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HEALTH EDUCATION, CORNERSTONE OF PRIMARY HEALTH CARE

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HEALTH EDUC ON, CORNERSTONE OF PRIMARY HEALTH E

Those misty pictures sent back by satellites clearly show our mother earth as one single, if not very big, unit of the universe. No longer is any imagination needed to perceive that it is round and limited in size. Seen from above and from so far away, all appears peaceful and well-ordered on our planet, whereas in fact it is the scene of endless struggles, strife and atrocities.

One of the outstanding injustices of our time is that millions of people are denied the possibility of obtaining health care. Some inequalities due to natural causes may be inevitable but those caused by humans must be remedied. That is what the World Health Assembly seeks to do by mobilizing all the WHO Member States behind the objective of Health for All by the Year 2000. And the count-down has begun - only 17 years remain in which to carry out this vast project that is to mark the advent of the new century.

The objective of Health for All by the Year 2000 can be attained only through a planned overall strategy. Such a plan was outlined at the Alma-Ata Conference in 1978 when primary health care was selected as the key strategy for the practical achievement of health for all. This idea produced some sceptical smiles from people who pointed out that we should never be rid of the sick, the unfit and the disabled. That is obvious but is not the point. Health for all means a world where individuals, families and communities all have access to essential health care and better protection against illness in their homes, at school, on farms and in factories. That world will at least be freed from preventable diseases and man-made hazards.

First and foremost among the components of primary health care is health education, and the subject of the Technical Discussions during the Thirty-sixth World Health Assembly is New Policies for Health Education in Primary Health Care.

As a subject, health education has not always been very clearly defined. What is really meant by it? WHO says that it is "any combination of information and education activities leading to a situation where people want to be healthy, know how to attain health, do what they can individually and collectively to maintain health, and seek help when needed."

Some new activities

This definition implies that health education should include a number of new activities in addition to the old ones. First of all, it should foster community involvement, which is essential for lasting success in any programme whether in education or anything else. The notion of community participation is, of course, an old one. It was advocated by the authors of the WHO Constitution in 1948 when they included the following principle in the preamble to that historic document: "Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people."

Incentives exist for populations to become actively involved and take responsibility for certain decisions and activities jointly with the health workers. A good health worker should know the most appropriate ways to obtain both individual and community involvement. For example, he or she will encourage a community to identify its health problems, discuss various solutions and establish straightforward and realistic objectives. The community will then be able to follow through in the execution of the different phases of the project.

Communities must formulate their priority needs or at least their felt needs. Contrary to a common belief of economists and planners, there is no occasion for a dilemma to arise between the establishment of an overall plan comprising the allocation of central resources and the principle of community involvement. To be truly national, any new policy must be built up from the grass roots. What is more, such a policy should thrive on the input from community involvement. In many countries the tendency towards decentralization highlights the need to facilitate community involvement in town or village management. Of course problems will arise. Communities may set goals they cannot reach unaided, either for financial reasons or because other sectors are also concerned in the proposed projects.

The need to arrange for simultaneous or successive intersectoral action makes it more difficult to reach the objective. In a malarious village, for example, efforts to improve community health may begin by environmental sanitation measures and the elimination of mosquito breeding sites, the aim being to strike at the cause of the disease concurrent with an attempt to cure its victims. In some circumstances, efforts in the field of environmental sanitation may easily run into complications. In such cases, the best alternative is to encourage and stimulate intersectoral cooperation by helping all the partners to see the need for and the utility of joint action. Because of their communication skills, health education specialists are better placed than others to convey the message and convince everyone concerned of the necessity of working together.

There is always a risk that change and innovation will upset the local people and lead to resistances that may be hard to overcome if due attention is not paid to traditional attitudes and the dynamics of social and cultural change. The technology employed must be appropriate to the needs, aspirations and cultural level of the people. Health education specialists will further the dialogue that should take place between professionals and non-professionals so that appropriate technologies are adopted, and will see to what extent the felt needs of the people and the epidemiologically proven needs may overlap. The wider the common ground established between these two classes of need, the more effective the work of the health team will be.

It is thus clear that health education functions and tasks may be different from what they used to be. Indeed, they have become so much broader and more diversified that it may be questioned whether the people concerned are properly trained to perform them.

Resistance to change

There is no denying that, in many cases, a shift in current training programmes is necessary. As has been 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."

Change may invite resistance, and it is to be expected that administrators, faculty and even the students may oppose any innovations in the teaching programmes tending to make learning less "academic" and more realistic and to widen the multi-disciplinary approach. The reorientation of teaching programmes will only become a reality, therefore, if political commitment to primary health care exists at the policy-making level.

Health education must be the concern of all health providers irrespective of their position in the health care system. Nevertheless, specialized staff in health education are needed, and at all levels, central, provincial and local. They must train other health workers and assist in the planning, implementation and evaluation of health programmes, including the coordination of resources.

Information and education

For such specialized staff, the mass media are of particular importance. In promoting primary health care a continuum of action is essential, ranging from advocacy and the developing of awareness to working with individuals and communities in drawing up plans, carrying out activities and monitoring action. At one end, information spearheads the movement while, at the other, education complements it by an "in-depth" action. The use of mass media and direct communication between individuals are complementary and mutually beneficial.

The main functions assigned to the information media are generally as follows:

- To help create political will by appealing to policy makers;
- To raise general health consciousness and help set norms bearing on health levels;
- To inform decision makers about the latest developments in health sciences and their limitations, and point out relevant experiences that deserve to be publicized;
- To help deliver technical messages in simple terms; and
- To help foster community involvement by reflecting public opinion, encouraging dialogue and facilitating feedback from the community.

Influencing behaviour

The ultimate purpose of health education is to influence the behaviour of individuals, families and communities in maintaining and developing their health. There is therefore a dire need to understand which factors foster or hinder certain types of behaviour, particularly those that promise more healthy outcomes. Furthermore, the values and practices that may have health impacts are deeply imbedded in the social and cultural aspects of life. As these may differ from country to country and even between one town and the next, extrapolating findings from a specific cultural, social or political context into general rules often yields disappointing results. It is important, therefore, to move away from concentrating on specific behaviour patterns and recognize the importance of "life-styles" in the prevention of disease and the promotion of health. It is within the context of life-styles that adherence to certain health practices becomes truly meaningful.

Knowledge is not the sole basis for healthy behaviour, as is evidenced by some doctors who smoke and some educated individuals who over-eat. But it remains true that knowledge is the sine qua non of health education.

Health education is therefore the cornerstone of primary health care. Its role is very much wider and more varied than in the past. Its aim must be to help each individual each family and each community to achieve the harmonious development of all their physical, mental and social potential.

Health education specialists, therefore, must meet this challenge and take their due place as major architects of Health for All by the Year 2000.

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Notes

The newsletter discusses measures being taken towards the objective of "Health for All by the Year 2000", foremost of which is health education. New activities should be included in health education; community involvement is central . Resistance to change is an obstacle to be dealth with; mass media are considered particularly important in extending health education - their role is outlined; a 'continuum of action' is essential, from advocacy to working with communities and monitoring. The article concludes with consideration of how behaviour can be changed.

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