must move in the other direction as well. HED has specific needs for consultation from several Headquarters functions, particularly in epidemiology and health economics. All HED external programmes should have routine access to review by the appropriate in-house disciplines. To strengthen the HED contributions within Headquarters will require a new full time position in HED for the purpose of coordinating this in-house mutual service activity. In addition, a person in each Headquarters programme division should be designated as the liaison person with the HED in-house coordinator.

With regard to HED external programme responsibilities, following the viewpoint of this report, there is the requirement for two additional positions: one full time documentalist and one full time specialist in self-care, mutual aid, and networking non-professional community health resources. Supplementary funds for these posts may be sought from voluntary associations whose own programme interests lie squarely in those areas, e.g., voluntary associations of patients with chronic disease. These resources must not replace basic WHO support, but be supplementary for purposes of expanding HED services to member states.

Health, health care, and health education are concepts undergoing radical revisions. Earlier assumptions and definitions no longer fit the present realities of global experience. It is increasingly clear that a social construction of health varies markedly from the dominant professional construction. A social view of health reveals new opportunities for making progress toward the goal of health for all by the year 2000. The central new option in development is the lay resource in health, a resource which has always been there but has been overlooked in most organized public health efforts designed to "help" people through more

services, more technology, more aggressive professional intervention. Many practical circumstances associated with accessibility, acceptability, productivity, and economy have encouraged health planners, administrators, and practitioners to take a fresh look at the lay health resource. We are now faced with the task of catching up with a social initiative and learning how the expert technical resources of health can be applied parsimoniously in facilitating the growth and effectiveness of the social resource. Beyond reorienting professional perspectives (no mean task), we must address major data deficits in our knowledge of the sources, processes, and problems of lay self-care and non-professional care-giving resources available at the local level.

We must continue to discard health education methods which perpetuate public dependency and suppress the potential for people to become more self-reliant in primary health. The means of HED to further stimulate people-empowering health education must be expanded as noted. This could lead to more restricted emphasis on behaviour modification approaches and the acceleration of interest in the socially oriented methods of innovation diffusion and resource networking. HED can most certainly provide leadership in creating a new consciousness of, and respect for alternative beliefs and practices for health throughout WHO operations.

HED must be the focal point for developing a new perspective on health education's potential throughout Headquarters. Health education in its contemporary framework of empowering people should be viewed as an operating philosophy for all WHO undertakings. To achieve the stated goals of health education in terms of self-care and self-reliance and the values expressed in the Declaration of Alma Ata means pervasive change throughout WHO. No Division or Unit can escape the implications of that mandate. There is excitement and challenge in the undertaking that faces WHO. But there is little doubt that the contribution of health education can be seminal. Revitalizing this key resource is an urgent priority.

VI. Recommendations

Please note the importance of interpreting these briefly stated recommendations in the context of the report pages referenced.

The impetus for this report was to look at health education concepts and practices from the standpoint of the layperson and family as a primary health care resource, and to draw off implications for the HED role. Recommendations are grouped as general to health education and specific to HED.

A. Regarding health education in general:

1. Health education must turn its attention to strengthening the natural resource of laypeople as the basic resource in primary health care. This means adding a third dimension to traditional health education goals of health promotion and disease prevention. The third dimension is supportive health education: education designed to strengthen the care-giving role of individuals, families, and other non-professional health care resources in the community. In effect, this is the developmental counterpart to programmes aimed at strengthening professional primary care resources. (pp. 8 - 10).

2. The task of health education in strengthening the lay primary care role is of equal importance for developing and industrialized countries. In both situations, lay practices in health care are under appreciated and often ignored (or even opposed) in planning for primary health care development. As developing countries move toward greater reliance on professional services, there is a need for immediate help in preserving the benefits of endogenous health practices while adding new skills. (pp. 6 & 7).

3. Health education methods, consistent with the aim of increasing self-reliance in health and strengthening the non-professional health resource in general, must give more attention to social development strategies and those methods which maximize the role of lay people in defining the problems, determining priorities, and actively participating in solutions. Such methods would include, for example, applications of diffusion and adoption theory, and social networking, and Friirian educational concepts. (pp. 8 & 25).
4. Health education practice must expand its content venue to include an appreciation of non-allopathic health beliefs and procedures. A "holistic" sensitivity in health education would broaden its cultural relevance and incorporate innovations beyond the present repertoire of the medical constructions of health. (pp. 11 & 12).
5. People-empowering health education requires valid information on the social (in contrast to professional) definitions of health, health deviance, and health care. To work with the lay resource in health means studying what it is and how it works, unbiased by professional criteria. Phenomenological sociology (so-called "grounded theory") can help improve the validity of data on lay health functions by deriving definitions of health functions from the population itself. (p. 15, 16 - 18).
6. Health education can no longer ignore its part in the control of iatrogenic disease. Cast in more positive terms, health education can contribute to strengthening people's ability to use professional health care when most appropriate and to relate to the care giver in an effective, self-protecting way. It is in the best interest of both patient and care-giver to maximize patient understanding and participation in health decisions and in the healing process. (p.9).

B. Regarding HED role in health education:

1. HED requires additional staff to fulfill its mission in strengthening the lay resource in primary health care. An initial increase in staff should give high-priority to a documentalist with responsibility for building an information system for the collection, storage, and efficient distribution of information on the lay resource in health, characteristics of programmes designed to enhance the lay resource, and research findings relevant to our understanding of the interaction of lay and professional care. A second, high priority need is for a staff person with special competence in self-care and self-help theory and practice and the strategy of community resource networking. And, finally, the first phase of HED expansion must include a person with special responsibility for in-house (Headquarters) collaboration on health education aspects of all relevant divisional programmes. (pp. 17, 21).
2. HED, through appropriate devices such as expert committees, working groups, and commissioned publications, can help clarify and disseminate health education concepts and practices as these relate to self-care, self-help, and the nurturing of the lay primary health resource generally. The substantial (and growing) interest in health empowerment of people, particularly in their primary care role, needs global forums to examine questions of social, legislative, economics, and professional factors as they effect, and are effected by, the lay primary health role, (full report).

3. HED should stimulate greater attention to the implications of the lay health care resource for professional training of health workers. The task here is to promote the development of curriculum modules, teaching methods, and materials feasible for use in professional training situations and to encourage demonstrations in diverse settings. (pp. 18-19).

4. In order to facilitate HED contributions to other Headquarters divisions, it is essential that a routine mechanism be established to mutually inform HED and other divisions of their programmes' potential vis-à-vis enhancing the lay health care resource. To this end, "Education Impact Statement" should be made available as a regular attachment to all divisional planning memoranda and MTP's. (p.23).

In addition to the above recommendations, it is clear that the magnitude of the philosophic shift from a professionally dominated construction of health to a socially dominated one will require more pervasive changes in WHO strategies well beyond HED. Several of these are indicated on p. 22.

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