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NEW POLICIES FOR HEALTH EDUCATION IN PRIMARY HEALTH CARE

Outline of background document for Technical Discussions
Thirty-sixth World Health Assembly, 1983
and
Questions for consideration by Member States

WHC 1/3

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In preparation for the World Health Assembly Technical Discussions 1983, Member States of the World Health Organization are asked to provide information on their plans and/or examples from their experience with new policies in health education.

In this outline, it has been attempted

- (a) to define new policies as they relate to primary health care;
- (b) to review characteristics that may distinguish former policies from new policies;
- (c) to outline some of the issues to be taken into consideration in formulating country-wide policies in health education that will support the principles of community involvement, coordination among developmental sectors, and self-reliance.

These issues and others are presented then as questions to be considered by Member States as they examine their own policies in health education in primary health care (Annex A).

Comments, reports and case studies received will be used in preparing the background document for the Technical Discussions at the Thirty-sixth World Health Assembly.

1. PURPOSE OF THE TECHNICAL DISCUSSIONS

1.1 The challenge and the opportunity

The early successes of public health were achieved largely through environmental changes. Since then progress has depended increasingly on the initiative or cooperation of the lay public. Health education has been a primary means of achieving these attitudinal and behavioural requirements of successful programmes. As with other aspects of health care and other forms of education, 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 2000¹ is for Member States to engage all segments of the population in the development of primary health care,² which includes health education as its first and most continuous element.³

This was clearly set forth by the WHO/UNICEF sponsored Conference on Primary Health Care at Alma-Ata² as well as by a number of regional Technical Discussions and deliberations,⁴⁻⁷ by the First All-Africa Conference on Health Education⁸ and by numerous regional and international meetings and technical reports from international nongovernmental organizations.

The selection of "New policies for health education in primary health care" as the topic for the Thirty-sixth World Health Assembly Technical Discussions presents an opportunity for countries to examine their current policies and to share with others their reflections on the ways in which such policies are in harmony with the Alma-Ata Declaration² and the "Health for All by the Year 2000" strategy.⁹ This implies that such policies:

- support the principles of health education, community involvement, appropriate health technology, coordination between health and other sectors of national and community development, self-determination and self-reliance;
- provide for the institutional framework, economic supports, information systems, behavioural research, and distribution of resources necessary to assure that "individuals, families and communities can assume greater responsibility for their health and welfare".^{1(p. 17)}

Too little policy support, however, is given as yet to these essential aspects of primary health care and to the global strategy of health for all. This situation dictated the decision of the sixty-eighth session of the Executive Board, in January 1981, to select health education as the topic for the 1983 Technical Discussions.

1.2 Purpose of the Technical Discussions

The Thirty-sixth World Health Assembly Technical Discussions have the following purposes:

(a) short-term:

1.2.1 To elicit from Member States, primarily, information on their plans and examples from their experience, to be summarized in the background document and combined to provide useful models and guides.¹⁰

1.2.2 To invite and encourage governments to examine their current health education policies and objectives and the methods they use for involvement of particular population groups at the various levels and the implementation of a multisectoral approach.¹¹(pp 19-20)

(b) long-term:

1.2.3 To help Member States build or extend a basis for planning, management and evaluation of the health education components of their national and community programmes of primary health care.¹²

1.2.4 To direct special attention in the future programmes of WHO to the monitoring and evaluation of health education components of primary health care policies and national programmes, including the development of indicators and criteria of community involvement, health literacy,^a health behaviour, and levels of individual and family self-care contributing to health promotion.^{12,13}

1.2.5 To help WHO better understand the needs of Member States in order to plan the allocation of its resources accordingly and improve its technical cooperation in the field of health education.

1.3 Definitions and scope

The topic for the Thirty-sixth World Health Assembly Technical Discussions requires definition of three terms in the title, "New policies for health education in primary health care". The following definitions are proposed for these terms.^b

1.3.1 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."¹ (p. 14) The goals, priorities and methods of "new" policies to be examined in particular are those concerning health education, with emphasis on community involvement and self-help, appropriate health technology, political action and intersectoral cooperation.²

1.3.2 Health education: Any combination of planned "activities leading to a situation where people want to be healthy; know how to attain health; do what they can individually and collectively; and seek help when needed".³ (p. 13) It is the intent of this definition to emphasize that health education goes far beyond providing information or eliciting the cooperation of the people as in targeted disease prevention programmes. It also aims to help people "acquire the power to make decisions that have to do with their own health".⁹

^a This expression refers to the minimum level of health knowledge needed by people to identify their major health risks, to know how to modify those risks, and how to tap individual, family or community resources to prevent or control those risks.¹² (p. 29)

^b See Annex B, pp. 26-27 and 32 for a glossary of other related terms.

"Health education" is used in this paper to embody (a) activities that lead to information directed at both policy makers and 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;¹⁴ and (d) other forms of social action that predispose, enable and reinforce voluntary behaviour conducive to health.

It must be recognized 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, economic and environmental factors, social norms and customs, etc. The promotion components of health education programmes must therefore provide not only for the "adoption of beliefs, attitudes and behaviour likely to further health" but press as well for an environment which supports the development of such attitudes and behaviour.⁴ (p. 8)

1.3.3 Health education in primary health care: The Alma-Ata Conference officially declared "education concerning prevailing health problems and the methods of preventing and controlling them . . ." as "first" among the essential components of primary health care,²(p.4) and education to enable people to exercise and have confidence in their "right and duty to participate individually and collectively in the planning and implementation of their health care".² (p. 3)

Health education is not a separate activity in primary health care but a component of every activity, to be integrated at all stages of the health care process from planning through evaluation.

2. FORMER AND NEW POLICIES: BACKGROUND AND EXPERIENCE

We will attempt to review in the following pages some of the basic differences between former and new policies in health education before dealing under point 3, with the issues involved in developing new policies.

One of the main differences between the former and the new policies could perhaps best be illustrated by contrasting past and present focus which has shifted, at the level of the individual, from "how to act", i.e. the teaching of skills, to "how to be", i.e. lifestyles and values. At the level of communities and nations two main trends emerge: a greater breadth of objectives coupled with the search for effective ways to develop national policies based on community goals on the one hand, and an intersectoral approach on the other hand.

2.1 From specific to diverse objectives in health policies

Policies in health education have been most widely adopted by national governments during periods of mass campaigns against singular communicable diseases such as malaria and immunizable diseases or as a component of highly targeted programmes such as family planning.⁸ In these instances, the objectives of health education and indicators of success could be sharply defined even in quantitative and behavioural terms. It was therefore possible to be highly specific because:

- the prevention of the particular disease was a national priority and had broad consensus as a goal;
- there were specific actions on the part of the public that were known to be essential to the success of the national preventive effort - such as obtaining an immunization;
- such specific health behaviour could be directly measured from routine records kept at the point of delivery of services, so that indicators of progress were more easily available and attributable to the associated health education activities.

The very principles of primary health care on the other hand, make it harder to specify the more diverse objectives of communities in the health education component of national policy. It is generally agreed that health education is an essential ingredient of the strategies for community involvement and that it plays a central role in supporting the will

and the ability of people to pursue their own individual and collective goals for health and development. However, the apparent breadth and diversity of the health education role in primary health care has made it difficult for most countries to position health education within new health policies.

Different communities are most likely to have different priorities. These may not always be attainable 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 are taken through other sectors and are not necessarily part of the health system.

These aspects of the new policies highlight the fact that more political and technical effort will be required to achieve certain features of the health education component - e.g. local or national involvement, appropriate technology, focused individual and collective behaviour and evaluation. As health education activities become more diverse and comprehensive, cutting across sectors and agencies, they will be correspondingly more difficult to monitor and evaluate. Yet, some way must be found in the new policies to give sufficient specificity to the health education component of primary health care so that programmes can be monitored and their impact evaluated to satisfy decision-makers that allocations are accounted for and the new policies are yielding health benefits.

2.2 Specifying the health education component of primary health care

What must the new policies include? Health education in the new policies requires that decision-makers understand and accept the need to make as well provision for communities to define and pursue their own goals, to understand and mobilize their own resources, and to control and evaluate their own efforts.

It is not merely a matter of efficient transfer of information through institutional channels of communication.¹⁵ Effective education for action is widely understood to include a subjective element of personal and social involvement in and commitment to the objectives of education. 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".

This essential relationship between health education and the active involvement of people in setting their own goals and promoting their own health is not new. It was emphasized in the preamble to the Constitution of WHO¹⁶ and in the report of the first Expert Committee on Health Education of the Public, convened in 1953¹⁷ and has been reconfirmed as both a means and an end in several WHA resolutions and in every major technical report on health education.¹⁸⁻²⁸ However, so long as the targets were specific diseases, this involvement was far from always being a compelling aspect of national health policies.

Research on health education and health behaviour has shown that efforts to increase individual and community participation in the planning process has resulted in more successful programmes in both targeted disease prevention and more general community development programmes.¹⁹⁻²⁴ Research has helped to unravel the elements of effective health education within the context of primary health care,²²⁻²⁴ but most of this applies to local activity. A fundamental issue for Member States remains:

- how to specify national policy on health education for purposes of planning, managing, monitoring and evaluating the allocation of central resources without betraying the principle of community involvement?

This is not an ultimate dilemma once the upward process of community involvement has been built up to the point of providing continuous guidance to national policy from the grass roots. In fact, national policy should thrive on community involvement. But initially, national governments must take the lead in setting guidelines and providing support to local community involvement for health.

3. ISSUES FOR CONSIDERATION IN DEVELOPING NEW POLICIES FOR HEALTH EDUCATION IN PRIMARY HEALTH CARE

In order to assist and encourage Member States to adopt or strengthen health education policies that provide for both the national guidance and the local initiative in developing primary health care, guidelines that are adaptable within countries are needed. Such guidelines should emerge from the experience of programmes and projects that have addressed with some success the principles of participation and self-reliance through health education as well as the multisectoral approach.

Such experience is now being sought from Member States through their comments on the issues raised in Annex A and from the literature on health education, health behaviour and community development. Some essential features of these guidelines may be anticipated by referring to the principles of the WHO Analysis of the Content of the Eight Essential Elements of Primary Health Care,³ ^a the Regional Technical Discussions,⁴⁻⁸ the Expert Committee Technical Reports,¹⁷⁻²² and the "Health for All" Series.^{1,2,11-13,29,30} For example, the following features of the new policies will need to be considered:

3.1 Centring health education within health policy planning and implementation

The Director-General's report to the fifty-third session of the Executive Board of WHO concluded that "if health education is to play a more pronounced role in helping people to assert themselves and to make a favourable impact upon the health and social systems established for their benefit" then governments must:

make more effective the role and function of health education services of health ministries and related agencies in support of national, state and local health programmes. If the participation of the people is to be utilized for improving health services at every level, health education which serves to promote such participation should be central to the planning, organization and implementation of health policies and programmes.^{25(p.47)}

This would imply that new policies for health education in primary health care must place offices for health education in a central position within structures where health, education and other developmental policies are formulated and where other departments can have direct access to its services. At the same time, the new policies should reflect a provision for wider sharing of human and other health education resources in order to strengthen local level activity and assure that the population's needs are served and aspirations are taken into consideration more effectively. This relates to the second feature of new policies.

3.2 Enhancing local problem-analysis and decision-making skills

The methods of approach of health education under the new policies will be different from those of campaigns of the past. As stated by a recent Task Force report on health education in family health:

But by far the most exciting technical challenge is the need to adapt the educational approach to situations where the goal is to "go with the flow" of client educational demands without preempting the clients' choice of content or their judgement of benefits. This means being able to live with an educational approach that focuses on enhancing problem formulation and decision-making skills . . . The state of the art in this kind of educational approach is still in its infancy. There is a clear and urgent need to test new methods of client-oriented and community-oriented education that emphasize the growth of skills in self-determinism.^{24 (p. 4)}

^a See Annex B for the analysis of the health education component ("essential element number 1").

3.3 Balancing efficiency and diversity

The recommendations of past reports have tended to urge that "much more systematic, substantial and detailed consideration and support need to be devoted to the planning, organization and evaluation of health education . . .".¹⁹ The need for more targeted planning and evaluation is made the more pressing in that:

- (a) increased participation is to be expected from formerly underserved populations;
- (b) more diverse needs, goals and standards will emerge and result;
- (c) fewer resources are available to serve the health needs of large populations.

Thus, priorities must be set in the interest of efficiency, yet there must be provisions for diverse priorities among communities.

3.4 Reconciling national plans with local plans

In recent years the importance of decentralizing the managerial process for national health development has come to the fore:

A general process of decentralization of administration is occurring in many countries and must be accommodated within the managerial process. The current trend is to strengthen decision-making powers at provincial, district, and community levels. Parallel with this, appropriate community organization is needed for communities to become full partners in the health development process.¹¹ (p.16)

This trend highlights the need to specify further the process of education in relation to participation at all levels, i.e., how to reconcile the products of local participation in planning with the orientations and the timing of "the national health policies to be followed, the objectives to be attained, and related targets, quantified as far as possible".¹¹ (p. 34) Eventually, the synthesis of local priorities should dictate national priorities. However a complete range of mechanisms for involving the community in health management has yet to be developed in most countries. Until such mechanisms and the capacity for community involvement to influence planning at central levels are developed, national plans must be flexible enough to accommodate local plans that may deviate from them.

3.5 Reconciling social criteria with health criteria

The WHO "Guiding principles"²⁹ for health programme evaluation acknowledge the necessity of "social criteria" such as improved conditions of employment in addition to health criteria such as reduced age-specific morbidity rates. This suggests the need for guidance on how to derive or assess the local social criteria and how to relate them to criteria concerned with behavioural or health outcomes. The above-mentioned document reminds us that social criteria are difficult to quantify and that "it is therefore often necessary to resort to an evaluation based on qualitative rather than quantitative assessment".^{ib.} (p. 22)

3.6 Measuring community involvement and social criteria

Part of the restraint in suggesting quantitative indicators of social criteria and community participation is the concern that such quantification could turn a highly complex learning process into a superficial exercise in counting votes or the number of passive participants in meetings:

One further field should be mentioned which is important in view of the nature of primary health care as a path to health for all, but in which only qualitative indicators may be possible - namely, community involvement . . . The term "community involvement" has been given preference 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.¹² (p. 20-21)

On the "short list of indicators" suggested for use in monitoring and evaluation of the Global Strategy for Health for All by the Year 2000 is one indicator relating directly to the health education policies of Member States. It concerns the degree to which:

mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning, i.e. active and effective mechanisms exist for people to express demands and needs; representatives of political parties and organized groups such as trade unions, women's organizations, farmers' or other occupational groups are participating actively; the decision-making on health matters is adequately decentralized to the various administrative levels.¹³ (p. 75)

As a first step in formulating more specific criteria in relation to this and other indicators, countries might want to estimate the percentages they would expect to achieve in connexion with each of the types of participation mentioned above,^{30,31} as well as outline short- and long-term plans of action. As proposed in the Seventh General Programme of Work for WHO:

Indicators will be used at the global level that are useful first of all at the national level; a number of such indicators have been selected based on national and regional strategies.¹² Regions and countries will add additional indicators if necessary in the light of their specific circumstances. During the period of the Seventh General Programme of Work (1984-1989) particular attention will be paid to those indicators which demonstrate the extent to which countries have developed strategies for health for all and to which primary health care is available to their people.³¹ (p. 135)

3.7 Measuring the diffusion of health knowledge

Health knowledge is the foundation upon which community involvement must be built. Some guidance on evaluation of this health education component is found in the WHO document on Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000 in which it is observed that:

It would be useful to have an indicator of health literacy but as yet no such indicator exists. Some suggested indicators of the effectiveness of dissemination of information for such an educational process might be the number of mass-media outlets . . . the extent to which health information is actually disseminated through them . . . indicators of access, such as the proportion of the population owning a radio or television set or reading newspapers . . . political parties, women's organizations, schools, farmers' associations, etc. The only way of assessing "health literacy" is to carry out community surveys. It must be emphasized, however, that a high degree of understanding of health problems and ways of solving them is not in itself an indicator of attitudinal and behavioural change. Such changes are not easy to measure: they, too, would have to be assessed by community surveys.¹² (p. 28)

This basic level or "floor" of health knowledge is needed by individuals, families or communities to be able to exercise their "right and duty to participate individually and collectively in the planning and implementation of their health care".² (p. 3) The methods of achieving this basic level of knowledge¹⁵ and the indicators involved will vary from country to country and from community to community. Therefore work is needed on the development of diagnostic tools that can be easily adapted to the conditions in different countries and easily applied by lay populations to assess their health education needs.³⁰

3.8 Reconciling health objectives and other developmental needs

Finally, there is the question of how health relates to other social and economic developmental objectives and perceived needs in the eyes of the community. This issue bears most heavily on new policies of health education in primary health care because the intersectoral planning, management and evaluation of health education will be compounded with community involvement as follows:

- the involvement of communities in developing their own objectives and priorities will blur the lines of demarcation between sectors assigned health education functions in national policy;
- the articulation of mechanisms for coordination of health education resources, channels of communication, and delivery of services at the national level will be reflected in part in the mechanisms set up at community level;
- the evaluation of health education will take into account not only the differences between health criteria and social criteria, but also the differences with the technical criteria of multiple agencies whose ultimate objectives for community development may be similar, but whose means of accomplishing these common ends will differ and even compete or conflict.

4. PLANNING FOR THE THIRTY-SIXTH WORLD HEALTH ASSEMBLY TECHNICAL DISCUSSIONS

In order to gather the necessary information from Member States on the basis of which the background document can be completed as a useful guide to the Technical Discussions, Annex A lists questions that countries are invited to consider in reviewing their policies for health education in primary health care. Annex A has been developed in consultation with WHO Regional Offices. Along with comments on the issues raised, case studies and examples are solicited from Member States. Some already have been forwarded to WHO headquarters by Regional Offices but more are needed.

Responses from the Member States will provide a springboard for the Technical Discussions at the Thirty-sixth World Health Assembly where participants will be asked to address various aspects of the general question at the heart of the problem:

how can specific objectives, methods and indicators for health education be integrated in national policies and plans in such a way as to:

- (a) encourage particular population groups to set their own objectives in the spirit of community involvement, self-reliance, and a multisectoral approach in primary health care?
- (b) provide the necessary support and backstopping?

Furthermore, the background document will propose for discussion guidelines for the development of new policies for health education in primary health care. These will provide suggestions for assessing national and community needs, and for planning, managing and evaluating health education; they will address the potential conflict between national and local objectives, between specific targets and diverse perceptions of need, and between the methods, procedures, criteria and indicators of the health and other developmental sectors. They will also cover such key issues as the orientation and training of policy makers, health administrators and health workers to new roles of health education; the placement of health education in ministries of health and in other sectors; information systems; and community participation in monitoring and evaluation.

Finally, countries will be asked to examine what actions the World Health Organization should envisage for health education in primary health care.

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ANNEX A

NEW POLICIES FOR HEALTH EDUCATION IN PRIMARY HEALTH CARE

Guide for analysing the issues involved

Many countries have already provided WHO with valuable information on their health education programmes and activities, but relatively little data on their policies for health education within the primary health care strategy and the process involved in formulating such policies.

The questions that follow are not intended as a formal questionnaire. They are merely a guide that countries can use in considering the many facets of this broad theme. Their purpose is:

- to encourage countries to review critically the current situation and to involve as many groups as possible, at all levels, i.e. local, provincial and national, in discussing the key issues involved;
- to elicit from each country comments, reports and other relevant material that will serve to prepare the Background Document for the Technical Discussions in 1983; of particular importance are case studies which show how a specific project was developed and the policies implemented.

These data will serve to accelerate the exchange of experiences and views among Member States and facilitate more effective planning, management and evaluation of the health education component of national and community programmes of primary health care. They will also help WHO and other international organizations to better understand the needs of Member States in this regard and to plan their resources accordingly.

Please feel free to comment on other areas than those suggested in this guide, and refer appropriate questions to other ministries or agencies with responsibility for key components of health education.

Thank you for your collaboration.

1. Development of health education policy in the health sector

1.1 Is there any recent statement of policy in legislation or official government documents affecting health education in the spirit of the Alma-Ata Declaration emphasizing community involvement and giving priority to health education? If not, is your government planning to issue such a statement and when do you envisage doing it?

1.2 What are (or will be) the main principles of such a policy? For example, is emphasis placed on:

- development of human resources, i.e.:
 - (a) training of health and other workers (teachers, agriculturists, etc.) in the effective use of educational, organizational and other measures which support behaviour conducive to health; and
 - (b) determining the skills needed by these various workers in fulfilling the health education component of their particular role?
- efforts towards development of PHC approaches e.g. self-reliance of the family and recognition of its major role in promoting health?

Note: An asterisk indicates that Member States are asked kindly to supply samples of most recent, representative reports or tabulations; or copies of questionnaires or record-keeping instruments. Some policy statements may not be in official documents.

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- increased administrative support for health education? If not, why?
- behavioural and other research, aimed at achieving a better understanding of the causes of health problems and possibilities of their resolution through the promotion of appropriate lifestyles?
- priority research requirements - e.g. priority accorded to basic, operational or evaluative research relating to health education?
- developing effective ways of reaching children and adolescents: Through health education in schools? Through youth movements? In the work setting? Through other channels and if so which ones?
- see Annex B for additional points on which you may wish to comment.

1.3 What is the process through which policies are developed at local, provincial and national levels in your country? Does the government envisage to strengthen/modify this process?

1.4 What are the major problems and constraints that confront the government in the development of health education policies?

1.5 What percentage of the budget of the Ministry of Health and other ministries is spent on health education activities?

1.6 What is the position of health education in the ministerial structure? What is the staffing position? Is the government planning any changes?

2. Basis for health education policy development

2.1 What are the five main problems affecting the population in general, or certain sub-populations (e.g. schoolchildren, specific occupational groups, working children, deprived populations, etc.) which call for the initiation or strengthening of health education interventions?

2.2 Are the available data on the magnitude and distribution of such problems adequate as a basis for developing health education policies?

2.3 Which institutes/agencies collect and analyse information on the nature and distribution of the health and social problems calling for health education interventions in your country? What is being measured? How is this information used to affect change in policy?

2.4 Are there any instances of studies or assessments of health education needs?*

2.5 What criteria do you take into consideration in delivering the health message and selecting media that will facilitate implementation of PHC policies, i.e. promote political commitment and people's involvement, help to reach the more isolated groups and those in greatest social need, etc.

3. Coordination with other sectors and non-governmental institutions

3.1 Is there a formal plan for the coordination of health education activities in the health sector with other governmental sectors (e.g. information, education, community development, youth, labour, agriculture, etc.)?

3.2 Is there a structure, such as an inter-agency commission, that brings together representatives of various ministries for discussing the planning, implementation and evaluation of health education interventions in the various sectors; formulating appropriate recommendations; and ensuring follow-up of proposed action?

*

Please supply sample documents if available.

Annex A

3.3 What type of coordination exists and at what level between official and private organizations with regard to health education activities and policy development?

3.4 What is the respective role of the Ministry of Health and other ministries in these and other intersectoral health education efforts?

3.5 What are some specific problems encountered in attempting to coordinate health education activities with other sectors? With non-governmental groups?

3.6 With which ministries/organizations do you find cooperation most effective? Why?

3.7 What are some of the most important groups (health, welfare, commercial, industrial, etc.) which carry out health education programmes? How does this affect the overall health education policies in your country?

3.8 Are there any codes on the advertising of products that may affect health adversely.*

4. Content of health education policies

4.1 With regard to the content of new health education policies, are there any new written goals or objectives specifying the outcomes expected from health education?***

4.2 What steps has the government taken or is planning to take towards:

- analysing the role and place of health education in the existing public health policies with regard to PHC?
- placing health education services centrally in the health and development structures in addition to, or rather than, situating them in separate ("vertical") programmes?
- promoting a multidisciplinary approach to health education?
- developing indicators and providing for continued monitoring of the situation and evaluation of effects of action attempted?
- making health education an integral part of the school curriculum?
- encouraging non-governmental organizations to be active in health education? What type of support is provided?
- developing cooperation with the media in view of their extensive and sometimes free contribution to the health education programmes in primary health care?
- assuring the validity of the health information published in the press or broadcast on radio or television?
- developing or strengthening a national resource-base concerned with new approaches in primary health care and able to provide health workers with reliable information and methodological advice?
- encouraging families to develop their capacity for initiative through self-help or neighbourhood groups?
- developing or strengthening relationships with women's movements, youth groups, cooperatives, religious groups, movements concerned with the protection of the environment or occupational safety, etc. to enrol their support in PHC?

* Please supply sample documents if available.

*** Please supply documents or samples.

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- developing applied behavioural research programmes?
- others?

5. Involvement of communities in policy development

5.1 Is there - outside of parliamentary structures - a formal mechanism for accommodating local community health objectives or population sub-group concerns into the national goals, priorities and implementation plans? How does it operate?

5.2 Is there a mechanism to ensure participation of representatives of local communities in the planning of health education programmes in PHC at national level? How does it operate?

5.3 What are the constitutional or administrative provisions which facilitate the implementation by local government or other community-level organizations of the primary health care approach, in particular the involvement of people?

5.4 What mechanisms of communication with the people are used by the local officials or leaders to set priorities on health matters?

5.5 What guidance (e.g. documents) or support in health education (e.g. financial resources, media, consultation), is available to local communities from the national level and how is this transmitted?

5.6 What barriers and problems have you overcome or will you need to overcome to further new policies of health education in primary health care through the development of community involvement, self-reliance and multi-sectoral cooperation?

5.7 Have state or local agencies or institutions within your country carried out community surveys of health behaviour, or studies of health education interventions? * What is done with the collected information?

6. Areas of focus for WHO collaboration

6.1 In what areas do you feel WHO collaboration would be of value in promoting health education within PHC:

- review of training programmes in health education at various levels of basic education in primary, secondary, technical schools or at university?
- development of teacher training to prepare teaching programmes and teachers in health education in PHC?
- promotion of continuing education by organizing seminars, workshops, etc. and issuing publications?
- further development of technical cooperation in the field of health education in PHC among countries, particularly between countries with similar patterns of development problems?
- development of regional and interregional networks to link major programmes and institutions dealing with health education in PHC?
- research and development on methods to promote community involvement and other aspects of health education in primary health care?

* Please supply documents or samples.

Annex A

- further development of appropriate mechanisms to facilitate the dissemination of programme evaluation and research findings with a view to improving practice?
- review of the role and content of communication for health and its potential in the light of new technologies applicable in settings at different levels of development?
- other areas for WHO collaboration?

7. In Summary: What is the most urgent action to be taken in your country?

EXCERPTS FROM
ANALYSIS OF THE CONTENT OF THE EIGHT
ESSENTIAL ELEMENTS OF PRIMARY HEALTH CARE

Final Report to the HPC
by the
HPC Working Group on PHC
10 August 1981

Annex B

PREFACE

This document attempts to analyse in matrix format the desired or required "programme content" of the eight essential elements* of primary health care at the four basic levels: the home, the community, the first health facility and first referral level. Prepared for use within WHO in the first instance, it is fully appreciated that the finalization of the document must result from experiences gained in the practical integration of the different activities in country settings; but, even so, the document in its present form can be useful at the country level for the planning and management of PHC/HFA strategies.

Part I consists of an introductory paper, explaining the conceptual framework within which the work was carried out; a brief paper defining the four levels of care and the persons involved at these levels; and lastly, a set of narrative summaries which complement the matrices. Part II is a detailed analysis, in the form of 10 matrices, of the type of activities and tasks that have to be carried out at the four levels, of the persons or professional categories that will be involved and of the type of support or material they will need. Two of the elements (prevention/control of locally endemic diseases, and appropriate treatment of common diseases/injuries) have each been exemplified by two matrices (malaria and hypertension; diarrhoeal disease and accidents in the home). The matrices can serve the purposes of a "check-list" to assist in the analysis of the content of programme delivery in individual programmes.

It is fully appreciated that the analysis so far carried out has a number of limitations and weaknesses: several important health programmes have not been included (respiratory tract infections and health of the elderly, to mention only a couple); the contributions from sectors outside health have not been exhaustively dealt with; and no attempt has yet been made to "merge" horizontally the eight elements at each level. To reiterate, the latter activity can only be meaningfully carried out in a concrete country programme situation with defined infrastructure, policies and priorities. The intention is, therefore, to use the feedback from the use of this document in countries to update the content and refine or modify its structure.

*Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 1978. WHO, Geneva, 1978. These excerpts include the matrix for only the health education element.
Geneva, October 1981

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EXPLANATORY TEXT CONCERNING THE WORK
OF THE PRIMARY HEALTH CARE WORKING GROUP
SET UP BY HPC

I. INTRODUCTION

1. The purpose of this paper is to explain the way in which the Working Group set up by HPC interpreted its terms of reference, how it tried to implement them and the conceptual basis of its work. It would be recalled that at its 220th session, the HPC had recommended to the Director-General ". . . that an HPC Working Group be set up as soon as possible after discussion with Director SHS to examine how the essential elements of primary health care are and/or should be related . . .". The Director-General had commented as follows: "Please let the Working Group . . . deal with substance and not with theory so as to permit the group to identify options available to us and thereby to countries in building up their PHC system through pragmatic and progressive integration of at least the essential components specified in the Alma-Ata Declaration". These comments were taken to mean that as a first step a programmatic analysis of the essential elements of primary health care would enable WHO staff to comprehend the implications of health care delivery at this level of a comprehensive health system. Subsequently, through practical integration of the main tasks the difficulties and, therefore, the options for pragmatic technical cooperation at the country level would become more evident.

2. In this perspective, it was felt that the use of the matrix format would allow the identification of the main tasks involved in programme delivery at the various levels of a health system based on primary health care, the persons responsible and the skills required for the fulfilment of these tasks; and other modalities such as supplies and equipment, logistic support and community interaction. Put another way, the matrix format was used as a process of "thinking aloud" with the specialist personnel concerned with each programme element and guided, to the extent possible, by past country experiences (the 10 matrices that have been developed are annexed as Part II of the Working Group's report).

3. Therefore, in this first phase of bringing together a lot of what was already known, it was necessary to tackle each programme vertically - this being an indispensable building block to a second phase involving the integration of activities. Indeed, working with the different programmes directly concerned with primary health care, there could hardly have been an alternative basic approach. The matrices should, therefore, be seen in the context of a "document of content" to facilitate integration and to permit cross-checking and updating of information concerning programme delivery at the country level.

4. After finalization of the matrices, it was felt appropriate to produce a three-page summary of each matrix in narrative form. These summaries complement the matrices in so far as they are intended to elucidate the conceptual framework underlying their preparation.

II. PLANNING AND MANAGEMENT OF PRIMARY HEALTH CARE

5. It is not the mission of this explanatory paper to discuss at any length the complexities of "planning and management" with regard to health care delivery at country level. This notwithstanding, it is necessary to touch on some important points the negligence of which tends to strangle genuine efforts at the creation of efficient and effective health care delivery systems.

The meaning of primary health care

6. The Working Group used the definition of primary health care that was elaborated in the Alma-Ata Declaration. It saw the fundamental difference between primary health care and basic health services as the focus of the former on the "consumer" of health care delivery systems (therefore on his/her immediate needs and his/her active involvement) and on the multisectoral approach to health development - health benefiting from, as well as contributing to, overall

socioeconomic development. In addition, primary health care is not seen as an entity in itself; but as an integral part of the comprehensive health system in any country (it being the first point of contact in most rural settings and urban slums) and being closely related to and supervised and supported by, higher levels of the system.

Planning and management

7. The planning and management of health care delivery in any country is directed from the central level. This is as it should be, but there is always one fundamental shortcoming, and that is, the almost complete absence of decentralization with little focus on the peripheral services and the lack of involvement of members of the communities to be served and of non-health sectors with direct relationship to national health development. WHO has recently developed a process entitled the "Managerial Process for National Health Development" (MPNHD) for use in countries particularly preoccupied with the implementation of their policies and strategies for primary health care. WHO has a duty to help train national personnel in the practical application of the process at all levels of the comprehensive health system for the process is not only a national responsibility but also has to be applied with a great degree of flexibility. Once the work of integration has been finalized, the matrices can contribute to what should be a learning-by-doing process.

8. It is not intended to go into the catalogue of problems that will be encountered in countries in the practical implementation of programmes concerned with primary health care. Mention should however be made of the spectrum of difficulties that was taken into consideration during the preparation of the matrices. It includes: lack of appropriate political commitment and clear policy formulation, inadequate problem definition (unavailability or improper use of data) and selection of priorities in the face of limited resources (human, financial and material), lack of identification of resources (internal and external), non-definition of realistic indicators of progress, lack of target setting and of channels/mechanisms for constructive dialogue with the communities and the absence of continuing evaluation of these mechanisms and of the effectiveness of programme activities. Some of these constraints will be dealt with succinctly.

9. Political commitment is all too often taken to mean the commitment of the Head of State, or of the topmost executive authority within a country. This commitment is, of course necessary; but of much greater importance is the commitment of the masses themselves that is necessary to galvanize them into action, for without this, primary health care then becomes an empty slogan. This is the real litmus test of commitment at the country level and it is because of this that an awful lot of work still needs to be done in different settings to understand the inner dynamics of community involvement.

10. As regards resources of all kinds, it must be realized that for some time to come there will always be a shortage. In this connexion, mention must be made of the "reallocation of resources" that has been talked about over and over again. In certain settings, reallocation of resources is an urgent need; in others, and indeed the majority, it has to be admitted that it is just simply impossible as the centre itself is already stripped to bare bones, and any form of reallocation is an impossibility and therefore a myth. However, it should be possible to allocate any additional resources (largely external) to primary health care.

11. It is difficult to discuss the problem of resources for primary health care without making a passing reference to capital and recurrent costs. For a large number of countries, a significant proportion of the capital costs will have to come from external sources. On the other hand, if primary health care is to be a going concern in any country, in the long run the recurrent expenditure must be generated from within the country itself. The realization and acceptance of this fact from the very outset is of crucial importance. From it stems the need, indeed the imperative that leaves no option but to think of the utilization of available human resources (community health workers and traditional birth attendants) that can be paid for in cash or kind by the communities themselves; of technologies that are socially and culturally acceptable, of low cost and of high relevance technically; of appropriate

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communication systems that can cut down on the needless dissipation of human effort and the wear and tear of limited transportation; and the definition of national drug policies including appropriate storage and distribution systems.

12. Thinking exclusively of the different levels of primary health care, there are other important subjects that should be addressed and that call for constant vigilance if success is to be achieved. These include training and retraining of personnel by higher echelons in the comprehensive health system, continuing supervision and support, provision of appropriate supplies and equipment, and last, but by no means least, provision of the necessary logistic support. By way of example, such "mundane" subjects as the human interaction between a professional and a traditional birth attendant, the redesignation of tasks for health and other personnel, the regular controls necessary to ensure that vital supplies are always available, and the organization of vehicle maintenance to ensure their constant road-worthiness, often make for the success or otherwise of health programme delivery. In short, if a health system based on primary health care is to function properly, there should not be an over-concentration on what can be called the sophisticated aspects of health care to the total exclusion of these fringe, but very important, prerequisites for success.

13. These and other problems closely related to them should be the constant preoccupation of health systems or operations research in countries. The Working Group was unanimous in the conviction that unless solutions to such problems were urgently sought (and with the awareness that they will vary from country to country) the inevitable consequence would be that activities concerned with primary health care would get bogged down or stay or move from one pilot area to yet another. WHO's experiences with pilot areas in the past are replete with examples of such problems.

III. ROLE OF THE INDIVIDUAL/FAMILY IN PRIMARY HEALTH CARE

14. If Health for All is to become a reality, there is a need to shock each individual into an awareness of the fact that the prime responsibility for his/her health belongs to him/her and no-one else. If it is true that in the constitution of every nation the government authorities are implicitly responsible for the health of the population as a whole, it is also true that this in no way negates the importance of the role to be played by the individual or by the family as a collectivity. The Working Group also discussed the activities of what are currently called "self-care groups" which are on the increase not only in Europe and North America but in other parts of the world - albeit in other forms. It is not the intention to dwell on the arguments for and against especially those advanced by members of the medical "establishment". Suffice it only to say that their growing importance must be recognized and that, in this connexion, each matrix specifies tasks to be carried out at the home level for "health begins at home".

15. In the matrix for PHC Element No. 1 - education concerning prevailing health problems and the methods of preventing and controlling them - considerable attention has been paid to the role of health promotion at the home level. In addition, in all the matrices, indications are provided of the promotional, preventive or curative aspects of health care that form part of the role of the individual or of the family. At first glance, it will appear that the individual is being called upon to submerge himself/herself in the problems of health care to the exclusion of the myriad of other problems that form part of normal daily life. This apparent paradox can only be ironed out in the second phase of horizontalization or integration of the tasks involved in the implementation of the essential elements of primary health care.

IV. ROLE OF THE COMMUNITY IN PRIMARY HEALTH CARE

16. As has been mentioned earlier in this paper, one of the key differentiating factors of the primary health care approach is its focus on the "consumers" of health care delivery systems: their problems, immediate needs, biases, aspirations, etc. This being so, the involvement and active support of the community are of crucial importance if primary health care is to succeed anywhere. The political commitment of the masses has already been touched

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upon; it has to be enlisted by education/information coupled with practical demonstration in a language which they can understand and with a cultural bias with which they are familiar. This political commitment can be enhanced by the involvement of some representatives of the communities in the planning of their primary health care system. In short, what the Working Group advocates is the complete involvement of the community in the planning, programming, implementation, monitoring and evaluation of the health system. This "bottom-up" approach cannot be minimized as it constitutes the key to success.

17. It is for this reason that in all the matrices areas for community support and interaction have been identified and given the place of importance they deserve. In order to advance the notion of the multisectoral approach to national health development, the creation of Community Development Committees has been advocated as against Village Health Committees. These committees will gain in size and importance in the progression from the lower echelons upwards; but the point of importance is that there must be a dynamic interplay between these committees and the different administrative levels of government. It is one of the responsibilities of these communities to choose from among their own people persons of proven integrity to be trained as community health workers (CHWs) and traditional birth attendants (TBAs) including the organization of functional literacy classes. These committees will also have to decide on ways of remunerating this category of workers either in cash or kind, on their method of work, on ways of replenishing drug supplies initially supplied by the government, etc.

18. Community support is also necessary for the dissemination of relevant information concerning primary health care and the much needed interaction between health and other sectors. To cite but a few examples, the creation of "cooperatives" will go a long way to improve the production of cash and subsistence crops and therefore the nutritional status of the community; and the use of locally available media for transmitting information concerning an immunization campaign will have positive repercussions on the immunization coverage. In addition, the community can generate from within the necessary human and material resources for the construction of recreational facilities for health promotion.

V. ROLE OF THE MINISTRY OF HEALTH AND OF
THE HEALTH SYSTEM INFRASTRUCTURE IN PRIMARY HEALTH CARE

19. There is a growing dissatisfaction with the conventional health care patterns as they have developed over the last few decades. All over the world, there are strong reactions against the over-reliance on advanced technologies, the abuse of drugs and of diagnostic and surgical procedures - such features lead to a dehumanization of health care and the appearance of new health hazards generated by a system supposed to protect people. In developing countries, little or no progress has been made in terms of coverage of health care. With the exception of a few countries, almost everywhere the major emphasis, in terms of expenditure for health, is placed on the care of the very sick, whereas the care of the healthy or less obviously sick has made far less progress. Such trends are being aggressively supported and promoted by vested commercial interests. Thus, the health care systems of practically all countries have little relevance to actual needs. As they have grown and consolidated over the years, the systems of affluent countries have become less flexible and less open to change, while in the developing countries a reorientation can be easier provided it starts forthwith.

20. Hardly anyone will question the statement that no viable society can any longer afford to limit the maintenance of health to the care of the sick. Only the societal and administrative structures whereby health is to be managed are subject to legitimate ideological variations; but whatever health system is chosen, the aim must be to make it a system for the whole man, not merely for the sick man. Maintaining health means the containment of all known major threats to public health (environmental, psychological and biological) by means of known technologies and the promotion of healthy life styles among all; enabling all those who are in good health to remain so; and providing relief to those who are in ill-health. This approach requires a complete redefinition of the types and numbers of health workers needed and a shrewd appraisal of their training curricula and work schedules, including those of medical doctors. The technologies to be used must also be scrutinized so as to ensure that the simplest appropriate technology is applied to each case.

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21. The exposé in paragraphs 19 and 20 epitomizes the new role of the Ministry of Health and the comprehensive health system embracing primary health care that it decides to establish. Traditionally, Ministries of Health have little political leverage and do not receive an important share of the national budget. But this very fact imposes a supreme responsibility to define objectives and priorities clearly, to select health care technologies judiciously, to maximize the use of essential drugs whose selection is the result of well-defined national drug policies, to mobilize community support and, once obtained, to ensure its involvement in all aspects of health care delivery and to inculcate sound principles of "management" that are so essential for success.

Health systems infrastructure

22. For countrywide health systems based on primary health care to function optimally in the delivery of health programmes to all sections of the population, the following points require serious consideration and constant vigilance: the appropriateness of the existing health infrastructure, the correct mix of different categories of health manpower needed at each level of the health system, the technical content of programmes, the appropriateness of the existing technology, support and management. Yet, in this age of technological advance, there is frequently a preoccupation with the sophistication of technologies to the detriment of establishing appropriate health systems infrastructure. The latter is just as important, if not more so, for the adequacy of the health infrastructure is a determinant factor in ensuring that health technologies are used with maximal cost-effectiveness.

23. There is no universal blueprint of a health system infrastructure. Each country must decide on the system that can best cater for its needs guided by the peculiarities of its political, administrative and cultural setting. This apart, there are however certain key factors to be borne in mind in order to ensure that actions taken at different levels are coherent and mutually supportive:

- (a) geographical and demographic characteristics of the various parts of the country;
- (b) quantity and quality of the available manpower;
- (c) definition of the function, scope and degree of sophistication of work to be undertaken at different levels;
- (d) definition of the lines of demarcation within the health infrastructure of the different levels of care - primary, secondary and tertiary - remembering that primary health care must remain the hub of the health system infrastructure;
- (e) siting of the first referral level or hospital in primary health care must be in a strategic location in view of its important coordinating, training and supervisory functions.

24. In the matrices that have been formulated, the delivery of primary health care has been shared between four main levels which are more fully described in a separate paper. With the exclusion of the home and communal levels, the other two levels mean different things in different settings, e.g. the first health facility can mean a dispensary, health centre or even the consultation room of a general medical practitioner.

VI. SUPPORT NEEDED AT VARIOUS LEVELS OF PRIMARY HEALTH CARE

25. The importance of the support provided by the higher levels of the comprehensive health system for the different levels of primary health care needs no emphasis. This support embraces planning of health care delivery in its multiple dimensions, the definition of appropriate curricula for the training and in-service training of all categories of health personnel using modern educational methodology, the establishment of a carefully planned schedule for the provision of supplies and equipment and the provision and maintenance of the right type of logistic support.

26. The constant support and supervision required at the different levels of primary health care should not be lost sight of. Throughout the elaboration of the matrices the Working Group kept this fact in the forefront and indications of what this support means in practical terms have been incorporated in the matrices. For the sake of reiteration, guidance, support and supervision from the first referral level to the first level health facility and from the latter to the communal and home levels include the right type of human interaction between professional and lay or traditional health personnel; provision of appropriate mechanisms for the acquisition of correct skills and knowledge for the accomplishment of prescribed tasks; constant guidance and supervision by the next higher level to ensure that the tasks are properly executed; regular distribution of the right type of supplies and equipment and organization on a strict basis of a system of maintenance on the spot of vehicles and equipment of all kinds.

27. A passing comment has been made of the importance of health systems research. This should be a built-in component of a comprehensive health system based on a primary health care system. Experience has shown that operations research is not often attractive to the best researchers, few as they are; therefore, as for evaluation, simple mechanisms must be designed to allow those working on the job to collect the right type of information for objective and critical analysis.

VII. THE RELATIONSHIP BETWEEN PRIMARY HEALTH CARE AND OTHER SECTORAL PROGRAMMES

28. There is hardly any need to belabour a point which has practically received universal acceptance and, that is, that national health development is not the prerogative of the health sector alone. Other sectors such as agriculture, education, water resources, social welfare, communications, etc., contribute equally, if not more, to the improvement of the health status of populations. This is the multisectoral concept implicit in the primary health care approach and which calls for a continuing dialogue between the health sector and other national sectoral programmes.

29. Literacy programmes of all types (e.g. adult literacy, functional literacy for "lay" health personnel) can contribute in no small way to the success of primary health care. Health legislation is another important aspect, but the proliferation of legislation for its own sake can be counter-productive unless effective mechanisms (reflecting cultural variations) for its enforcement have been previously identified. The improvement of the health status of agricultural, industrial and migrant workers calls for special approaches involving control of occupational health risks, promotion of the humanization of work and a well coordinated programme of research. Here again, the need for continuing dialogue with industry, the Ministries of Labour and Health needs no emphasis.

VIII. POSSIBLE USE OF THE MATERIAL PRODUCED

30. The burning question that has troubled many minds is to what use should the material that has been formulated by the Working Group be put? As has been clearly indicated in the introduction, the first important use is to help us in WHO understand the complexities of programme delivery at the country level in our respective programme areas. This awareness should, in itself, facilitate the indispensable interaction between all programmes directly or indirectly related to primary health care. The very expression "primary health care" conjures up in our minds different things for different people; and yet there needs to be a unified concept if our motivation, approaches and practical identification with country activities are to be intensified.

31. Next comes the question as to what use can best be made of the material at the country level. It can be used for cross-checking purposes for individual programmes; but more importantly, it can become a useful tool at the country level only after the process of horizontalization or integration of programme activities has been undertaken and this, most ideally, in countries.

Annex BDefinitions of various levels of primary health care

1. These definitions are to be seen as working definitions for the purpose of analysing and describing the resources needed at the primary health care and supporting levels in order to carry out the activities making up the minimum eight elements of PHC. Emphasis is placed on the situation of a developing country with a low GNP, predominantly agricultural economy, with about 80% of the population living in rural areas and urban slums, high birth rates and infant and maternal mortality rates, and the following main health and health-related problems: malnutrition, infectious diseases, infant diarrhoea, malaria and other vector-borne diseases, complications of pregnancy and labour.

The details of what is available at the different levels will vary greatly between countries, but the definitions given hereunder, with the attached graphical illustrations of the levels (Fig. 1) indicate what needs to be there, or developed, in order to effectively implement a primary health care strategy.

In order to develop a viable PHC strategy before the year 2000, it is not enough that the infrastructure, as described above, be set up. The essential prerequisite is a thorough commitment to the strategy, not only by the Government but even more so by the local community and by the supporting health personnel. This in turn requires that efficient and effective mechanisms be set up, or strengthened, for a continuous dialogue between the different levels, other national sectoral programmes, and the communities.

2. Definitions/descriptions of the levels (refer also to Fig. 1).

Home level: This refers to the basic unit in any community: the household. The family members are the ones primarily responsible for activities at this level, whether they are seen as individuals, mothers of children or heads of the household. Persons from the neighbourhood, as well as home-visiting community workers of various kinds (including trained health workers) interact with the family and are directly involved in activities at this level.

Communal level: Activities at this level concern the health of a whole community (village/town or group of villages) and require common facilities and/or joint voluntary efforts of community members. Examples are cleaning campaigns, construction of facilities, information/education about immunization sessions, etc.

The Community Development Committee, or equivalent (see Fig. 1) is the central coordinating mechanism for activities at this level, but it also provides support to activities at the other levels, in particular the home level (see the individual matrices - column for "community support"). The Community Development Committee interacts with, and is supported by, the individual community members, in addition to various community groups, as well as national sectoral programmes including health.

Community health workers (CHWs),¹ as well as other community workers and volunteers, function also at this level both in promotional/informational activities and in planning/implementation of communal health activities. Many communities have created an actual facility for the CHW at this level.

First health facility level: This refers to the first level where a trained health professional is available and where facilities are available for running clinic sessions. The kind of facility and the type of staff available will vary from country to country (see Fig. 2).

¹ For the purposes of this paper a CHW is defined as a person selected by the Community for a course of training of varying duration organized by the national health authorities. It includes traditional healers of all kinds, particularly traditional birth attendants (TBAs) and village health workers (VHWs).

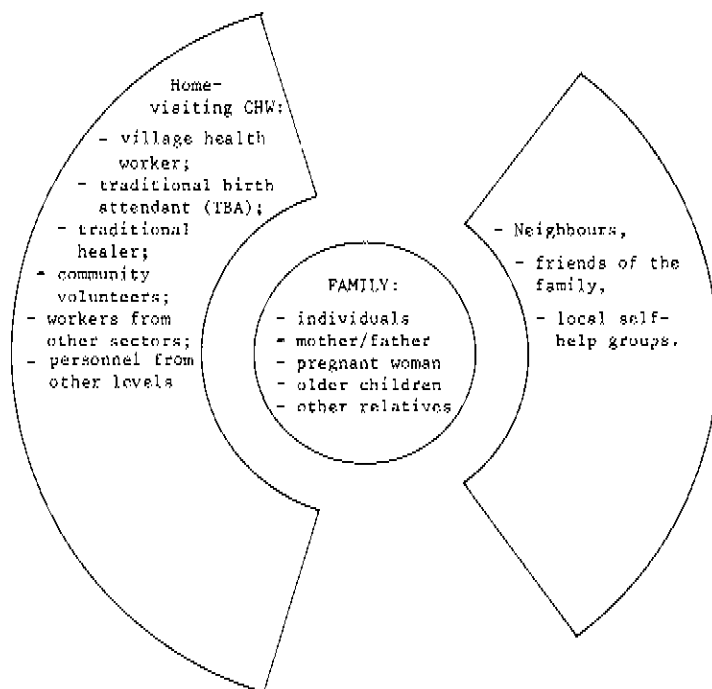
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In addition to the static clinical activities, the staff interact both with the home level (during home visits) and the communal level. This level also fills a major supportive role in training and supervision of all kinds of CHWs.

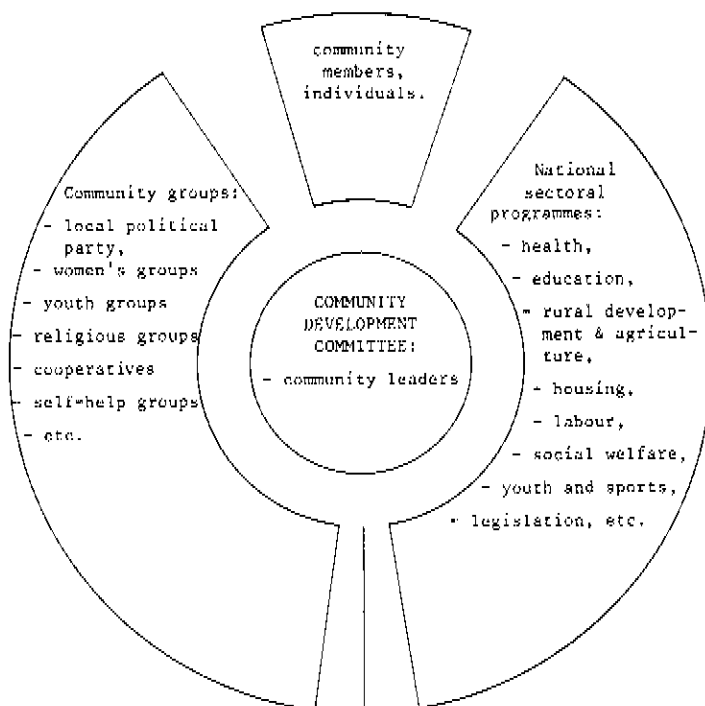
First referral level: There are two types of referral systems in a PHC strategy (Fig. 2). The first is a clinical referral system which includes the supervision of performances at lower levels. The second is an administrative referral system - usually the District Health Office. This is the level involved in planning, management and support of activities related to sanitation, health education/information, disease control campaigns, etc.

PERSONS, GROUPS, CATEGORIES OF PERSONNEL
INVOLVED IN FHC AT HOME AND COMMUNAL LEVELS
AND SUPPORTING PROGRAMMES

HOME:



COMMUNAL:



- *
- local health workers
 - CHW
 - pharmacy assistant, etc.

*These workers need not be members of the Community Development Committee but do constantly interact with it.

Figure 2

PHC HEALTH SERVICE INFRASTRUCTURE

FIRST LEVEL
HEALTH FACILITY:

- "health house"
or similar,
- dispensary,
- health centre
with or without
beds.

- nurse and/or
- nurse/midwife
- assistant nurse
or other auxilliary
staff, incl. CHW

Sometimes:

- medical assistant
or physician
- sanitary inspector
- dietician
- pharmacy assistant
- laboratory assistant

FIRST REFERRAL
LEVEL:

Clinical:

- rural hospital,
- district
hospital, etc.

- physician (G.P.)
- nurse
- midwife
- hospital aide
- laboratory technician
- X-ray technician

Sometimes:

- pharmacist
- medical assistant

Administrative:

- District
(or province)
health
office

- public health medical
officer
- public health nurse/
supervisor
- sanitarian
- nutritionist/dietician
- storekeeper

Sometimes:

- health education assistant
- laboratory technician
- water agency technician
- statistical assistant.

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PHC ELEMENT No. 1: EDUCATION CONCERNING THE PREVAILING
HEALTH PROBLEMS AND METHODS OF PREVENTING AND CONTROLLING THEM

Narrative summary

INTRODUCTION (General objectives)

Education for the promotion of health and the prevention of disease is the first of the eight essential elements of primary health care mentioned in the Alma-Ata Declaration. This emphasizes the fact that in the final analysis it is the individual who will decide to be healthy or not, to accept health measures, to work with others in creating a healthy environment and to work for the promotion of health for himself/herself or the community in which he/she resides. This should not, however, be construed as meaning that the individual is the sole person responsible for his own health. There are a number of issues outside the control of the individual that govern his own health: socioeconomic conditions, political issues, cultural trends and norms, religious beliefs, etc. It is within this framework that health education and information must work in order to be successful.

Information and education, therefore, must foster activities leading to a situation where people: want to be healthy; know how to attain health; do what they can individually and collectively, and to seek help when needed.

CONTENT AT DIFFERENT LEVELS OF CARE

The health of the individual, family and of the community depends on a number of factors including the environment and lifestyle. It will be futile to try to maintain health and promote healthy living without changes or modifications in the environment and in unhealthy habits and life styles of individuals. In addition, outside forces may also influence the individual and the community to change some of the more healthy life styles in order to replace them with what seems to be acceptable in other cultures. It is evident, therefore, that information and education must not only deal with those trends that need to be changed but also with the maintenance of others that seem to be appropriate.

Specific tasks and ways of providing for their attainment are outlined in the matrix. The activities are subdivided into three interdependent areas of involvement: health promotion, prevention of disease and maintenance of health and education to deal with disease. Some of the types of action required at different levels are detailed hereunder:

Home level:

The family is the basic unit of self-reliance in health and the prime focus for most information and education activities. Specific tasks include:

- acquisition of basic knowledge in order that the individual will come to value health and know how to maintain it;
- acquisition of an understanding of local health hazards and how to avoid them;
- recognition of health variants and of disease and acquisition of the ability to take proper self-care decisions or to seek help.

Communal level:

Without adequate communal support, health will be difficult to attain or maintain. Collective action is required to create the socioeconomic and environmental conditions within which individuals will be motivated to take their health into their own hands to the greatest extent possible. This includes:

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- easy access to sound and useful information on prevailing health problems and methods of preventing and controlling them;
- a clear understanding of the technologies and services available and their advantages and disadvantages;
- positive health information through the mass media, including the avoidance of its use to promote the utilization of products which may be detrimental to health or creating an undue dependence on nonessential medicaments and practices.

Health services (including first health facility and first referral level):

The health services have a responsibility for encouraging and facilitating family self-reliance and the involvement of the community in the planning and implementation of health care systems. Unless this is understood, people will continue to be "recipients" of health care, i.e. passive observers rather than taking the responsibility for their health into their own hands. Specific tasks include:

- counselling of patients including promotion of healthy behaviour;
- provision of sound health information;
- organization of formal health education activities;
- fostering interdisciplinary approaches to support the family and individual;
- close cooperation with the mass media to foster positive health information.

INDICATORS OF PROGRAMME EFFECTIVENESS

Realizing the fact that the effectiveness of information and education programmes should eventually be manifested by the attainment of a better level of health in the population, their evaluation becomes a very complex process. For, indeed, the attainment of a better level of health in any population is dependent on a number of factors of which information and education of the individual and of the communities constitute just one element. Recourse would therefore have to be had to the use of interim evaluation, that is, to compare the output (knowledge or participation) as against the input (provision of information and encouragement and organization for action). In that case information and education programmes might have to use the following as indicators:

- increased knowledge of the importance of proper nutrition, common health hazards and how to avoid them;
- increased competence in dealing with disease or accidents;
- reduction of those diseases or conditions in which the role of the individual is of primordial importance, such as, reduction of infant morbidity and mortality due to diseases preventable by personal hygiene, reduction of home accidents, etc.;
- sustained participation in individual or group recreational activities;
- increased utilization of health facilities;
- increased coverage of health topics in the mass media and the use of advertising practices which foster healthy living.

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GLOSSARY OF TERMS

The purpose of this glossary is to explain the terminology used in the framework of the matrices.

- Element: Refers to the eight elements of primary health care, as defined in the Alma-Ata Declaration.
- Activity: Refers to broad activities that constitute essential components of the content of a particular PHC element.
- Level: Home, communal, first health facility and first referral level. See the paper on "Definitions of various levels of primary health care".
- Tasks: The core content of primary health care: the detailed tasks that have to be performed in order to improve/maintain health. The decision as to which tasks are essential (i.e. priority tasks) has to be taken at the national level, based on the priority ranking of health problems and strategies.
- Person(s) responsible: Refers to the various persons at different levels who will have full or partial responsibility for carrying out the tasks required. Who is exactly responsible for a specific task will vary from country to country, depending on existing legislation, health system infrastructure, cultural factors, etc.
- Competence and knowledge required: Skills and knowledge that persons who are going to carry out the specific tasks need to possess, i.e. the content of education or professional training programmes. The type of knowledge needed may often be the same, for example, for a physician and the mother of a child; while the depth required will vary considerably.
- Supplies and equipment: The "hardware" support needed at different levels for specific tasks, such as, clothes for the newborn baby at home; obstetric equipment at the first health facility or referral level; material for preparing blood slides; microscope; drugs, etc.
- Logistic support: Various types of support activities from higher levels, such as supervision, educational programmes, referral systems, consultant expertise, etc. It also includes facilities for transportation, transport and equipment maintenance, etc.
- Community support: Refers to a variety of intersectoral programmes or activities at the level of the community that can provide direct support to activities at the other levels in the matrix.

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Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support
1. Health Promotion	1.1 Home	<p>a) Acquisition of basic knowledge of personal hygiene, proper nutrition, common health hazards and how individual and group behaviour influence and promote health</p> <p>b) agreement to act on the basis of knowledge acquired</p>	<p>- Family members</p>	<p>- knowledge of available health facilities</p> <p>- ability to impart knowledge to others</p> <p>- knowledge of functional literacy techniques</p> <p>- knowledge of how health contributes to individual family welfare</p> <p>- as above</p>	<p>- health promotion literature</p> <p>- demonstration materials including material for functional literacy classes</p>	<p>- adequate means of communication to facilitate health education/information efforts, e.g. informal networks of village communicators, local radio, local newspapers, etc.</p> <p>- public recreational facilities for individual and group activities</p> <p>- provision of appropriate literature</p>	<p>- volunteers to help in health promotion</p> <p>- activities of self-help groups</p> <p>- promotion of the concept of healthy behaviour by community leaders</p> <p>- support for functional literacy programmes</p> <p>- support for functional literacy programmes</p>
	1.2 Communal	<p>c) support to family members</p> <p>a) mobilization of community groups to promote positive health, e.g. parent-teacher associations</p> <p>b) involvement of families in decision-making concerning their health, through self-help groups, etc.</p> <p>c) acquisition of knowledge on available health resources and</p> <p>d) community work on recreational facilities such as sports fields</p> <p>e) awareness by industry of its responsibilities for health promotion</p>	<p>community health workers volunteers teachers</p> <p>community health and development workers teachers volunteers self-help groups</p>	<p>- as above</p> <p>- knowledge of human resources within the community</p> <p>- knowledge of the fact that health care delivery is an integral part of overall community development</p> <p>- skills in motivating community groups and in assisting them in mobilizing their energies for health promotion and protection</p>	<p>- as above</p> <p>- as above in 1.1</p> <p>- appropriate tools and building materials</p>	<p>- as above</p> <p>- voluntary and non-voluntary codes of practice by industry, advertisers, etc., e.g. on labelling, advertising and marketing</p> <p>- provision of supplies and equipment not available locally</p> <p>- tax allocations for promotion of recreation</p>	<p>- as above</p> <p>- support for mass media health information/education programmes</p> <p>- enlistment of the food industry to make better known the caloric content of food and to observe hygiene requirements</p> <p>- support for existence of public recreational facilities</p>

PHC ELEMENT NO. 1 (Cont'd)

Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support
1. Health Promotion (cont'd)	1.2 Communal (cont'd)	f) introduction of health promotion in school curricula and in non-formal education	school authorities	- as above in 1.1 and 1.2 overlaid	- teaching materials, radio receivers, etc.	- communal meeting facilities	- volunteer help in school health programmes
	1.3 First level health facilities	a) counselling of patients on how to maintain or regain health b) education/information of individuals, families and communities in health promotion	medical assistant nurse midwife	- ability to communicate effectively - knowledge of threats to health in the community - knowledge of how individual families may be motivated to adopt/maintain health by behaviour patterns	- basic health promotion literature and audio-visual materials	- training in communication techniques and in community development work	- recognition of the potentials offered by the first level health facility and its timely and proper use e.g. for child immunization
	1.4 First referral level	a) as above in 1.3 b) group counselling for health	physicians nurses midwives health inspectors pharmacy assistants, etc.	- ability to communicate effectively with individuals and groups - ability to impart knowledge - knowledge about resources - human and material - in the communities they serve, including patterns of leadership and skills of members	- audio-visual materials and equipment on prevalent health problems	- special facility for educational and information purposes	- community involvement in the dissemination of information on health promotional activities

PRC ELEMENT NO. 1 (Cont'd)

Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support
2. <u>Prevention of disease and maintenance of health</u>	2.1 Home	<p>a) acquisition of correct and sufficient know-how of:</p> <ul style="list-style-type: none"> - prevention of locally endemic diseases - prevention of accidents including burns and fractures - maintenance of health by positive action such as sport, rest, etc. - correct nutrition - water and waste sanitation <p>b) correct maternal and child health practices, including family planning and immunization</p> <p>c) correct use of essential drugs</p> <p>d) acquisition of correct information on available health services within the community and at the first level health facility and timely utilization such as proper immunization of children, accepting guidance in family planning, etc.</p>	family members	<ul style="list-style-type: none"> - knowledge and ability to act properly in case of emergencies - knowledge of possibilities and limitation of self-care - skill in elementary first aid - knowledge of methods of prevention of endemic disease 	<ul style="list-style-type: none"> - first aid kit - simple illustrated guides and material on disease prevention 	<ul style="list-style-type: none"> - provision and maintenance of educational facilities - provision and maintenance of sport and recreation facilities 	
		e) support to family members	CRMs volunteers	as above	as above	<ul style="list-style-type: none"> - home visits by first level health facility workers 	<ul style="list-style-type: none"> - organization of classes or sessions to teach family members (esp. mothers) elements of disease and accident prevention

PHC ELEMENT No 1 (Cont'd)

Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support
<p>2. <u>Prevention and maintenance of health</u> (cont'd)</p>	<p>2.2 Communal</p>	<p>a) sustained involvement in:</p> <ul style="list-style-type: none"> - creation of healthy environment in the community: i.e. water, waste disposal and environmental safety, food hygiene, etc. - building of sports and creative leisure facilities (such as cottage industries etc.) - working towards self-reliance in agricultural production, etc. 	<p>community health workers (CHWs) teachers volunteers self-help groups</p>	<ul style="list-style-type: none"> - ability to communicate effectively with individuals and groups - knowledge of resources available within the community and the first level health facility - knowledge of skills of different members or groups in the community - knowledge and skill of preventive and health promoting measures that can be undertaken by the community itself 	<ul style="list-style-type: none"> - relevant education and information materials on current health issues of the community 	<ul style="list-style-type: none"> - support by first level health facility and first referral level in organizing classes or sessions for development of skills and know-how in disease prevention and health promotion 	

Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support
2. <u>Prevention of disease and maintenance of health (cont'd)</u>	2.3 First level health facility	a) education of family members, community leaders, CHWs, teachers and volunteer workers in prevention of common and endemic diseases b) education on health maintenance by correct nutrition, environmental safety, immunization, maternal and child health, occupational health (esp. agriculture)	medical assistant nurse midwife	- ability to communicate effectively with individuals and groups - adequate knowledge of contents of health messages to be delivered - knowledge about the community they serve, both physically and socially	- reference material on current health problems of the area - guidelines on educational methods and materials - audio-visual equipment, i.e. slide projection, diapositives, etc.	- selection of education of some community members or volunteers to establish contact with first referral level when needed - availability of tools and building materials	- organization of sessions and classes to teach about the prevailing health patterns and methods of preventing them as well as means of health maintenance - organization of community involvement projects such as construction of water and waste disposal facilities
	2.4 First referral level	a) education of individual patients and community at large on prevention of endemic diseases b) support and reinforcement of educational activities of the first level health facility	physicians nurses midwives health inspectors pharmacy assistants, etc.	- ability to communicate effectively - some knowledge of counselling - knowledge of information and education resources within the community and surrounding area that might be utilized, such as newspapers, radio stations, etc. - adequate knowledge of communities the first referral level serves, both physically and socially	- audio-visual material and equipment on prevalent health problems for group education	- special facility for education and information purposes - transportation - availability of tools and building materials	- community involvement in educational activities - organization of community involvement projects such as construction of water and waste disposal facilities

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PHC ELEMENT No 1 (Cont'd)

Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support	
3. <u>Education to deal with disease</u>	3.1 Home	a) acquisition of knowledge of symptoms of easily diagnosable prevalent diseases and how to deal with them	family members	- ability to recognize possibilities and limitations of self-care in each specific situation	- suitable reference material	- arrangements for individual and group education	- provision of assistance to sick people such as preparation of meals, taking care of children, etc.	
		b) ability to take proper decisions for self-care or for seeking help		- knowledge of appropriate action to be taken in each specific situation	- appropriate medicaments and supplies			
		c) support to family members		- as above	- as above	- mobilization of family members for participation in health education programmes conducted by first level health facility and first referral level on how to deal with disease		
	3.2 Communal	a) organization of self-help groups assisting family members in their health and social problems b) assignment of one or more persons in each community to assume special responsibility for health within the community c) decision-making in case of prevailing diseases on the proper action to be taken	community health workers teachers volunteers self-help groups	- ability to communicate effectively - adequate knowledge of resources in the community: human, institutional, agricultural, etc. - knowledge of the concept of community organization	- access to easy and illustrated reading material	- community meeting facilities		

PHC ELEMENT No 1 (Cont'd)

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Activities	Level	Tasks involved	Person(s) responsible	Competence and knowledge required	Supplies and equipment	Logistic support	Community support
3. <u>Education to deal with disease</u> (cont'd)	3.3 First level health facility	a) education/information of individual patients and community on symptoms of easily recognizable diseases especially among children, and ways of dealing with each case b) information of community at large of the services available at first level health facility and at the first referral level	medical assistant nurse midwife	- ability to communicate effectively with groups and individuals - knowledge of resources in the community, both human and material - literacy and numeracy	- simple audio-visual equipment such as slide and film strip projections, demonstration facilities such as pictures, posters, etc.	- provision of material not available locally - provision of medications appropriate for use by each family	- volunteers to collaborate with first level health facility - communal room or place for meetings, gatherings, etc.
	3.4 First referral level	a) reinforcement of educational and informational activities of the first level health facility b) counselling of individual patients on how to deal with disease and avoid recurrence c) provision of on-the-job training in education and information for the CHWs	physicians nurses midwives health inspectors pharmacy assistants, etc.	- ability to communicate effectively with individuals and groups - ability to impart knowledge - knowledge about resources (human and material) in the communities they serve, including patterns of leadership and skills of members	- audio-visual materials for education of community members and also for teaching of first health level workers	- as above in 1.3	- involvement in organization of volunteer groups both for permanent health work and in case of emergencies

ANNEX C

EXCERPTS FROM THE SEVENTH GENERAL PROGRAMME OF WORK
(1984-1989)

6. PUBLIC INFORMATION AND EDUCATION FOR HEALTH

184. The existence of a public that is aware of actions it can take to promote its own health and that is motivated to undertake such actions is essential to the primary health care approach. Without this, the effectiveness of the other components of the health system will be greatly diminished. In fact, the Declaration of Alma-Ata on primary health care mentioned education concerning prevailing health problems and the methods of preventing and controlling them as the first of eight essential components of primary health care.

185. Numerous obstacles impede individual and community action for health. They range from lack of knowledge of basic hygiene, cultural taboos, unhealthy life-styles and insufficient encouragement of cultural factors that promote health to inadequate and ineffective health education, motivation and public information efforts, all too often operating in isolation from the mainstream of the health systems. In addition, aggressive advertising of products harmful to health usually overwhelms the feeble educational efforts aimed at fostering healthy life-styles, particularly among the young.

186. Health education and health information activities by the public and private sectors are often uncoordinated, under-financed and have not been developed as a fully integrated, essential element of national health strategies.

187. These activities are an important part of such strategies, for they mobilize political, financial, managerial, technical and popular support. Countries will be encouraged to develop health education and public information support for all health programmes as an integral part of their health system. WHO will promote the establishment of interdisciplinary and intersectoral working groups in countries to ensure that health education and information efforts are coordinated and mutually supportive. These groups should include representatives from mass media, the educational sector and voluntary organizations, and should work closely with national health councils or similar bodies, since all healthy behaviour cannot be promoted through action within the health sector alone. WHO will support this process by mobilizing global public opinion and political commitment, popularizing and disseminating information appropriate for national use, collaborating with countries in educational and information activities, assisting in the training of the personnel required, and fostering appropriate health education and communication research.

- Objective 6

188. To foster education and information activities which will encourage people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health, and to seek help as needed.

- Targets

189. This programme's activities will aim at fostering national and international action so that by 1989:

- (1) most countries will have coordinated and mutually supportive public health information and education efforts involving ministries of health, information, education and other related sectors, which reach their entire population;

(2) all countries will have coordinated programmes that disseminate relevant and technically sound information to increase individual and community capabilities for involvement and self-reliance in health and to promote healthy behaviour, particularly regarding family health and nutrition, environmental health, healthy lifestyles and disease prevention and control.

- Approaches

190. Health education and information of the public are two sides of the same coin; similar messages have to be delivered by whatever media are most appropriate to do so. Messages for delivery through the mass media will be prepared in such a way as to stimulate without unduly frightening, and as to maintain a proper balance between individual and community needs. WHO will prepare such messages and will help countries to translate them into their cultural and language needs and to apply them in the ways most appropriate to them. Two lines of development will be pursued. The first will broaden the avenues available for dissemination of health information through promoting greater participation of health and other related sectors in coordinated efforts. WHO will promote and support the development of strategies and procedures to increase coordination between ministries of health, education, communications, agriculture, rural development and related sectors, community groups, industry, the mass media and concerned nongovernmental organizations with regard to health education and information at both the national and international levels. Consistent efforts will be made to promote acceptable self-care practices by individuals and communities. All types of health workers will be expected to take part in the health information and education of the public. In addition, innovative approaches to involve teachers in primary and secondary schools, agricultural and rural development workers, literacy and adult education programmes, labour and industry groups and traditional health workers in the dissemination of health information will be encouraged and supported.

191. The second type of approach will seek to improve the effectiveness of the education and information programmes, wherever they are carried out, through improving methods and materials, including the introduction of training in health education into the curricula for training all categories of health workers. In addition to strengthening the use of existing methods, the development of new methods and exploration of alternative media and methods, including the use of traditional media, will be encouraged to reach individuals and communities which have no contact with the media currently in use. WHO will provide information and support in the development of appropriate materials for education of the public and for training personnel of all types to provide health education and information to the public.

192. Information materials will be developed, locally adapted and field-tested, particularly as it relates to the need to develop positive and adequate eating habits and for exercise and for outdoor leisure activities and sports, and to the risks connected with the health effects of smoking and the use and abuse of alcohol and drugs. Self-help activities will be emphasized. Guidelines and training material for health and other workers will be adapted to different target groups in all major languages in each region, aiming to make people aware of the health, as well as economic advantages of healthy behaviour, which will open possibilities for alternative use of resources. This can be carried out with the collaboration of United Nations agencies, particularly UNESCO, ILO, FAO, UNICEF and nongovernmental organizations concerned. Support will be provided to develop and improve training in health education and information for all concerned workers in health and related areas. The inclusion of skill development in communication and in stimulating behavioural change in such training programmes will be encouraged.

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193. In the implementation of the above approaches, the information content will be determined collaboratively with the technical specialists concerned. Particular emphasis will be placed on reaching children and adolescents. Attitudes and behavioural patterns are formed early in life; consequently, particular emphasis in the programme will be on the young and the involvement of the educational sector will be vital; specific curricula will be developed not only for health educators but also for all other workers in the health and other sectors who are in contact with parents and young people. Material will be developed and incorporated in media, such as pictures, comic books, and cartoons. The needs of other high-risk and underserved population groups will also be emphasized.

194. The dissemination of educational and information support material for primary health care, promotion of healthy behaviour and life-styles, and the facilitation of individual and community self-care, will be especially encouraged. Support to specific requirements regarding elements of family health, environmental health, and disease prevention and control will be selectively provided wherever necessary, according to local conditions.

C. HEALTH SCIENCE AND TECHNOLOGY

195. The health system infrastructure provides the human and material means for delivering health care, but its impact on health depends on the substance of what is delivered. A vast amount and bewildering variety of health technologies exist but they are not always available to all who need them and they are not always appropriate to those in need. For this reason it is necessary to reappraise health technologies, selecting those that are appropriate in specific circumstances, generating new technologies as required and searching for behavioural alternatives wherever possible. To do so, systematic scientific endeavour is required. Technology reappraisal and development is needed to arrive at suitable ways of protecting and promoting the health of people of all categories and ages, including specific population groups such as young people, workers and the elderly. The promotion of their mental health is no less important than that of their physical health. A healthy environment can contribute to both physical and mental health. No known civilization has been able to eliminate disease whatever the measures they have taken; so technology for the prevention and cure of disease is highly important and is likely to remain so. This includes technology for diagnosis, treatment and rehabilitation in general, as well as for the prevention and control of specific groups of diseases.