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Technical Discussions

NEW POLICIES FOR HEALTH EDUCATION IN PRIMARY HEALTH CARE

Background document for Technical Discussions
Thirty-sixth World Health Assembly, 1983

CONTENTS

<u>THE MAJOR ISSUES</u>

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

World Health Assembly, 1977

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

Declaration of Alma-Ata, 1978

These two statements give the background against which new policies for health education in primary health care should be developed. The major issues involved are discussed in the following three sections.

1. INTRODUCTORY REMARKS: THE CONCEPT OF PRIMARY HEALTH CARE AND HEALTH EDUCATION

In accordance with resolution WHA 10.33 of the Tenth World Health Assembly, the Executive Board at its sixty-eighth session decided that the subject of the Technical Discussions at the Thirty-sixth Assembly would be: "New Policies for Health Education in Primary Health Care". It is significant to note that it is not health education <u>methods</u> that were selected for discussion, but rather health education <u>policies</u>.

Member States of the World Health Organization and nongovernmental organizations (NGOs) were asked to share the experience they have had in harmonizing health education policies with the concepts of primary health care. Reflecting the information collected, the first part of the present document:

1. reviews some of the concepts and issues to be taken into consideration in formulating national policies in health education;

2. analyses the evolution of health education policies in Member States and in WHO;

3. outlines a suggested process for the contribution of health education to the strategy of primary health care.

1.1 <u>Some definitions</u>

The topic for the Thirty-sixth World Health Assembly Technical Discussions requires definition of three terms in the title. The following definitions are proposed:

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

<u>Health education</u>: Any combination of information and education activities leading to a situation where "people <u>want</u> to be healthy; <u>know</u> how to attain health; <u>do</u> what they can individually and collectively to maintain health, and <u>seek</u> help when needed".46(p.13) This definition aims to promote conditions that will help people to "acquire the power to make decisions that have to do with their own health".25

"Health education" is used in this paper to embody (a) information activities directed at 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;[77] and (d) other forms of 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, the general educational level of the community, other economic and environmental factors, social norms and customs, and so on.[4] The promotion components of health education policies must therefore provide not only for the "adoption of beliefs, attitudes and behaviour likely to further health" but press as well for an environment which supports the development of such attitudes and behaviour.[78](p.8)

Furthermore, it should be stressed that health education is not merely a matter of efficient transfer of information through institutional channels of communication.[57] Effective education for action is widely understood to include a subjective element of personal and social involvement and of commitment to the objectives which the educational effort aims to promote. Indeed, this is what makes health education so essential to the family and community participation goals of the global strategy of health for all by the year 2000.

Health education in primary health care: The International Conference on Primary Health Care jointly sponsored by UNICEF and WHO and convened at Alma-Ata in 1978 at the invitation of the USSR government,[45,22] officially declared "education concerning prevailing health problems and the methods of preventing and controlling them ..." as the "first" among eight essential components of primary health care.[45](p.4) It also emphasized the "right and duty (of people) to participate individually and collectively in the planning and implementation of their health care".[45](p.3) Hence the importance of health education in giving people the confidence to exercise this right.

1.2 Purpose of the Technical Discussions

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

-   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;[64](pp.19-20)

-   to help Member States build or extend a policy basis for planning, management and evaluation of the health education components of their national and community programmes of primary health care;[48]

-   to direct the attention of Member States to the importance of monitoring and evaluation in strengthening health education, including the development indicators and criteria regarding: community involvement, health literacy,[a] health behaviour, and levels of individual and family self-care;[48,54,60]

-   to provide WHO with a better understanding of the needs of Member States in order to plan the allocation of its resources accordingly and to improve its technical cooperation in the field of health education.

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[a] Health literacy 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.[48](p.29)

1.3 The challenge and the opportunity

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

This issue was clearly set forth at the Alma-Ata Conference which stands out as a turning point in the history of health education.   As well, it was stressed by a number of regional technical discussions and deliberations[27,74-81] and by numerous international meetings of nongovernmental organizations, the latest being the XIth International Conference of the International Union for Health Education.[26,28]

What must the new policies include?

The main objective is to provide support for educational efforts aimed at fostering community involvement and self-reliance, promoting a greater diversity of objectives in policy-making, harmonizing national and local plans, facilitating intersectoral action and the use of appropriate technology.

1.4 Promoting community involvement and self-reliance

Of the several features of the Declaration of Alma-Ata which have implications for health education, the one that is central to its role is <u>participation</u>.

The essential relationship between health education and participation is not new.   It was emphasized in the preamble to the Constitution of WHO which stated that "informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people."[47]   It was reaffirmed in the report of the first Expert committee on Health Education of the Public, convened in 1953,[49] as well as in several WHA resolutions (see 2.4) and in every major technical report on health education.*

Experience has shown that efforts to increase individual and community participation in the planning process have resulted in more successful programmes in both targeted disease prevention and more general community development programmes.

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

1.5 Enhancing decision-making skills at local level

Health education appears as the approach par excellence when it comes to encouraging and enabling communities to identify their health problems, select solutions, set targets, and translate these into simple and realistic goals that they can monitor.[50,11]

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

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* Fuller details on the subject will be found in the following documents, cited in the list of references: 15,32,42,43,51,52,58,59,69,72,73,79.

1.6 Allowing for a diversity of objectives in policy making

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

The very principles of primary health care, on the other hand, make it necessary for national policies to find ways of taking into consideration the more diverse objectives of communities in their planning so as to integrate the varied priority needs identified at the local level.

1.7 Harmonizing national and local plans

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

This question will no longer be a dilemma once the 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 the input resulting from such community involvement.   But initially, national governments must take the lead in setting policies that will authorize, encourage and support local community involvement in health.

In recent years the importance of decentralizing the managerial process for national health development has come to the fore.   In fact, many countries have taken steps to strengthen decision-making powers at provincial, district, and community levels.   This trend highlights the need to facilitate community involvement in planning through health education, so that local action blends with "the national health policies to be followed, the objectives to be attained, and related targets, quantified as far as possible".64(p.34)

1.8 Facilitating intersectoral action

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

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

It should also be stressed that interpersonal communication is one of the major instruments which should be employed in setting up and maintaining effective intersectoral collaboration mechanisms.   Health education therefore must play a part in informing all who are concerned of the necessity and benefits of working together.50

1.9 Using appropriate technology

This presupposes that the technology is responsive to the needs and aspirations of the people and that it takes into consideration the health culture of the community concerned, i.e. the power structure, the dynamics of social and cultural change and the political and economic organization which influence this culture.[1,8] Instead of providing communities with a predetermined framework of health care, the purpose is to enable community members to play an active role in planning, implementing and evaluating health services.

Here, health education has a major responsibility in furthering a dialogue between professionals and non-professionals so as to accelerate a two-way transfer of technology between the health system and the people. This will increase the area of interface where the felt needs and the epidemiologically assessed needs overlap and provide a basis for real teamwork.

1.10 Measuring community involvement and the impact of health education

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

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

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

These, then, are some of the key issues that need consideration in developing new policies for health education. It will be of value to examine now the experiences of Member States in this respect.

2. EVOLUTION OF HEALTH EDUCATION POLICIES IN MEMBER STATES AND IN WHO

The questions posed to Member States in the outline of the background document on new policies for health education,[66] sent out in July 1982, were not in the form of a formal survey, so the returns cannot be presented statistically. Nevertheless, several major patterns and constraints emerge in relation to the broad issues of decentralization, community involvement, appropriate technology and multisectoral development.

2.1 Decentralization and community involvement in planning

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

In most communities, an infrastructure for health care is already in place, however poorly suited it may be for primary health care. It would be unrealistic, therefore, to expect health education to initiate a "bottom-up" planning process, starting from zero and free of any central influence. Furthermore, in view of their scarce resources, most countries have to make some budgetary plans at a central level, in advance of local decisions. This means that by the time resources reach the local level, their allocation may already be fixed. The order of initiative, then, is most frequently from central to local level.

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

2.2 Four predominant policy patterns

The flow of information, actions and decisions between centralised and decentralised levels are found to fall in four predominant patterns among the Member States.

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

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

A third type of policy emphasizes intersectoral development with centralized coordination. Concern for cooperation with other sectors and their involvement in health promotion has prompted both large and small countries to supplement their sectoral system of planning and implementation with new structures that are to act as a link and facilitate a global approach to problems. They have set up, at central level, coordinating agencies, community development institutions or more comprehensive delivery systems, often without new resources. In practice, however, the sectors tend to continue to plan, implement and evaluate their own programmes separately, although with greater focus on secondary planning and implementation at the local level and new demands placed on communities to coordinate their local resources as a condition for continued support from central agencies.

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

A major departure from past practices is that planning and implementation are increasingly a shared responsibility between centralized agencies and local groups.   "No longer should the health services filter down through a number of layers to 'reach the underserved'. An upward movement, starting from the people, has now been initiated."[26] This increased local involvement in health planning does not become equated with total responsiblity for financing and carrying out programmes. On the contrary, far from leading central government agencies to abrogate their roles in supporting the implementation of programmes,[30,42] the new policies in citizen participation, community involvement and self-care tend towards a constructive partnership in which each party has a specific contribution to make.

This local involvement has been found to characterize successful health programmes, as reflected in a study of national experiences conducted for the UNICEF/WHO Joint Committee on Health Policy:

(a)   at the village level, preventive and curative health services that adequately cover and are sufficiently used by the population have been achieved where the population concerned has taken major responsibility for primary health care and where the government has collaborated in the effort;

(b)   the notion of major responsibility implies the notion of a great deal of self-reliance not only in decision making with respect to priorities for health care but also in the provision of resources (manpower, facilities, logistic support, and probably funds) that are needed to bring health services into line with the defined priorities.[42]

Another innovative approach of the new policies is the building up, within the community, of multi-sectoral development based on local sectoral experience.   In some countries the local coordinating councils are nongovernmental.

2.3   Implications for health education

It is generally agreed that information and education for health are an essential ingredient to forging partnership ties between central agencies and local communities and between sectors involved in primary health care.   But reports from Member States reflect concern over the fact that methods required to achieve this partnership are far from being sufficiently developed.   Hence, the demand for research on the role of health education in connection with community development experiences.

2.3.1   The organizational placement: The positioning of health education has an important impact on its capacity to act effectively and influence the integration of information and education with all aspects of health care as well as with other sectors.

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

From the standpoint of getting the existing health education resources oriented towards primary health care, the experience seems to be that a high placement in the ministry of health gives health education greater flexibility and more responsiveness to needs. When, however, it is subsumed under disease-specific or population-specific departments such as communicable diseases or maternal and child health, its efficacy is decreased.

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

2.3.2 **Legislative support**: Sometimes, legislative measures follow health education and serve to legitimise certain behaviours conducive to health that have been promoted by the educational input; sometimes, on the contrary, it is necessary to have recourse to regulations to support educational efforts.

Four broad types of legislation can be identified. The first aims at facilitating a large spectrum of initiatives and measures which concur to health development, as proposed by the Seventh General Programme of Work of WHO which invites Member States to consider the adoption of legislation that is conducive to healthy lifestyles, to reorient their health budget towards more relevant technologies, to develop new types of health workers where necessary, and so on.[70](p.60)

The second is concerned with restricting or prohibiting the promotion of products that can have a harmful impact on health. Many countries have taken at least some policy action against exaggerated claims of the health benefits of medicines, foods, medical appliances and practices. Some have extended restrictions to the advertising of harmful or potentially harmful products, in certain cases even prohibiting any advertising for baby foods, cigarettes or alcohol in at least some of the media (see WHA27.43, WHA31.47, WHA33.32, WHA34.22 and WHA35.26).[29,37,61,62]

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

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

At the level of communities, "informed consent" is just as useful with respect to such issues as fluoridation of drinking water, vaccinations or various measures concerned with the protection or improvement of the environment.

Family planning is an area where "informed consent" takes on particular importance.

2.3.3 **Financial support**: While certain developed nations spend less than 0.1% of their health budgets on health education activities, some developing countries may be spending up to 3%. In both cases, over 90% of health expenditures are allocated to hospital care and personal health care and some two-thirds of this amount are in relation to manpower.

This may not be the best way of measuring, since these figures do not permit conclusions to be drawn. It is difficult to determine what percentage of health expenditures should go to health education without referring to a country's total budget and to the percentage attributed to health within that budget. If the ministry of health budget is too low, even assigning 5% to health education would still be inadequate. One goal, however, should be to attribute a similar amount to operations and to manpower. Any major shift of resources for health education in primary health care is likely to come from the "referral care" and manpower sectors.[9]

2.4 Evolution of the health education concept in WHO

Policies for health education as articulated by the World Health Assembly over the past 30 years* have shifted the emphasis:

- from centralized to decentralized planning;

- from singular (specific disease) to diverse objectives;

- from building health literacy and skills in support of specific programmes to promoting a global educational approach to problems;

- from focussing on individual behaviour change to a concern for organizational, economic and environmental factors which are conducive to healthy lifestyles, self-reliance and political action for health promotion.

Regional Offices have devoted considerable attention to these issues in new policies for health education in primary health care.[13,74-81] The concepts and approaches that are reflected in their documents are consistent with those in the latest generation of World Health Assembly resolutions and WHO planning documents.

In this connection, the most recent document in the "Health for All" series published by headquarters is the Seventh General Programme of Work of WHO, which provides for a greater integration of health education and information activities.[70] Thus, health education is now placed in a broad perspective in which information and education are seen as two elements of the same continuum. This continuum involves activities ranging from advocacy, arousing health consciousness and reaching out to large numbers of the population through the media, to an approach involving interpersonal relations in dealing with specific individual and community aspirations and problems.

A recent reorganization at WHO headquarters reflects this trend; in 1982, information and health education were brought together in a new Division of Public Information and Education for Health. This reorganization implies a commitment to respond more effectively to the needs of Member States for support from WHO in strengthening this aspect of their work and supporting their efforts at promoting self-reliance and community involvement.

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

> Nothing ever starts at one moment of time. The beginning and evolution of a process vary according to historical and local circumstances. The process tends to take place in stages, the achievements of one stage uncovering new problems, which in turn lead to new resolutions. Sometimes progress takes place gradually; at other times the build-up of events leads to qualitative breakthroughs.[65]

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* For resolutions dealing with health education per se, please refer to WHA1.41, WHA23.61, WHA27.27, WHA27.28, WHA31.42.[55,56]

In the following pages an attempt will be made to identify some of the critical stages at which information and education for health can facilitate and reinforce the involvement of communities in health care and promotion and, through that involvement, help ensure that the technology used is appropriate and the intersectoral approach is strengthened.

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

New policies expect communities to go even further than "participation" at the planning stage. They expect them to take the initiative by undertaking a self-study of their values and needs related to health, documenting needs and barriers, and deciding to which needs they wish to give priority. The encouragement and resources required may come from within the communities or from outside. Whatever the case may be, policy backing is a must. A brief description of the initial four steps involved follows.

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

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

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

It is useful to understand this point from the start and to expect that the initial diagnosis by the community will focus on needs rather than on solutions. Sometimes the needs will be expressed as health problems, such as "sick children"; sometimes they will be expressed as social concerns. But health workers should be able to find the health issues underlying them.

2. Do the felt needs truly reflect the major issues in the communities?

Felt needs should be verified and documented for the purpose, later, of setting priorities. In smaller communities, this can be in the form of an opinion survey or a consultation by a village health committee. In more advanced circumstances, it may be useful to resort to sampling techniques to verify the distribution of the problems identified in the community and their relative importance to the community's development or quality of life.[19,63,67]

3. What are the priorities?

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

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* Note: The numbers in this section correspond to those in the graphic representation of the process in Annex 1.

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

For the professionals, this dialogue involves a real technical challenge in that it requires them "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 <u>or</u> their judgement of benefits. This means being able to live with an educational approach that focuses on enhancing problem formulation and decision-making skills.[73](p.4)

4. Central support comes into play

Based on the community's expression of priorities, the responsible central or provincial agencies can, at this point, allocate resources and formulate a technical plan to help the community, taking into consideration programmes delivered by other agencies or services to the same community. The emphasis placed here on central functions in formal planning and allocation of resources suggests that new policies should not allow government agencies to interpret community involvement as an excuse to withdraw their support for local health services, or to pass on to the community their responsibility for the technical aspects of planning and delivery of services.

What are the functions of health education in this initial phase of the process?

<u>Vis-à-vis the community</u>: It has essentially a consciousness-raising role. Its major objectives are to facilitate access to health and related information; to develop community capabilities in problem identification; to help people set priorities among the different categories of problems they have detected, taking into consideration such factors as the magnitude and severity of a problem (contagiousness, susceptibility to treatment and so on); and last but not least, to promote a social partnership between lay and professional resources based on the recognition that both are essential and complement each other.

<u>Vis-à-vis the decision makers</u>: It has an advocacy role in ensuring that programmes are built on the people's perception of needs, with priority given to goals which reflect both the felt needs of the people and the needs as defined by health professionals.

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

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

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

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

The mechanisms of coordination vary from more formal bodies to regular meetings for sharing information. The initiative to establish and regularly use different coordinating mechanisms mostly lies with the authorities at central, regional or local levels, but may also be the responsibility of a nongovernmental organization. Experience from some countries suggests that multisectral coordination - the third cornerstone of the primary health care triad - is better accomplished by the community than by the central agencies. This is particularly so when there is a mixture of government and private resources for health being developed at the local level.

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

Although coordination is essential, it should be realised that overlapping is far from being always harmful: sometimes, it may act as a reinforcement. Furthermore, coordination should not be equated with control.

6. Action develops. But is the technology used appropriate?

Early in the implementation of plans, questions come up: Do the services and programmes meet the goals and priorities set by the community? Is the technology suited to its circumstances? The people themselves can best answer; this first level of evaluation should therefore reflect the community's views. This position is perhaps a departure from conventional policies but experience suggests that participation in evaluation has been a catalyst for social action, even more powerful than participation in the administrative or management functions of implementation.[30,42]

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

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

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

Although this type of evaluation requires technical know-how, it is nevertheless important that it be placed under the control of the community concerned. There are three reasons for this. One is awareness of the benefits, which result from participation in evaluation, and the reinforcement this provides for continued involvement;* another reason is more effective communication between the people and the health personnel. A third is that the criteria selected have a better chance of being relevant to the recipients' goals and needs, as they perceive them. This more than makes up for the disadvantage of using methods that may be less sophisticated or rigorous.[7,18,20,33]

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* At the individual and family level, self-monitoring of progress has been found, as well, to be highly conducive to self-confidence and behaviour change.[10]

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

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

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

> Information and education are among the many supports needed by communities to enable them to carry out the functions of multisectoral planning and of evaluation. What will be the specific input of health education at this stage?
>
> Vis-à-vis the community: The objective here is to build up the skills of the people and develop their self-reliance. More specifically, health education should help people set targets, offer alternatives to reach these targets, then assist the community in translating these targets into "simple, understandable, realistic and acceptable goals which the community can monitor";[50] health education should identify local cultural practices which lend themselves to certain modifications and build on these rather than promote alien practices;[71] it should develop educational material relevant to the local culture and as practical as possible; finally, it should determine in which areas lay resources need to develop their skills and plan appropriate training activities.
>
> Vis-à-vis the decision makers: Health education has the responsibility, on the one hand, to interpret and document the short- and long-term benefits to be derived from community involvement in monitoring and evaluation processes; on the other hand, it should propose mechanisms to facilitate communication between the various sectors.
>
> These functions aim at enabling action through a process of information and education involving various combinations of training, technical cooperation and community organization that lead to a productive association of lay and professional resources.

With its growing experience, the community is now able to move on to a more sophisticated level of community development, involving a new cycle of planning and action. As illustrated in steps 9 to 12 in the graphic representation of the process (Annex 1), the community reviews accomplishments, determines unmet needs, identifies barriers and proceeds with action to achieve greater involvement from all sectors to help fill gaps.[34,74,65] With adequate policy support, it is now ready to become involved in the more comprehensive evaluation of the multiple local and central programmes in the community. This will make it possible for central agencies to be advised by the communities on the gaps and limitations in the total package of services and programmes.

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

Furthermore, the community's increasing skills enable it to become involved in development programmes in other sectors. This will have, in the long term, an indirect impact on health and can serve as an entry point for the introduction of comprehensive programmes. Experience shows that community participation in one sector, such as health, education, agriculture and so on, often brings about a spread of activities into other sectors in which communities wanted services. This, in turn, increases the amount of local involvement.42(p.53)

> In this new cycle of planning, action and evaluation, what is the role of health education?
>
> Vis-à-vis the community: It should strengthen the process leading to increased self-reliance and healthy lifestyles by providing continual feedback on progress achieved; focus on the social supports to health, including organizational, economic and environmental factors; help coordinate and harmonize the health communications emanating from the various sectors so as to reinforce their total impact; provide training in health education to workers from other disciplines; encourage communities to develop funding schemes for health development;14,41 while at the level of individuals and families it should encourage a similar process of analysis, priority setting, development of self-reliance, evaluation of progress and so on.
>
> Vis-à-vis the decision makers: It should aim at the integration of education for health with suitable developmental activities in other sectors such as education, agriculture, industry, women and youth organizations and so on; it should provide evidence of progress so as to reinforce political commitment to primary health care concepts and support to the principles of community self-reliance and involvement; it should stimulate policy support for the type of research, training and media development that will enable health education to perform effectively.
>
> This type of health education is essentially concerned with reinforcing the will of communities and of decision makers to move towards a social partnership in planning and action for health.

This review of issues, policies and experience, together with the proposed process provides a background that should help the development of new policies. Such policies will naturally reflect the circumstances of each country,39 within the broader guidelines provided by the WHO global strategy of health for all by the year 2000.

IMPLICATIONS FOR NEW POLICIES IN FOUR AREAS

The implications derived from the previous sections will now be examined with reference to:

- manpower development;
- communication (media);
- research;
- the nongovernmental and voluntary sector.

4. MANPOWER DEVELOPMENT

4.1 Priority No. 1: skilled and motivated manpower

The best policies can be developed at all levels. But without trained people to implement them, these policies will remain on paper. The No. 1 priority therefore is to develop skilled manpower. In this instance, technical competence is not enough. The need is for manpower that will introduce the educational dimension in all the aspects of its work.

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

Thus, reorientation of health education policies implies new roles in health education for all health care providers. These new roles, in turn, require new forms of training in line with new strategies for working with communities, and a more comprehensive and realistic appreciation of the demands of research and evaluation.

4.2 The need for a reform

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

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

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

Reorientation of training programmes will only become a reality, therefore, if political commitment to primary health care exists at the strategic points of policy-making and implementation of manpower development. Such policy support needs to be based on a clear understanding of the objectives involved in integrating education for health in basic, in-service, continuing and post-graduate education for the various categories of health and other workers concerned.[38]

4.3 Reorientation of training programmes: the objectives requiring support

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

For health care providers, these objectives are:

(a) to foster a concern for development as a global process, of which health is one aspect; and

(b) to strengthen their capacity:

   - to develop and apply a people-oriented health technology which respects people's aspirations and felt needs;

   - to act as facilitators of action by the people rather than take action themselves and expect "participation";

-   to promote a constant transfer of technology between the health system and the people;

-   to assume an advocacy role vis-à-vis decision makers;

-   to recognize the contribution other professionals can make to the promotion of health, enhance and coordinate their efforts.

The process outlined in section 3 gives evidence of the importance of such attitudes and skills in promoting community involvement and self-reliance.

For teachers, who also have a major responsibility in health maintenance and promotion,[50,82] the objectives are:

(a) to foster awareness of the role of health in enabling children to develop their potentialities to the utmost; and

(b) to strengthen their capacity:

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

-   to link the school health experiences with health issues and programmes in the community, and the concerns of families as expressed through parent associations and other community groups;

-   to team up with health workers in these efforts and in a joint search for innovative approaches such as, for instance, experiments in developing "critical viewing" skills so as to offset the influence of media advertising on children[6,12,17] or new ways to implement the school medical checkup.[44]

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

Other professionals concerned include agricultural extension agents, social welfare workers, labour union organisers, insurance agents, religious leaders, housing and water resource authorities, inspectors in agricultural, manufacturing and packaging industries. The list could be extended to include virtually every occupation that entails contact with the public. If such workers are routinely to include health education functions in their work, then training activities need to be supported by policy and in some instances even required in order to ensure quality control. In all instances, the early, continuing involvement of these other sectors and occupations in planning is essential to their role as partners rather than as tools of the health sector.

If the categories of workers who have a role in health education are indeed numerous, yet "every one's job" turns out to be "no-one's responsibility".[76] Hence the need for specialized staff in health education whose expertise is required at central and provincial levels for the training of other workers in health education as well as for the planning, implementation and evaluation of health programmes, including the coordination of resources. In this respect, the recommendations of the PAHO/WHO Inter-regional Conference on the postgraduate preparation of health workers for health education are still most pertinent and need renewed policy support.

4.4 The lay resources in health

In respect of lay resources, an important function of training should be to enhance the capability of individuals and communities to analyze health and health-related problems.

Indeed, it can be argued that training in investigation methods and quasi-experimental approaches to everyday living are among the most fundamental tools that can be transferred to individuals, families and communities. For if people have the skills to enquire systematically into their conditions and to experiment with solutions, however simply, they will become less dependent on others and able to decide for themselves what their needs are and how these needs should be filled - including training to develop appropriate skills.[7,20]

Among the lay resources, there is one group that requires special attention: women. The influence that educated wives and mothers, alert to health problems and to self-care possibilities, can have on health levels in the family and the community is well documented.[83]

Another sector of great potentiality concerns the workers in industry. Experience in training programmes undertaken jointly with labour unions and employers has yielded valuable data on methods and approaches leading to self-reliance in health.

5. COMMUNICATION (MEDIA)

5.1 A continuum of action

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

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

There is a consensus today regarding the main functions of information media.[50] These are:

- to help create political will by appealing to policy makers;

- to raise general health consciousness and help set norms which have a strong bearing on health levels;

- to inform decision makers about the latest developments and limitations in health sciences, and publicize relevant experiences for replication;

- to help deliver technical messages;

- to help foster community involvement by reflecting public opinion, encouraging dialogue and facilitate feedback from the community.

5.2 Promoting a dialogue between health and media personnel

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

Surveys show, furthermore, that health is a topical subject, high on the list of media consumer interests. It is therefore good practice to put health in programmes or in print. However, if media experts are to crystallize their willingness to develop health messages, they need good content, provided regularly and sustained.

Here, two problems arise: (a) differences between health care providers and media personnel in their conceptual approach to the use of media; and (b) the absence of a dialogue between health and media personnel. Too often, the health care providers do not fully understand their role and responsibility in making available to media experts the kind of material they can use.

Policy support is therefore needed to overcome these barriers and create a new outlook. More specifically this implies:

a)   initiating a variety of measures that will foster close cooperation between health and media professionals;

b)   developing mechanisms to ensure a constant flow of information from the health sector to the media sector;

c)   organizing in-service training programmes:

  -   to strengthen the sense of social responsibility of media professionals in their work and the importance of featuring health in this perspective;

  -   to foster their awareness of the potential of health as a source of prime material for media consumption, and their interest in transmitting technical messages;

  -   to expose media professionals to validated health information and create awareness of the risks involved in transmitting information on treatment and therapy, often biased by its spectacular character: should the information not be totally correct or complete, expectations of improvement may be unwisely raised;

  -   to educate media professionals about the negative health impact of certain messages carried by the media, especially advertisements of various commodities;

  -   to enable health workers to understand the needs of media professionals - whose responsibility is to inform the public and do it in ways that appeal - and how they can build on these needs;

  -   to train health workers in effective communication techniques and make them perceive the importance of using a language accessible to others.

5.3 A broad concept of communication

Currently, the word media is used not only to refer to print media, radio and television. It also covers traditional means of communication such as puppet plays or folk art. Combining as they do accepted channels of communication with interpersonal approaches, these media are critical to the success of community self-studies and action phases illustrated in section 3. Here, policy support could be in the form of subsidies to traditional communicators (actors, puppeteers, story tellers) to encourage them to incorporate health messages in their activities.

Despite all our efforts to create better educational tools, still the most effective means remains the personal contact, with its one-to-one relationship where "teacher" and "student" change roles continuously, each learning from the other.   This is dynamic, constructive communication.   Hence, the importance for the health service provider to be technically prepared to assume this function as an integral aspect of his/her daily task.[28]

If information and education for health are part of health development, health in turn is part of the mainstream of life.   Health care providers need to be more aware of this reality.[24]   They also need to become more sensitive to the importance of the communication flow between the people and professionals, and between the professionals themselves, as a major asset in a process of development where sectoral barriers have no place.

6.   RESEARCH

6.1 Why research?

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

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

An important point: research in health education must be essentially concerned with applicability and must be planned within the broader perspective of health systems research.

6.2 Scope of research

Seen in the perspective of health education goals i.e. encouraging people to want to be healthy, to know how to attain health, to do what they can individually and collectively to maintain health, and to seek help as needed - the issues inviting research become clear.

The fact of wanting to be healthy has deep cultural, socio-economic and political roots.   While governments aspire for a healthy nation and individuals regard health as an asset in the hierarchy of values health does not have the position it merits.   Despite its recognized economic and social impact, by and large health has been really valued only when it has been lost.

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

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

While knowledge is not the sole basis for healthy behaviour – as evidenced by smoking or over-eating among some educated individuals – it is nevertheless the sine qua non of health education.

With regard to providing individuals and communities with adequate knowledge to attain and maintain health, the research needed falls within the domain of communication, educational psychology and educational sociology.   Here, an effort must be made to identify factors facilitating learning such as teaching methods, mass media techniques, conditions conducive to learning, opportunities for education, the role of the modern media (radio, TV, newspapers, films, posters) and of the traditional media (puppet shows, storytelling, dramas and songs, etc.) as well as other particular factors that may prevail in a given community.

Until recently, most of the research carried out in health education was in these areas.   Study of the findings, especially those in the field of educational psychology, should prove very useful.

The issues related to individual and collective action for health are most interesting.   Research dealing with individual action emphasises self-care and its limitations in prevention, treatment and health promotion, while mutual-aid societies, self-help groups and community participation are at the heart of collective action. Research in this area is essentially focussed on processes that foster self-reliance and is therefore both culture- and time-bound.   It is also concerned, at the level of community action, with the different models developed to provide solutions (cognitive, behavioural, based on social interventions, etc.[3]) as well as with the supportive role of regulations and legislation.

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

Synthesis of the above four areas of research brings out the fact that some findings of a global nature might be applicable to local situations (such as studies in the psychology of education) while others are strictly limited to specific conditions;   still others may fall in between these two extremes.

6.3 Applicability of research

In many countries, policy is catching up with knowledge of theory in the sense that governments are now convinced of the need for greater emphasis on primary health care and health education;   they are awaiting clarification of the theories which already exist before deciding on the appropriate strategies of health education to be supported.

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

Furthermore, a very concrete contribution can be made by research to health planning by determining priority areas of input, i.e. those areas where the felt needs of the people overlap with epidemiologically assessed needs.   Priority concern should be with areas of overlapping needs, where maximum return can be obtained.[50]

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

6.4 Extending the research potential

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

Furthermore, numerous simple research tasks and fact-finding endeavours could be undertaken by non-professionals.[63,67] Although some areas of research need sophisticated methods of approach and expertise, this should by no means lead to a generalization. Much can be done — and should be done — by the community itself in terms of simple enquiries and observations, provided the people receive some training (see section 3). Furthermore, community self-studies are likely to address values and social concerns rather than being quantitative.

Finally, health service officials should be mentally ready to question some of the assumptions upon which a number of activities in information and education for health have been based and should have the capacity to verify their validity by experimentation. Equal emphasis should be placed on training activities to provide more practitioners with research knowledge and more researchers with knowledge about practice; both are needed.

6.5 A multidisciplinary approach

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

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

6.6 Some key issues for consideration

These include:

- the barriers to rapid implementation of research findings;

- the interplay of social, political and economic factors and their impacts at the level of planning, implementation and evaluation of primary health care programmes including health education as an integral component;

- the integration of health education in formal and informal community programmes at their earliest stage; and last but not least,

- the role of the health worker in helping community members to identify their health problems and design solutions, thus helping them to become their own agents for change.

6.7 The priority concerns

Improved strategies in health education require better research, which awaits better training in research and guidance as to problems identified through practice. The quality of practice however is influenced by training and by policies which await improved knowledge and information from research. Thus the wheel comes to a full cycle.

The order of priority for strengthening the linkages therefore calls for new policies to develop simultaneously the research aspects of training and practice, so that research in health education can fully benefit both from academic discipline and from practical experience.

In the meantime, it should be recognized that there is a wealth of research findings that exist, yet remain unused. Mechanisms must therefore be found to make these available so that they can serve to enhance the effectiveness of health education in reaching the goal of health for all.

One important issue to keep in the forefront of all planning is that no research should ever be designed without taking into full consideration the moral and ethical issues involved.

7. NONGOVERNMENTAL AND VOLUNTARY ACTION

From the earliest stage of the formulation of the strategy for health for all, the World Health Assembly pointed to nongovernmental organizations as a key element in the implementation of goals.

Collaboration with nongovernmental organizations is mentioned 22 times in the Seventh General Programme of Work of WHO. In addition, a footnote in the section dealing with the classified list of programmes indicates that "since collaboration with nongovernmental organizations is an important approach for all programmes, it is not mentioned specifically in each programme described to avoid repetition."[70](p.54)

This constant reference to the nongovernmental sector is not surprising in view of the impact of voluntary groups on health development throughout history. In one country alone, with a population of only five million, voluntary associations number over 100,000, a majority of which with health education built into their activities.[16]

Nongovernmental organizations provide indeed a context that is ideal in many ways for involvement and for the growth and development of self-reliance as they are an expression of the will of the people to use their own initiative in improving the quality of life. This will is translated into pilot projects - often taken over and given wider scope by government agencies at a later stage - or activities to fill certain gaps or to supplement government action. The Seventh General Programme of Work specifically calls on nongovernmental organizations to channel their resources for health at every level into support of the strategy of health for all, to develop joint action with governmental agencies through technical cooperation, and to broaden their involvement in the implementation of health programmes, from accident prevention, leprosy, cancer, sexually transmitted diseases or cardiovascular diseases to research in human reproduction and drug policies. With regard to information and education for health, coordination is no less important in promoting acceptable self-care practices by individuals and communities as well as greater involvement in health promotion on the part of such groups as: the teaching profession at primary, secondary and university levels and in technical schools, agriculture and rural development workers, professional associations, and labour unions which represent important allies for health education.

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

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

- formal recognition of voluntary associations through appropriate legislation;

- moral recognition of their key role through official involvement in coordination bodies concerned with planning, implementation and evaluation of programmes;

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

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

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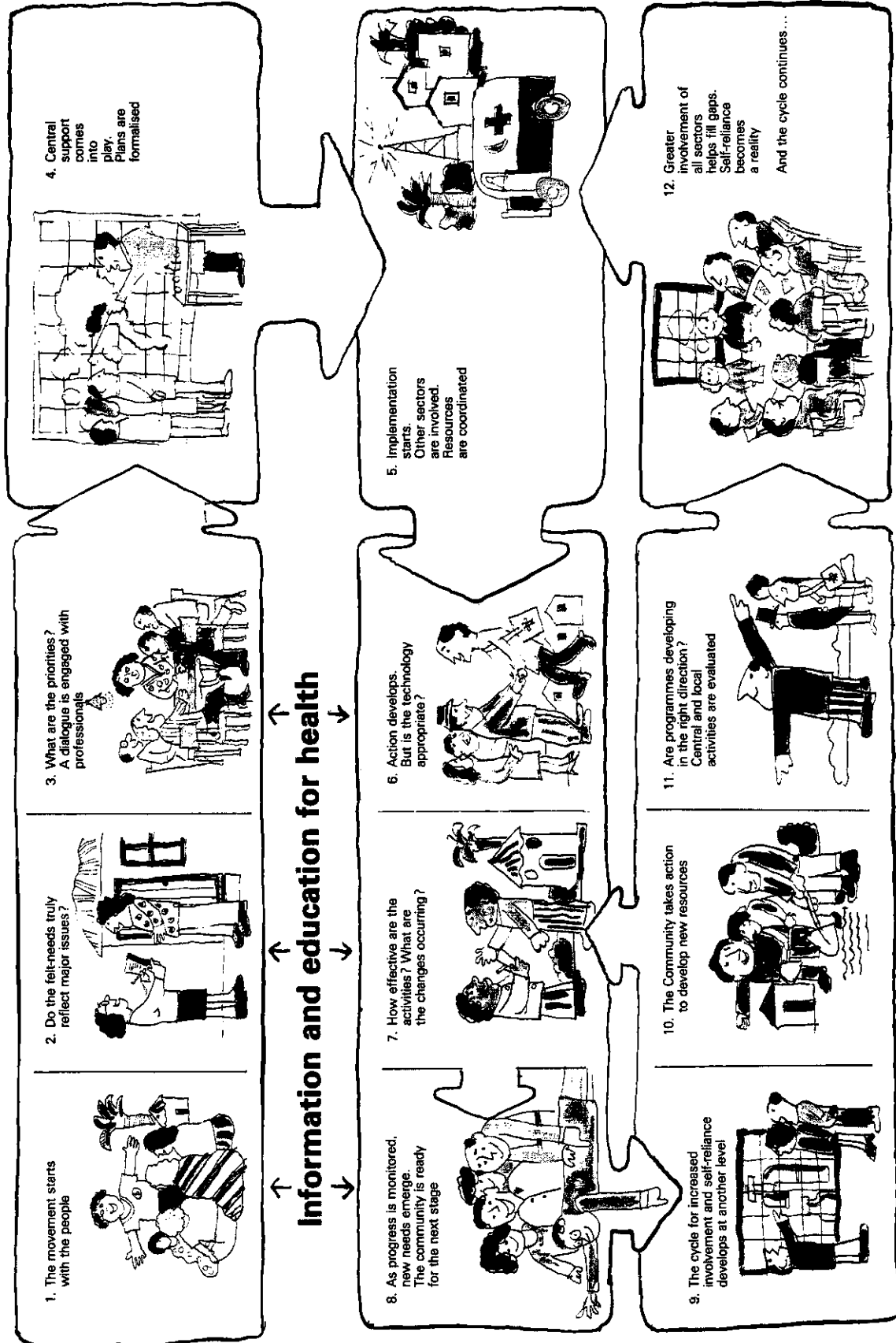

C O N C L U S I O N

New policies for health education must include clear, unequivocal recognition of the need for community involvement in health planning, evaluation and development of appropriate technology. To fulfill its task effectively, health education must therefore receive broad support from policies which:

- reflect a commitment to the equitable distribution of health and related resources;

- provide for its integration at those stages of the health care process - from planning through implementation to monitoring and evaluation - where the effective involvement of people and their increased self-reliance requires additional understanding and skills;

- give full importance to the intersectoral approach and the need for coordination in the perspective of a continuum between public information, education for health and education in general;

- assign health education responsibilities to all health workers, teachers and media personnel as well as to selected personnel in other sectors;

- provide for the institutional framework and the economic and legislative supports that bring about the kind of environment in which "individuals, families and communities can assume greater responsibility for their health and welfare";53(p.17) and last but not least,

- specify without ambiguity the fundamental objective of education for health and of community involvement, i.e. to help each individual, each family, each community to achieve the harmonious development of all their physical, mental and social potential.

CENTRALISED FUNCTIONS

DECENTRALISED FUNCTIONS

Information and education for health

1. The movement starts with the people

2. Do the felt-needs truly reflect major issues?

3. What are the priorities? A dialogue is engaged with professionals?

4. Central support comes into play. Plans are formalised

5. Implementation starts. Other sectors are involved. Resources are coordinated

6. Action develops. But is the technology appropriate?

7. How effective are the activities? What are the changes occurring?

8. As progress is monitored, new needs emerge. The community is ready for the next stage

9. The cycle for increased involvement and self-reliance develops at another level

10. The Community takes action to develop new resources

11. Are programmes developing in the right direction? Central and local activities are evaluated

12. Greater involvement of all sectors helps fill gaps. Self-reliance becomes a reality

And the cycle continues...

This graphic presentation of the information and education for health process is not meant as a blue-print for planning although it deals with essential issues that need to receive policy commitment. Nor does it purport that countries should stop on-going activities and start anew. Based on experience with successful implementation of one or several aspects of the process, it suggests that a practical approach for countries would be to support initiation in phases, in regions or districts, and to modify the process as the experience develops. An immediate purpose of the chart is to provide a basis for discussions from which a model, or at least guidelines, may evolve which could be of value to Member States.

SOME QUESTIONS FOR CONSIDERATION DURING THE TECHNICAL DISCUSSIONS

It is suggested that the various groups discuss the following questions so that the final report may provide useful and practical guidance to Member States in the elaboration and implementation of new policies for health education in primary health care.

1. What measures should be taken to translate into practice the political will to provide health education with the support it needs to contribute effectively to the objectives of primary health care, especially as regards:

   - promoting community involvement and self-reliance

   - enhancing decision-making skills at the local level

   - allowing for a diversity of objectives in policy making

   - harmonizing national and local plans

   - facilitating intersectoral action

   - using appropriate technology

2. What measures are necessary, at the policy level, to ensure that health education aspects of

   - manpower development

   - the use of media and

   - research

     are in line with the objectives of primary health care?

3. How can we translate into practice the political will to involve more fully the nongovernmental sector in efforts to promote health?

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29 March 1983

PSC/83/122

Dear Mr. Ling,

      This is to acknowledge receipt of your letter of 21 March to Revy Tuluhungwa. Revy is away on mission at this time and I am holding the letter and enclosure (as well as the WHO booklet on breastfeeding you sent) for him until his return to New York early next month.

      Best regards.

Yours truly,

April Avedisian
Secretary, PSC Service

Mr. Jack C.S. Ling
Director
Division of Public Information
  and Education for Health
WHO
Geneva
Switzerland

WORLD HEALTH ORGANIZATION   ORGANISATION MONDIALE DE LA SANTE

Téléphone Central/Exchange: 91 21 11
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In reply please refer to :
Prière de rappeler la référence:

Mr Revy Tuluhunghwa
PSC
UNICEF
New York.

21 March 1983

Dear Revy,

                        Health Education

        I enclose herewith a copy of the background document for the Technical
Discussion on Health Education which will take place in Geneva during the
first week of May.   I very much hope that you will represent UNICEF and
come to this technical discussion.

        As you can see, Health Education has very much broadened in recent
years to encompass many communication activities.   In particular, you will
be interested to note Health Education's role in community involvement.
We even have a proposed model of the Health Education/Community Involvement
process.

        As you know, we have struggled with the question of community
participation for many years.   I am happy that our group here have at least
addressed themselves to this question in a way which I hope will be of use
to those engaged in development work.   Needless to say, our perspective is
health in its broadest sense.

        I have sent three copies of this document to Richard Jolly who will
no doubt be distributing it to his people in PDPD.

        With best regards,

                                    Yours sincerely,

                                    Jack Ling,
                                    Director,
                                    Division of Public Information
                                    and Education for Health.

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Notes

Background document for Technical Discussions Thirty-sixth World Health Assembly, 1983. Also letter transmitting this document to Revelians Tuluhungwha (UNICEF, New York) from Jack Ling, Director, Division of Public Information and Eduction for Health, WHO, Geneva giving further background.

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