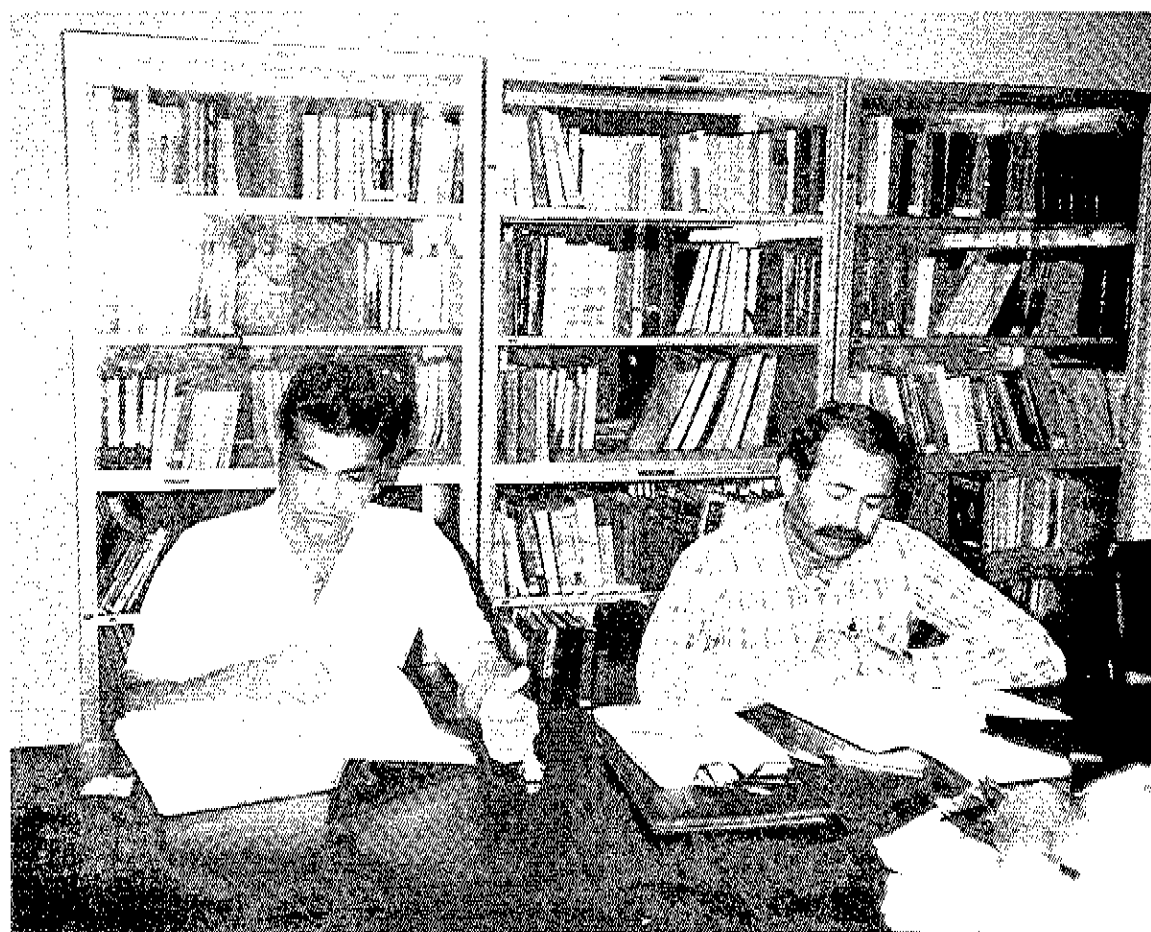


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HEALTH LEARNING MATERIALS FOR DEVELOPING COUNTRIES: THE CHALLENGE

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WORLD HEALTH ORGANIZATION

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The Nepal project mounts an exhibition to promote HLM activities

THE HLM CHALLENGE(1)

One of the most serious barriers to health care in the developing world is the lack of appropriate training materials for primary health care staff. Educational materials for health staff, as well as information for the promotion of health in the community, are essential components of the primary health care approach. They are vital for the continuing education of health personnel in service, for students in training and their teachers. They are also essential for community and religious leaders in other sectors involved in the promotion of health in the community, such as schoolteachers or social welfare workers.

Where teaching and learning materials exist, they are often of poor quality, out of date or not relevant to the local health care situation. Many of the existing materials are adapted or translated from texts produced in a developed country, where the health and health care situation is quite different, so they are not suitable for use in developing countries. Not only are vitally needed training and reference materials for health staff missing, but the skills and facilities to design, develop and produce such materials are mostly lacking in the developing world.

This is the challenge for managers and trainers of health care staff in developing countries, and for all those involved in delivering primary health care and in raising the level of health in the community. It is a challenge which has been taken up by the health authorities in a number of developing countries all over the world, with technical assistance and collaboration from the World Health Organization (WHO).

(1) The term "Health Learning Materials" (HLM) is defined as all those materials (text or audiovisual) required to meet a country's total needs for health teachers, learners, staff in the field and their continuing education, and for health promotion for the public, in line with the goal of Health for All by the year 2000 through primary health care.

A STRATEGY FOR NATIONAL SELF-RELIANCE

Effective primary health care depends on the training given to health staff such as doctors, nurses, midwives, community health workers and district health managers. To be effective, this training must be supported by teaching and learning materials such as reference texts, instruction manuals, teacher guides and audio-visual aids. The materials must be specifically designed and developed to meet the needs of teachers, students and health care staff in service, as well as the communities they serve.

A World Bank study⁽²⁾ published in 1980 concluded that "the textbook (defined as including all printed materials used in education) is the single most potent and cost-effective instrument for raising and maintaining academic standards." With this in mind, the problem of lack of training materials for health care staff can not be solved simply by sending textbooks, training manuals and reference books to developing countries. The needs are so great, in terms of quantity and variety of content, language and level, that a central distribution of training materials can never hope to be sufficient.

What is more, the training materials could not possibly be appropriate or entirely relevant to local needs and customs if they are produced outside the local situation in a developed country. Training and promotional materials for primary health care staff are best developed in the country where they will be used, so that they reflect the local language and culture, as well as national health needs. The only answer is to help developing countries to produce the materials they need themselves for their national staff, by designing them specifically for use in local conditions.

Each individual country needs to develop or adapt materials for its own use, not only because of differences in language and culture, but because the educational level of the staff and the tasks they perform differ widely from country to country. To be effective, this must be a genuine national effort, involving teachers and students of health sciences, supervisors of health staff and experienced field staff in service. If the target users of the materials are involved in their development, then they are much more likely to be committed to using them effectively. So the emphasis in developing a national project for the production of local training materials must be on national "institution-building", so that local skills and facilities are developed which will endure in the long term.

(2) Publishing for Schools: Textbooks and the Less Developed Countries. Washington, DC, World Bank 1980 (Staff working paper No. 398).

It is clear that, although developing country projects need financial assistance from external donors in the early stages of establishing a national project, the ultimate aim of any such venture must be to promote eventual self-reliance in the developing country. If there is to be a continuing supply of training materials to meet the needs of health staff for training and continuing education, and to respond to the changing priorities for health care in the community, then a national health learning materials project must develop a long-term capacity. This means using the skills of national staff, to design, produce and evaluate appropriate materials, and using local resources.

Short-term assistance from external donors will not provide a lasting solution, as no national skills or resources will endure after the withdrawal of external funds. So from the outset, the emphasis must be placed in the long term on the promotion of national self-reliance and on national institution building.



The primary aim of the Interregional HLM Programme is to promote national self-reliance through the strengthening of national institutions

OBJECTIVES OF THE INTERREGIONAL HEALTH LEARNING
MATERIALS (HLM) PROGRAMME

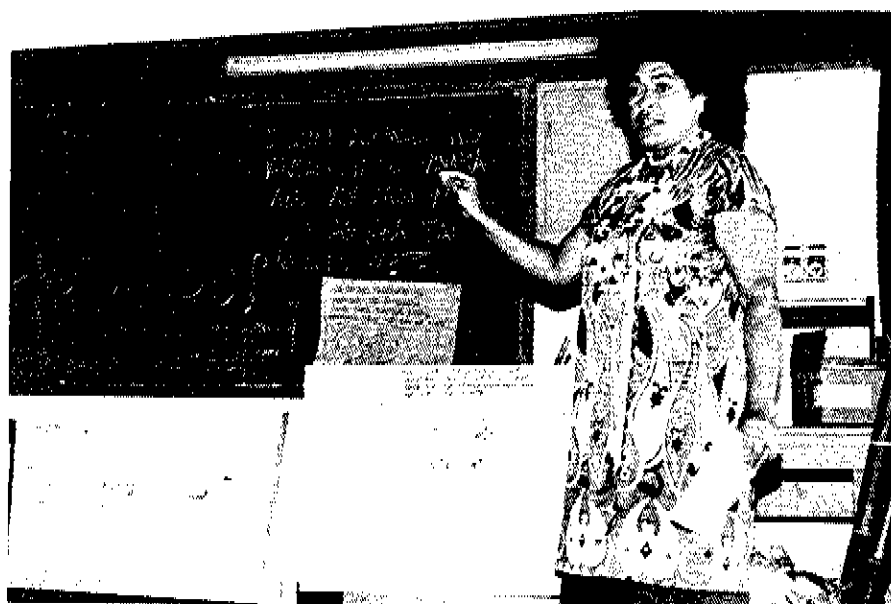
To meet the challenge of providing health training and information materials for the developing world, WHO, with the support of the United Nations Development Programme (UNDP) set up the Interregional Health Learning Materials Programme in 1981, with a central clearinghouse in Geneva.

The objectives of the Programme are:

- (1) to help developing countries to achieve self-reliance in the design, production and evaluation of health teaching, learning and information materials, for national health needs and in support to primary health care.
- (2) to encourage these countries to work together, pooling their resources and their experience in the development of HLM.

The primary aim of the Programme is to strengthen national training institutions in the health and education sectors in the developing world, thereby promoting self-reliance. The secondary aim is to encourage a spirit of collaboration amongst developing countries, by working together in intercountry networks towards the common aim of independent national capacity to produce educational materials for health.

In practice, intercountry collaboration and resource-sharing has proved to be an ideal mechanism for the promotion of growing national self-sufficiency in HLM development.



A health educator in Fiji developing health messages for the community

PUTTING PLANS INTO ACTION

In 1984 national HLM projects were launched in three developing countries: Kenya, Nepal and Sudan, with financial aid from an external donor, the Arab Gulf Programme for United Nations Development Organizations (AGFUND). These three pilot projects for the HLM Programme were started in countries where the lack of training materials for primary health care staff was a crucial problem. This provided an opportunity to test plans for national HLM development projects in practice.

National HLM projects are usually based in a health science training institution at university level or in the health manpower development or health education divisions of a ministry of health, or are part of a ministry of education. They operate as an integral part of an established national health or education infrastructure and not as independent "external" projects with external resources and expatriate staff. The emphasis is on the promotion of national skills and expertise, using locally available resources, with donor assistance in the early stages to strengthen the national institution and its key staff.

For each country project, the national government commits about one-third of the total cost of the HLM project and seeks external financial support, with the assistance of WHO, to acquire the equipment and specialist skills needed to build up an independently-functioning unit to produce training and information materials.

An investment in staff training is a vital element in all national HLM projects. Specialist skills are needed in writing and editing of training and communication materials, and in the design and illustration of educational texts and visual aids. Staff with printing and production experience are also important. Management skills for project managers are a special requirement, including the ability to promote HLM activities to international donors, other government institutions and the local community. Fundraising to support the development of HLM activities is a major component in managing a national HLM project.

Training of national staff is carried out locally as much as possible to ensure the relevance and appropriateness of the training to national staff needs and the local situation. In order to make most effective use of scarce funds and resources for training, joint workshops are often held for the staff of several neighbouring countries in the same language group. The African Medical and Research Foundation (AMREF), a non-governmental organization based in Nairobi, with broad experience in research and training throughout Eastern Africa, collaborates with the HLM clearinghouse in Geneva to organize tailored training courses for project staff in English-speaking countries.

For more specialist training and technical advice, particularly for project managers and senior HLM project staff, expert consultants are identified, and often financed, by the HLM clearinghouse at WHO Geneva to provide training courses and technical assistance in the developing countries.

Specialized courses in management or educational technology are organized by health science training institutions in developed countries. These are also sources of training for project staff, although they are obviously more expensive.



Training of nurses and other staff is carried out locally as much as possible to ensure relevance and appropriateness to local needs

THE TRACK RECORD ON THE HLM PROGRAMME

The early national HLM projects rapidly demonstrated that project plans to develop self-reliance in a truly national project were entirely feasible. They also showed that national HLM production is a tangible end-product which many international donors are interested in funding. International agencies and non-governmental organizations are attracted to the Programme goals of promoting self-reliance in developing countries, of strengthening the resources of national institutions and encouraging intercountry collaboration towards the common HLM goal.

Since the beginning of the Programme, donor funds have continued to be committed to national HLM projects and to new projects in developing countries where the HLM challenge is taken up by the national health or education authorities.

So far, with assistance from the HLM clearinghouse, all country projects have succeeded in finding an external sponsor to launch the HLM project and develop HLM activities. In times of financial stringency, when donor funds are more difficult to obtain, a measure of the viability and success of the networks of HLM projects must be the continued flow of external funds committed to the Programme.

An Interregional Meeting on Health Learning Materials organized by WHO Geneva in Arusha, Tanzania in December 1984 brought together project managers from nine national HLM projects, as well as non-governmental organizations and health science institutions involved in the Programme. It created an opportunity for HLM specialists to exchange experiences and review the status and progress of country projects.

Some national projects were in the early stages, conducting needs and resources surveys on HLM or acquiring equipment and training staff. Others were already relatively advanced and producing printed texts of training manuals.

The main emphasis of discussion amongst project managers was on the key issue of training for national project staff, through the use of consultants, workshops, on-the-job training and specially tailored study courses.

At this early review stage, the ideal of intercountry collaboration to pool scarce resources for training, and to undertake research and development of educational materials, was strongly promoted both by the central clearinghouse and by national project managers.

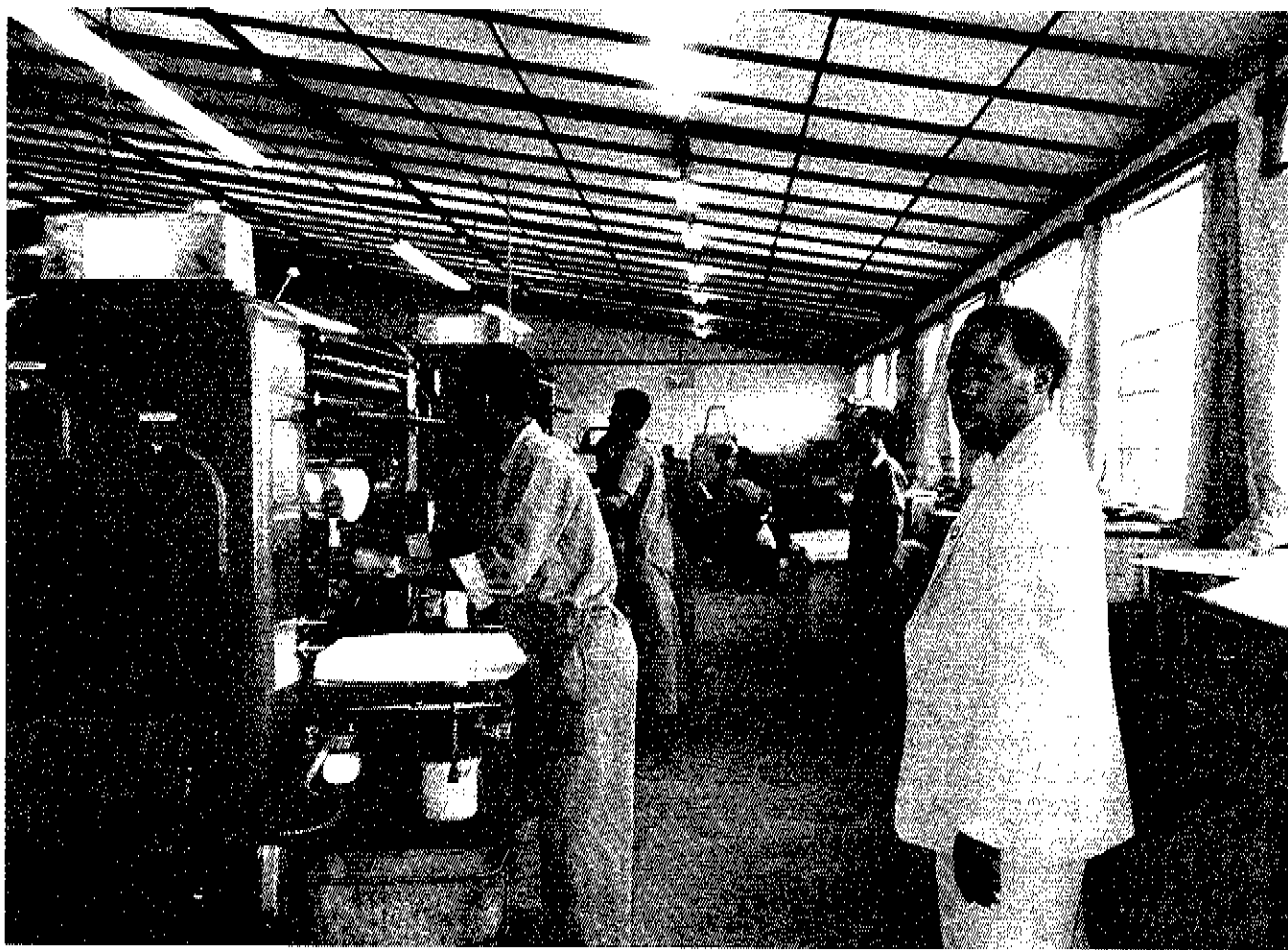
Following the recommendations of this meeting, the role of the central clearinghouse in Geneva was developed to function as a focal point for the identification, collation and distribution of information and materials and as a clearing mechanism to provide technical assistance in response to national developing country needs. WHO's role also focussed on liaison with donors, and the identification of expert consultants and training courses for national HLM project staff. Above all, the function of WHO's central clearinghouse was to stimulate national HLM activities and promote intercountry collaboration on HLM.

During the three years following the first review meeting, the number of developing countries which joined the HLM network more than doubled, with great success in attracting donor funds to the Programme. This was due both to the increase in public relations activities by the central clearinghouse, and to the growing sense of self-reliance and the promotion skills of country HLM managers.

Investment in training paid off, so that experienced project managers and key national staff with specialist skills were able to spread the benefits of their training and experience to other, newer HLM projects in the Programme, through exchange visits, study tours and joint workshops.

Four distinct networks of HLM collaboration emerged within the Programme, based on language groupings. The largest and most experienced network is English-speaking and developed in East Africa as a result of contacts and intercountry activities organized for Ethiopia, Kenya, Sudan, Tanzania and Uganda, with frequent exchanges with the English-language project in Nepal.

The French-language network was launched as an outcome of a workshop for writers and editors of French-language educational materials held in Rabat, Morocco in March 1986, which brought together francophone project managers from Bénin, Morocco, Mozambique and Rwanda. Mozambique has also emerged as the leading national project for contacts with other Portuguese-speaking African countries.



To achieve self-reliance, national HLM projects need to have access to a pool of trained staff, such as printing technicians

Representatives from four lusophone African countries, Angola, Guinea-Bissau, Mozambique and Sao Tomé and Príncipe, met in Maputo, Mozambique in 1987 to discuss joint activities on Portuguese-language HLM development. Although no actual network emerged for this language group, Angola and Guinea-Bissau opted to join the Interregional HLM Programme and Mozambique offered to train printing staff from other lusophone countries. There was also an exchange of Portuguese-language materials as models for adaptation.

Morocco, which develops Arabic-language materials for its rural health staff, is also a member of the Arabic-language network of countries in WHO's Eastern Mediterranean Region. A WHO-funded intercountry meeting for Arabic-speaking countries was held in July 1987 in Damascus, Syria, to promote the sharing of information and education materials in Arabic.

WHO's Regional Office for the Eastern Mediterranean based in Alexandria, Egypt, has operated a regional clearinghouse on health teaching and learning materials since 1986, focussed mainly on the development of Arabic-language information and education materials. This Regional clearinghouse has established a network of country focal points in ministries of health to identify and exchange appropriate model materials for adaptation by other countries in the same language grouping.

The regional clearinghouse in Alexandria is stimulating intercountry exchange and resource sharing in the HLM field, as well as collaborating on the Interregional HLM Programme with WHO's central clearinghouse in Geneva.

OBSTACLES AND STEPPING STONES
ON THE ROAD TO NATIONAL SELF-RELIANCE

A second interregional meeting on HLM was held in Arusha, Tanzania in March 1988 with HLM specialists from eighteen countries participating in the Programme. Project managers, WHO clearinghouse staff and NGO representatives exchanged experiences and ideas, reviewed progress in developing HLM projects and planned strategy for the future. Obstacles to national HLM development were discussed, as well as achievements.

Discussions and recommendations focussed on two main topics: technical aspects of national HLM production and the strategy for achieving national self-reliance.

In general, progress on many national HLM projects has been much slower than anticipated. Experience has shown that the preparatory stage for a national project, when staff are recruited, premises are equipped and project plans finalized, can last anything up to eighteen months, often before external funds are committed to the project. Donors like to see some evidence of a successful plan already in operation or some tangible evidence of the feasibility of a project before granting major financial support.

As a result of this experience, more recent project plans for national HLM units are smaller scale and less ambitious and costly. Practical feasibility is the aim rather than comprehensiveness. By starting small and building on achievements, a project can always submit additional project proposals for funding at a later stage.

Lack of funds is a common obstacle to self-reliance for project managers. Even after the initial preparatory stages, funds for recurrent costs must still be met for transport and communication, writers' and editors' meetings, for paper and other expendable supplies, and for staff salaries and continuing education.

Ultimately, all expenses for the national HLM project should be absorbed into the government health or education budget, but this can only happen gradually, with political support and planning for the HLM project.

Several experienced country projects, such as Nepal, Kenya and Tanzania, operate successful mechanisms to achieve financial self-sufficiency. The Nepal project manager has obtained government approval for the creation of a revolving fund for HLM production, augmented by sales of printed training and information materials to health staff and the public. The Tanzania project manager has developed skills in promotion and fundraising with non-governmental organization donors, to ensure support for the development of the national HLM unit.

The lack of foreign currency to purchase equipment and supplies abroad is another common obstacle. So management and planning skills play an important role in promoting national self-reliance. A more "business-like" approach to the management of HLM units is needed. Some project managers negotiate commercial contracts with international agencies such as UNICEF to design, develop or print posters, brochures or other printed material, with payment made to external dollar accounts. Other project managers conserve scarce foreign currency by developing detailed proposals to donors for grants of printing paper or equipment.

Many projects experience difficulties in recruiting and retaining national staff with specialist skills in HLM development and production. Government salaries do not attract staff with commercially applicable skills such as printing, computing and word-processing or illustration and design. Posts for such specialist staff often do not exist within the government health or education infrastructure and must be created and financed. A common problem for project managers is the loss of skilled staff to the commercial sector.

Project managers and central clearinghouse staff also felt that information on the effectiveness and impact of HLM produced is often lacking, because national projects do not fieldtest or evaluate materials with target user groups. This is reflected in the quality and usability of materials as well as their relevance to local health needs. Both the relevance and appropriateness of materials are matters of concern to HLM project managers and target users of the materials. A priority schedule of training and information materials needed for health staff and the community should be the basis for all national HLM production.

As a rule, country projects do not yet benefit enough from each other's experiences and achievements. There is room for great improvement in intercountry collaboration, both on national HLM production techniques and on mechanisms for self-reliance. The interregional meeting in 1988 showed that an exchange of experiences amongst country managers could produce immediate tangible results.

INTERCOUNTRY NETWORKING
AS A MECHANISM TO BUILD NATIONAL SELF-RELIANCE

Intercountry collaboration to exchange materials and experiences, share training facilities and maximize scarce resources is much discussed as a mechanism to strengthen national institutions and promote national self-reliance. On a practical level, however, training facilities and materials can only be shared amongst countries in the same language-group or within the same geographic area.

With this in mind, a "lead" institution was established in 1988 for the most active network in English-speaking East African countries, in the College of Health Professions in Nairobi, where the Kenya national HLM project is based. This "lead" institution will stimulate intercountry networking on HLM in Ethiopia, Kenya, Sudan, Tanzania and Uganda, and service new country HLM projects in Eastern and Southern Africa.

The networking functions of the Kenya "lead" institution are strongly supported by the Kenya Ministry of Health, which provides premises and administrative services for its operations. These include the promotion of exchanges of materials, staff and experience; the sharing of fieldtesting, evaluation techniques and training facilities; and the duplication and distribution of education and communication materials.

The Kenya "lead" institution will also develop an HLM resource centre for the five network countries. This centre will provide display, study and training facilities, as well as duplication, artwork and printing services for new HLM projects. It will be responsible for computerized cataloguing and dissemination of information on educational materials to participating countries.

This network, stimulated and coordinated by the Kenya "lead" institution is the model pilot scheme for future HLM networks. A similar six-country network of national HLM projects is planned for the Asia and Pacific Region, with the "lead" institution operating from the successful Nepal HLM project at the Institute of Medicine in Kathmandu.

The WHO Regional Offices for Africa and South-East Asia are both planning regional clearinghouses on HLM, along the lines of the WHO clearinghouse for the Eastern Mediterranean in Alexandria. These will work with WHO Geneva to support country HLM activities on a much closer basis, with more direct contacts with the developing countries themselves.

With the aim of promoting developing country self-reliance, WHO is endeavouring to de-centralize the "lead" functions of the central clearinghouse on HLM. The aim is to delegate responsibility to regional and intercountry clearinghouses in the developing countries. The intercountry clearinghouses should be based on institutions in experienced national HLM projects, which stimulate intercountry collaboration on HLM.

Operating mechanisms have still to be worked out and practical experience gained, but the Kenya "lead" institution and its network is the first step in the delegation of independent responsibility to developing countries for their own national self-reliance. The joint aims of the Interregional HLM Programme, formulated in 1981, are slowly reaching fulfilment.



The developing countries must now accept the challenge of self-reliance and take their own initiatives to achieve this end

DEVELOPING COUNTRIES TAKE UP THE HLM CHALLENGE

As more countries join the Programme, the central clearinghouse at WHO Geneva will gradually delegate its coordinating, catalytic role to regional and intercountry networks and their lead institutions, which are obviously closer to the developing countries and their needs.

WHO's task for the immediate future still will be to support current national HLM projects and assist new entrants to the Programme. WHO will continue to promote their independence, both financially and technically. Its function will also be to develop guidelines for country projects to help them achieve self-reliance and improve the effectiveness of national HLM production. The central clearinghouse will identify mechanisms for the financing and operation of the HLM networks, as well as organizing support from WHO Regional Offices and intercountry lead institutions.

The future of WHO's Interregional HLM Programme lies in the gradual devolution of responsibility to the developing countries themselves; this has always been the ultimate aim. What is more important, the developing countries must now accept the challenge of self-reliance and take their own initiatives to achieve this end.

REFERENCES

1. Alma-Ata 1978: Primary Health Care, Health For All Series No. 1, WHO Geneva (1978)
2. Publishing for Schools: Textbooks and the Less Developed Countries, World Bank Staff Working Paper No. 398, World Bank Washington 1980
3. Interregional Meeting on Health Learning Materials, Arusha, Tanzania 1984, Report, unpublished WHO document HMD/85/1
4. Project Formulation and Proposal Writing by Dr K. Janovsky, unpublished WHO document WHO/EDUC/87.187
5. Interregional Meeting on Health Learning Materials, Arusha, Tanzania 1988, Report, unpublished WHO document HMD/88.1