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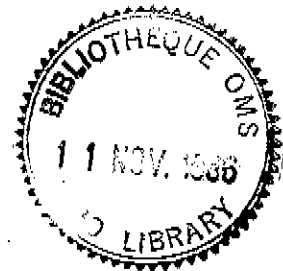
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**NEW POLICIES FOR HEALTH EDUCATION
 IN
 PRIMARY HEALTH CARE**

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A review based
 on the Technical Discussions
 held during the Thirty-sixth World Health Assembly, 1983

1 serial by

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PREFACE

Technical Discussions take place each year at the same time at the World Health Assembly. These Discussions do not form an official part of the proceedings of the Assembly. All participants in the Assembly - whether delegates, observers, or representatives of other organizations - may take part but they do so in a private capacity, not as delegates of their governments or as officials of their organizations.

The subject of the Technical Discussions during the Thirty-Sixth World Health Assembly in 1983 was New Policies for Health Education for Primary Health Care. In preparation for them, an outline document was developed in advance and circulated, together with a questionnaire to all Member States, Associate Members and a number of nongovernmental organizations in official relations with WHO. On the basis of the replies received, a background document was prepared, and this was available to all the 305 participants at the Discussions.

The general chairman and a panel of experts first addressed a plenary session. The participants were then divided into eight discussion groups. After a final session of all the groups it was possible to draw up a joint report. The Chairman's address and some of the panel presentations have already been published in Hygie: The International Journal of Health Education, 1983.

This Public Health Paper is based upon the outline document, the background document, the Chairman's address, and the report of the meeting as a whole. It has been compiled on the assumption that a subject of such great importance to all countries will be of interest to all public health administrators and policy makers.

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CHAPTER 1

PRINCIPLES AND CONCEPTS OF PRIMARY HEALTH CARE REQUIRING NEW POLICIES FOR HEALTH EDUCATION

"The main social target of Governments and WHO in the coming decades should be the attainment by all the citizens of the world, by the year 2000, of a level of health that will permit them to lead a socially and economically productive life."

World Health Assembly, 1977

"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

Declaration of Alma-Ata, 1978

These two statements provide the background against which new policies for health education in primary health care need to be developed. The major issues involved in the transition from current policies to new policies which will better reflect the concepts of the Alma-Ata Declaration are discussed in the four chapters of this paper.

In Chapter 1 policies are identified which are necessary for the reorientation of health education functions, stemming from the primary health care approach. Chapter 2 analyses new trends in policies related to health education and primary health care, and underlines those areas in which political will and commitment will be required to foster the development of appropriate types of health education. Chapter 3 identifies specific manpower, media and research resources which the new policies will need to develop. Finally, Chapter 4 outlines a scenario of idealized steps in the process of community involvement for primary health care, showing how health education can contribute to each step.

EVOLUTION OF THE HEALTH EDUCATION CONCEPT IN WHO

From its beginning, the Constitution of the World Health Organization announced that "informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people" (47). The first Expert Committee on Health Education of the Public reaffirmed this principle as early as 1953 (49). A decisive stage was reached in achieving this ambitious goal when, at Alma-Ata, USSR, the International Conference on Primary Health Care, sponsored by UNICEF and WHO, identified education as the first of eight essential components of primary health care (45). This was a natural outcome of a decision taken by the World Health Assembly the year before to adopt health for all by the year 2000 as a goal. Health education was put first in the Declaration of Alma-Ata because it was recognized as fundamental to the attainment of all health, social and economic goals.

An evolution of policies for health education, as articulated by the World Health Assembly over the past 30 years, has shifted the emphasis:

- from central to local planning;
- from singular (specific disease) to diverse objectives;
- from building health literacy and skills in support of specific programmes to promoting a holistic educational approach to problems;
- from focusing on individual behaviour change to a concern for organizational, economic and environmental factors conducive to healthy lifestyles, self-reliance and political action for health promotion (55,56).

The most recent document in the "Health for All" series published by headquarters, the Seventh General Programme of Work of WHO, provides for a greater integration of health education and public information activities (70). Thus, health education is now placed in a broad perspective in which information and education are seen as elements of the same

continuum. This continuum involves activities ranging from advocacy, arousing health consciousness and reaching out to large numbers of the population through the media, to an approach involving interpersonal relations in dealing with specific individual and community aspirations and problems.

At WHO headquarters in 1982, public information and health education were brought together in a new Division of Public Information and Education for Health. The reorganization reflects a commitment to respond more effectively to the needs of Member States with support from WHO in strengthening this aspect of their work and in supporting their efforts to promote self-reliance and community involvement.

OBSTACLES AND CONSTRAINTS

Three fundamental principles of primary health care - community involvement, intersectoral cooperation and appropriate technology - were inherent concepts in the earliest theories of health education and community development. Although sometimes not so labelled, they have appeared in successful public health programmes and health education projects. Why then are they not more widely and consistently practiced? One reason is, quite simply, that they have not been sufficiently supported by policy.

The reports sent by many countries in connection with the Technical Discussions show at least three ways in which policy has failed health education and consequently the primary health care approach.

First, most policies, including World Health Assembly resolutions in earlier times, have limited health education to the role of a tool in the service of specific disease programmes. To be sure, that role of health education is not to be denied. But, it tends to relegate health education to a subordinate role in such programmes. To be effective, health education needs to be placed at the intersection of all sectors.

The second way in which policy has failed primary health care is in its fiscal support for health education which has been too meagre to permit achievements to match the expectations in primary health care.

Third, policies have created conditions where the planning and decision-making processes required for community participation and appropriate technology to bear fruit are reversed. Typically, in most countries that have initiated community participation strategies, planning and evaluation have been centralized; only implementation has been left to the local level. Therefore, the whole concept of community participation has been misunderstood. This policy and its application reveal the little credence that health professionals give to the ability of people to decide on matters of health for themselves, despite rhetoric to the contrary.

These and other obstacles, constraints and misdirected resources for health education will be reviewed in the chapters that follow. In this chapter, the special features of the primary health care approach calling for new policies for health education will be assessed.

THE CHALLENGE AND THE OPPORTUNITY

In accordance with the decision of the Executive Board at its sixty-eighth session, the subject of the Technical Discussions at the Thirty-sixth Assembly was: "New Policies for Health Education in Primary Health Care". It is significant to note that it was not health education methods that was selected, but rather health education policies.

As with other aspects of development, of public health and of education in general, health education has tended to be slower in benefiting the less privileged or socially isolated people who need it most. The challenge of the Global Strategy for Health for All by the Year 2000 (53,68) is for Member States to engage all segments of the population in the development of primary health care (45).

This need to involve people was clearly set forth at the Alma-Ata Conference which stands out as a turning point in the history of policy support for health education. In addition, the relationship of health education and involvement was stressed by a number of regional technical discussions and deliberations (27,74-81) and by numerous international

meetings of nongovernmental organizations, the latest being the XIIth World Conference of the International Union for Health Education.

Although international shifts in the concepts of health education have become evident, this reorientation will serve little purpose if it is not supported by political will and by the will of the people to translate these concepts into reality at every level. This fundamental issue was deliberated within the six working groups that were organized in connection with the Technical Discussions.

SOME DEFINITIONS

The topic for the Thirty-sixth World Health Assembly Technical Discussions required definition of several basic terms. The following definitions were used:

Policies: "A national health policy is an expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them (53, p. 14).

Health Education: Any combination of learning experiences designed to lead to a situation where people "know how to attain health; do what they can individually and collectively to maintain health, and seek help when needed" (46, p. 13). This definition aims to promote conditions that will help people to "acquire the power to make decisions that have to do with their own health" (25).

"Health education" is used in this paper to embody (a) advocacy and related information directed both at policy-makers and at communities; (b) community organization; (c) activities that assist individuals, families and communities to understand the health consequences of particular lifestyles and to engage in the protection of their health (77); and (d) other forms of action that predispose, enable and reinforce voluntary behaviour conducive to health.

Too often in the past, policies have not taken sufficiently into account the fact that people, in reaching health decisions, are influenced by factors often outside their control, such as working conditions, the marketing of consumer products in certain countries, the general educational level of the community, other economic and environmental factors, and social norms and customs (4). The promotion components of health education policies must therefore provide not only for the "adoption of beliefs, attitudes and behaviour likely to further health" but must also advocate an environment that supports the development of such attitudes and behaviour (78, p. 8). Such an environment is powerfully influenced by the mass media and social institutions in which people live, work and play.

In fact, health must be regarded as a shared responsibility. Although health education is intended to help people assume greater responsibility for health, it should not lead to the belief that people's behaviour alone is responsible for their state of health. This would result in guilt - unfairly assigned to the victims of social and community health problems.

Therefore, it should be stressed that health education is not merely a matter of efficient transfer of information through institutional channels of communication (57). Effective education for action is widely understood to include an element of personal and social involvement and of commitment to the objectives which the educational effort aims to promote. Indeed, this is what makes health education so essential to the family and community participation goals of the Global Strategy of Health For All by the Year 2000.

Community involvement: Community participation has a wide range of application in health education and primary health care, extending from consultation to a major role in decision-making. This involvement may be limited to the local elite or elders, or it may extend to men and women more generally and to young people interested in changes within their community. The level of decision-making with which people may be involved ranges from the community setting, through the provincial departments to the national government, as well as through the political party or parties of the country (42, p. 9).

There are many definitions and stated positions regarding the term "community". In this report, "community" is taken to mean a group of people who can be identified as living within and having a sense of belonging to a geographic area. Depending upon the settlement pattern and population density, a community may consist of a village or a town, a part of a village or town, or several non-contiguous settlements within a rural or urban area (42).

PHC CONCEPTS AND HEALTH EDUCATION POLICIES

Effective individual and community involvement and the development and application of appropriate technology, two important elements of primary health care, require for their effectiveness health education at the community and individual level. Community involvement and health education are therefore inseparable. It is not a question of which comes first, it is a question of how can we shape policies that will allow us to mobilize both simultaneously.

It was generally acknowledged in the Discussions that the emphasis on new policies for health education did not necessarily mean that these were new concepts of health education. The concepts of primary health care are highly congruent with the most time-honoured concepts of health education.

Some of these original purposes and functions of health education tended to be obscured in the 1950s and 1960s when the "community development" movement made community participation an end in itself and many countries created a separate cadre of community development workers. At the same time, many health educators were placed under vertical programmes for the control of specific diseases, so that the function of health education came to be identified as a tool to achieve specific changes in behaviour that would increase the cooperation of the public or their use of the services of that programme. In this way, even health education specialists became increasingly oriented to the behavioural change objectives of centrally planned programmes.

The Technical Discussion groups agreed that the renewed purpose in health education should be on empowering people with knowledge and ability for self-care and active involvement in health development. The scope for health education should be broad, rather than limited just to health and disease, and should be linked with issues concerning lifestyle, development and quality of life.

While it was agreed that health education had important inputs to make in traditional programmes such as prevention of disease, it was stressed that it should also focus on problems of development which affect specific population groups such as workers and their working environment, target populations such as migrant workers, vulnerable groups such as women, children and the handicapped.

Health education should aim at enabling people to make choices and should not take a moralizing or sermonizing approach in making people feel guilty, should their efforts not lead to the desired results.

It was agreed that health education should focus not only on individual and community levels but also on the political, professional and policy-making levels. In some countries, efforts have been concentrated on the former and the need remains to influence the political and policy-making elements. It was also agreed that maximum use should be made of community resources that have the greatest influence on individual behaviour such as religious groups, teachers, women's groups, farmers, herbalists and so on. In this context, messages and information provided by people from the community itself have a better chance of being accepted and understood within the culture and mores of that community.

All of these factors need to be considered by each country as it exercises its responsibility of setting its own policy priorities with regard to health education. Emphasis will vary widely in accordance with needs and available resources.

1. Promoting community involvement and self-reliance

Of the several features of the Declaration of Alma-Ata which have implications for health education, the one that is central to its role is participation. Experience has shown that efforts to increase individual and community participation in the planning process have

resulted in more successful programmes in both targeted disease prevention and more general community development programmes (32,40,51,52,69,72,73).

The term "community involvement" has been given preference today over "community participation" because "it is not sufficient merely to participate, which may be simply a passive response; there should be mechanisms and processes to enable people to become actively involved and to take responsibility for some decisions and activities jointly with health professionals" (48, pp. 20-21).

Community involvement is essential in any development process. Some participants in the Discussions saw community involvement as being effectively implemented through strictly socialist types of political structure. To others, community involvement is more spontaneous. The support of leaders often must be sought in the introduction of health education activities. The answer in one country, as an indication of highest success, was that the queen served as chairperson of a committee on health.

Strengthening organized community groups for their active involvement in health development was considered necessary for developing community self-reliance in health. It was felt that once communities have been sensitized and become involved in their own decision-making processes and in setting up their own priorities, they can proceed to implement collectively their local health programmes using all available resources. On the other hand, it was also emphasized that communities should not be motivated or mobilized for health action unless the required support is ensured by other levels, thus preventing the communities from becoming disillusioned.

Health education should focus on such community actions which are feasible and practical and can be carried out within local realities.

It was agreed that community participation and involvement implies a sharing of power and responsibilities - avoiding the total abdication by the health sector on the one hand or domination and exploitation of the people on the other. It ensures a full partnership between all concerned in which a total task relationship is developed.

Whether the health education process starts from the community or central level will depend on the size, political structure, stage of development and other social and cultural factors. Various examples were given which illustrate this point. Nevertheless it was agreed that optimizing participation is an important factor and that health policies should be sensitive to opportunities for engaging ordinary people in determining health problems and in being active in their solution.

Generating effective local participation involves a long-term effort where the results might not be achieved quickly. However, the results may be more lasting and contribute more profoundly to community health than would more dramatic external interventions that might have highly visible short-term effects. Central authority can assist here in providing coordination of efforts between communities as a way of strengthening individual community efforts and disseminating successful approaches to other communities.

Whenever front line health care facilities are available these should be made available not only for health care but also used in support of community health education efforts. Similarly existing educational facilities (one example of political orientation centres was given) can incorporate health education activities in an acceptable and economical manner.

Community involvement should not be merely a temporary activity. To achieve continuous involvement, structures are required. Several participants mentioned that in recent years in their countries there had been considerable decentralization to local community organizations. In some countries there were village councils which were responsible not only for health development but for all general development efforts, including those in education, agriculture, sanitation, etc.

Among the prerequisites, it was pointed out that such involvement must take place at all stages. Several participants gave examples of involvement of the communities themselves in evaluation, which can be an important motivating factor and a catalyst of social action. Such examples came both from developing countries and from industrialized countries. Another

prerequisite is for the health professionals to engage in dialogue with the population on its own terms, bearing in mind the community's standards and frame of reference. Lack of effective two-way communication is undoubtedly the cause of a number of failures.

Several participants questioned whether it was always possible to rely on the views expressed by the population when making the necessary community diagnosis and planning programmes. Some serious health problems, such as schistosomiasis, may not be felt as serious. It is therefore necessary to supplement the information and the opinions received from the community with scientific, sociodemographic, medical and economic data.

One participant noted that the priority needs expressed by individuals were not necessarily the same as those of the community, and someone might have to arbitrate.

The importance of conceiving health education within a wide framework of efforts to train knowledgeable and independent citizens, capable of deciding their future for themselves, was also stressed. It is within this overall framework that all levels and all sectors of the population need to be made more aware, in order to mobilize their energies for the common good. Thus local leaders (administrative and/or traditional), teachers, agricultural extension workers, women's associations, youth clubs, religious movements, professional groups, trade unions, etc., will be involved according to the circumstances.

Several countries are endeavouring to bring about collaboration with practitioners of traditional medicine by engaging in dialogue with these practitioners and offering them supplementary training. Among the practical difficulties encountered are the fear of registration and bureaucratic supervision by the public authorities, the obligation to divulge their methods, and the loss of their prestige and/or their clientele. Local situations will need to be studied, bearing in mind the importance of these practitioners within their communities.

In addition to health benefits, which are not always evident at first sight but only in the medium- and long-term, it is necessary to study, where appropriate, the possibility of providing various incentives or additional motivating factors for the community.

Finally, it is clear that community involvement can only come about within a climate of mutual respect, and with a great deal of attention to preserving the cultural and social identity of the population concerned.

2. Enhancing decision-making skills at the local level

Health education is a particularly effective approach for encouraging and enabling communities to identify their health problems, select solutions, set targets, and translate these into simple and realistic goals that they can monitor.

In this respect, there is a need to test new methods of client-oriented and community-oriented education that emphasize the growth of skills in self-determinism (73, p. 4).

The participants in the Discussions recognized the vital importance of policies that mandate the strengthening of decision-making skills at the local level. Policies should be announced and promulgated which will encourage skills development at all levels of the system and particularly in the community.

Among the specific types of action which should be fostered by these policies, one group identified the following:

- (1) It is important that high officials and other programme personnel come in contact with the people of the community as often as possible. This serves as an incentive for the community to participate in the process of developing skills and local leadership. It also helps to assure that these prominent leaders are clearly associated with the programme.
- (2) Special courses should be provided in the community for various groups, with special attention being given to the convenience of time and place. For working people, for example, evening or weekend courses may be desirable, and schedules of health workers should be made flexible to accommodate this.

- (3) It is not sufficient simply to establish a programme and to teach the skills needed to implement it. Monitoring and evaluation are essential, and community people can be prepared to take an active part in these aspects as well.
- (4) Special attention should be given to the use of peer-group techniques. In one example cited, these methods had been especially successful in dealing with the problem of unwanted teenage pregnancies, and led to the development of other related programmes.
- (5) Health programmes should build upon the skills already existent in the community. Full use should be made of the knowledge which is there.

Some examples of community-level decision-making will be presented in Chapter 4.

3. Allowing for a diversity of objectives in formulating policy

Policies in health education have most often been adopted by national governments during periods of mass campaigns against specific communicable diseases such as malaria or the immunizable diseases, or as a component of highly targeted programmes such as family planning (27). In those instances, the objectives of health education and the indicators of success could be clearly defined, even in quantitative and behavioural terms, for whole nations and for each community.

The principles of primary health care, on the other hand, make it necessary for national policies to deal with the more diverse objectives of communities so as to integrate the varied priority needs identified at the local level. One community, for example, might give priority to improved water supply, while others are more concerned with the draining of a swamp, the construction of a clinic, or the control of teenage alcohol use.

The need for a broad diversity of objectives stems also from the much more comprehensive definition of health now being employed in relation to primary health care. For this reason, many of the important objectives in today's health programmes are outside the realm of physicians and other members of the institutional health system.

It is necessary, therefore, that policies recognize the need to involve many other sectors and disciplines in attaining these objectives, and that strategies designed to translate these policies into effective action take this need into account. It is also important to recognize that specific objectives of national programmes may differ from the priorities or needs felt at the community level.

4. Harmonizing national and local plans

The question that needs to be examined is this: What are the mechanisms to be developed within a national policy for health education that will make possible efficient planning and allow for the allocation of central resources without jeopardizing the principle of community involvement?

Community involvement can ultimately provide continuous guidance to national policy from the grass roots. National policy should in fact thrive on the input resulting from such community involvement. But initially, national governments often must take the lead in setting policies that will legitimize, encourage and support local community involvement in health.

In recent years the importance of decentralizing the managerial process for national health development has come to the fore. Many countries have taken steps to strengthen decision-making powers at provincial, district, and community levels. This trend highlights the need to facilitate community involvement in planning through health education, so that local action blends with national health policies (34).

Various participants in the Technical Discussions expressed strikingly different views of the planning process.

One country, for example, has developed health care teams at the district level, composed of the local medical officer, nurses, community health aides, and other health workers. Chairmanship of these district teams may reside in any member. This team is the

basic planning unit, working in conjunction with lay members of the community. Plans then proceed "upward" through the system to the parish and national levels.

In contrast, other participants indicated that community level planning and participation should not be "spontaneous" but rather a part of a structured and centralized system. Some communities, it was reported, are not "cooperation-minded".

One participant observed that central decisions do not change situations locally unless local people are involved at every stage.

Once a national policy has been worked out in the light of the needs and wishes of the communities concerned, and an institutional framework has been set up, programmes are planned according to the objectives selected. The majority of groups felt that integrating the opinions and contributions of local communities into this process is an important task for the central level.

Planning is based on the identification of needs, which may of course differ from one part of a country to another or even within the same district. One participant stressed the need to establish a "geography of health".

5. Facilitating intersectoral action

Often, communities set priorities that may not be attainable solely through the communities' own actions: sometimes organizational and financial support is required; sometimes these priorities can only be achieved through political, economic or environmental change. As a result, many collective actions concerning health need to be taken in cooperation with other sectors.

Promoting intersectoral action is not without problems, whether at the phase of planning, management or evaluation (3). Local involvement may provide some of the solutions needed because the very participation of communities in developing their own objectives and priorities tends to blur the lines of demarcation between the sectors to which national policy assigns health education functions.

Several participants reported the successful formation of intersectoral commissions or councils at the national level, with the widest possible participation in accordance with the characteristics and possibilities of the country. It was recommended also that such committees be fostered at the community level, again in accordance with the circumstances. In fact, intersectoral cooperation is often more easily developed at the local level. An example was cited in which agricultural concerns were of the highest priority in a given community. By developing intersectoral collaboration to deal with these needs, a process was initiated which was then used for health and other purposes. Thus cooperation in one area becomes a point of entry for a broader programme of development.

The critical importance of intersectoral cooperation between health and education was unanimously stressed. Primary and secondary schools were viewed as major resources for health education and community development, for numerous reasons, and teachers were therefore identified as essential partners in these efforts. It was highly recommended that school health education curricula be strengthened, and some participants urged that hygiene become a required course. Children can frequently become change agents in their families and communities.

The teaching staff, as well as the health workers who relate to the schools and the parent-teachers associations, all have a part to play in ensuring that health instruction is an integral part of the school curriculum and that proper learning experiences in relation to healthy living are presented to the children. This is too big and important a subject to be left to chance or the whims and fancies or goodwill of individuals. There is an urgent need for policy decision at the highest level. In some cases this would be at cabinet level so that the ministry of health and ministry of education know clearly that they must get together. In some smaller countries the mechanism already exists as a ministry of health and ministry of education are under one and the same minister. However, unless there is a clear policy given even within that situation, a dichotomy may exist, just as it has existed in many ministries of health where in some instances there has been a great gulf between preventive services and public health on the one side and curative and therapeutic services

on the other. It must be remembered that health education is not only a part of health but also a part of general education.

The Technical Discussions emphasized the special role of school health education as part of the curriculum in primary and secondary schools and in teachers colleges. It was contended that unless the child is educated for health during his school years he is liable to show relatively little concern for health when he becomes an adult. School health education, therefore, was considered to be part and parcel of overall health education. It was considered necessary to closely coordinate school health education and community health education.

It appears that intersectoral cooperation is easier to implement at the local level where health concerns are perceived as an integral part of development generally. It is only as we proceed up the ladder of administrative jurisdictions that health concerns become disengaged from the overall development process. At these higher levels, individual sectors often have fixed values, policies and administrative styles that put up barriers to intersectoral cooperation. Sectoral isolation at higher levels and lack of awareness of what other ministries are doing can lead to confusion and failure at the field level.

At the same time it was stressed that effective intersectoral cooperation cannot be achieved unless and until the various components of the health sector itself interact effectively.

It has to be recognized, in respect of intersectoral cooperation at the national level, that sometimes there are frank conflicts of interest between different sectors. Health education about smoking and the tobacco industry is a common example. Even in the absence of conflicts of interest, however, the inertia of complex systems make it difficult to bring together the many components of government and industry which need to cooperate, for example, over such matters as food hygiene or traffic accidents.

Some of the areas in which adequate policies of intersectoral cooperation are not available include policies that allow for the use of nongovernmental organizations, traditional medical practitioners, community leaders, women's organizations, trade unions, business organizations, and the mass media. Although the concepts of primary health care call for the involvement of these institutions, existing policies are seldom able to accommodate them.

Primary health care is a matter for everyone. All energies must be mobilized: in the family, at work, in social groups, at school, and in training centres of all kinds, to ensure its promotion. Health education will enable everyone to recognize the importance for himself, for his family, and for his community of taking part in collective activities such as the construction of sanitation systems or simply helping to finance them.

6. Using appropriate technology

The "appropriate technology" principle of the primary health care approach requires health workers to offer technology that is responsive to the needs and aspirations of the people and that it should be compatible with local values, resources and abilities of the community who use it. Health education is in itself an appropriate technology in the sense that it enables community members to play an active role in planning, implementing and evaluating health services, thereby achieving relatively high health benefits at low cost.

In general, the Technical Discussions agreed that health education has a major responsibility in furthering a dialogue between professionals and non-professionals to accelerate a two-way transfer of technology between the health system and the people. This will provide a basis for real teamwork based on the needs felt by the community and those epidemiologically assessed by the professionals.

The need was recognized to take advantage of modern communications technology wherever it is available. It was also stressed, however, that traditional folk methods of communication, such as legends, songs, plays and drums, can be effectively used in health communication. The choice of the appropriate educational technology for a given purpose depends in very large measure on an understanding of the audience - their literacy levels, traditions, accessibility of modern media, and similar factors. It was also suggested that a

concept or term be coined for "appropriate or key health communications" parallel to appropriate technology.

Sometimes extensive and inappropriate equipment is used for health education purposes, depleting the already scarce resources. Such equipment is also difficult to operate and maintain. Breakdowns are frequent. This is unwarranted in terms of educational objectives. Therefore, policies are required to ensure the use of appropriate technology in health education.

7. Measuring community involvement and the impact of health education

As health education activities become more diverse and comprehensive, cutting across sectors and agencies, they will be correspondingly more difficult to monitor and to evaluate. Yet some way must be found to give sufficient specificity to the health education component of primary health care, so that resources can be centrally managed, monitored and their impact evaluated. This will satisfy decision-makers that allocations are accounted for and that the new policies are yielding benefits.

More sensitive measures of health education outcomes are needed so that the results of programmes can be detected within shorter time periods than is often the case in evaluations currently conducted. Programmes requiring annual renewal of budgetary support can rarely wait a decade to prove their value.

In such evaluation, qualitative indicators are just as necessary as quantitative indicators (31,36,48,60). In this respect, the "short list of indicators" suggested for use in monitoring and evaluation of the Global Strategy for Health for All by the Year 2000 provides one indicator relating directly to health education policies. It concerns the degree to which "mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning." These include active and effective mechanisms for people to express demands and needs; the involvement of representatives of political parties and organized groups such as trade unions, women's organizations, farmers' or other occupational groups; measures to ensure that decision-making on health matters is adequately decentralized to the various administrative levels (54, p. 75).

As a first step in formulating more sensitive and specific criteria in relation to this and other indicators, countries might estimate the totals or percentages they would expect to achieve in connection with various types of participation. They might also outline short- and long-term plans of action with measures of progress indicated for each phase or year of the plans.

CHAPTER 2

POLICY TRENDS AND GAPS IN THE INFRASTRUCTURE FOR HEALTH EDUCATION

The Member States are beginning to place greater emphasis on a broad type of health education to foster involvement of individuals and communities and promote healthy lifestyles (23). Such programmes and priorities are often established by the centralized agencies, although local initiatives to create self-care groups and organizations are also becoming more and more common. Some countries have encouraged the further development and coordination of these local organizations by offering them planning functions, grants for specific programmes, educational materials or equipment as well as political support.

In most communities, an infrastructure for health care is already in place, however poorly suited it may be for primary health care. Furthermore, in view of their scarce resources, most countries have to make some budgetary plans at a central level, in advance of local decisions. This means that by the time resources reach the local level, their allocation may already be fixed. The order of initiative, then, is most frequently from central to local level, and it would be unrealistic to expect that health education alone can initiate an overturning so that all planning initiates locally.

One policy option used by some countries has been to provide grants or incentives to localities for health and development purposes. This represents a compromise between the necessity of some central accountability for equitable distribution of national resources on the one hand, and the necessity for more local self-determination on the other. Grants or incentives may be either restricted (e.g. for water or family planning) or open in their use (e.g. for community development) or they may specify appropriate services and facilities to be funded. In this process, communities are required to define their needs and priorities and then to control the use of the allocations within a range of national or provincial priorities.

FOUR PREDOMINANT POLICY PATTERNS

The flow of information, actions and decisions between central and local or peripheral levels are found to fall in four predominant patterns among the Member States.

One type of policy supports both central planning and central implementation. This pattern predominates in small countries and in a few large countries where it has been found convenient, for the sake of equity and efficiency, not only to plan centrally but also to implement programmes and services from the capital city.

Another type of policy mandates central planning with local implementation. This is a predominant pattern of large countries, in which central implementation of programmes and services is impractical. Central plans are passed on within sectors (health, agriculture, education and so on) from central agencies to regional or local agencies to be adapted to local conditions. Implementation and evaluation of experiences are recorded at the local level and assembled, then acted upon at the central level.

A third type of policy promotes intersectoral development with central coordination. Concern for cooperation in health among many sectors has prompted both large and small countries to supplement their sectoral system of planning and implementation with new structures that are to act as a link and facilitate a global approach to problems. These consist of community development institutions or more comprehensive delivery systems set up at central level, often without new resources. In practice, however, the sectors tend to continue to plan, implement and evaluate their own programmes separately, although with greater focus on secondary planning and implementation at the local level.

Finally, a fourth model is emerging as the concepts of primary health care are more fully expressed in policy and practice. It would be easy for Member States to elaborate an ideal model if there were no prior existence of sectoral programmes, no tradition of central planning and implementation, and no barriers to coordination to be overcome. However, far from being negative, these traditions and apparent barriers can be used as starting points in the reorientation of policies. Planning and implementation are increasingly a shared

responsibility between central agencies and local groups. No longer are health services expected to filter down through a number of layers to "reach the underserved". Rather, an upward movement, starting from the people, has now been initiated.

This increased local involvement in health planning does not become equated with total responsibility for financing and carrying out programmes. On the contrary, far from leading central government agencies to abrogate their roles in supporting the implementation of programmes, the new policies in citizen participation, community involvement and self-care tend towards a constructive partnership in which each party has a specific contribution to make.

THREE CONDITIONS REQUIRED FOR ACTION

It is generally agreed that information and education for health are essential ingredients in forging partnership ties between central agencies and local communities and between sectors contributing to primary health care. But reports from Member States at the Technical Discussions reflected their concern that the conditions and political will required to achieve such partnerships are far from being sufficiently developed. Hence, new policies need to provide for an infrastructure of organizational, legislative and financial support necessary for the successful implementation of health education.

1. Organizational placement: The positioning of health education has an important impact on its capacity to act effectively and to influence the integration of information and education with all aspects of health care as well as with other sectors such as schools, agriculture and communications.

Most countries have an office or division of health education within the health ministry, staffed by at least one person professionally qualified in health education and supported with some media and managerial workers. A few have additional health education units in other ministries (education, environment, agriculture, etc). Some place health education centrally in the health ministry to give it more leverage in relation to the health education resources of specific programmes. Sometimes these programmes have their own health education staff, who may or may not report to a central office of health education. These patterns illustrate the variety of configurations that exist.

The structure or entity responsible for health education will continue to vary from country to country. The keypoint is that, however placed and constituted, it must be capable of assisting all the health services, preventive and curative alike, and the services of other development sectors and communities, to plan, carry out and evaluate health education projects and activities.

Participants stressed the need for health education units at local, state and central levels of the health organization. Each of these units would be manned, where possible, by a multidisciplinary team. The team would comprise workers specialized in health education, mass communication, audiovisual techniques and behavioural sciences. To the extent health education units are well-organized, well-staffed and adequately financed, it is possible to develop meaningful information and health education programmes in support of primary health care.

Among the possible functions of such health education units would be: to muster political will both for primary health care and health education as a part of it; to support the planning, implementation and evaluation of health education at local, state and central level; to harmonize health education activities at all levels; to promote collaboration between health and non-health sectors; to train other health, policy makers and administrators for health education aspects of their work; to stimulate individual, family and community action; to involve, where possible, traditional healers in health education activities; to initiate educational activities that involve the individual families and their community at the grass-roots level; and to undertake research and to provide data where necessary for various health education processes.

From the standpoint of orienting the existing health education resources towards primary health care, the experience seems to be that a high placement in the ministry of health gives health education greater flexibility and more responsiveness to diverse needs. When,

however, it is subsumed under disease-specific or population-specific departments such as communicable diseases or maternal and child health, the efficacy of health education is decreased in primary health care.

The ideal for health education is to be placed in a position (a) where it is accessible to all programmes and services having informational and educational functions; (b) where it can develop a broad network of contacts with related programmes inside and outside the agency; and (c) where it can ensure that effective educational and informational approaches are adopted in policy and programme planning.

2. Legislative support: Sometimes, legislative measures follow health education and serve to legitimize actions conducive to health that have been promoted by health education; sometimes, on the contrary, it is necessary to have recourse to legislation or regulations to give backbone to the educational efforts themselves. Four broad types of legislation can be identified.

The first includes a broad spectrum of initiatives and measures conducive to health development. This was proposed by the Seventh General Programme of Work of WHO which invites Member States to consider the adoption of legislation that supports healthy lifestyles, more relevant technologies, and new types of health workers where necessary (70, p. 60).

The second is concerned with restricting or prohibiting the promotion of products that can have a harmful impact on health. Many countries have taken at least some policy action against exaggerated claims of the health benefits of medicines, foods, medical appliances and practices. Some have extended restrictions to the advertising of harmful or potentially harmful products, in certain cases even prohibiting any advertising of baby foods, cigarettes or alcohol in at least some of the media (see WHA27.43, WHA33.32 and WHA35.26) (29,37,61, 62). Caution must be exercised, however, to avoid curtailing the advertisement and dissemination of needed self-care products.

A third type of legislative measures is aimed at providing financial resources for health education activities. Some policy options under considerable consideration include the granting of tax exemptions on revenues that companies derive from specific activities in support of healthy lifestyles or from the provision of media time or space for the same purpose. Measures also are envisaged for setting up compensatory mechanisms (such as tax credits) for insurance companies offering reduced premiums to non-smokers, safe drivers, and others practising healthy lifestyles.

Finally, a fourth category of legislative measures deals with the "informed consent" that physicians need to obtain from patients in certain countries before any procedure - preventive or therapeutic - is performed. Such consent implies education. This requirement is an extension of a similar informed-consent provision in the World Medical Association's Helsinki Declaration as revised in 1965 in Tokyo (2). It ensures individual and family involvement in health care decisions.

At the level of communities, "informed consent" is just as useful with respect to such issues as fluoridation of drinking-water, vaccinations, or various measures concerned with the protection or improvement of the environment, and what to expect of health services. Family planning is an area where individual "informed consent" takes on particular importance. The importance of informed consent in the relation between health education and legislation was reflected in the following observations and conclusions:

- (a) health education, however well-conceived and implemented, has only a modest chance of positively influencing lifestyles if it is daily counterbalanced by too many harmful temptations; legislation may therefore be needed to reduce these harmful temptations;
- (b) most societies have traditionally incorporated rules and social pressures discouraging lifestyles harmful to the community and individuals; these traditions, however, can rarely cope with the situation created by the steadily increasing speed of industrial development, travel and communication;

- (c) from the village to world level, communities have therefore attempted to cope with the situation by enacting regulations and laws at the communal, provincial, national and international levels; some of the best known examples are the laws and regulations concerning the trade and use of narcotics, explosives and acutely toxic substances.
 - (d) each regulation or law may have drawbacks and side effects; development of protective legislation should therefore be placed within the local/national socioeconomic context to reach a realistic balance between the impact of the legislation and the aspirations and needs of the people.
3. Financial support: While certain developed nations spend less than 0.1% of their health budgets on health education activities, some developing countries may be spending up to 3%. In both developing and developed countries, over 90% of health expenditures are allocated to hospital care and personal health care.

It is difficult to determine what percentage of health expenditures should go to health education without referring to a country's total budget and to the percentage attributed to health within that budget. If the budget of the ministry of health is very low, even assigning 5% to health education would still be inadequate to meet health education needs. One goal, however, should be to allocate to health education an amount similar to the amount allocated to health manpower. Any major shift of resources for health education in primary health care is likely to come from the "referral care" and manpower sectors (9).

THREE TYPES OF HEALTH EDUCATION REQUIRING SUPPORT

With the organizational, legal and financial support outlined in the foregoing paragraphs, health education can support the primary health care approach while continuing to serve the educational needs of communities in specific programmes. Three levels of health education can be described as follows:

1. Predisposing health education, to initiate self-study of basic health needs and involvement in planning for health by individuals, families and communities. This type of health education establishes health literacy and evokes the desire of people to participate in decisions concerning their wellbeing. It is generic, independent of specific disease control programmes, and should be supported as a continuous function of local institutions such as schools, mass media, community development agencies and political or consumer advocacy organizations. It awakens and arouses the latent will of people to control their own health and wellbeing. It also advocates for change among decision-makers.
2. Enabling health education to help achieve the goals of specific health programmes or services by facilitating the necessary behaviour. This level of health education is specific, dependent on the prior determination of behavioural changes required within particular disease prevention, treatment or rehabilitation programmes, and should be supported largely under the budgets of such programmes as a centralized function, allocated as appropriate to regional and local agencies. Policy should indicate that enabling health education is a necessary component of each mandated programme, in addition to the predisposing health education which is independent of such programmes.
3. Reinforcing health education to support the incorporation of health actions into broader lifestyle, self-care and community development. This type of health education is oriented to the consolidation of health gains from basic and sectoral programmes, and seeks to extend or replace these through intersectoral action (at the community level) or self-care and lifestyle modifications (at the individual level) by reinforcing behaviour conducive to health. This level of policy should be developed in relation to organizational, economic and environmental supports for positive health action as well as in health education per se.

Supporting policies in relation to health manpower development, health education research and communications media are necessary to strengthen the capacity for individual countries to undertake these three levels of health education. These additional resources required for health education in primary health care are the subject of the next chapter.

CHAPTER 3

RESOURCES TO BE DEVELOPED OR TAPPED BY NEW POLICIES

The implications derived from the previous chapters are now examined with reference to five resources that need to be developed, redirected or used more effectively by new policies for health education in primary health care:

- (1) manpower development (personnel);
- (2) communications (media);
- (3) research and evaluation (knowledge);
- (4) the nongovernmental and voluntary sector;
- (5) the World Health Organization and other international organizations.

MANPOWER DEVELOPMENT

Priority No. 1: skilled and motivated personnel

Without trained people to implement them, the best policies exist only on paper. The first priority therefore is to develop skilled manpower. Here, technical competence is not enough. The need is for personnel who will introduce the educational dimension in all aspects of their work.

The word "manpower" is used in its broader sense, including all those men and women who have a role in or affect health education policies and practices. This includes legislators and policy-makers who must be educated with regard to the importance of health education as a priority among local needs.

Education of other key personnel besides health workers is extremely important, e.g. the village school teacher, religious and other community leaders, youth leaders, etc. Special emphasis is needed for the education of women in order to help them to fulfil their role as the principal health care provider of the family and as a catalyst for community action. An important role of mothers is to be able to influence the maternal and child health and other primary health care services so that they genuinely answer the family's needs.

Two of the main objectives of primary health care - involvement and self-reliance - will only be achieved if health care providers have developed a new outlook, and are not only concerned with disease prevention and control but are intent on using health technology focused on people's needs and aspirations (1) and on promoting a multisectoral approach to health action.

Thus, reorientation of health education policies entails new roles in health education for all health care providers, including lay volunteers and mutual self-help groups. These new roles, in turn, require new forms of training in line with new strategies for working with communities, and a more comprehensive and realistic appreciation of the demands of research and evaluation.

The need for reform

To develop or improve the qualifications of personnel, training programmes should apply the very methods that health care trainees are later expected to use with the community (5). They should therefore enable trainees to take on more responsibility for their own training instead of being passive learners, and provide opportunities for health and other workers "to learn together, so that later they can work together without an excessive spirit of 'professionalism' and appreciate their respective responsibilities" in the promotion of health (50).

This requires, in many instances, a major shift in current training programmes. As stressed in the WHO Seventh General Programme of Work, "manpower policies, where they exist, often have little relevance to the long-term and changing needs of the health system and the communities and individuals within it" (70, p. 65).

The Technical Discussions suggest, as a necessary practical step for ensuring manpower development, the introduction of policies to ensure that staff of adequate quality are available in sufficient quantity for effective action. In order to train such staff it is important to develop machinery for coordination with the education sector and to obtain technical and financial inputs from the international organizations.

Some participants stressed the appropriateness of achieving technical cooperation and exchange of information between countries.

Even if the curricula of health workers in training could be reformed in the near future, countries cannot afford to wait until the present students become the majority. Reorientation of manpower now in service is essential. It must be practical and take place at the field level, and not merely be verbalized in the classroom.

It is to be expected that there will be resistance to attempts at modifying curricula and training programmes with a view to making learning less "academic" and creating greater interaction between medical faculties, schools of nursing, public health, and institutions where the liberal arts are taught. Such resistance is likely to originate from administrators as well as from the faculty and the students.

Reorientation of training programmes will only become a reality, therefore, if political commitment to primary health care exists at the strategic points of policy-making and implementation of manpower development. Such policy support needs to be based on a clear understanding of the objectives involved in integrating education for health in basic, in-service, continuing and postgraduate education for the various categories of health and other workers concerned.

Reorientation of training programmes: the objectives requiring support

These objectives will be briefly enumerated for two categories of workers, in the light of recommendations made by the Expert Committee on New Approaches to Health Education in Primary Health Care (50) and the Technical Discussions.

For health care providers, these objectives are:

- (a) to foster a concern for development as a global process, of which health is one aspect; and
- (b) to strengthen their capacity:
 - to develop and apply a people-oriented health technology which respects people's aspirations, felt needs, and self-care potential;
 - to act as facilitators of action by the people rather than take action themselves and expect "participation";
 - to promote a constant transfer (in both directions) of technology between the health system and the people;
 - to assume an advocacy role for health vis-à-vis decision-makers;
 - to recognize the contribution other professionals can make to the promotion of health, and to enhance and coordinate their efforts.

Medical students, student nurses and more generally all future members of the health team should be trained by specialists in human relations to enable them to communicate health education messages effectively. They should know how to use the various means of communication available to the populations whom they serve.

For teachers, who also have a major responsibility in health maintenance and promotion (50,82) the objectives are to strengthen their capacity:

- to provide school learning experiences that are conducive to self-care, healthy lifestyles and a desire to participate in development efforts in the community, while setting the example through their own behaviour;

- to link the school health experiences with health issues and programmes in the community, and the concerns of families as expressed through parent associations and other community groups;
- to team up with health workers in these efforts and in a joint search for innovative approaches such as, for instance, experiments in preschool education to develop "critical viewing" skills that enable children to resist the influence of media advertising (6,12,17) or new ways to implement the school medical checkup (44).

Outside the health and education sectors, there are other workers who should be considered partners in the health education components of primary health care. Journalists, broadcasters and other mass media specialists head the list, and the next section of this chapter deals with their particular training needs.

Other professionals concerned include agricultural extension agents, social welfare workers, labour union organizers, insurance agents, religious leaders, housing and water resource authorities, inspectors in agricultural, manufacturing and packaging industries, and the practitioners of traditional medicine. The list could be extended to include virtually every occupation that entails contact with the public. If such workers are routinely to include health education functions in their work, then training activities need policy support.

Several countries are endeavouring to bring about a dialogue with practitioners of traditional medicine by offering them supplementary training. Among the practical difficulties encountered are the fear of registration and bureaucratic supervision by the public authorities, the obligation to divulge their methods, and the loss of their prestige and/or clientele. Local situations will need to be studied, with the importance of these practitioners within their communities borne in mind.

The categories of workers who have a role in health education are indeed numerous, yet "every one's job" often turns out to be "no-one's responsibility." Hence the need for specialized staff in health education whose experience and qualifications are required at central and provincial levels for the training of other workers in health education and for the planning, implementation and evaluation of health programmes, including the coordination of resources. In this respect, the recommendations of the PAHO/WHO interregional conference on the postgraduate preparation of health workers for health education are still most pertinent and need renewed policy support (35).

The lay resources in health

In respect of lay resources, an important function of training should be to enhance the capability of individuals and communities to analyse health and health-related problems. For if people have the skills to inquire systematically into their conditions and health problems and to experiment with solutions, however simply, they will become less dependent on others and will be able to decide for themselves what their needs are and how these needs should be filled - including training to develop appropriate skills (18,20).

Women in the community deserve special attention in health education training. The influence that educated wives and mothers, alert to health problems and to self-care possibilities, can have on health levels in the family and the community is well documented (83).

Workers in industry constitute another group with high potential. Experience in training programmes undertaken jointly with labour unions and employers has yielded valuable data on methods and approaches leading to self-reliance in health.

COMMUNICATION (MEDIA)

A continuum of action

Promoting primary health care involves a continuum of action, from advocacy and developing awareness to working with individuals and communities in elaborating plans, carrying out activities and monitoring action. At one end, information with its array of media spearheads the movement towards health; at the other end, education focused on personal decisions and actions, complements the impact of information.

In the history of education for health, attitudes towards mass media have varied from unrealistic expectations to total dismissal of their value. Experience shows that neither communication media nor interpersonal communication, when used singly, can have the total effect desired. They have different functions to perform, which mutually enhance each other's effectiveness.

There is a consensus today regarding the main functions of information media. These are:

- to help strengthen political will by appealing to policy-makers;
- to raise general health consciousness and to clarify options concerning actions that have a strong bearing on health levels;
- to inform decision-makers and the public about the latest developments and limitations in health sciences, and to promote the replication of relevant experiences;
- to help deliver technical messages;
- to foster community involvement by reflecting public opinion, encouraging dialogue and facilitating feedback from the community;
- to inform the public regarding their rights in health care.

Promoting a dialogue between health and media personnel

The discussion, at the international level, on communication in support of development has awakened in many media personnel, and reinforced in others, the sense of social responsibility in their professional work. Instead of being merely observers and reporters of events, many who work in the media have come to appreciate the power of communication and the need to participate more actively in the development process (21).

The obvious influence of the mass media in health communication was recognized in the Technical Discussions. It was noted that communications technology has made rapid progress but not all health professionals have recognized its potential. One participant suggested that schools may lose their prominent place as institutions of health learning and be replaced by media.

Surveys show, furthermore, that health is high on the list of media consumer interests. Media managers are therefore pleased to use health topics in radio/television or in print. However, if media experts are to put into practice their willingness to develop health messages, they need sound and accurate content, provided regularly and sustained.

Taking the foregoing into account, appropriate policies need to be formulated to ensure proper and balanced use of media in health education. Used wisely, media presents a powerful ally for health education. Production of material for use by the media must be undertaken, utilizing the resources and skills of media professionals.

Health care providers and media personnel often differ in their conceptual approach to the use of media. New policies should foster dialogue between health and media personnel. More specifically this implies policies that will:

- (a) encourage close and continuing cooperation between health and media professionals;
 - (b) develop mechanisms to ensure a constant and free flow of information from the health sector to the communication media sector including the production of health material for use by the media;
 - (c) organize in-service training programmes and seminars where professional personnel can meet;
- to strengthen the sense of social responsibility of media professionals in their work and the importance of featuring health in this perspective;

- to foster their awareness of the potential of health as a source of prime material for media consumption, and their interest in transmitting technical messages;
- to expose media professionals to validated health information and create awareness of the risks involved in transmitting information on treatment and therapy, often biased by its spectacular character; should the information not be totally correct or complete, expectations of improvement may be unwisely raised;
- to educate media professionals about the negative health impact of certain messages carried by the media, especially advertisements of various commodities;
- to enable health workers to understand the needs of media professionals - whose responsibility it is to inform the public in ways that appeal - and how they can build on these needs;
- to train health workers in effective communication techniques and make them perceive the importance of using a language accessible to others.

A broad concept of communication

The word media is used currently to refer not only to print media, radio and television. It also covers traditional means of communication such as puppet plays or folk art. Combining as they do accepted channels of communication with interpersonal approaches, these media are critical to the success of community self-studies and action phases illustrated in the following section on Research and Evaluation. Here, policy support could take the form of subsidies to traditional communicators (actors, puppeteers, story tellers) to encourage them to incorporate health messages in their activities.

Despite all our efforts to create better educational tools, still the most effective means remains the personal contact, with its one-to-one relationship where "teacher" and "student" change roles continuously, each learning from the other. This is dynamic, constructive communication. Hence, the importance for health service providers to recognize the importance of two-way communication and be technically prepared to perform this function as integral to their daily tasks (28).

What is necessary is that a balance should be struck between the mass media and other systems that reach people directly. The media should be used to bring out important issues, while at the same time their efforts should be harmonized with actions taken by the health sector that will affect health behaviour, thus leading to better results. In addition, health education should be sensitive to critical issues which are the concern of people, and collaborate with the mass media in arousing people's interest in these critical issues.

Any action going beyond interpersonal communication, using mediated communication and reaching large numbers of people is part of media work. It must also be stressed that media work is not limited to journalism. Radio and television in particular are in large parts channels of entertainment, and health education messages can be effectively incorporated in music or drama.

It was agreed that we are in an epoch of complementarity in which each sector has special strengths that should be recognized and used. Properly used, the media can prepare the ground for health education efforts and maintain the kind of community action that is needed. The different forms of mass communication are therefore important for sensitizing and sustaining public opinion, but they are most effective when supplemented by well-designed community activities.

In some of the developing countries, people have relatively little access to mass media, many of them not knowing how to read and having no radios and television. Yet, even in these areas, the access to media is growing fast. Moreover, the media have much influence on the small but important segment of the population that makes critical decisions, including politicians and professionals. It was stressed that the media should be used in gaining support of politicians in the promotion of health.

The potential usefulness of television in the developing world should not be minimized. In many parts of the world radios are almost universally present, even in the farmer's field and the homemaker's kitchen. Where television has succeeded in reaching communities and families, its impact on attitudes is very strong. Moreover, in many countries, especially in developing areas, television is not commercial; therefore there is often a real opportunity to make proper use of this medium at little cost.

RESEARCH AND EVALUATION

Evaluation of services, activities and programmes in health education is necessary to their eventual improvement, but evaluation is only one part of a continuum of research needed to inform policy and planning in health education.

Why research?

If the ultimate purpose of health education is to influence the behaviour of individuals, families and communities in maintaining and developing their health, it is important to understand which factors foster or hinder certain traits of behaviour, and which others might be used to influence the types of behaviour that promise more healthy outcomes. As people's participation in their health care is more widely accepted as their "right and duty", research needs to identify strategies that will make it possible to translate this concept into sustained practice.

Health education, as a basic component of primary health care, must face up to the challenge of examining basic assumptions upon which it has operated in the past. It may well be that some of these assumptions are not compatible with enabling individuals and communities to take logical decisions regarding their own health.

The Technical Discussions emphasized that research in health education must be increasingly concerned with applicability, especially in the developing countries, and must be planned within the broader perspective of health systems research.

Scope of research

What are the fields in which research is most needed? Seen in the perspective of health education goals - i.e. encouraging people to want to be healthy, to know how to attain health, to do what they can individually and collectively to maintain health, and to seek help as needed - the issues inviting research become clear. They concern the values and knowledge that encourage personal initiative and effective communication between the lay public and health care workers.

The fact of wanting to be healthy has deep cultural, socioeconomic and political roots. While governments aspire for a healthy nation and individuals regard health as an asset, in the hierarchy of both national and personal values health rarely enjoys the position it merits. Despite its recognized economic and social impact, by and large health tends to be truly valued only when it has been lost.

In regard to this important issue, research is needed to determine how health can gain the necessary recognition at the level of the nation as well as of the individual and the community, as a value enhancing the social and political image of the country and the welfare of individuals. If findings show that it is difficult to promote health as a value by itself, then health may have to be associated with other values that the community appreciates, such as happiness, affluence and comfort.

The values, customs and practices that may influence health are deeply rooted in the social and cultural aspects of life. As these differ from country to country and even between communities in the same country, extrapolating findings from a specific cultural and political context into general rules tends to yield disappointing results. Research, therefore, must move away from concentrating on specific behaviours and must address the importance of "lifestyles" in the prevention of disease and the promotion of health. It is within the context of lifestyles that adherence to certain health practices becomes truly meaningful (77).

While knowledge is not the sole basis for healthy behaviour - as evidenced by smoking or over-eating among some educated individuals - it is nevertheless the sine qua non of health education. In the area of knowledge transfer, research is needed in communication, educational psychology and educational sociology. It should be designed to identify factors facilitating learning such as teaching methods, mass media techniques, conditions conducive to learning, opportunities for education, the role of the modern media (radio, TV, newspapers, films, posters) and of the traditional media (puppet shows, storytelling, dramas and songs).

Research dealing with individual action emphasizes self-care and its limitations in prevention, treatment and health promotion, while mutual-aid societies, self-help groups and community participation are at the heart of collective action. Research in this area is essentially focused on processes that foster self-reliance and is therefore both culture- and time-bound. It is also concerned, at the level of community action, with the different models developed to provide solutions (cognitive, behavioural, based on social interventions) as well as with the supportive role of regulations and legislation.

Research into seeking help is fundamentally a study of relationships: relations between the health care provider and the individual, which are influenced by the image of the health care provider, the confidence people have in his or her competencies, and the degree to which the community's felt needs are reflected in the services provided. This type of research is useful only if it is concerned with local situations, because relationships differ from community to community.

Applicability of research

In many countries, governments are now convinced of the need for greater emphasis on primary health care and health education; they are awaiting clarification of the theories which already exist before deciding on the appropriate strategies of health education to be supported.

It should be clearly recognized that any research carried out on processes of information and education for health should have immediate practical relevance for health improvement. As part of health systems research, its findings must serve to establish a better dialogue between health care providers and potential users, propose innovative or more effective ways of providing information and education, and bring about more efficient involvement of individuals and communities in the improvement and maintenance of their own health.

When research is aimed primarily at seeking solutions to problems encountered in programme implementation, simultaneous efforts must be made to develop adequate mechanisms to ensure that findings can become operational as soon as possible.

Extending the research potential

The limited pool of highly trained manpower for research in health education can be extended through the multiplier principle of transferring fundamental skills to practitioners in the field, provided that the expertise offered is focused on problems identified by the practitioners themselves and can therefore be of value to them in solving these problems.

Furthermore, numerous simple research tasks and fact-finding endeavours could be undertaken by non-professionals (63,67). Although some areas of research need rigorous, controlled methods, this is by no means universal. Much can be done - and should be done - by the community itself in terms of simple inquiries and observations, provided the people receive some training (see Chapter 4). Moreover, community self-studies are more likely to take into account values and social concerns.

A multidisciplinary approach

To be socially relevant, research in health education must not be the sole domain of "researchers". The people, health staff, administrators, politicians and the researchers themselves must all participate in the various stages of the research, ranging from problem definition, setting the hypotheses and deciding on methodology, to interpreting the findings and their application.

The collaboration of governmental agencies, educational institutions and nongovernmental organizations should always be planned from the beginning.

Some key issues for consideration

These include:

- the barriers to rapid implementation of research findings;
- the interplay of social, political and economic factors and their impacts at the level of planning, implementation and evaluation of primary health care programmes including health education as an integral component;
- the integration of health education in formal and informal community programmes at their earliest stage; and last but not least,
- the role of the health worker in helping community members to identify their health problems and design solutions, thus helping them to become their own agents for change.

NONGOVERNMENTAL AND VOLUNTARY ACTION

From the earliest stage of the formulation of the strategy of health for all, the World Health Assembly pointed to nongovernmental organizations as a key element in the implementation of goals. It is well known that in many countries it was voluntary organizations, such as parents' groups or religious or charitable organizations, which pioneered important aspects of intersectoral health education and care. Very often it is only after such organizations have led the way that municipalities and government departments begin to accept responsibility for these health activities.

Nongovernmental organizations provide a context that in many ways is ideal for involvement and for the growth and development of self-reliance in so far as they express the will of the people to use their own initiative in improving the quality of life. This will may be translated into pilot projects - often taken over and given wider scope by government agencies at a later stage - or activities to fill certain gaps or to supplement government action. The Seventh General Programme of Work specifically calls on nongovernmental organizations to channel their resources for health at every level into support of the strategy of health for all, to develop joint action with governmental agencies through technical cooperation, and to broaden their involvement in the implementation of health programmes, ranging from accident prevention, leprosy, cancer, sexually transmitted diseases or cardiovascular diseases to research on human reproduction and drug policies.

With regard to information and education for health, coordination is no less important in promoting acceptable self-care practices on the part of individuals and communities.

What policy measures would be of value to nongovernmental groups in meeting the expectations of governments and acting as partners in promoting health for all?

Three major types of supports, usually provided by countries, need renewed commitment:

- formal recognition of voluntary associations through appropriate legislation;
- recognition of their key role through official involvement in coordination bodies concerned with planning, implementation and evaluation of programmes;

- financial support through general subsidies or grants for specific programmes, whether these funds fully finance the activities concerned or supplement the funds provided by the voluntary organizations themselves.

Reports received from countries bring out one point: the concept of voluntary organization should not be limited to structured groups such as nongovernmental organizations or professional associations, service clubs, consumer associations, mutual-aid societies and so on, which provide an effective platform for reaching the grass roots; it should also embrace citizen groups or groups emerging spontaneously to cope with a pressing problem.

The important role of religions in health and health care permeates the history of mankind. It is natural, therefore, that professionals concerned with the improvement of health should turn to religious leaders not only to promote more active support on their part but also to offer them assistance in meeting training needs. In this respect, valuable experiences have been reported with regard to the training in health of Buddhist priests, Moslem leaders, and Christian clergy.

Certain participants in the Discussions stressed the need for governments to coordinate the work of nongovernmental organizations so that they supplement governmental action and do not enter into competition with it. In some countries this coordination already exists: the nongovernmental organizations act within specific areas and on specific tasks fixed by agreement with the national authorities.

On the other hand, other participants underlined the fact that in order to maintain the viability of the voluntary sector, official policy should be careful not to control it; the government's role is to provide a platform for coordination to encourage voluntary organizations, through financial or other forms of support, to encourage the community to take an active interest.

The consensus was that nongovernmental organizations should bear in mind government programmes when carrying out their own functions, without involving controls which would limit their initiative.

In order to put into practice the political will to involve the nongovernmental sector more closely in efforts to promote health, it was suggested that encouragement should be given to the creation of councils or federations of related nongovernmental organizations, with the aim of facilitating their participation and avoiding duplication of efforts.

THE ROLE OF WHO AND OTHER INTERNATIONAL AGENCIES

WHO as the international coordinating authority in health has the distinct role of coordinating, promoting, informing and cooperating with Member States, international agencies and nongovernmental organizations in the field of health education, especially as an essential element of primary health care. The mandates given to WHO by its Assemblies since 1949 in the form of resolutions relating to health education have indicated the type of activities with which it should be involved. These are mainly in the four areas of service, training, research and coordination.

In service, the role of WHO is to strengthen, upon request, health education services in the ministries of health and in other governmental services having health education functions. In training, the Organization is requested to facilitate preparation in health education of all categories of health workers and workers in other related areas who have health education functions. This, in collaboration with Member States, might be accomplished through such provisions as fellowships, study grants, seminars, training courses, and in-service training programmes. Continuing education also could be in the form of dissemination of knowledge and skills on a regular basis through provision of manuals, guides and audio-visual material.

In research, collaboration is needed between international institutions and organizations embarking upon health education research activities as part of health services research. Technical cooperation among developing countries needs strengthening to build a more generalizable scientific base for health education in these parts of the world.

In coordination, WHO has a leading role in collaborating with other United Nations agencies and nongovernmental organizations in promoting the policies and activities needed to attain the goal of health for all through primary health care. This necessitates the strengthening of WHO's collaboration with the agencies having specific functions in health education. Notable among these agencies are UNESCO, UNICEF, ILO, FAO, UNFPA and the World Bank. Among nongovernmental organizations, special mention must be made of the League of Red Cross Societies, the International Union for Health Education, the International Council of Nurses, International Council of Women and the nongovernmental organizations concerned with specific diseases or health conditions.

CHAPTER 4

THE CONTRIBUTION OF HEALTH EDUCATION TO THE STRATEGY OF PRIMARY HEALTH CARE: A PROPOSED PROCESS

In this chapter an attempt is made to identify some of the critical stages at which information and education for health of the three kinds identified in Chapter 2 can facilitate and reinforce the involvement of communities in health care and promotion and, through that involvement, help to ensure that the technology used is appropriate and the intersectoral approach is strengthened.

The process proposed has been illustrated in a graphic representation (see Figure 1) which reflects a dynamic interaction between local and central structures leading to increased community self-reliance and capacity for coordination of resources from all sectors. The 12 steps entailed in the process will be described in this section.

The new policies emanating from PHC concepts will encourage communities to go further than "participation" at the planning stage. They imply that communities should take the initiative by undertaking a self-study of their values and needs related to health, documenting needs and barriers, and deciding to which needs they wish to give priority. The encouragement and resources required for these first steps may come from within the communities or from outside. In either case, policy backing is a must at both national and local levels. A brief description of the initial four steps follows.

Step 1. The movement starts with the people: What are the problems they perceive?

The self-study process should address prevailing values and concerns for the quality of life or social problems as much as specific health problems. These problems will not necessarily correspond with formal epidemiological and socioeconomic analyses.

In the review of lessons learned from past experiences in community development and participation, the report of the 1977 UNICEF-WHO Joint Committee on Health Policy noted: "An approach based entirely on the identification of felt needs by the community overlooked the fact that the villagers' perceptions of needs did not necessarily correspond to the steps to be taken to satisfy those needs. Healthy children are commonly a felt need in all communities; but sanitary latrines, fly reduction and other environmental control steps that lead to healthy children usually are not seen as felt needs" (42, p. 13).

It is useful to understand this point from the start and to expect that the initial diagnosis by the community will focus on needs rather than on solutions. Sometimes the needs identified will be expressed as health problems, such as "sick children", but more often as quality of life or social concerns. Health workers should be able to link the quality of life concerns or needs to the health issues underlying them, resulting from them or relating to them.

Step 2. Do the needs identified in the self-study truly reflect the major issues felt by the community as a whole?

Felt needs should be verified and documented for the purpose, at a later date, of setting priorities. In smaller communities, this process can take the form of an opinion survey or a consultation by a village health committee. In larger towns and cities it may be useful to resort to sampling techniques to verify the distribution of the problems identified in the community and their relative perceived importance to the community's development or quality of life.

Step 3. What are the priorities?

With information in hand on perceived needs, communities are able to make preliminary decisions on priorities. Their choices will generally be among broadly defined classes of social or health problems such as infant deaths, teenage drinking, traffic accidents, zoonoses, malaria, diarrhoea and other such concerns. Sometimes the priorities may even be expressed in terms of symptoms (e.g. fever) rather than diagnoses (e.g. malaria).

At this point the process enters into a new stage: the dialogue with the professionals starts. How much do the felt needs of the community correspond to the epidemiologically assessed needs? Are they related to national priorities and programmes? What are the resources available for implementation: locally? from other sectors than health? from nongovernmental sources?

For the health professional this dialogue involves a number of challenges. Not the least is a willingness to recognize that locally identified priorities have validity and need to be accommodated in broad national schemes. Two-way communication skills are of special value in these dialogues which require negotiation rather than arbitrary imposition of objectives.

Step 4. Central support comes into play

Based on the community's expression of priorities, the responsible central or provincial agencies can, at this point, allocate resources and formulate a technical plan to help the community. Programmes or services delivered to the same community by other agencies of course need to be taken into consideration. New policies should not allow government agencies to interpret community involvement as an excuse to withdraw their support for local health services, or to pass on to the community their responsibility for the technical aspects of planning and delivery of services.

Functions of health education in this initial phase of process

- (1) Vis-à-vis the community: Health education has essentially a consciousness-raising role. Its major objectives are to facilitate access to health and related information; to develop community capabilities in problem identification; to help people set priorities among the different categories of problems they have detected, taking into consideration such factors as the magnitude of a problem and its susceptibility to treatment; and to promote a social partnership between lay and professional resources based on the recognition that both are essential and complement each other.
- (2) Vis-à-vis the decision-makers: Health education has an advocacy role in ensuring that programmes are built on the people's perception of needs, with priority given to goals which reflect both the felt needs of the people and the needs as defined by health professionals.

These various functions aim at predisposing communities for health action and are designed to crystallize the latent will of people to participate in improving their own health.

The next phase is concerned with implementation. Monitoring, evaluation, training and intersectoral action are its main features.

Step 5. Implementation starts; other sectors are involved; resources are coordinated

One objective, from the start, is to associate all potential resources and to achieve coordination. For countries in which programmes and services for health are more centralized, implementation needs to be coordinated among the various sectors which have a responsibility for primary health care. There is also the additional task of taking into consideration the activities of numerous nongovernmental agencies. For example, in one country it has been estimated that 950 organizations are involved in carrying out health education functions (40).

The mechanisms of coordination vary from formal coordinating bodies to informal meetings for sharing information. The initiative to establish and regularly use different coordinating mechanisms mostly lies with the official agencies at central, regional or local levels, but may also be the responsibility of a nongovernmental organization. Experience from some countries suggests that multisectoral coordination is more readily accomplished at the community rather than the central level, especially when there is a mixture of government and private resources for health being developed at the local level.

In any event, it is useful if the mechanisms set up for coordination of health education resources, channels of communication and delivery of services, follow the same pattern at the national and at the community level.

Although coordination is essential, it should be realized that overlapping is far from being always harmful. Sometimes, it may act as a reinforcement. Many voices transmitting the same message may be more convincing than one. Furthermore, coordination should not be equated with control.

Step 6. Action develops. But is the technology used deemed appropriate by the community?

Early in the implementation of plans, questions come up: do the services and programmes meet the goals and priorities set by the community? Is the technology suited to its circumstances? The people themselves can best answer. This first level of evaluation should therefore reflect the community's views.

This position represents a departure from conventional policies, but experience suggests that participation in evaluation is a catalyst for social action, even more powerful than participation in the administrative or management functions of implementation (30, 42).

Another advantage of community-level evaluation lies in the rapidity of the feedback. Those who are in charge are immediately informed of problems, such as inappropriate hours or location for the delivery of a service, readability problems with selected educational materials, the assigning of a male physician to a family planning clinic when a female physician would be preferred, a language problem, or a series of offensive questions in an interview schedule.

The ability to detect such problems lies within the capacity of most communities, with little or no outside assistance; and the ability to quickly make corrections lies within the administrative capacity of most organizations. This leads to a visible improvement which makes this level of evaluation highly rewarding for all concerned, and which therefore has strong reinforcing value as an educational process. Even if the changes are trivial in terms of health outcomes, they tend to be powerful from the standpoint of community attitudes and behaviour and, ultimately, of the successful implementation of programmes.

Step 7. How effective are the programmes? What are the changes occurring in the community?

Although this type of evaluation requires technical know-how, it is nevertheless important that it be placed under the control of the community concerned. There are three reasons for this. One is awareness of the benefits, which result from participation in evaluation, and the reinforcement this provides for continued involvement; a second reason is more effective communication between the people and the health personnel (49). A third reason is that the criteria selected have a better chance of being relevant to the recipients' goals and needs, as they perceive them. This more than compensates for the disadvantage of using methods that may be less rigorous.

On the matter of criteria, the 1977 report to the UNICEF-WHO Joint Committee on Health Policy (42, p. 14) noted that quality-of-life criteria "are of far greater concern to planners and developers than they were a decade ago". Nevertheless, until new policies for health education in primary health care gain full implementation, the danger remains to focus on "material improvements, which produce visible and quantifiable results", rather than concentrating on the development of "educated, self-reliant citizens, able to make decisions about their future, a notion that does not easily lend itself to quantification" (42, p. 12). Involving the community in assessing progress is very likely to focus attention on the quality-of-life criteria where it belongs.

Step 8. As progress is monitored, new needs emerge, unused resources are identified

The community now starts to perceive clearly the positive and negative aspects of the process, what needs are unmet, what barriers remain and what resources are still untapped. This takes the community to a new stage in the continuum of planning, action and evaluation. New ways are to be found to draw in other sectors that are not yet involved and to develop additional community skills to cope with the problems. In this process of learning, the people's sense of accomplishment grows, as does their self-confidence, their awareness of unused resources and their appreciation of intersectoral relationships (10).

Functions of health education at this stage

Vis-à-vis the community: The objective here is to build up the skills of the people and develop their self-reliance. More specifically, health education should help people set targets, offer alternatives to reach these targets, then assist the community in translating these targets into "simple, understandable, realistic and acceptable goals which the community can monitor" (50); health education should identify local cultural practices which lend themselves to certain modifications and build on these rather than promote alien practices (71); it should develop educational material relevant to the local culture and as practical as possible; finally, it should determine in which areas lay people need to develop their skills and to plan appropriate training activities.

Vis-à-vis the decision-makers: Health education has the responsibility, on the one hand, to interpret and document the short- and long-term benefits to be derived from community involvement in monitoring and evaluation processes; on the other hand, it should propose mechanisms to facilitate communication between the various sectors.

These functions aim at enabling action through a process of information and education involving various combinations of training, technical cooperation and community organization that led to a productive association of lay and professional resources.

Steps 9-12. The community studies barriers and resources and takes action; programme evaluation followed by intersectoral response

With its growing experience, the community is now able to move on to a more sophisticated level of community development, involving a new cycle of planning and action. As illustrated in Steps 9-12 in the graphic representation of the process (Figure 1), the community reviews accomplishments, determines unmet needs, identifies barriers and proceeds with action to achieve greater involvement from all sectors to help fill gaps (34,65,74).

The model guidelines make Steps 9 and 10 a process of identifying unused or undeveloped resources in the community, and increasing community self-reliance and capacity for coordination of multisectoral resources. Finally, in Step 11, the community needs policy support for its involvement in the more comprehensive evaluation of the multiple local and central programmes developing in the community. This will make it possible for central agencies (Step 12) to be advised by the communities in the gaps and limitations in the total package of services and programmes.

Such evaluation should not only take into account the differences between health criteria and social criteria, but should also give consideration to the technical criteria of agencies whose ultimate objectives for community development may be similar, but which use different means to accomplish these common ends.

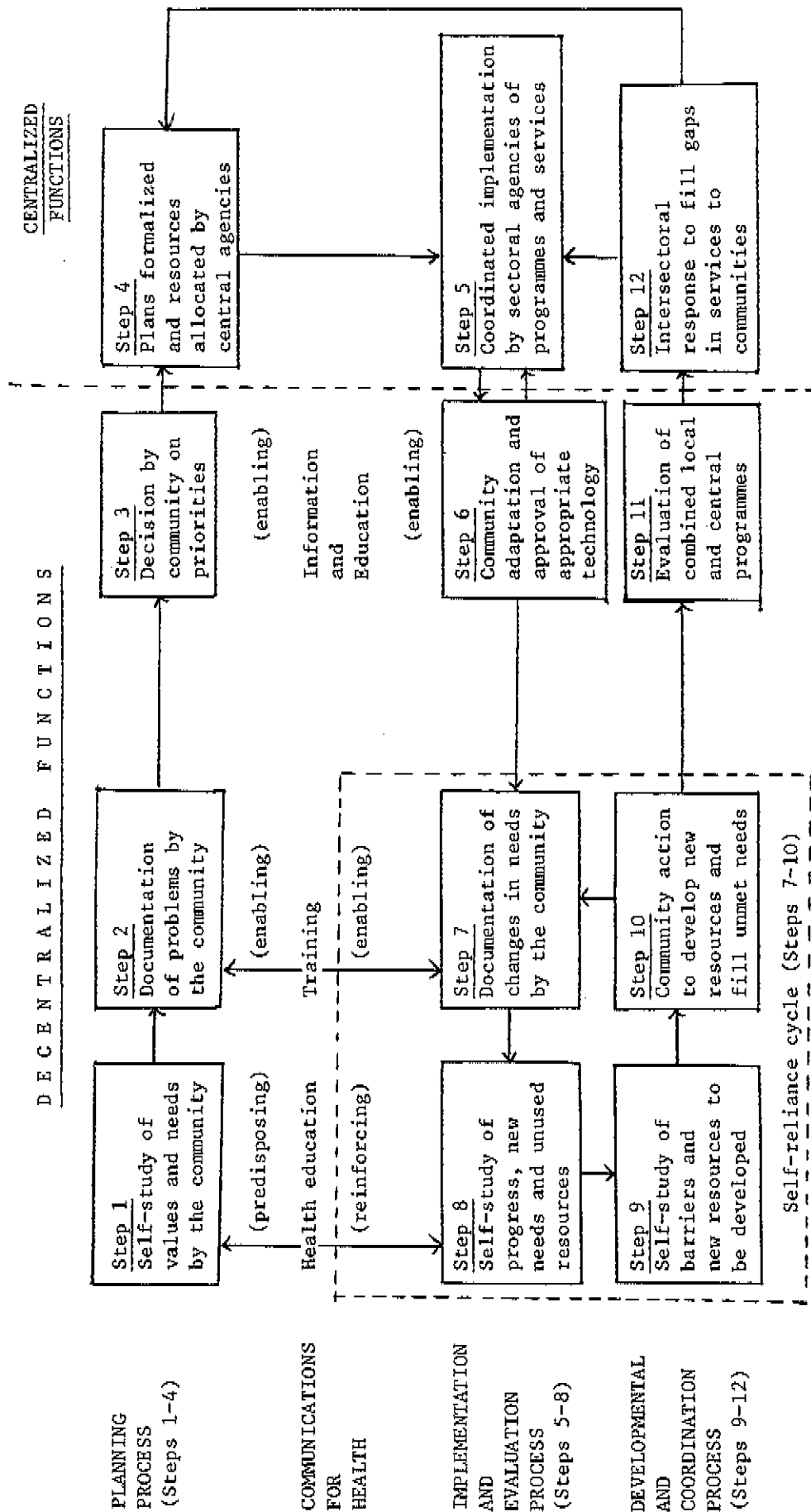
Role of health education in this cycle

Vis-à-vis the community: It should strengthen the process leading to increased self-reliance and healthy lifestyles by providing continual feedback on progress achieved; focus on the social supports to health, including organizational, economic and environmental factors; help coordinate and harmonize the health communications emanating from the various sectors so as to reinforce their total impact; provide training in health education to workers from other disciplines; encourage communities to develop funding schemes for health development (14,41); while at the level of individuals and families, it should encourage a similar process of analysis, priority setting, development of self-reliance and evaluation of progress.

Vis-à-vis the decision-makers: It should aim at the integration of education for health with suitable developmental activities in other sectors such as education, agriculture, industry, women and youth organizations and so on; it should provide evidence of progress so as to reinforce political commitment to primary health care concepts and support to the principles of community self-reliance and involvement; it should stimulate policy support for the type of research, training and media development that will enable health education to perform effectively.

This type of health education is essentially concerned with reinforcing the will of communities and of decision-makers to move toward a social partnership in planning and action for health.

Figure 1 : Steps requiring support of new policies for health education in primary health care to achieve community involvement, application of appropriate technologies, evaluation, multisectoral coordination and increased self-reliance.



RECOMMENDATIONS OF THE
TECHNICAL DISCUSSIONS
OF THE
THIRTY-SIXTH WORLD HEALTH ASSEMBLY

New policies for health education in primary health care must include clear, unequivocal recognition of the need for the active involvement of the community in health planning, and the implementation and evaluation of appropriate services and technology. Of the many recommendations suggested by individual participants, the following are the ones most generally applicable to policy everywhere, regardless of the stage of development. Even these few may need further adaptation to fit specific circumstances. To fulfil its task effectively, health education should receive a strong mandate from national policies which:

1. facilitate that type of institutional framework and the economic and legislative supports that will bring about an environment in which people can exercise their "right and duty to participate individually and collectively in the planning and implementation of their health care";
2. reflect a commitment to the equitable distribution of health and related resources;
3. recognize that health is not strictly a medical issue, but environmental, cultural, biological, social and economic as well, and provide therefore for the research, training and intersectoral cooperation necessary to develop health education and self-reliance in all aspects of development;
4. assure that there is a central unit within the framework of health services, staffed by specialists in health education with resources required to carry out its function, and placed on the same administrative level as other essential health services to permit access to all other units concerned with health education;
5. provide for the integration of health education, including the effective utilization of communication media, at those stages of the health care process - from planning to monitoring and evaluation - where the effective involvement of people and their increased self-reliance requires additional understanding and skills;
6. give full importance to the coordination of public information and education for health with education in general, recognizing that these must be mutually supportive;
7. assure that health education responsibilities are incorporated in the functions of all health workers, teachers and media personnel as well as related personnel in other sectors;
8. specify without ambiguity that the fundamental objective of information and education for health and of community involvement is to help each individual, each family, each community to exercise their right to achieve the harmonious development of their physical, mental and social potential;
9. recognize that this and other objectives of health for all by the year 2000 and primary health care, and consequently of health education, will not be achieved unless specific attention is given to the role of women in the promotion of health, and to their need for health education to perform this function.

For WHO, the recommendations made by the Technical Discussions reflect an endorsement of the new emphasis on information and education for health in primary health care by continuing and further strengthening activities in which WHO will:

10. collaborate with Member States in developing information and media that will heighten the sensitivity of decision-makers to the needs for health education and community involvement in primary health care, and help to strengthen the political will to support new policies on these matters;

11. cooperate with Member States in strengthening the health education services so that they will be able to assist all other services in their health education functions, recognizing that this will require the allocation of more resources within WHO staff;
12. facilitate community involvement in planning and evaluating primary health care programmes by developing guidelines, manuals and training materials disseminated to countries for adaptation;
13. strengthen intersectoral cooperation through continuing collaboration with UNESCO, UNICEF and the World Bank, FAO, ILO, UNFPA and other international organizations in further supporting health education in primary health care in all its aspects;
14. and regularly organize seminars, training programmes, workshops and meetings on health education on global, regional and national bases.

Some additional observations from the Technical Discussions

To implement the political will to support health education, several key issues need to be taken into consideration, in particular:

- the allocation of the budgetary and human resources is essential for the implementation of health education programmes;
- the support of political parties and of organizations connected with them at the national, provincial and outlying levels is conducive to the mobilization of potential resources and to coordination within and between sectors;
- the setting-up/or strengthening of an institutional framework at the national level, responsible for coordinating the planning, implementation and evaluation of national health education programmes, is essential;
- health education should not be used as a substitute for services that must be provided to the people, nor should health services be regarded as complete without an integrated health education component;
- poorly planned and non-integrated health education carries inherent risks of which health workers must be aware;
- health education should avoid promoting in people an obsession with health; nor should it attempt to say what "normal" health behaviours are and thus make people feel "deviant" or guilty;
- intersectoral cooperation can only be successful when good intrasectoral organization exists;
- our responsibility is to advance with the people and to provide them with information so that they themselves can protect their health;
- health care providers need to recognize that times are changing, people's attitudes are changing, our work and responsibilities are changing;
- research in industrial countries cannot be generalized to developing countries, so more research is needed in developing countries;
- the broadest possible involvement of traditional medical practitioners, community leaders, women's organizations, nongovernmental organizations, trade unions, business organizations, and the like is needed; although primary health care calls for the involvement of these institutions, existing policies are not always able to accommodate them;
- there is a need to develop, through an interdisciplinary approach, a global conceptual framework which would facilitate implementing, evaluating and tailoring policy and programmes of health education to local needs;

- health education must develop using criteria different from those that have prevailed for a long time - ones based on moralizing approach of "don'ts"; rather than attempt to understand the needs of individuals and communities and helping them reach goals of their own choosing, health care providers have tended to encourage people to want what they themselves felt they should want;
- an objective of health education is to promote an exchange between two cultures, that of the professionals, and that of the lay people, bearing in mind two things: firstly, that this exchange occurs with people as they are and not as the health professionals would like them to be, and secondly that any progress in the field of health is relative;
- a new image of health education must prevail, thanks to new approaches and new technologies involving both professionals and lay groups;
- health education is an interdisciplinary and intersectoral process that has as its final goal the promotion of health in its broadest context, i.e. not merely as a health phenomenon but as a social and cultural, an economic and technical, and finally a political phenomenon;
- health education should not promise more than it can attain; that said, it must be realized that the WHO Seventh General Programme of Work covering the period 1984-89 indicated that the role of information and education for health would be more prominent than ever before.

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