UNITED NATIONS CHILDREN'S FUND FONDS DES NATIONS UNIES POUR L'ENFANCE

UNITED NATIONS, NEW YORK, N.Y. 10017
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NOTE FOR THE RECORD

PROGRAMME COMMITTEE - New York, 17 November 1983

Discussion on health education

1. Current Status

Muriel Glasgow and Revy Tuluhungwa presented an overview of health education in the area of water supply and sanitation to the Programme Committee in an attempt to shed some light on the concept of health education; to examine ways in which it is currently addressed by UNICEF and Governments and communities, thus highlighting gaps and constraints; and to examine measures to strengthen health education in this sector.

UNICEF staff are already convinced of the importance of strengthening the health education components in water supply projects, as is evident from the activities supporting health education which are developed and are being executed.* However, staff lacks the time, expertise and specialist resources necessary to plan, implement and evaluate in a more systematic manner the health education component.

Governments and communities face many constraints too. A recent study in 43 Commonwealth countries, showed that although all countries claimed to involve communities in health education there were considerable differences, quantitatively and qualitatively between countries, due, in part, to cultural and social realities; and further that while official stated preferences were for community participation in health education, actual priority was given to the production of materials for health education.**

* An analysis of the health education components in water supply and sanitation programmes was carried out July-August 1983. Ms. Priscilla Loanzon, doctoral student at Columbia University undertook an internship at UNICEF to carry out this exercie. Her report is under preparation.

** A. Walt and P. Constantinides "Community Health Education in Commonwealth Countries", Commonwealth Secretariat, Marlborough House, London, 1983.

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In light of the above, the following list was drawn up detailing the types of problems that beset health education.

Governments:	Constraints
	- Lack of health education planning and programming (skills/experts)
	- Disregard of existing community, organisation and social institution
	- Location of health education units in ministries of health which are normally oriented towards curative and distinct from PHC
	- Limited resources of MOH
	- More focus on curative and rehabilitative services
	- Inadequacy of trained health education personnel/health educators
	- Focus on one-way information dissemination model
	- Emphasis on communication media and technology as distinct from message focus
Community and Family:	- Deep-rooted harmful beliefs and practices
	- Lack of resources/knowledge to translate health education messages into action
	- Women overburdened or kept out of mainstream
	- Most have no access to health/medical facilities - therefore more reliance on traditional practioners and volunteers for services and education
	- Suspicious of new ideas, particularly those from outsiders

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UNICEF:

- Lack of clear definition of health education
- Limited definition of sanitation - so far focus has been more on excreta disposal facilities and less on hygiene, food preservation and protection, etc.
- Lack of health education planning and programming expertise: Reliance on technical (engineering) staff. Therefore too much emphasis on technical aspects
- Difficult to fundraise for health education
- Inadequate information base on socio-cultural and behaviour aspects. Therefore superficial health education components.

2. Points emerging from the discussion

2.1 To strengthen the health education component in UNICEF-assisted programmes substantively, we should begin first by analyzing the model followed in UNICEF, viz, the health information model. Health education is seen as an activity, and not as a process, a continuum. The response is usually the dissemination of a message which is not supported or based on social norms of the society. We emphasize its development, testing through implementation - i.e. passing the message on. Little attention is paid to existing knowledge, societal norms, feedback, or even how the message is received and acted upon. We insist on community participation in health education, but emphasis is placed on production of communications materials. The problem with this approach is (a) it is usually a passive model with people receiving the message but usually lacking the resources to carry it out; (b) it provides little opportunity for feedback; (c) linkages are not usually possible in this approach.

What is energetically being proposed by some agencies, UNICEF among them, is a more interactive, dynamic model which aims at changing behaviour by involving in the process programme managers, health providers, communities, existing community-level organizations, and giving them opportunities for reaction and participation, the participatory model.

This involvement has to be synchromeshed with all the players involved, placing emphasis on moving away from health education as having only an information-giving role, detached from the social, cultural and economic context of the people receiving the health messages.

For example, take the usual health message on boiling of water. The health education information model would focus on telling people to do it. The participatory model would necessitate first identifying people's knowledge, lifestyles, resources and cultural preferences which govern their health behavior, and only if boiling water is feasible within that context will the message have the slightest chance to evoke action. The case of guinea worm, one behavior to be changed if the spreading of the disease is to be limited is to convince people from wading in the same water they would collect for drinking. The health information model will implore people infected with the disease not to go into the water. In the participatory model, communities will be enlightened about the dangers of spread of infection and that protective measures requiring their input would be needed, such as the construction of a fence around the well or water point, to help bring about the required behavior. Ideally this should be part of a water protection/provision programme.

Both models, however, have an inherent problem - bringing about behavior change which is the ultimate goal of all health education activities. Studies have shown that their is no direct link between knowledge and behavior change.

There are several steps to bringing about behaviour change which include:

(a) Peoples' dissatisfaction with their current status,

(b) Compliance (the resources to carry out the message and the relevance of the message are critical),

(c) Identification (social supports),

(d) Internalization (when behavioral change is rooted).

The timing varies among people regarding the urgency of the need to change behavior. Some do, some don't. Behavior change should be voluntary and not forced, as the latter would raise a lot of ethical questions. It is a complex issue, but nevertheless, it should be a goal of all health education activities.

2.2 Health education 'definition'

There are as varied definitions for the concept as there are health educators and specialists. The definition most fitting to UNICEF's purposes is that given by Dr. Lawrence Green, a noted health education specialist. Health education is defined as any combination of learning activities designed to promote and facilitate the voluntary adaptation of behavior conducive to health. In the UNICEF context this implies that any educational activity proposed should include elements of training, communications and community organization/participation.

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Thus, health education activities need to be systematically planned, bearing in mind the need for:

(a) Behavioral objectives to be set (what the programme would like to accomplish in terms of human behavior related to water and sanitation or improved health as a whole),

(b) Educational strategies to be used (training, communications, community organization),

(c) Information content of activities to be developed; segmentation of target groups (actual health education messages to be transmitted to intended group),

(d) Communications methodology and techniques (group discussion, focus group interview to role play, interpersonal communications, media, workshops/seminars, audio-visuals, comics, etc),

(e) Community organization (teams/committees to be formed, role of influential groups/leaders/community organizations),

(f) Training curriculum and activities to be developed (skill building, leadership roles, etc.),

(g) Operational and monitoring indicators to be set (targets) to relate to overall programme objectives e.g. percent increase in number of people using latrines; percent of decrease in incidence of water and sanitation related diseases; could be used to help develop standards for evaluation),

(h) Evaluation ((g) would help in evaluating the impact of the health education intervention).

Note: Each of the above has its corresponding facilitating, constraining and reinforcing factors, which would help guide the direction of the activities to be developed.

The preceding represents the optimum attention that could be given to health education in programmes, if staff and budgetary factors are not considered constraints. But since there is usually no one person in UNICEF offices who has the responsibility for developing the health education component, except in a few countries, the listing above could only be illustrative.

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It is time now for UNICEF to evolve a policy addressing the whole area of health education in UNICEF-assisted programmes. There are many solutions that are possible. Among the long-term solutions are the advocating of a health education cell within the Planning Ministry. This would have the ultimate impact of the Government being able to look across programmes in the various sectors, to determine the most essential activities that need to be developed and to attempt to coordinate these activities without having to generate or employ numerous cadres of workers. Medium-term solutions could be the refresher training of health education personnel in the current approaches to health education and the secondment of people from the health education departments to work with the project.

In UNICEF, we must reorient ourselves on the philosophy behind the health education concept so that we all speak harmoniously about this activity.

3. Action proposed

(Of course these solutions take time, money and expertise. There is therefore need to address staffing issues as these are of critical importance to programme preparation and delivery. Field offices, as stated before usually have neither the time nor the expertise, though the conviction is evident. Staff responsible for this component are not always trained in health education methodology, hence the emphasis on communication in UNICEF-assisted programmes.)

1. Re-define health education, community participation and sanitation in UNICEF context;

2. Prepare guidelines and field manuals to determine how best to incorporate the health education participatory model in all ongoing projects;

3. Organize orientation/training activities (UNICEF and Government staff);

4. Review management and operation of HE/PSC/PHC services in UNICEF and Government structures;

5. Support and mobilize strategically NGOs, the media, schools, religious bodies, etc.;

6. Document case studies of health education activities:

    - Processes, highlighting lessons learned,
    - Technology relevance.

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Notes

Development Forum was published by the UN University and the Division of Economic and Social Information, UN/DPI
The article enquires about the 'current rethink' of development; RRN Tuluhungwa stresses the importance of village level communications.

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