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INTEROFFICE MEMORANDUM

TO: Dr. Nyi Nyi

DATE: 6 December 1984

FROM: R.R.N. Tuluhungwa

FILE NO.: PSC/84/439

SUBJECT: 1985 JCHP Meeting: Information, Education and Communication for Health Paper

Attached find a copy of the above described paper prepared by Dr. Gill Walt.

This "revised" version includes comments/observations made by Dr. Hellberg and Mr. D. Johnston of WHO, through Ms. M. Glasgow and Mr. M. Ahmed, as well as comments/observations raised during a meeting attended by Dr. K. Edstrom, Mr. J. Ling, Ms. M. Glasgow and I last week. The changes include factual corrections and rearrangement of the recommendations. Five copies have been sent to WHO by special delivery.

I am sending a copy of the paper to the following persons for their comments. I suggest, either late tomorrow (Friday 7 December) or Monday, you call a small meeting to review it.

cc:

Mr. T. Vittachi
Mr. R. Jolly
Mr. M. Ahmed
Mr. J. Williams
Dr. K. Edstrom
Mr. N. Bowles
Ms. M. Glasgow

ENCLOSURE

RRNT/mbg

INFORMATION, EDUCATION AND COMMUNICATION FOR HEALTH

A background paper for the WHO-UNICEF
Joint Committee on Health Policy

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INFORMATION, EDUCATION AND COMMUNICATION FOR HEALTH

A background paper for the Joint Committee on Health Policy

The last five years have witnessed a burgeoning of interest in health education, information and communications. Until recently each of these subjects was considered in isolation as a separate field, and interation between them was neglected. Today this distinction is recognised to be artificial. Moreover, ideas about health and people's roles in achieving and maintaining health have changed, so that the concepts have themselves broadened. It was in the light of this change and the increased attention being paid to education, information and communication for health that this paper was commissioned by UNICEF and WHO to appear on the agenda for consideration by the next Joint Committee on Health Policy meeting in January 1985.

The main objective of the paper is to help the two agencies to increase the effectiveness of their information, education and communication support to country efforts in Primary health Care and the Child Survival and Development Revolution (WHO-UNICEF 1984). It considers the following four areas:-

(i) discussion and clarification of various terminologies used currently by the two agencies;

(ii) major issues facing information, education and communication for health, as currently planned and implemented in countries at community levels, with particular emphasis on developing countries;

(iii) some current activities and issues in this area of work - supported or undertaken by the two agencies;

(iv) development of practical suggestions for the two agencies to begin systematic efforts to support effective information, education and communication for health programmes in developing countries.

Two caveats are in order. First, it is impossible in such a brief paper to do more than paint broad brushstrokes. The last few years have witnessed a considerable growth of interest in this field, not to mention a proliferation of activities. This paper is in itself only a part of that process. It can only touch on a number of issues which deserve far greater attention. Second, the brief for the paper is to concentrate on developing countries. There is much interesting work going on in this field in the industrialized world, in particular the move towards health promotion (Anderson 1983). Although there are obviously links between the developed and developing world, and both can learn form the other, there are also large differences in health problems and available resources. This paper is concerned with the practical realities facing developing countries at a time of considerable financial restraint.

I Discussion and clarification of various terminologies currently used by the two agencies.

"Health education in primary health care aims to foster activities that encourage people to: want to be healthy; know how to stay healthy; do what they can individually and collectively to maintain health; and seek help when needed" (WHO 1983).

"PSC (project support communication) is the use of development communication techniques ranging from interpersonal communication to mass media, in support of programmes on all levels" (UNICEF 1984). "It aims to facilitate advocacy, community education and participation, behavioural changes and new skills acquisition" (Tuluhungwa 1983).

Current concepts in information, education and communication for health have a long history, and it is useful to trace their antecedents in order to understand how and why they have changed. Two separate trends are apparent. The first emerged from the health sector itself, and addressed health problems through health education in an expert-directed "top-down" approach. The second emerged from community development work, and focused on health care as only one of a number of efforts defined by community people to improve their own well-being, a "bottom-up" approach.

In its earliest days, health education mirrored a paternalistic attitude to communities. For example, health educators believed that if people would only listen to, and act upon, their advice, they would enjoy better health. For years the KAP model - giving Knowledge to influence Attitudes and so change Practices - was the sine qua non of health education. Methods tended toward didactic teaching of 'hygiene' in school and health clinics and was typically a one-way downard information process. Content related to encouraging utilization of health services, and preventive and curative aspects of specific diseases. In the 1950's Caribbean health education was almost exclusively directed at malaria

(Brandon 1984). ALthough education for enlisting individual and community support for such health education programmes was acknowledged as important (WHO 1954), it was often logistically difficult for health educators.

Community development, on the other hand, started as a mass educaiton activity for the rural poor. From the outset it was concerned with working with communities to change behaviour by imparting new skills and knowledge. Although health was part of some integrated rural projects, it was not normally a focus for community development. Communications support for such development projects was aimed to accelerate the implementation of projects and to make them more effective. However there was often a gap between community priorities, and the 'product' on offer (Bunnag 1982), and participation was often relegated to a contribution of community money,time or labour. Informed concurrence and involvement in the development process from early stages was rare. Similarly support communications was often seen as a separate component to a project, providing audio-visual materials for example, and not part of a dialogue between the community and outside agencies.

By the 1970's dissatisfaction with the role of health education and communications in development projects was paralleled by many other changing ideas regarding health. The costs of health care were explosive, and yet services were not even reaching rural and poor periurban populations. Disillusion with medical science and technology and the marginalization of traditional and lay knowledge was compounded by the acknowledged shortcomings of health services to improve people's health. There was a call to improve basic services to improve people's

lives, to "...expand and improve facilities for education, health, nutrition, housing and social welfare, and to safeguard the environment" (United Nations 1970). In a number of countries national programmes or special projects had demonstrated alternatives were possible (Djukanovic & Mach 1975).

These and other influences converged in the Alma Ata Conference on Primary Health Care in 1978, and became part of the broad policy thrust of Health for All by the Year 2000: a concept which addressed not only issues of equity and social justice, but sought ways to involve people as partners in health through the Primary Health Care approach (PHC). The focus moved from health care services to a much broader concern with health and wellbeing. The first of the eight essential activities for PHC was listed as "education concerning prevailing health problems and methods of preventing and controlling them" (WHO-UNICEF 1978), and later health education was given an explicit role. "Its primary responsibility is to promote individual and social awareness leading to people's involvement and self-reliance" (Mahler 1982).

Thus in the 1980's new approaches to health have highlighted both the bottom-up and top-down approaches. There is a recognized need to create community awareness, so that communities can themselves contribute to and take responsibility in health improvements, as well as to have experts and policy-makers provide advice, support, legislation and resources to health priorities defined by community groups. The focus of health education of the present era is to develop the process and dialogue by which both approaches can address the same sets of health problems.

Terminology

As concepts have changed and the challenge has been to involve people in the wider concept of health rather than simply health services, so the functional difference between information and education has diminished. "Most information officers today view their task as that of disseminating knowledge with the purpose of mobilizing support and serving as a communications bridge between the people and the public services. Few health educators nowadays leave out of their brief the need to influence policy and reach the decision-makers" (Ling 1983). Certainly, communications are increasingly being seen as a vital resource in both WHO and UNICEF's attempts to consolidate and even accelerate Health for All by the Year 2000 and the Child Survival and Development Revolution as part of Primary Health Care.

In terms of nomenclature, it may be better to be eclectic than to insist on rigid definitions. Health education remains a widely known and used generic term, in spite of what are, for some, its negative connotations. Partly for that reason, and partly to embrace the broader functions envisaged for it, health promotion is preferred by many. Information and education for health is increasingly used in WHO. Project support communications (PSC) remains a term special to UNICEF. However, social communications is also used, as is health education and there is latterly a move towards programme communications. Development support communications is commonly recognized in development circles and utilized by other international agencies.

For the purposes of this paper, information, education and communication for health will be used, except where reference is made to existing institutions such as health education units,or existing staff like PSC officers or health educators (assumed here to be professionally trained in health education).

II Major issues facing information education and communication for health as currently planned and implemented in countries at community levels, with particular emphasis on developing countries.

If countries are to re-orient their approaches to information, education and communication for health, there are many critical questions to be faced. Only a few broad issues are highlighted here.

1. Perceptual and structural constraints

Health education and PSC are sometimes regarded by both agencies and governments as marginal activities. Both health educators and PSC officers complain that they are brought in to projects at late stages of planning, that they are seen as 'back-up' to projects, necessary but separate requirements. Ironically, when projects fail, it is often the communications or education side which is held responsible. PSC is equated narrowly with media, and not with its wider functions which include community education. Health educators are expected to mobilize support for projects communities have not necessarily been consulted about. They also have to cope with the technical prejudices of other health professionals, the water and sanitation engineers, the doctors and nurses.

Misperceptions about the roles of PSC officers and health educators often limit them functionally and structurally. Most PSC officers come from a social science, journalist or communications media background, and this has led to some confusion between their programme support role and their information role. They are also often not nationals although this is now changing in recognition of the need for communications to take account of cultural norms and variations (United Nations 1983). As they are directed towards programme implementation, PSC activities are distinctly separate from general information and fund-raising work. However, this distinction is not always observed. When they collaborate with health education units within countries it is most often in their capacity as communications, or media, experts.

Health educators are usually nationals who come from different backgrounds and work mostly in health education units, in Ministries of Health. Although some health educators have social science orientation, in most developing countries, their professional background is nursing or public health (health inspectors or sanitarians more commonly than doctors). There are few staff in the field, and tend to perceive their role narrowly as the executive arm of the health service (WHO 1982). Except for a few health educators who have undergone professional and specialized training, health education training has up to recently tended to be narrowly orientated, "a tool in the service of specific disease programmes" (Green 1984), and there has been little communicatons training (in advocacy skills, in 'facilitation'). These factors inhibit their co-ordination or catalyst functions with other sectors (education, media, water supplies) and non-government or international organizations, and community groups. Their capacity for training others is likewise limited, both quantitatively and

qualitatively. Very little promotive work or advocacy is done: few health education units get involved in fiscal measures, legislation or voluntary codes of practice. Finally, evaluation of health education activities is rare, and little research is undertaken. None of these is surprising given the lack of recognition and support most health education units receive from governments.

Perceptual and structural constraints are also reflected in WHO and UNICEF, which in turn have implications for policy support within countries. WHO inevitably has its closest contacts with Ministries of Health, and their health education units, which it has helped to set up, and continues to support. The implication of the convergence of information and education is that health education units will themselves have to change: to become more out-going, making links with community groups as well as other sectors; to take on advocacy roles, focused not only on the media, but also on health professionals and decision-makers, as well as policy makers in other sectors. As presently constituted, health education units are hardly able to meet this challenge however attractive it may be to them. UNICEF, on the other hand, has a wider network within countries, working more often than WHO does, with Ministries of Education, Social Welfare, Water Supplies, Information, as well as with NGO's including women's organizations. Identifying the mechanisms through which both agencies can work at country level is important if joint support for information, education and communication for health is to be practical.

2. Approaches to communication

a) The communication process

The relationship between communication and community participation is symbiotic. "There can be no development communication without the participation of all parties involved: the community cannot share in development unless it can enter into a dialogue with the agencies external to it - government or foreign donor agencies - from the earliest stages of project design, through implementation" (Bunnag 1982).

The communication process is a complex one, and it is all too often treated more as an ad hoc downward flow of information than as a dialogue over time, as a package of techniques, than as a process. It may demand a patient dialogue with communities, especially where there is a conflict between community priorities or values and external agents' offers of assistance. PSC officers and health educators working with communities are involved in long-term activities, sometimes with health taking secondary place to other development issues. They are not always supported or trained in these roles, and the exigencies of programme design and budgeting often interfere in the dialogue process.

b) Technical support - the media

Over the past twenty years there has been a massive increase in the spread of the mass media (especially television, videos and radio) in developing countries. The concentration of people in towns and

cities, the rise in school enrolment, the extensions of road and rail networks, have increased the potential for mass communication. The effects have been greater in the middle-income countries, but even in low income countries radio ownership is widespread.

Communication though mass media is attractive because it reaches large audiences. Its effectiveness, however, may be limited. Experience in using mass media techniques to change people's behaviour in both developing and industrialized countries has been disappointing (Walt & Constantinides 1983) although projects have sometimes failed because of planning and implementation faults rather than necessarily the medium utilized (Jenkins 1983). McCron and Budd have argued that if the mass media have any influence on their own it tends to be in the direction of reinforcing existing beliefs and opinions, rather than in changing or converting them (McCron & Budd 1979). In many countries the mass media are limited to urban populations, are reluctant to give popular listening time to subjects such as health, and do not control or restrict undesirable advertising which may conflict with education messages. The contacts between media and health or development personnel are often rather tenuous.

In spite of this, the mass media remain a potentially valuable tool, both as a medium for advocacy and, when used in conjunction with other methods like health services support, as a reinforcing agent. The critical factor is that they are not used alone, but as part of a package, and that they are used sensitively in terms of language and values. Radio could be so obviously the most powerful medium

in any local society if only the tribal languages in the programmes and the quality of the narrators were better" (Fuglesang 1981).

c) Social marketing

Introduced in the 1970's, and employed in many population programmes, social marketing is beginning to be considered more seriously by a number of agencies. It is used to describe the use of marketing principles and techniques to advance a social cause. It calls for "effort to be spent on discovering the wants of a target audience and then creating the goods and services to satisfy them" (Kotler & Zaltman 1971). Social marketing techniques may try to create a demand for health actions, by utilizing concepts of consumer research, focus groups, facilitation and incentives to maximize target group response.

The potentials of social marketing are only just being explored. Experience shows that it is not a simple concept: In Barbados after a mass campaign, women showed they understood the value of breastfeeding, but they lacked a support system to put it into practice (Grant, 1984). Considerable financial and professional resources are necessary to research into the needs and problems of a target audience, message acceptability and practicability (Manoff 1983) and not all countries have that capacity.

The commnication process has been mentioned because of its complexities. Embarking on information, education or communication policies that do not recognize this may exaggerate claims for success which may

be true for the commercial sector but do not apply to social issues. The message is as important as the medium, and needs reinforcing. Without good follow-up mass campaigns achieve little. Involving communities is a two-way process which has itself important policy implications for action.

3. Infrastructure support

Government support for information, education and communication for health depends on political, economic and social factors that differ from country to country. The political will endorsed at Alma Ata as a necessary, though not sufficient, element in re-orienting governments' attitudes to Primary Health Care, will finally be measured by the extent to which resources have been re-allocated within and between health and other sectors.

Inadequacies in support for information, education and communication for health exist in all countries to some extent or other. Inadequate resources, for example, are put into health education units: they remain for the most part poorly financed, badly staffed, low in influence and firmly implanted in Ministries of Health in capital cities.

Inadequate organization retains control centrally, so that local communities can seldom be real partners in decision-making: participation is thus often relegated to voluntary labour. Inadequate contacts with other sectors means that many health education activities go on in isolation from each other. Some of the most radical health activities have been initiated in the adult education field. "Adult education processes of consciousness raising and social analysis tend to promote mobilization of people to act in their own interests:

a process which can be focused upon improvements in their own health" (Tandon 1984). Primary and secondary schools too, have been a rich source of PHC activities, educating, informing and communicating with their own communities (Rohde & Sadjamin 1980). The problem is that this effort is large unco-ordinated, and not always known about, unless directly funded or supported by international or other agencies which encourage dissemination of the experience.

And finally, inadequate training leaves many health professionals unsympathetic or uninterested in information, education and communication for health, and PSC officers or health educators inappropriately trained to be the initiators, planners, evaluators and advocators they are increasingly expected to be. Re-training and re-orientation of staff employed in health education and communication sections is necessary to develop and support the new priority for information, education and communication for health.

III Some current activities and issues in this area of work supported or undertaken by the two agencies

WHO has identified three priority areas for action in information and education for health in its Seventh General Programme of Work: technical cooperation, human resources development and research (WHO 1982b). UNICEF has declared the Child Survival and Development Revolution to be possible through the universally relevant and low-cost techniques of growth monitoring, oral rehydration therapy, breast-feeding and immunization (GOBI). To these have latterly been added food supplements, family spacing and female education (FFF), but it is acknowledged

that they are more costly and difficult to implement than the four GOBI measures (Grant 1984).

In such a short paper it is impossible to do justice to the range of activities being supported by both agencies separately and jointly. It would be a major research undertaking to collect and collate activities adequately, although UNICEF's State of the World's Children, used more as a tool for advocacy, also provides a useful review of activities in countries.

For WHO much re-orientation in information and education for health has to go on at regional level. All regions are different, with varying problems and priorities, and the annual reports of the regional directors reflect this. Information and education for health differs in thrust from region to region.

Activities typical to most regions are inter-country meetings on a variety of topics such as community participation in Primary Health Care, health education in family health, health behavioural research. Specialists and consultants are provided to assist in a number of tasks - curriculum development in health education for primary schools, for example. In some countries, WHO health education specialists have been useful catalysts, and have been able to co-ordinate activities between sectors and agencies. In southern Sudan, a number of activities which included a VIP latrine demonstration project, preparation of health education teaching aids, a newsletter, regional and international workshops, school health projects, brought together health workers, extension workers and teachers as well as a number of agencies.

Much of this was achieved through the appointment of a health education specialist able to forge links across sectors (Sudanese Regional Ministry for Services 1984). Financial assistance and subsidies are given for a limited range of activities, including collaborative projects with other international agencies. Information activities tend still to be seen separately from education, although the new trend includes advocacy: "convincing mass media representatives to become supporters of the HA/2000 approach and then encouraging them to promote the concept, not only to the public at large, but most of all to...decision makers at all levels" (EMRO 1981). Most regions are involved in some way or another in developing human resources, and WHO has given strong support to training institutions and to individuals by way of fellowships. A number of meetings have been held in the last two years to re-orient thinking on the integration of information and education and on the new approaches in health education.

Of course, health education, unlike other technical subjects, has never been the sole responsibility of one section in WHO. Many WHO programmes have accepted the need for educating and informing people about specific issues (smoking, diarrhoeal diseases, appropriate technology) and have devised communications strategies, modules, materials or newsletters for so doing. They may or may not have had much recourse to the Division of Information & Education for Health in planning or disseminating such material. The regions then, may receive information and education material from several parts of WHO.

UNICEF, of course, is already a partner in many development schemes, and needs WHO's technical assistance in its promotion of the particular aspects of PHC it has chosen to emphasize. The agency's major concerns today are not only how to spread the information and technology regarding GOBI-FFF, but also how to educate families and mobilise health and non-health sectors as well as NGO's to guarantee utilisation of services. UNICEF believes that any significant improvement in the health of children will depend precisely on this process.

Support is being directed at two levels. From headquarters UNICEF, through its annual State of the World's Children Report, is progressively persuading top-level policy-makers of the value of the low-cost and simple GOBI interventions for children, and at village level community workers are empowering parents by promoting these simple actions. From Guatemala, Egypt and Honduras, UNICEF-assisted oral rehydration therapy (ORT) campaigns have reported dramatic falls in the number of child deaths from diarrhoea (Grant 1984). In all of them basic community workers and health and non-health professionals were involved in promoting and sustaining use of ORT packets, backed up by the use of communication materials, radio and T.V.

Because of successes like these, UNICEF is looking toward social marketing techniques to improve the effectiveness of communications. In Brazil, for example, a nationwide government campaign to promote breastfeeding was launched in 1981 after two years advocacy and consultation by UNICEF. It was multi-sectoral and multi-strata, worked with health professionals as well as with industry and communities. Messages were carefully researched, and the campaign was envisaged as ongoing - involving other activities

such as legislation, the building of creches, and so on (de Cunha 1981). The effects of the programme have yet to be evaluated. A national vaccination crusade in Colombia in 1984 centred on three vaccination days in June, July and August, and co-ordinated a set of complementary efforts from a variety of institutions and the media, including a personal input from the President (Ministry of Health, Colombia 1984).

UNICEF has also organized national workshops (in India for example) on the Child Survival and Development Revolution for leaders of labour and industry, agriculture and education, the media and the voluntary organizations. The attempt has been to "mobilize all organized resources" (Grant 1984).

As with all such efforts, careful planning has to be undertaken to ensure follow-up. On their own, campaigns or even workshops may be useful as political demonstrations to the community or the world, but if they do not sustain action, they fail. There is always the danger that they divert both resources and attention from other priority areas or away from development.

UNICEF is involved in other interventions also related to health, such as water and sanitation programmes in which health education plays an important role. Since 1983 there has been a programme officer in the Water and Environmental Sanitation Team at headquarters, with special responsibility for health education, whose job it is to establish links with other specialist agencies as well as the PSC network in UNICEF. One of the main objectives has been to improve planning and evaluation procedures so that health education is not seen as a separate component but is part of programming (Glasgow 1984).

IV Practical suggestions for the two agencies to begin systematic efforts to support effective information, education and communication for health in developing countries.

1. An essential step for re-orienting and supporting information, education and communication for health in countries is to identify the mechanisms through which this can be done. Using their advocacy skills UNICEF and WHO should identify those countries interested in, or already developing, new policies in information, education and communication, and assist them in setting up the bodies which will help to plan, monitor and evaluate strategies for information, education and information. Another focus could be those countries which are part of the joint activities such as JSPHC (Joint Support to Primary Health Care Implementation in Selected Countries) programme and WHO/UNICEF Nutrition Support Programme (JNSP) where information, education and communication is seen to be at the core of the programme but responsibility for it has not yet been assigned to a particular multi-sectoral agency for body within country. UNICEF and WHO should help to identify and mobilize multi-sectoral resources to reinforce the place of information, education and communication for health in these countries.

2. Any joint activity information,education and communication for health must take place within the context of government policy, of government plans and priorities. It would be useful to review training curricula, which probably need strengthening in planning, management, evaluation, communications and advocacy skills.

Mechanims for consultation, co-ordination and effective monitoring of activities in this field, need to be set up, if not already existant, between UNICEF, WHO and governments.

3. Creating networks of contacts is particularly important in information, education and communication for health, because activities are going on under so many different auspices. Identifying voluntary groups, consumer associations, trade unions, mass organizations, even sections of industry, as well as institutions like adult education is the first step to stimulate demand. A stocktaking situational analysis of such groups by PSC officers and health educators could be a joint activity supported by WHO-UNICEF. Multi-sectoral workshops in countries to catalyse such groups in PHC activities or to encourage lay self-help groups and to strengthen links between non-government organizations working in this field would also be useful joint activities for the two agencies in the attempt to develop new attitudes and broader approaches to PHC. Much more needs to be done to establish contacts with the media.

4. The two agencies should stimulate and facilitate an exchange of experience at all levels. At headquarters joint annual planning sessions for information, education and communications may help co-ordination between the two agencies. This should be considered for regional staff as well. More effort should be made to disseminate lessons from the field. This could be done by regional workshops and visits to successful projects in countries. It would also be useful to draw together a number of substantive case studies in information, education and communication for health to help appraise activities in this field.

5. Greater priority from UNICEF and WHO for information, education and communication for health would help to legitimize increased attention for these activities within countries. A greater financial commitment and re-orientation at the headquarters of the two agencies would also be helpful. Reasons may need to be found from existing budgetary sources.

6. A review of the work of health education units and of PSC roles, functions and structure. More discussion is needed on how they can support the process of dialogue with communities without imposing their more technical views, or where contacts with communities are limited logistically, on how their objectives can be more realistically directed, say towards health promotion activities. Much will depend on the specific country and its resources, and any such review should be done with the staff of both units jointly.

7. Staff development and re-training are necessary to raise consciousness about the new approaches and methods in information, education and communication in all programme areas. Headquarters staff need to take on advocacy roles to their own regional and field staff, and support seminars that explore and translate the skills and mobilizing experiences of other sectors, such as Adult Education, be undertaken jointly with each agency complementing the skills and expertise of the other. More collaboration between the two agencies in the development of communications and educational components of country programmes might be engendered through better understanding of their use and potential. It would also be useful to review training curricula, which probably need strengthening in advocacy, planning, management, evaluation and communication skills.

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PROPOSED JOINT WHO/UNICEF STRATEGY AND POLICY DISCUSSION PAPER ON SOCIAL COMMUNICATION/EDUCATION FOR HEALTH

1. Background

At a WHO/UNICEF inter-secretariat meeting held in Geneva, 1-2 March 1984, it was "emphasized that collaboration between the two agencies in the area of information and education materials needed to be systematized and to be seen as part of programmes rather than ad hoc activities". Before this can be achieved however it was suggested that the two agencies develop jointly an international strategy for social communication and education for health in support of Primary Health Care/Child Survival and Development Revolution. To be able to do this, it was further decided that a policy discussion paper be prepared for the WHO/UNICEF Joint Committee on Health Policy meeting in February 1985.

2. Outline of Proposed Paper

The following outline for the paper was suggested at a meeting on 11 June 1984 attended by:

Dr. Karin Edstrom - WHO Liason for UNICEF

Dr. Susan Cole-King - Senior Programme Specialist (Health) Programme Development and Planning Division (PDPD)

Mr. Newton Bowles - Consultant, (PDPD)

Mr. Manzoor Ahmed - Senior Education Adviser (PDPD)

Ms. Muriel Glasgow P. Programme Officer, (Health Education PDPD)

Mr. R.R.N. Tuluhungwa - Chief, PSC Service, Division of Communication and Information (DCI)

Ms. Vicki Marsick - Officer-in-Charge Staff Development and Training, Division of Personnel (DOP)

(a) The ultimate objective is to enable the two agencies to increase the effectiveness of their support to country efforts in Primary Health Care/Child Survival and Development Revolution programmes in order to strengthen positive health behaviour practices in communities, and to improve international communications/advocacy for health.

(b) <u>The paper will encompass the following:</u>

- an analysis of the various terminologies currently in use in the two agencies with the aim of clarifying what is meant by "social communications * and education for health";

- a summary of problems relating to social communication and education for health as currently planned and implemented in country health programmes especially at community levels;

- an appraisal of current activities in social communication and education for health supported or undertaken by both agencies at global and national levels - this section must include a critical review of constraints and achievements;

- formulation of action-oriented recommendations to improve approaches of the two agencies for supporting countries in this area and for global collaborative programmes; and

- inclusion of an annotated bibliography.

3. Work Plan

The group agreed that the final draft must be ready by end of October 1984. To meet this deadline, it was recommended that:

(a) A meeting of the technical staff from the two agencies and the consultant be held in Geneva, 19th July to agree on the objective and scope of the paper. Mr. R.R.N. Tuluhungwa to attend.

(b) The terms of reference for the consultant should be developed and agreed upon by end June, and the consultant should be identified and recruited by mid-July.

(c) The paper should be reviewed by the technical staff of the two agencies by mid-September.

(d) The draft should be circulated to selected field offices of the two agencies by end October and their comments synthecized into as an addendum. by end December 1984.

(e) R. Tuluhungwa is to consult WHO, particularly Dr. Hellberg, on possible consultants.

R.R.N. Tuluhungwa/M. Glasgow

UNICEF-New York

15 June 1984

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* known as Programme Support Communication (PSC) in UNICEF.

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Information Education and Communication for Health -- A background paper for the WHO UNICEF Joint Committee on Health Policy by Gill Walt - Lecturer in Health Policy - Evaluation and Planning Centre - London School of Hygiene and Tropical Medicine

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