Health Promotion in Developing Countries

Briefing book to
THE SUNDSVALL CONFERENCE ON SUPPORTIVE ENVIRONMENTS 1991
BRIEFING BOOK

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THE SUNDSVALL CONFERENCE ON
SUPPORTIVE ENVIRONMENTS

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FOREWORD

This briefing book will interest all who recognize that health embraces a far wider field than what is usually seen as falling within the ambit of health practice. If the disadvantaged and underserved in every part of the globe are really to enjoy the incalculable benefits of good health, it will be essential for every man, woman and child on this planet to “think health”, to recognize health implications in almost every facet of daily life, and to take the right kinds of action, for combating health problems and for helping themselves and their neighbours towards healthier ways of living.

Health promotion lends itself to a wide range of interpretations. Health promotion is, in essence, social and political action for health. It seeks to empower people with a knowledge and an understanding of health and to create conditions conducive to pursuing healthy lifestyles. But the means to bring this simple message to all mankind will call for a real effort of understanding and will on the part of all concerned - from government level down to each individual, even to children. It is never too early to start learning, and teaching, the messages of good health.

It is in this context that the World Health Organization conceives “health promotion”. The illustrations and stories included in this briefing book are sound evidence that approaches and activities that promote health and well-being are already being applied in the developing world. The Third International Conference on Health Promotion, held in Sundsvall, Sweden, in 1991, for which this book was prepared, will encourage and motivate people everywhere to think and act for health, and to bear in mind that “without health there can be no development”.

Hiroshi Nakajima, M.D., Ph.D.
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ACKNOWLEDGEMENTS

As organizers of the Sundsvall Conference the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), the World Health Organization and the United Nations Environment Programme wish to acknowledge their deep appreciation of the coordinating role undertaken by the Conference Secretariat to develop a series of thought-provoking Briefing Books on the theme "Creating Supportive Environments for Health".

The Conference Secretariat is honoured to accept the Briefing Books which have been developed, produced and contributed by the Governments of Canada, Denmark, Finland, Norway and Sweden, including the County Administrative Board in Västernorrland, and the World Health Organization.

Each Briefing Book explores the theme in the context of a particular issue (education, housing, energy and transport, social support and care, food and agriculture, work, health promotion and environmental action in developing countries). Readers are encouraged to view each Briefing Book as one in a series exploring various dimensions of supportive environments, which is the major theme of the conference.

This Briefing Book was prepared by the Division of Health Education at the Geneva Headquarters of the World Health Organization in support of current moves to extend health promotion strategies to developing countries in pursuit of the Health for All goal.

Acknowledgement is made to the large number of individuals and groups committed to health and development in the Third World who are already working towards the promotion of health. Moved by a concern for humanity and believing in the capacity of ordinary people to help themselves, they are frequently working against heavy constraints and in the face of inertia, using innovative approaches to work with people on matters of health.

Thanks are due to all the individuals, NGOs, community groups and agencies whose documented stories and shared experiences appear in these pages making it possible for others to find appropriate models for action and to derive benefit from them.

In preparing this book, special mention must be made of the valuable inputs and contributions of Hamadi Benaziza, Jack Jones and Desmond O’Byrne of the Division of Health Education. John Bland was most cooperative in editing the document.

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SUMMARY

Health has been a prime concern of mankind since prehistoric times. Today we have the knowledge and tools to prevent disease but these tools are not evenly distributed amongst the world’s populations. The World Health Organization’s ultimate aim is to attain the goal of health for all in the spirit of social justice. Substantial improvement in health cannot be achieved without improvement in socio-economic conditions. Poverty, poor living conditions and lack of education are major determinants of ill health. The Declaration of Alma-Ata set the target, ‘‘Health for All by the Year 2000’’ (HFA), and urged for a better use of the world’s resources, with a genuine policy of independence, peace, detente and disarmament.

The Declaration identified primary health care (PHC) as the key to attaining HFA which offered a rational and practical means for working towards the goal. Action for HFA rests upon political will and societal commitment, community participation, intersectoral support and appropriate technology available through governmental and non-governmental systems. PHC has provided the framework for health development and for dealing with inequities in health. Investments in PHC have paid good dividends in many countries, including the least developed ones, and have shown appreciable improvement in health indicators.

The industrialized countries have sought ways of achieving HFA targets with emphasis on promoting healthy lifestyles and behaviour that minimize the risk of diseases, and on creating supportive environments for health. In developing countries stress is placed on enlisting active community involvement in ensuring basic sanitation and water supply, maternal and child care and control of communicable diseases, though the importance of lifestyles issues is also recognised. Success has been achieved, for instance, in reducing tobacco smoking and improving dietary habits, and this in turn has been reflected in fewer deaths from cancer and cardiovascular diseases. Acceptance of immunization, antenatal and natal care, improvements in safe water and sanitation have led to decreased morbidity and mortality.

The increasing concern on lifestyle issues and health supporting behaviour brought into sharp focus the importance of health promotion. The term health promotion was introduced in the twenties and has since evolved to include comprehensive strategies of social and political action for health.

A number of international conferences and working groups on health promotion including the world conferences in Ottawa and Adelaide have helped to identify strategies and actions that could advance progress towards HFA.

A Call for Action, a strategy document prepared by a Working Group on Health Promotion in Developing Countries in 1989 examines the scope of health promotion and its application in developing countries. It builds on earlier experience and highlights key action areas that include advocacy for health and health-supportive public policies, building alliances with all sectors of society, enabling and empowering people, and strengthening national capability for community involvement in health development.

Health promotion is described as social and political action enhancing public awareness of health, fostering healthy lifestyle and creating conditions conducive to health. Health promotion is a process of activating communities, policy-makers, professionals and the public for health-supportive policies, systems and ways of living. It is manifested through
acts of advocacy, empowerment of people, and building social support systems that enable people to make healthy choices and live a healthy life.

The Sundsvall Conference has a truly global focus in mind and will address supportive environments for health both in the context of developed and developing countries. While focusing on developing countries, it is necessary to consider factors that make health promotion particularly relevant to their health needs and to draw upon the rich experience already gained in these countries in health and development programmes.

Though health promotion is not as yet included as an explicit action area in the health systems of developing countries, some of these countries are showing interest in moving towards health promotion. As one of the preliminary steps, this briefing book examines ongoing health actions and experiences in the developing world that fall within the health promotion strategy areas defined in the Ottawa Charter and the Call for Action. The book underlines the common ground trod by primary health care and health promotion, establishes the fact that health promotion strategies have already been initiated in many developing countries, and presents the framework on which to further strengthen health promotional activities.

In the context of the realities prevailing in the developing countries, advocacy for healthy public policy appears in different guises and involves a wide range of agencies and institutions that assume advocacy roles. They include the health and development sectors; the community; political, religious, professional and other non-governmental agencies; the media; universities, institutes of higher learning; research institutions; and international agencies. Many case-histories are recorded that illustrate advocacy efforts through a variety of different approaches.

Educating and empowering people have been activities of the health sector for several decades. Person-to-person communication and interactive group education process have also long formed part of health education. Organizing communities for health and using the mass media to communicate health messages feature in nationwide programmes on water and sanitation, maternal and child health, nutrition and family planning among others. Many countries have experience in training thousands of community level workers to undertake health education roles. The benefits of multi-faceted approaches in health education have been recognized, and a number of projects with creative adaptation of social marketing strategies have been implemented.

Along with the successes there have been constraints; inadequate educational inputs due to administrative and other insensitivities, victim blaming and undue emphasis on top-down health instruction. The right and the ability of people to undertake health actions themselves are frequently not fully recognized. Nevertheless, there have been changes in the right direction, and the health and development sectors are now paying greater attention to fostering equal partnership with the people. The empowerment of different population groups for health action is beginning to become a reality. Women, youth, school-age children - in and out of school - and disadvantaged communities have been singled out as the key groups; their educational needs as well as their activities when empowered can make to community health. The powerful role of the media in empowering people is readily accepted.

This briefing book describes experiences from many developing countries in creating and maintaining support systems, and in building strong alliances for health. It discusses
how social support for health can be promoted by encouraging approval of healthy practices and establishing social norms that are conducive to health. And it indicates ways in which healthy practices have been legitimized, how societal forces were mobilized in support of health, how communities and community organizations have influenced public policies and created the climate making healthy choices easy and possible, and what roles non-governmental, professional, political and interest groups can play in this context. Many of the examples underscore the importance of supportive facilities to ensure positive health action by individuals and families who are already aware and convinced of what needs to be done. Such support can best be assured by building strong alliances between all systems that support health and by networking with them so as to bring about concerted action for health.

The focus for the future must be on greater social action for health aimed at strengthening advocacy, improving efforts to empower people, and influencing social and systems support for health.
RESUME

La santé est depuis les temps les plus reculés une préoccupation majeure de l’être humain. A l’heure actuelle, nous disposons des connaissances et des outils nécessaires pour éviter la maladie, mais ces outils ne sont pas tous également répartis dans le monde. Or, l’objectif ultime de l’Organisation mondiale de la Santé est d’instaurer la santé pour tous dans un esprit de justice sociale. Il ne saurait y avoir d’amélioration réelle de la situation sanitaire sans amélioration de la situation socio-économique. La pauvreté, des conditions de vie précaires et l’absence d’éducation sont des facteurs déterminants de la maladie. La Déclaration d’Alma-Ata a énoncé l’objectif de la “Santé pour tous d’ici l’an 2000” (SPT) et plaidé en faveur d’une meilleure utilisation des ressources de la planète moyennant une authentique politique d’indépendance, de paix, de détente et de désarmement.

La Déclaration faisait des soins de santé primaires (SSP) la clé de voûte de l’instauration de la SPT car ils constituent un moyen rationnel et pratique d’y parvenir. Les mesures prises dans l’optique de la SPT reposent sur la volonté politique et l’engagement de la société, la participation communautaire, l’appui intersectoriel et la technologie appropriée disponible par le biais des systèmes gouvernementaux et non gouvernementaux. Les SSP ont constitué le cadre du développement sanitaire et du redressement des inégalités en santé. Les investissements consentis dans la mise en place des SSP ont produit de bons dividendes dans de nombreux pays, y compris les moins avancés, et permis de faire progresser sensiblement les indicateurs sanitaires.

Les pays industrialisés ont cherché des moyens de parvenir aux objectifs de la SPT en privilégiant la promotion de modes de vie et comportements sains susceptibles de réduire autant que possible le risque de maladie et en créant des environnements favorables à la santé. Les pays en développement, quant à eux, insistent sur les moyens de susciter l’engagement actif de la communauté pour assurer l’hygiène de base et l’approvisionnement en eau, les soins de santé maternelle et infantile et la lutte contre les maladies transmissibles, tout en reconnaissant l’importance des modes de vie. Des succès ont ainsi été remportés dans la lutte contre l’usage du tabac et l’amélioration des habitudes alimentaires, ce qui s’est traduit par une réduction du nombre de cas de cancer et de maladies cardio-vasculaires. L’acceptation de la vaccination et des soins prénataux et périnataux ainsi que l’amélioration de l’hygiène du milieu et de l’approvisionnement en eau propre ont permis de faire régresser la morbidité et la mortalité.

Le regain d’attention accordé aux modes de vie et aux comportements favorables à la santé a fait ressortir l’importance de la promotion de la santé - expression introduite dans les années 1920 et qui a, depuis, évolué pour inclure des stratégies globales d’action sociale et politique en faveur de la santé.

Plusieurs conférences internationales et groupes de travail sur la promotion de la santé, notamment les Conférences mondiales d’Ottawa et d’Adélaïde, ont été l’occasion de définir les stratégies et les modalités d’action qui permettraient d’accélérer les progrès en vue de la SPT.

Un document stratégique ("A Call for Action") préparé en 1989 par un groupe de travail sur la promotion de la santé dans les pays en développement expose le champ de la promotion de la santé et son application dans les pays en développement. S’inspirant d’expériences antérieures, il met en lumière les principaux secteurs où il faut agir, notamment le plaidoyer pour la santé et pour des politiques favorables à la santé, la
constitution d’alliances avec tous les secteurs de la société, le fait de donner aux gens les moyens d’agir et enfin le renforcement des capacités nationales d’engagement communautaire en faveur du développement sanitaire.

On définit la promotion de la santé comme l’ensemble des mesures sociales et politiques susceptibles de renforcer la prise de conscience des questions de santé, de favoriser des modes de vie sains et de créer des conditions favorables à la santé. Promouvoir la santé signifie inciter les communautés, les décideurs, les professionnels et le grand public à agir en faveur de politiques, de systèmes et de modes de vie qui puissent contribuer à la santé. Il s’agit donc de mener une action de plaidoyer, de donner aux gens les moyens d’agir et d’instaurer des systèmes sociaux d’appui permettant aux individus de procéder à des choix favorables à la santé et de vivre de façon saine.

La Conférence de Sundsvall, qui se situe dans une perspective véritablement mondiale, va envisager les environnements favorables à la santé dans le contexte tant des pays développés que des pays en développement. Tout en se concentrant sur les pays en développement, il faut absolument examiner les facteurs qui permettent d’adapter la promotion de la santé à leurs besoins sanitaires et de tirer parti de la mine d’expérience déjà acquise dans ces pays avec les programmes de santé et de développement.

Bien que la promotion de la santé ne soit pas encore explicitement considérée comme un domaine d’action dans le système de santé des pays en développement, certains d’entre eux souhaitent agir dans ce sens. Dans un premier temps, le manuel d’information évoque les actions et expériences sanitaires en cours dans le monde en développement qui intéressent les secteurs stratégiques de promotion de la santé définis dans la Charte d’Ottawa et dans le document stratégique. Il rappelle quel est le terrain commun aux soins de santé primaires et à la promotion de la santé, confirme que des stratégies de promotion de la santé ont déjà été adoptées par de nombreux pays en développement et présente le cadre dans lequel devront être renforcées les activités dans ce domaine.

Compte tenu des réalités du monde en développement, il y a différentes façons d’encourager des politiques favorables à la santé et cette action implique toute une gamme d’organismes et d’institutions qui ont un rôle de promotion. Il s’agit notamment des secteurs de la santé et du développement, de la communauté, de groupements politiques, confessionnels, professionnels et autres organismes non gouvernementaux, des médias, des universités et des instituts d’enseignement supérieur, des établissements de recherche et enfin d’organismes internationaux. De nombreuses études de cas illustrent les efforts de promotion par différentes voies d’approche.

Éduquer les gens et leur donner les moyens d’agir sont des activités du secteur de la santé depuis plusieurs décennies. La communication personnelle et l’éducation de groupe interactive font elles aussi partie depuis longtemps de l’éducation pour la santé. Organiser les communautés en faveur de la santé et utiliser les médias pour faire passer des messages de santé font partie des programmes nationaux relatifs à l’eau et l’assainissement, la santé maternelle et infantile, la nutrition et la planification familiale entre autres. De nombreux pays ont l’expérience de la formation de milliers d’agents communautaires auxquels sont confiées des fonctions d’éducation pour la santé. On sait aujourd’hui quels sont les avantages d’une approche multiforme de l’éducation pour la santé et l’on a mené plusieurs projets impliquant une adaptation des stratégies de marketing social.

Mais, à côté des succès, il y a eu des problèmes: insuffisance des apports éducatifs à cause de négligences administratives et autres, recherche de victimes et polarisation sur l’éducation sanitaire venue d’en haut. Il est rare que l’on reconnaîsse vraiment le droit et l’aptitude des
gens à entreprendre eux-mêmes des actions sanitaires. Malgré tout, il y a eu des changements dans le bon sens, et les secteurs de la santé et du développement se soucient aujourd'hui davantage de favoriser un partenariat avec la population sur un pied d'égalité. On commence à donner à différents groupes les moyens d'agir sur le plan sanitaire, avec comme groupes cibles les femmes, les jeunes, les enfants d'âge scolaire - qu'ils aillent à l'école ou non - et les communautés déshéritées; on a étudié leurs besoins éducatifs ainsi que les activités qu'ils pourraient mener s'ils en avaient les moyens et de nombreuses études de cas attestent des contributions importantes qu'ils peuvent apporter à la santé communautaire. Nul ne conteste le rôle majeur des médias à cet égard.

Le manuel rend compte des expériences faites par de nombreux pays en développement pour mettre sur pied et entretenir des systèmes d'appui et pour instituer de solides alliances en faveur de la santé. Il examine les moyens d'encourager l'appui social en faveur de la santé en favorisant l'adhésion à des pratiques saines et en instaurant des normes sociales favorables à la santé. Il explique, d'autre part, comment ont été légitimées certaines pratiques favorables à la santé, comment des forces sociales ont été mobilisées à l'appui de la santé, comment des communautés et organisations communautaires ont influencé les politiques et créé le climat nécessaire pour qu'il soit possible et facile de procéder à des choix sains, et enfin il indique le rôle que les organismes gouvernementaux, professionnels et politiques, et les groupes d'intérêt peuvent jouer dans ce contexte. Bon nombre des exemples soulignent l'importance des services d'appui pour que les individus et les familles déjà conscients et convaincus de ce qu'il faut faire puissent agir dans le sens de la santé. Le meilleur moyen de mettre en place cet appui est de constituer de solides alliances entre tous les systèmes qui favorisent la santé et d'instituer un réseau d'interconnexion pour instaurer une action concertée en faveur de la santé.

A l'avenir, il faudra privilégier une action sociale approfondie en santé pour renforcer l'action de plaidoyer, améliorer les efforts pour donner aux gens les moyens d'agir et infléchir l'appui de la structure sociale et des systèmes.
RESUMEN

La salud ha sido una preocupación primordial de la humanidad desde los tiempos prehistóricos. Hoy en día contamos con los conocimientos e instrumentos necesarios para prevenir las enfermedades, pero estos medios no están uniformemente repartidos entre los pueblos del mundo. El propósito más importante de la Organización Mundial de la Salud es alcanzar la meta de la salud para todos con espíritu de justicia social. No se puede mejorar sustancialmente la salud si no mejoran las condiciones socioeconómicas. La pobreza, las malas condiciones de vida y la falta de instrucción son los principales determinantes de la mala salud. La Declaración de Alma-Ata fijó la meta de la salud para todos en el año 2000 y exhortó a hacer una utilización mejor de los recursos mundiales, siguiendo una verdadera política de independencia, paz, distensión y desarme.

En la Declaración se identificó la atención primaria de salud como la clave para alcanzar la salud para todos, pues brindaba un medio racional y práctico de trabajar para arribar a dicha meta. Las actividades de salud para todos dependen de la voluntad política y el compromiso social, la participación de la comunidad, el apoyo intersectorial y el acceso a la tecnología apropiada por intermedio de los sistemas gubernamentales y no gubernamentales. La atención primaria ha brindado el marco de referencia para el desarrollo sanitario y para hacer frente a las desigualdades en materia de salud. En muchos países, incluidos los menos adelantados, las inversiones en atención primaria han redituado buenos dividendos y mejorado considerablemente los indicadores sanitarios.

En los países industrializados se han buscado formas de alcanzar los objetivos de la salud para todos haciendo hincapié en el fomento de los modos de vida y las formas de conducta sanos que reduzcan al mínimo el riesgo de enfermedades, así como en la creación de entornos propicios para la salud. En los países en desarrollo se insiste en conseguir la intervención activa de la comunidad para asegurar el saneamiento básico y el abastecimiento de agua, la asistencia a las madres y los niños y la lucha contra las enfermedades transmisibles, aunque también se reconoce la importancia de los modos de vida. Por ejemplo, se han logrado buenos resultados en la reducción del tabaquismo y el mejoramiento de los hábitos alimentarios, lo que a su vez se ha reflejado en un menor número de muertes por cáncer y enfermedades cardiovasculares. La aceptación de las vacunas, los cuidados prenatales y la asistencia durante el parto, junto con las mejoras en el suministro de agua salubre y el saneamiento, han permitido disminuir la morbilidad y la mortalidad.

El interés creciente por el tema relativo a los modos de vida y de comportamiento propicios para la salud ha puesto de relieve la gran importancia que tiene la promoción de la salud. La expresión “promoción de la salud” se utilizó por vez primera en los años veinte y desde entonces ha ido evolucionando hasta abarcar, en la actualidad, estrategias globales de acción social y política en pro de la salud.

Varias conferencias y reuniones de trabajo internacionales sobre promoción de la salud, incluidas las conferencias mundiales celebradas en Ottawa y Adelaida, han ayudado a identificar estrategias y actividades que podrían acelerar los progresos hacia la meta de la salud para todos.

En un documento de estrategia en el que se hace un llamamiento a la acción, elaborado en 1989 por un grupo de trabajo sobre la promoción de la salud en los países en desarrollo, se examinan el alcance de ésta y su aplicación en dichos países. El documento está basado en experiencias anteriores y pone de relieve los sectores de actividad decisivos, entre ellos...
la defensa de la salud y las políticas públicas favorables para la salud, la formación de alianzas con todos los estamentos sociales, el aumento de la capacidad y la autonomía de la gente, y el reforzamiento de la capacidad nacional para la intervención de la comunidad en el desarrollo sanitario.

La promoción de la salud se describe como una acción social y política que acrecienta la conciencia pública en cuestiones sanitarias, favorece los modos de vida saludables y crea condiciones propicias para la salud. Es un proceso que consiste en poner en movimiento a las comunidades, a las autoridades, a los profesionales y a la gente para conseguir políticas, sistemas y formas de vida propicios para la salud. Se manifiesta en actos de promoción, delegación de funciones a la gente y creación de sistemas de apoyo social que permitan a las personas tomar decisiones saludables y llevar una vida sana.

La Conferencia de Sundsvall está basada en un enfoque verdaderamente mundial y se ocupará del tema de los entornos propicios para la salud tanto en los países desarrollados como en los países en desarrollo. Al concentrar la atención en estos últimos, es necesario considerar los factores que hacen de la promoción de la salud algo particularmente pertinente para sus necesidades sanitarias y aprovechar la rica experiencia adquirida por estos países en los programas sanitarios y de desarrollo.

Si bien la promoción de la salud no se ha incluido todavía como un conjunto de actividades explícitas en los sistemas sanitarios de los países en desarrollo, algunos de éstos están mostrando interés por encaminarse en esa dirección. Como paso preliminar, en este libro de orientación se examinan las actividades y experiencias sanitarias que actualmente tienen lugar en el mundo en desarrollo y que encajan dentro de las áreas estratégicas de promoción de la salud definidas en la Carta de Ottawa y en el correspondiente llamamiento a la acción. Asimismo, se subraya que la atención primaria y la promoción de la salud pisan el mismo terreno, se indica que en muchos países en desarrollo ya se han iniciado estrategias de promoción de la salud, y se proporciona el marco de referencia para fortalecer aún más las actividades en dicho campo.

En el contexto real de los países en desarrollo, preconizar una política pública saludable presenta diferentes aspectos y atañe a una gran variedad de entidades e instituciones que asumen funciones de promoción. Entre ellas se cuentan los sectores sanitario y del desarrollo; la comunidad; los grupos políticos, religiosos, profesionales y otros organismos no gubernamentales; los medios de comunicación social; las universidades y otra instituciones de enseñanza superior; las instituciones de investigación; y los organismos internacionales. Se presentan muchos casos específicos que ejemplifican los esfuerzos de promoción basados en diferentes métodos.

Instruir y delegar funciones a la gente han sido actividades del sector de la salud durante varios decenios. La comunicación interpersonal y el proceso de educación mediante grupos interactivos también han formado parte durante mucho tiempo de la educación sanitaria. La organización de las comunidades para emprender tareas sanitarias y el empleo de los medios de comunicación de masas para transmitir mensajes sanitarios son aspectos destacados de, entre otros, los programas nacionales sobre agua y saneamiento, salud de la madre y el niño, nutrición y planificación familiar. Muchos países tienen experiencia en la formación de miles de agentes comunitarios que desempeñan funciones de educación sanitaria. Se han reconocido las ventajas de los enfoques multifacéticos en este campo, y se han puesto en práctica varios proyectos que adaptan con imaginación las estrategias de la comercialización social.
Junto con los éxitos también ha habido restricciones: esfuerzos educativos insuficientes a causa de la indiferencia administrativa y de otro tipo; atribución de la culpabilidad a las propias víctimas; y una insistencia excesiva en la educación orientada del vértice hacia la base. Con frecuencia no se reconocen cabalmente el derecho y la capacidad de la gente de emprender actividades sanitarias por sí misma. A pasar de todo, se han producido cambios en la dirección correcta y actualmente los sectores sanitario y del desarrollo prestan más atención al establecimiento de relaciones de asociación igualitarias con la gente. Empieza a materializarse la capacidad de los diferentes grupos de población para emprender actividades sanitarias. Se han seleccionado como grupos clave las mujeres, los jóvenes, los niños de edad escolar -tanto dentro como fuera de la escuela- y las comunidades desfavorecidas. Se han analizado sus necesidades educativas así como sus actividades cuando se los ha habilitado para actuar, y muchas historias de casos atestiguan la contribución considerable que dichos grupos pueden aportar a la salud de la comunidad. Se acepta fácilmente el poderoso papel de los medios de comunicación social en la habilitación de la gente.

En este libro de orientación se describe la experiencia de muchos países en desarrollo en lo que se refiere a la creación y el mantenimiento de sistemas de apoyo y el establecimiento de alianzas firmes en favor de la salud. Se discute la manera de promover el apoyo social infundiendo estímulo para que sean aprobadas las prácticas saludables y se establezcan normas sociales conducentes a la salud. Se indica también cómo se han legitimado las prácticas saludables; la manera en que las fuerzas de la sociedad se han movilizado en apoyo de la salud; cómo han influido las comunidades y las organizaciones comunitarias en las políticas públicas y han creado el clima que permite y facilita la adopción de decisiones saludables; y el papel que los grupos gubernamentales, profesionales, políticos y de presión pueden desempeñar en este contexto. En muchos de los ejemplos se subraya la importancia de los medios de apoyo para conseguir actividades sanitarias positivas de los individuos y familias que ya son conscientes y están convencidos de lo que debe hacerse. El mejor modo de conseguir ese apoyo consiste en forjar alianzas firmes entre todos los sistemas de apoyo sanitario y en establecer redes con ellos con miras a una acción concertada en pro de la salud.

En el futuro, el interés deberá centrarse en estimular la acción social encaminada a fortalecer el fomento de la salud, mejorar los esfuerzos por habilitar a la gente, e influir en el apoyo de la sociedad y de los sistemas a la salud.
The 3rd International Conference on Health Promotion will take place in Sundsvall, Sweden, 9-15 June 1991. The conference is being hosted by the five Nordic countries together with the World Health Organization, WHO and is co-sponsored by the United Nations Environment Programme, UNEP. The theme of the conference will be

"Action for Public Health - Creating Supporting Environments"

The conference will focus on practical action. The scope of the conference covers political, economic and managerial aspects in creating supportive environments. An associated purpose is to strengthen links between those interested in public health and those concerned with environmental issues.

Until now environmental and health development issues have mostly been discussed separately. This can be illustrated by major international events dealing with environmental concerns such as the first international conference on the environment (Stockholm, 1972), which contributed to the establishment of the United Nations Environment Programme (UNEP) in 1973. In 1987, the World Commission on Environment and Development published its report "Our Common Future", which was followed by the UNEP document "Environmental Perspective to the Year 2000 and Beyond" and adopted by the UN General Assembly in December of that year.

In the health area, the Alma Ata Conference on Primary Health Care (1978) developed a platform for the WHO's "Health for All" strategy, which was reaffirmed at Riga in 1988. The Ottawa Charter (1986) provided a conceptual framework for health promotion and the Adelaide Recommendations on "Healthy Public Policy" (1988) outlined areas for action. In addition, a WHO Working Group on Health Promotion in Developing Countries issued "A Call for Action" in 1989.

Over three hundred participants from all over the world will attend the conference in Sundsvall. There will be a broad representation from both developing and industrialized countries. A serious attempt has been made to achieve a balanced representation of women and men, public health and environmental perspectives and governmental and non-governmental points of view.

Sundsvall will be a working conference. About half of the time is devoted to workshops to discuss practical issues and how to create supportive environments. The workshop discussions will be based on Briefing Books covering major aspects and proposing alternative solutions. The sectors will be food, energy and transportation, education, nutrition, work and unemployment, social care, housing, and community environments and developed countries.

Briefing Books are being made by the host countries Denmark, Finland, Norway and Sweden. Canada, which hosted the conference on Health Promotion in 1986, has also prepared a Briefing Book. A Briefing Book dealing with Health Promotion in developing countries has been produced by WHO in Geneva. The County Administrative Board in Västernorrland, Sweden has developed a Briefing Book looking at the regional and local perspectives in an industrialized country.
The Sundsvall conference will result in a statement for joint public health and environmental action. A report highlighting the main issues will be an input to the ECO conference in Brazil, 1992 and for discussion at the World Health Assembly in May of the same year. Finally, a handbook for action will be produced and to which the Briefing Books will be an essential contribution.
THE CONCEPT OF SUPPORTIVE ENVIRONMENT

There is a growing interest in both the environment and in public health and their implications for the future of mankind and our planet. As a result, the quest for sustainable development has come to be focussed on the interaction between health and the environment.

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socio-ecological approach to health.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, agriculture, energy production, urbanization and social environments - is essential and must be followed by action to ensure positive benefit to the health of the public.

The concept of supportive environments implies that action is oriented towards determinants of the health of populations. This kind of approach points towards practical ways of solving the political, economic and managerial problems involved with developing sustainable health and environments.

The concept of supportive environments emphasizes:

1. The role of environmental aspects in health, thus moving away from a narrow lifestyle perspective.
2. The enabling and promotion approach as well as protection.
3. The importance of creating a supportive environment to provide prerequisites for equity within the community.
4. The importance of sustainable development as an issue for health.
5. People’s understanding of environment in a broader sense, including not only physical but also social, cultural, political, economical and ideological dimensions.
6. The active and genuine encouragement of people’s participation and involvement.

The concept of supportive environments can be used to build bridges between sectors and professions; between theoretical concerns and practical action for an improved environment and public health; and between the developing and industrialized world.

Major factors accounting for failures to create supportive environments for health are:

- A lack of awareness of the effects of various social and physical environments on health;
- Conflicting interests usually associated with economic considerations; and
- The lack of available or acceptable solutions to complex technical and organizational problems.
Achieving supportive environments will require a new awareness of the possibilities for improving health through environmental change. It will also require a strong future orientation that links public health to sustainable developments, for example a more careful consideration of long-term consequences. It will also require a new emphasis on strategic planning and development of management skills to facilitate cooperation between sectors. A basic prerequisite is empowerment of people.
Health has been a prime concern of mankind since before the dawn of history. Some of the earliest written records of past millennia reported on the struggle between humans and disease, between the factors that made for a long and healthy life and those that made life harsh and short.

Today we have the knowledge and the tools to prevent disease, to improve our health and to give ourselves, our families, our communities and our nations the best possible chance of staying healthy. Unfortunately, that knowledge and those tools are not evenly distributed among all mankind.

Advances in health sciences, a better understanding of risk factors and better epidemiological information on health status, ill-health and premature death, in various stratas of society, have made us more aware than ever before of inequities in health.

In the early decades of this century, many international health bodies were created, culminating in the creation of the World Health Organization (WHO) in 1948, shortly after the end of the second world war. Though the nature of health problems and strategies for health have changed since that time, WHO’s ultimate aim has remained: health for all people - “not merely the absence of disease” but a “state of complete physical, mental and social well-being”.

Over the years, it became clear that substantial improvements in health would not be achieved without the improvement of social and economic conditions. Poverty, and poor living conditions, together with lack of education or illiteracy, including “health illiteracy”, have been identified as major impediments to health. The vital need to bring about greater social justice in achieving health for every individual on this planet was first brought into sharp focus at the Thirtieth World Health Assembly, held in Geneva in May 1977.

The Declaration of Alma-Ata - an historic statement

The following year, WHO and the United Nations Children’s Fund (UNICEF) jointly convened an international Conference on Primary Health Care in Alma-Ata, USSR, attended by delegates from 134 countries. At the end of the Conference, the delegates unanimously endorsed the truly historic statement that is now known as the “Declaration of Alma-Ata”.

The kernel of this seminal statement was that “a main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. This target is known for short as “Health for All by the Year 2000” - or by its initials, HFA.
The Declaration stated that an acceptable level of health for all people "can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts". And it urged "a genuine policy of independence, peace, detente and disarmament" which could release additional resources in order to accelerate social and economic development.

**Primary Health Care - an effective and practical approach**

The Declaration identified Primary Health Care (PHC) as the key to attaining HFA as part of the global quest for social and economic development, in a spirit of social justice. The heavy burden of sickness, the high cost of health technology and the inadequacy of health services coverage called for a bold new approach; primary health care offered a rational and practical means for both developing and industrialized nations to work towards the Health for All goal.

PHC places emphasis on eight key factors: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

**Four Pillars - a four-fold objective**

The underlying philosophy that pervades the concept of Primary Health Care is the spirit of equity and social justice - that is, the recognition that health is a fundamental right of all peoples of the earth. The success of the Primary Health Care approach largely rests on the ability within each nation to enhance social action and support for health.

WHO identifies four pillars on which action for HFA must be based:

- political and societal commitment and determination to move towards HFA as the main social target for the coming decades;
- community participation, the active involvement of people, and the mobilization of societal forces for health development;
- intersectoral cooperation between the health sector and other key development sectors such as agriculture, education, communications, industry, energy, transportation, public works and housing;
- systems support to ensure that essential health care and scientifically sound, affordable health technology are available to all people.

PHC is people-oriented. Its success must therefore rest with the people. This explains why the primary health care approach, both in developing and industrialized countries, has a four-fold objective:

(a) to enable people to seek better health at home, in schools, in fields and in factories;
(b) to enable people to prevent disease and injury, instead of relying on doctors to repair damage that could have been avoided;

(c) to enable people to exercise their right and responsibility in shaping the environment and bringing about conditions that make it possible, and easier, to live a healthy life;

(d) to enable people to participate and exercise control in managing health and related systems, and to ensure that the basic prerequisites for health and access to health care are available to all people.

National and international action which followed the Alma-Ata Conference sought to translate principles into practical programmes that took account of the diverse political and socio-economic climate in all of WHO’s member countries. The concepts and principles of HFA have moral, political and social implications for all nations and political hues, and have helped to provide a framework for health development and to deal with inequity in health care.

In many countries, including some of the least developed, political and financial investments in primary health care have paid good dividends. These countries have shown appreciable improvements in such sensitive indicators as infant mortality rates, deaths among children under five and life expectancy. Immunization coverage has increased dramatically between 1970 and 1990 from less than 5% to about 67%, and it is estimated that in 1988 about 32% of the cases of diarrhoea in children aged 0-4 were treated with oral rehydration solution, thereby protecting millions of children from premature death and disability.

The industrialized countries too have sought ways of achieving the health-for-all targets in the context of their needs and resources. For them, the emphasis is on health as reflected in life-styles and behaviour that minimize the risks of sickness - particularly noncommunicable diseases, AIDS and injuries - and on creating and maintaining environments supportive to health. The heavy cost of medical care, especially when it involves high technology, also causes the developed countries a particular concern, and they feel the need for health policies that emphasize caring and prevention in addition to curing disease. The examples of successes are the reduction in tobacco smoking and improved dietary habits, reflected in a decline in deaths from cancer and cardiovascular disease.

Yet, despite substantial progress, much still remains to be accomplished with scope to bring about dramatic reductions in premature deaths and disability. For instance: HIV infection continues to spread rapidly throughout the globe; every year over half a million women die from problems linked to pregnancy and childbirth; diarrhoea kills approximately 3.5 million children every year, while about another three million deaths in children could be prevented annually with improved immunization coverage. The same is true in regard to morbidity and mortality attributable to smoking, excessive drinking and eating habits, and risky sexual behaviour. All of these health problems can be prevented by applying today’s knowledge and technology. Health conditions in the Third World must be viewed in a wider socio-economic context where nearly a billion people are trapped in the vicious circle of poverty, malnutrition, disease and despair; 100 million children are currently denied primary school education, 1.5 billion are without access to basic health services; and 1.75 billion people have no access to safe drinking water.

Fortunately, the philosophy and strategies underlying the Declaration have not ceased to evolve, and serve as an important foundation for further progress. They are impelled by
Health Promotion in Developing Countries

growing public awareness that access to health care by all people and the health demands of the community, including the basic requirements and living conditions essential for health, are not yet fully reflected in public policies. That awareness was accompanied by a growing readiness on the part of health personnel, politicians and non-health sector leaders to move towards partnership with the people, and to enable people themselves to control their destiny - at least as regards their personal and communal health.

Health Promotion - a call for social action

In the latter part of the 1980s, international conferences and working groups on health promotion helped to identify strategies and actions that could advance progress towards HFA. In doing so, they helped to revitalize interest in the goal of HFA, as well as reinforcing interest in approaches that might bring it closer.

The first of these meetings, with particular bearing on the industrialized countries, was held in Ottawa, Canada, in 1986. The Ottawa Conference resulted in a charter for health promotion which proposed a strategy comprising five action areas: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services.

The participants at the Ottawa Conference furthermore pledged themselves to advocate a clear political commitment to health and equity in all sectors, to respond to "the health gap" within and between societies by tackling inequities in health, and to recognize health and its maintenance as a major social investment and challenge.

Two years later, another Conference on health promotion was convened in Adelaide, Australia, to address the first of the five health promotion action areas - building healthy public policy. This conference too attracted participants primarily from industrialized countries.

Meanwhile, in 1989, a working group on health promotion in developing countries, convened in Geneva, produced a strategy document called A Call for Action. This document examines the scope of health promotion and its application in the developing countries. It builds on earlier experience and highlights key areas for action that include: generating social and political action for health; fostering health-supportive public policies and building alliances with all sectors of society; identifying grass-roots strategies for enabling and empowering people; and strengthening national capability, as well as political will, for health promotion and community involvement in health development.

A Call for Action also underlines the role of health promotion in creating and continually reinforcing conditions that encourage people to make wise health choices and enable them to live healthy lives.

The document puts emphasis on advocacy in creating and sustaining the necessary political will to achieve healthy public policies across all sectors, and to develop strong alliances within governments, and between governments and the community. And it says again what cannot be said too often: that health promotion, building community and systems support for health, must be a component in the training of a wide range of health and health-related workers.
Sundsvall: a global focus

The Sundsvall Conference in 1991, for which this briefing book was prepared, has a truly global focus in mind. This third international conference was chosen to address the second of the five areas of action identified at the Ottawa Conference - creating supportive environments. The term environment is considered in the broadest sense of the term - social, political, economic and cultural, as well as the physical environment.

The strengthening of health promotion policies, strategies and social actions for health in developing countries has become more and more indispensable for the achievement of HFA. Many factors justify the need for accelerating and intensifying actions for health promotion, and mobilizing societal forces for health. Chief among them are:

- Many developing countries are in a phase of “health transition”. They labour under the double burden of communicable diseases that have not yet been controlled and a steady increase in degenerative noncommunicable diseases. To these has been added the “new” epidemic of HIV infection and AIDS. Rapid urbanization, population growth and the struggle for social and economic development have triggered growing concern about life-style and environmental issues. Underlying these problems are poverty, illiteracy and poor living conditions, all of which make it all the more urgent to satisfy basic human needs - the essential prerequisites for health and well-being.

- Social justice and human rights for women, children, workers and minority groups are coming increasingly to the attention of the public and are prime issues for national action. Health and well-being are important components of these issues, and there is increasing pressure on countries everywhere to improve the health and the quality of life of all the people.

- Social and economic development aimed towards national progress and societal well-being is a primary goal of almost all nations. Yet health is not yet fully recognized as an integral and essential component of social and economic development, although the point was stressed by the U.N. General Assembly and successive World Health Assemblies. Decision-makers and development planners must be convinced of the need to integrate health concerns into all development activities, even though economic, environmental and health concerns may at times be at cross-purposes with each other.

- Popular movements to protect the environment for today and tomorrow are gathering support and gaining social and political strength. They will have very significant implications for health development action in the future.

- The mid-point meeting to review the progress towards HFA/2000, convened in Riga in 1988, urged countries to review and strengthen PHC strategies, to intensify social and political action, to develop and mobilize leadership, to empower people in general, and to make intersectoral collaboration a force for HFA. These are the issues which have to be addressed in planning actions for health promotion, and which make health promotion strategies as vital to developing countries as to the industrialized nations.
All these changing and challenging conditions offer opportunities for developing countries to strengthen their health promotion strategies and actions in support of HFA goals and socio-economic development in general.

Health promotion is a concept that has evolved during this century. In the present context and times, it offers a sound strategy for protecting and improving public health, and encouraging individual and collective initiatives and action for health.

As the 1988 Riga Conference underlined, Health for All will remain a goal of all countries far beyond the target year of 2000. Long-term targets and strategies will not remain constant, but must be adjusted and adapted to suit the health issues, needs and situations of people and of the times. The primary health care approach, with its accent on equity, effectiveness, affordability, community participation, intersectoral collaboration and appropriate technology will long continue to be valid. As envisaged in the Declaration of Alma-Ata, health is seen as a resource for everyday life, not just an objective of living; it is a positive concept that goes beyond healthy life-styles to embrace the well-being of communities.

In the context of the task set for the Sundsvall Conference - to identify more effective ways of creating supportive environments - we should consider the factors that make health promotion particularly relevant to developing countries. These include: continuing inequity of access to health knowledge, services and technology; increasing rates of chronic and noncommunicable diseases, added to the still-continuing burden, though on the decline, of communicable diseases; changes in life-style brought about by rapid urbanization and socio-economic development; growing pressure for social justice and human rights for women, children, workers and minority groups; and increasing calls for rapid economic and industrial development, with a consequent potential for adverse effects on health. It is also useful to draw upon the rich experiences gained in these countries with health and development programmes.

Health promotion is in brief the social action dimension of health development, another dimension being biomedical and technological interventions embodied in public health practice. It is a sound concept that can revitalize Primary Health Care approaches in both developing and industrialized nations. The goal of health promotion is health for all, which can be achieved in two ways: by promoting healthy life-styles and community action for health, and by creating conditions which make it possible to live a healthy life. The first entails empowering people with the knowledge and the skills that are needed for healthy living. The second calls for influencing policy-makers in the direction of health-supportive public policies and programmes. Both require strong social support for health action to be accelerated and maintained. A public that knows its rights and responsibilities, supported by political will and awareness at all levels of government, can make Health for All a reality.

There is an emerging consensus which describes health promotion as social and political action enhancing public awareness of health, fostering healthy lifestyles and community action in support of health, and empowering people to exercise their right and responsibility in shaping environments, systems and policies conducive to health and well-being for all.

Health promotion is, in fact, enlightened health activism. Health promotion is a process of activating communities, policy-makers, professionals and the public for health-supportive policies, systems and ways of living. It is manifested through acts of advocacy, empowerment of people, and building social support systems that enable people to make healthy choices and live a healthy life.
2 A CALL FOR ACTION: PROMOTING HEALTH IN DEVELOPING COUNTRIES

Health promotion as a concept is well accepted in the industrialized countries and is being applied in developing countries as well. It has been described in a number of different ways, as have the terms health education, health promotion, health communication and social mobilization. They are in fact inseparable concepts of social action for health.

In order to obtain insight into health promotion from policy-makers and senior health administrators from the developing world, a Working Group on Health Promotion in Developing Countries was convened by WHO in Geneva in October 1989. The meeting had a twofold purpose: to explore the application of health promotion concepts and strategies in developing countries, and to recommend specific ways in which these concepts and strategies can be transformed into action in the context of realities in developing countries.

The meeting on health promotion in developing countries was particularly timely. The 1980s were for the Third World countries a period of economic hardship in the face of mounting debt-servicing costs, declining export earnings and the burden of high population growth. Many developing countries, particularly those from Sub-Saharan Africa and some in Latin America, experienced a real decline in their per capita income; the per capita income in the 1980s declined by 2.4% per year in Sub-Saharan Africa and by 0.7% per year in Latin America. The economic adjustment policies required as a condition for future credit involved considerable belt-tightening for the people, and reductions in public sector expenditure, with disproportionate cuts in allocations for education, health and social services. For instance, the share of health services in the national budget declined from 5.5% to 4.2% (a decline of nearly one-fourth) in 20 developing countries between 1973 and 1986. In addition, the devaluation of national economies meant higher costs for imported drugs and medical supplies. The result was to compound the problem of the one third of the world’s population who have little or no regular access to essential drugs.

The adjustment policies and economic constraints are of immediate significance for public health. The principle of equity and universality in health-care will come under much pressure as increasing emphasis is placed on self-sustaining health services and cost-recovery strategies, including partial or total user charges for medical care. Indeed, ways must be found, without sacrificing equity, for more efficient and cost-effective use of public sector resources for health.

Austerity programmes and pressure for economic adjustments call for a major effort to sustain and further enhance the share of public sector resources allocated for health. That effort was highlighted and emphasized in the strategies identified by the Working Group for Health Promotion in Developing Countries.
A Three-fold Strategy

Enhancing health knowledge and understanding is just one essential step in promoting health-supportive action by people. Creating conditions - social, economic and environmental - that are conducive to health is another essential requirement. These can only become a reality when there is heightened awareness for health among policy-makers, politicians, economic planners and the public alike, and when this awareness is transformed into policies, legislative support and favourable resource allocations for health. Nothing less than full mobilization of all societal forces for health and human well-being will be needed.

Three principal strategies of social action are clearly set out in the report of the working group - *A Call for Action*. The strategies are: advocacy for health, social support and empowerment of people. Taken together, the three principal strategies constitute a powerful instrument for both promoting healthy life-styles and creating conditions conducive to health. But, in a way, each has its own distinctive characteristics and primary focus. Advocacy encourages and places pressure on leaders, policy-makers and legislators to act in support of health. Social support, including health system support, reinforces and sustains conditions that encourage and enable people for health supportive action and that ensure wide-spread and equitable attainment of health. Empowerment prepares individuals and groups with the knowledge and skills to act. Together, the strategies provide valuable means for health promotion.

Let us look closely at each of these three strategies before we examine some relevant experiences in developing countries.

Advocacy for Health

The aim of advocacy is to generate public demand, place health issues high on public agenda, and effectively reach the influential group of policy-makers, elected representatives, professionals, political and religious leaders, power brokers and interest groups to act in support of health.

Advocacy directed at policy and decision-makers helps them to recognize that health is an economic and political asset. It is aimed at strengthening political commitment favourable to health, promoting social policies that are conducive to positive action for health and supporting systems that are responsive to the needs and aspirations of the people. It focuses on creating supportive environments, facilities and conditions that make health choices easier and feasible for people, and placing health high in development priorities ensuring the allocation of an appropriate share of national resources for health, both within and beyond the health sector.

Advocacy directed at professionals, public figures and service providers should seek to sensitize them to the needs and demands of people and to the desirability of reorienting health systems and services accordingly. It should help professionals and decision-makers to recognize that knowledge and understanding alone, without adequate support systems, is not enough to lead people to action. “Society must make it possible”, as Dr Nakajima stated at the XIII World Conference on Health Education, in Houston, USA, in 1988, “for people to live healthy lives. A grand alliance of people, policy-makers and health professionals is necessary”. Advocacy should therefore aim at promoting multisectoral activities to achieve basic prerequisites and conditions of life essential for healthful living. All societal forces
- social, political and economic - must be mobilized to promote action for health development.

Advocacy directed at the public should help to create a critical mass of interest and support for positive health action. It should be aimed at heightening public priority for health, stimulating public discussions and debate, and generating demand and public pressure for healthy public policies and environment.

Advocacy for academic leaders should aim at stimulating interest in studying and researching policy aspects and factors that facilitate progress in health. They must be important allies in providing a sound and scientific basis, backed by facts and figures, for making a persuasive case for health and health supportive policies.

An impressive example of effective advocacy is the Alma-Ata Declaration reflecting the collective political will of all governments for equity and social justice in health. Other such examples include political commitment and resource allocation by governments for population programmes. Equally impressive achievements in enlisting political support include the launching of the smallpox eradication programme with success, the dramatic reduction in malaria, and the virtual eradication of yaws. All these examples reflect how national and international agencies can combine their efforts for policy and strategy development.

Advocacy, political commitment and supportive policies are often themselves a product of social support systems and empowerment of people. Advocacy should therefore be viewed in conjunction with the other two principal strategies for health promotion, namely social support and empowerment.

Social Support for Health

Strategies for strengthening social support are directed both at community organizations and institutions that legitimize and encourage healthy life-styles as a social norm and foster community action for health, and at systems that provide the infrastructure for health-care services and related development activities which influence health. Alliances must be established with all influential forces in society, generating demand and pressure for health-supportive environment and policies, and ensuring widespread and equitable attainment of health goals.

Strategies to strengthen systems support within the health sector should aim at developing people-centered services and responsive health systems. It will be necessary to provide a new direction to training that will prepare health workers, both socially and technically, to respond to the needs and expectations of people, to build effective alliances with other sectors for working across sectoral lines for health-related actions, and to involve communities as true partners in decision-making and managing health-care programmes.

The health sector needs to utilize all channels through which people express their concerns and demands for health and health-supportive policies and programmes. These include: elected representatives, political parties, consumer groups, social and religious institutions, voluntary organizations, interest groups and public hearings. The media play an important role in increasing public awareness and support for public action. It is advisable to take advantage of many such channels that activate the public and policymakers’ interest in health.
Activities in sectors other than health, such as education, food and agriculture, communications, public works, energy and transport, commerce and industry, have health implications, yet these sectors rarely have clearly-stated goals for health. Strategies to strengthen social support for health should help leaders and workers within these sectors to recognize the health implications of their plans and programmes. They should also be aimed at building and strengthening mechanisms at all levels to enhance intersectoral action.

To date, intersectoral action for health is more rhetoric than action. To make intersectoral action a reality, concerted efforts must be made to demonstrate how ill-health and disease are closely linked with illiteracy, poverty, insanitary living conditions, environmental pollution and so forth. As leaders and members of various organizations gain knowledge about health implications, organizations will be better able to link health to their own interests and purposes. True intersectoral cooperation occurs on the basis of mutual interest. Areas of mutual interest must be identified and complementary roles defined.

A wide variety of social institutions, professional associations and voluntary organizations are engaged in health activities at the community level and in promotional efforts at political and professional levels. Strategies for social support should aim at initiating and maintaining close partnerships with these organizations and groups and fostering working alliances between them for complementary and coordinated efforts for health protection and promotion. Purposeful networking among such community-based professional, voluntary and humanitarian organizations can help mobilize community resources and set in motion the much-needed social, political and community action for health.

Empowerment for Health

People have the right to information on how to maintain, protect and promote health. "Health literacy" among people must therefore be an essential and important component of the health-for-all strategy. Education concerning health problems and methods of preventing and controlling them is cited in the Alma-Ata Declaration as the first of eight essential elements of primary health care, emphasizing the importance of community self-reliance, social awareness and community participation in the health and human development process.

The strategies of empowering people equip individuals, families and communities with the knowledge and skills which will enable them to take positive actions for health and make sound health choices. Such individual and collective choices also require a supportive physical, social and economic environment, and accessible services and facilities. Information, communication and health education of the public are at the heart of this empowerment process.

Strategies of empowerment for health should be directed at all people, the public and policy-makers alike, using all available and credible channels and stressing the importance of health as a personal and social value. They should be implemented at all levels, local and national, as well as in the home, the school, the workplace and other community settings.

Empowerment strategies should help people to learn about specific behavioural choices that influence their own health, and that of their families and communities. This includes helping people to recognize factors that influence healthy lifestyles, including beliefs, attitudes, opinions and skills, as well as health knowledge.
In addition to helping people to acquire the ability to practice a healthy lifestyle, empowerment strategies should enable people for full participation in national and community-level health actions. They should help people to develop social and political skills, such as resource mobilization, negotiation, lobbying, problem-solving, and networking skills, so that people can take steps to meet their needs and aspirations and influence the physical, social, cultural and environmental conditions that effect their health.

Empowerment strategies should also help people to create enthusiasm, conviction and commitment to community welfare. They must also help people to identify resources and support for national and community-level health actions.

Empowerment strategies should complement advocacy and social support strategies in encouraging people to take more control of their own health and be partners in the systems that can help them to lead healthy lives.

None of these three principal strategies is particularly new, nor are they particularly unique to health promotion. Nonetheless, when they operate in concert, they bring about positive social action, creating and continually reinforcing conditions that enable individuals to make wise life-style choices, and encouraging them to lead healthy lives.

Many health-related programmes in developing countries have brought together these action components, using successful approaches and methods that are appropriate and, at times, innovative. Though these programmes may not be labelled "health promotion" as such, they are examples of experiences gained by public health planners, administrators and practitioners that have relevance to all those who are trying to extend health promotion to the developing world.
If I hear I forget,
If I see I remember,
If I do I know.

*Chinese aphorism*
Advocacy is a key action word in health promotion strategy. The primary aim of advocacy is to foster public policies that are supportive to health.

Formulation of policies is a complex process. Ultimate responsibility for public policy, including public health policy, generally rests with the government. Let us examine how policies are developed, who are the actors involved and the ways societal forces influence the process of policy development. What are the various channels - social, political, professional and commercial - through which people express their concern for policy change?
Health Promotion in Developing Countries

Public health policies focus on both the provision of biomedical care, such as treating illness, and on prevention, such as immunization, safe water and sanitation, maternal and child health and promotion of healthy life-styles. However, prevention, being less glamorous, has not received the resources and attention it deserves for achieving the goal of health for all people.

The attainment of health goals requires the action of many social and economic sectors in addition to the health sector. Considering the close relationship and inter-dependence of health and social and economic development - health being dependent on and, at the same time, leading to progressive improvements in living conditions - public health policies must be viewed in the broader context of public policies, and as an integral part of the social and economic development process.

All factors affecting health should receive the attention they deserve in developing health and public policies. The point is highlighted in the Alma-Ata Declaration, which stresses that health improvement is to be considered together with "improvement of nutrition ....; increase in production and employment, and a more equitable distribution of personal income; anti-poverty measures; and protection and improvement of the environment".

Health cannot be attained by the health sector alone. Improvements in living conditions are essential prerequisites for improvements in health, which in turn lead to economic development and improvements in the quality of life. Policy development in such a broad context, taking into account all aspects of human development, social and economic progress, can aptly be described as "healthy public policy".

Nearly all countries, developed and developing alike, already proclaim national policies supporting the concept that health is a basic human right, that equity of access to health is important, that a healthful environment is desirable. However, laudable pronouncements and "paper policies" are of little value unless popular political rhetoric is translated into reality and supported by appropriate resources to move from philosophy to action.

Advocacy for health and healthy public policy is an action area that is increasingly on the agenda of the health sector and all concerned with health and human wellbeing. Advocacy is literally described as pleading in support of or in favour of an issue or case, or to recommend it. Advocacy for healthy public policy involves encouraging, persuading and putting pressure on leaders and all relevant bodies to initiate and formalize health supportive policies, legislation and resource allocation that can help meet the health needs and interests of the people.

Indeed, a major challenge lies in influencing those who are influential in shaping policies. Mobilizing vigorous public support and establishing alliances with influential forces in society - social, political, professional, economic, religious and various interest groups - are indispensable to creating and sustaining political will and commitment favourable to health and to obtaining an appropriate share of national resources. Strategies that generate public interest and ensure that health is viewed, not only as a social imperative but also as a political asset and sound economics, offer the most promising avenues to effective advocacy. Advocacy for health must be viewed in the broad context of social and economic development. Advocacy efforts must be directed at fostering social, political and community action for health, and must address both substance and rhetoric.

Advocacy for healthy public policy needs to be considered in the context of certain significant realities:
1. Most countries are striving to implement time-limited development plans which give priority to rapid economic gains through industrialization and greater food production. Economic necessities in many countries oblige them to concentrate on exports to earn foreign exchange, at the expense of meeting local needs. One example is Peru, a major fishing country which for 30 years consumed only one ton out of over a hundred tons of fish caught, exporting the rest as fish meal; a new policy was, however, introduced in 1985 to reverse this trend.

2. The nature of the political system prevailing in each country is a crucial factor affecting the process of policy formulation, as well as the nature of policy as related to distributive justice, health and welfare.

3. The educational level and public awareness of development, health and welfare issues are frequently below the desired standard. Additionally, the decision-makers have sometimes not been fully informed or made aware of the health implications of development policies.

4. Some countries are beset with political uncertainties, severe strife, natural disasters and rapid population growth, all of which off-set or slow down development efforts.

5. There are competing demands on the limited resources for development. What is available tends to be diverted to activities that bring in revenue and economic returns. Additionally, international donors often tend to encourage projects offering quick and visible returns. The long-term benefits of investing in health and the development of a health work-force are often overlooked.

The above factors point to a limitless scope for advocacy in support of healthy public policy, and to the urgent need for advocacy in developing countries within the social, political and economic context.

ADVOCACY APPROACHES

Experience has shown that no single approach in itself can suffice to ensure successful advocacy for health-supportive public policies. Advocacy is most effective when individuals and groups and all sectors of society are engaged in this process. Examples of advocacy initiated by government sectors, community organizations, nongovernmental organizations, media, universities, researchers and international agencies are presented here to show a range and diversity of advocacy strategies undertaken in developing countries.

1. Advocacy by Governments - leading role of the health sector

It is understandable that among the government organizations the health sector takes a leading role in advocacy for health. Health administrators, professionals, technocrats and planning divisions within the health and related ministries, and their advisory committees, play an important role in assisting the policy-makers, the leaders and the public identify the priority health issues. However, the strength and significance of such efforts may vary depending on such factors as the political climate, the political will and commitment of governments in realizing equity and social justice, the priority given to economic and
industrial development and the professional capacity, interest and commitment of health administrators and technocrats in pursuing the case for health and competing with other demands.

Box 1

China, Sri Lanka & Kerala, India: interaction of health and development

In all these areas there was a strong commitment to the goal of equity, and concerted efforts to ameliorate the conditions of the disadvantaged and poorer social groups. In all important sectors, the development strategies contained elements aimed at realizing these goals.

The state and public agencies assumed an important role in meeting the basic needs of the people. In China this was the norm, while in Kerala and Sri Lanka the supply and distribution of certain goods and services essential to basic needs occupied a central place in public policy and were not left to market forces.

Development policies avoided the urban bias common to the strategies of many developing countries in the early phases of their planning. Consequently, resources for the social and economic infrastructure and investments in development were more equitably distributed. The differences in living conditions between rural and urban areas were not markedly widened by the development process. Civic amenities spread to the rural areas. Sri Lanka, for example, was able to maintain a rural/urban balance that limited the internal migration to metropolitan areas.

The political processes were designed in such a way that demands could be formulated and responded to at the community level. In China, this was achieved by decentralized decision-making in the communes and lower units. In Kerala and Sri Lanka, a highly competitive democratic system from the local to the national levels helped to give forceful expression to community needs and elicit responses from the state.

In economic development programmes, strategies for raising productivity and income in backward parts of the economy, which contained the poor majority, received priority.

In all three areas, high priority was given to education, policies were aimed at equitable distribution giving the rural population access to education. The strategies pursued brought education within reach of the whole school-age population through a system that provided free or heavily subsidized education. In all three cases there was a very high level of female participation in the school system.

The improvement in the status of women and the removal of forms of discrimination against females - as in the case of education - played an important role in enhancing the capacity of the population as a whole for social advancement.

Food security for all segments of the population became an essential objective of public policy. Different policy instruments were used in each case, and included state management of the trade in staple foods (China and Sri Lanka), food rationing with food subsidies (Kerala, Sri Lanka), free food supplements for target groups (Sri Lanka), and land reform to encourage food production in small allotments (Kerala).


Box 2

People's initiatives for better housing

Rio de Janeiro's Favela do Gato, or "Shanty Town of the Cat" provides an example of a peripheral urban community which has successfully organized and advocated for the improvement of its housing conditions. Favela do Gato, like so many other urban areas in the Third World, grew up on Rio's periphery as rural residents left their homes in search of a better life in cities. These men, women and children scavenged for wood, metal, cardboard or whatever materials they could find with which to build their homes.

With the support of the Group for Community Projects of the University Federal Fluminense, the slum dwellers negotiated a deal with the national housing authority, which resulted in the setting up of 71 model houses and a community centre, granting of individual financing, and absorption by the public authorities of the costs for the land and infrastructure. Each family chose its site and the position of the house upon its plot of land - an unusual opportunity for a low-income housing scheme. The layout of a section of the favela was planned on the basis of the residents' wishes.

During Argentina's former military government, many of the urban poor left Buenos Aires when bulldozers stripped the city of its shantytowns in the late 1970s. However, many other residents remained close to the income sources and urban services found in the city. Since adequate housing is expensive and scarce, large numbers of those who stayed have taken up residence in the decaying buildings near the heart of the city.

Fortunately, efforts are being made by various groups like "Grupo Habitat" to improve these conditions and provide better housing for residents. Tenants' groups in Buenos Aires have devised two strategies for helping poor urban tenants to renovate their homes. One plan provides technical assistance from university engineering students through the auspices of Grupo Habitat. The other involves a labour pool of tenants with construction skills who are available to make home improvements. The organization is also pressing for corrective legislation to change the difficult requirements involved in renting, and to reduce down-payments for long-term apartments.

Source: (1) Grassroots Development, 12:1, 2-7 (1988)
(2) Occasional papers in planning, No. 9. Department of Country Planning, The Queen's University of Belfast. (1985)

In countries where governments are committed to realizing the national goal of equity and social justice and are striving to reflect this in all programmes, health professionals and decision-makers in health and related sectors are encouraged to consider all factors that influence health, ensure policy formulation and foster programme development efforts. The equity-oriented economic and social policies provide a basic fabric into which matching health policies and strategies can be interwoven as an integral part of the development process, permitting access to health care by all people.

Despite the constraints of relative poverty, dramatic achievements in health have been made in countries like China and Sri Lanka and in the State of Kerala, India. For example, the life expectancy at birth in China and Sri Lanka in 1983 and 1987, despite per capita
income levels as low as US$350.00 p.a., were estimated at 69 and 70 years and 67 and 71 years respectively. This is higher than the average for upper- and middle-income groups in countries with an average per capita income of US$2,050.00 p.a. Furthermore, Sri Lanka provides 93% of its population with access to health-care despite its low income level.

A clear description of the inter-action between health and development policies can be seen in Box 1.

Another example is that of the United Republic of Tanzania, which also supports an equity-oriented health strategy. Among the poorest of African countries (per capita income US$240), it has the third lowest infant mortality rate in sub-Saharan Africa. The country is moving towards an improved health status by combining a health strategy based on primary health care with literacy programmes and equity-oriented development of rural areas. Health is an inseparable part of a development strategy which emphasizes self-reliance and equity. The result has been a 30% reduction in infant mortality rate over two decades.

### Self-help in Sarawak

Sarawak is a vast area in the north of the island of Borneo, part of the Federation of Malaysia. The coastal areas are populated, the interior consists of dense forests and mountains. Water is rarely in short supply but the problem is to bring it to the homes where it is needed.

In the 1960s, the Sarawak Rural Health Improvement scheme was oriented towards educating kampong (long house) dwellers on how to improve their personal hygiene, build toilets, clean their compounds and fence their animals. The response was poor and, in 1967, a new strategy was adopted which included - in addition to education - motivating people to help themselves with technical support and incentives. Rural health supervisors selected from the community and trained to work with people played an advocacy role, activating people and providing the thrust in mobilizing community action.

Piped water in homes was an incentive that called for community effort based on gotong-royong or self-help. The initiative came from the householder for a house water connection, who then undertook to contribute money and free labour towards building and maintaining the supply to the community, constructing a sanitary toilet, cleaning surroundings by digging drainage ditches and fencing in pigs. As a result, the communities in Kampong Skiut received a piped supply from a spring on a mountain a mile away; in Kampong Suba-Bau received water from a catchment basin with the help of a hydraulic ram that brought the water to storage tanks; and people in Kampong Remun and Lebor cleaned the dam, the source of their water supply on the Renum River. Other long house communities in remote areas hauled pipes airlifted to a convenient spot, and built a dam higher up to avoid pollution. The government, WHO and UNICEF provided equipment, supplies and services in addition to peoples' contributions and free labour.

By 1977, out of 2,800 kampongs under the project, 771 kampongs covering 200,000 people had piped water in their homes, sanitary toilets and cleaner homes. By 1980, 1,400 kampongs were so covered. The project area has since been extended and to date 5,072 long houses have been covered by the scheme.

Advocacy and appropriate support moved communities to action, thereby changing the environment for long house dwellers.

Filipino women take the lead

An unusual sight could be seen on a hot day of May 1985 in Makati, a suburban town in the Philippines: some 500 women were breast-feeding their babies in the street. Why this demonstration? To protest against the aggressive and inappropriate promotion of bottle-feeding and the resulting poor health of infants. This mass action, the first of its kind to be staged by Filipino women on the issue of breast-feeding was the climax of several years of resolute efforts to create nationwide awareness that “Mothers’ milk is best for baby”. It was organized by the National Coalition for the Promotion of Breast-feeding and Child Care”, a private organization launched in 1983 and affiliated to the National Movement for the Promotion of Breast-feeding. Mothers from all walks of life were enjoined to participate in the mass action.

The area of concern to the National Movement from the start was the marketing of breast-milk substitutes and the promotional methods used by the infant formula industry. A need was felt to establish a national code of conduct for the marketing of breast-milk substitutes. A code of ethics was drafted as early as 1979 by experts. In collaboration with WHO and after consultations with the Ministry of Trade and Industry, consumer groups, the infant food industry and professional and medical groups, a final draft was agreed upon in 1983, but adoption of the code by the country’s legislative body was still pending.

The mothers’ march in the streets in May 1985 rekindled public interest in the code. A few days after the event, the infant food companies issued a joint statement expressing their support for the adoption of a national version of the International Code for the Marketing of Breast Milk Substitutes. The code that had been pending with the legislative body was signed in 1986.

Source: Marcia A. Rodriguez, Health Reporter, Manila Bulletin, P.O. Box 769, Manila, Philippines.

Costa Rica is another country which showed a remarkable decline in mortality during the period 1970-1980. The infant mortality rate in 1970 stood at 66 per 1000, but declined to 20 per 1000 in 1980, while life expectancy increased from 65 to 72 years during the decade. After the fall of a military government, state initiatives diverted resources towards socio-economic development, establishing a social security system and building an infrastructure for more equitable distribution of public utilities such as power, water and telecommunications. All this contributed to social wellbeing and health.

A mix of policies, with emphasis on equity and wellbeing, has made an impact on health in all these countries and activated the health sector to make appropriate efforts for health, not only within their own sector, but also in other development sectors as well. Additionally, achievements within sectors other than health, such as access to education, food security, improved housing, water and sanitation, and communication, were all important factors that had an impact on health. In those countries where government policies aimed at equity and social justice are slow to be translated into action, advocacy for healthy public policy must be forceful to be effective. Greater initiatives must be taken by all sectors and at all levels if weaker sections of the population are not to be neglected and left behind. Politicians, health administrators and professionals, together with their allies in other development sectors, must provide leadership in convincing those at the highest political level that health is a vital part of all development, that a close relationship exists between health and

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economic development, and that health supportive policies with the allocation of an appropriate share of national resources to health are essential for human progress and wellbeing.

The health sector must arm itself with hard-hitting facts that substantiate the long- and short-term impact that neglecting health issues can have on the national economy and development. They must endeavour to establish strong alliances with leaders in other sectors, including the media, academics, professionals and the public.

Governments have tried different approaches to achieving health goals. Countries like Sri Lanka and Papua New Guinea have made investments in health (10-15% of the national budget) that go far beyond what might be expected, considering each country’s national resources. Socialist countries like Cuba and Viet Nam have taken primary health care seriously and ensured impressive population coverage. All these countries have achieved good dividends for health. On the other hand, countries such as the Republic of Korea, have focused on economic development and progress, and better health of the people has followed.

In the final analysis, the health sector of each country must find ways of advocating health within the framework of the country’s political and socio-cultural climate.

Box 5

Advocacy role of the Voluntary Health Association of India (VHAI)

The Voluntary Health Association of India (VHAI) came into being in 1974 as a result of a decision by leaders of voluntary hospitals and health associations to promote community health in order to balance the over-emphasis on expensive hospital-oriented health services. Today, VHAI is a federation of more than 3,000 health organizations throughout India, working to promote social justice in the provision and distribution of health care. Its work spans a wide range of activities including shaping public policy for health, providing training, involvement in public affairs and communication for health.

The advocacy activities of the VHAI are directed at the parliament and the press. The health concerns of thousands of voluntary organizations working in the health field go unnoticed by policy-makers, so the VHAI realized that it was in a position to bring these concerns to their notice and offer recommendations at the decision- and policy-making level in government ministries, the planning commission and parliament. Today, the VHAI interacts with the main political parties to impress upon them the health realities confronting the nation, highlighting areas needing immediate attention. Some of its ideas and recommendations are now reflected in the manifestos of these political parties.

With the formation of a new government in India in late 1990, VHAI’s persistent efforts led to assurances from the Deputy Prime Minister and the Minister of Health that there would soon be a comprehensive law on smoking with strict sanctions for offenders, a review of the drug policy and agriculture policy, and increased importance given to primary health care.

The Association has also initiated work in such areas as health and the environment, and the problems of the adolescent girl; a feature film and a booklet on the subject has been produced with UNICEF support. In its advocacy efforts, the VHAI has always been careful to establish close rapport with the media.

2. Advocacy by the Community

Heightened public awareness, concern for health, and understanding of health issues are essential for building political support at grass-roots and higher levels. Awakened communities hold the key to successful advocacy for healthy public policy. The community is the public and without its involvement a truly public "policy" cannot evolve. Poverty and illiteracy do not prevent people from recognizing their needs or being willing to call for action. Therefore it is appropriate that advocacy for community support should help to create a social climate favourable to health and to arouse public interest and community action that will generate upward pressure for political support.

Inherent in the community life of most developing countries are age-old traditions that encourage mutual self-help (e.g. gotong-royong in Indonesia and shramadana in India and Sri Lanka). These traditional values provide a sound basis for advocating collective action for health. There are many examples of local-level community action introducing some highly innovative community-based activities: setting up rural cooperatives for commonly-used medicines, designating depot holders in local communities for condom resources, building and maintaining village water supply systems, organizing feeding programmes for children in- and out-of-school, and building community centres, schools and health centres.

Such examples of advocacy in developing countries build confidence among professionals and decision-makers in the ability of poor and disadvantaged communities to advocate effectively for health. The initiative that people can take in placing health high among development priorities depends upon the extent to which the bottom-up process has been strengthened in the prevailing political and managerial systems.

A well-known example is of a policy-decision in one country to reduce the birth rate by introducing a high-pressure approach to promoting sterilization; the unpopularity of this policy played an important part in the election defeat for the ruling party.

Examples from Latin America and Malaysia, in Boxes 2 and 3, illustrate how the poorest can advocate for better housing and water supply targeting government policy-makers. An example of people's advocacy having an impact on industry and state policy is found in Box 4.

3. Advocacy by Nongovernmental Organizations

There are many international, national and local nongovernment organizations (NGOs) committed to serving the health and welfare needs of humanity. Many of these started off by providing medical care for the sick and looking after the health of mothers and children, but now have multisectoral activities including income-generating schemes. Religious organizations have many hundreds of health and health-related programmes scattered around the world, frequently working among socially and economically disadvantaged population groups.

The advocacy work of such organizations, both religious and secular, is often of a quality and effectiveness that could well be exemplary in many ways. The achievements and experiences gained through their projects show how health needs can be met with limited resources. Activities of the Voluntary Health Association of India (VHAI) summarised in Box 5 illustrate ways in which a national-level NGO can advocate for health.
The Rotary Club and the Aga Khan Foundation are two examples of the many NGOs which support health programmes. Others, like the International Planned Parenthood Federation (IPPF), confine themselves to specific areas of work. Many NGOs, such as the World Assembly of Youth, have established a working relationship with the UN agencies, including WHO, and play an excellent role of advocacy in support of health.

**Box 6**

**The Narmada Valley Project**

The Indian press raised certain issues in relation to this irrigation and hydro-electric project, pointing out that - while desirable for enhancing economic development - similar projects elsewhere had posed problems of resettling displaced populations, and had adverse effects on the environment and health.

Among the negative effects cited were:

- Cultivable land to relocate displaced population was not available.
- Remaining grazing lands (those remaining unsubmerged) had little soil cover, of poor quality, and were totally unfit for cultivation.
- Cash compensation was in most cases inadequate, resulting in lowered standards of living and a worse quality of life for a large majority of displaced persons.
- Most displaced people were tribal people. The sudden influx of modern systems, destruction of the environment on which their life was dependent, displacement and resettlement bewildered the tradition-bound tribal families, leaving them powerless and on the verge of social, cultural and economic collapse.
- Many of these people drifted towards cities, where they were unable to cope with the alien environment.
- Those who were resettled did not yet have adequate housing or employment.
- Mortality rates have risen among these people, and food reserves and incomes have fallen; cattle too are dying.
- Building irrigation dams increased the incidence of certain vector-borne diseases such as malaria, schistosomiasis and filariasis requiring surveillance, monitoring and control measures; other ailments cited were fluorosis, skin infections and sexually transmitted diseases brought in by migrant labour; the incidence of cholera, gastro-enteritis and other water-borne diseases was likely to increase.

**Action needed**

The Narmada Planning Group prepared a work plan for the health sector, including monitoring the health profile of the project areas and providing suitable infrastructure facilities for curative and preventive measures. Despite the above study and work plan, there was no representative from the health sector on either the Narmada High Power Committee or the Narmada Planning Group. No further studies were made of the health situation. In short, the health sector was excluded from the planning and carrying out of the project.

4. Advocacy Role of the Media

The mass media can play a strong advocacy role in creating public awareness and bringing about action for health, and often target decision-makers as well as interest groups who in turn press for suitable policies. The effectiveness of their advocacy role, however, depends upon the freedom the media enjoy and the influence they carry with the national political system and the public. Whatever the political climate, the media have a positive role to play in influencing individual and community health.

As literacy levels increase in many developing countries, the printed media gain greater importance in informing people and awakening in them a concern for people's rights and a desire to improve lifestyles. More and more enlightened and enthusiastic opinion and action leaders are emerging who are not afraid of exposing themselves to the media. Professionals and public figures are now more ready to be provocative and less reluctant to interact with the media. Leaders do not only influence the printed word; they are themselves influenced by it.

The broadcast media have much larger outreach and play a more direct role in advocacy with the masses. Radio and television are popular forms of communication which are increasingly being used to inform the public and raise their interest in health issues. Broadcast coverage in developing countries is expanding dramatically to the point where its messages can reach millions of people at any given point of time.

In mass immunization campaigns particularly, the role played by the mass media has been very significant. Televising the involvement of the head of state or other dignitaries can bring home to millions of viewers the national importance of the campaign.

In many Asian and African countries, the traditional media are very valuable in creating social awareness for health action. Folk songs, mobile theatre, puppet shows and street plays are popular means of communication with a strong appeal for both rural and urban people. Sometimes these events are also televised.

The media have often taken the initiative in supporting health activities. The press in particular has brought into focus the social and health implications of the population explosion, rapid urbanization, child labour, environmental pollution and large hydroelectric projects which promise economic development through irrigation and energy production. The Narmada River Valley Project in India was presented as an example during a symposium organized in 1989 by WHO in the South-East Asia Region on "the implications of public policy on health status and quality of life". This controversial irrigation and hydroelectric project received a great deal of coverage in the press and was the subject of debate between the government, donors and beneficiaries. The example of the Narmada valley project is detailed in Box 6.

This example mentions forms of advocacy other than that undertaken by the media, illustrating the case for multi-pronged advocacy efforts. To strengthen the advocacy role of the media, the health sector must facilitate and support the effective contribution of this powerful ally. The media sector must be exposed to health issues and fully informed about health, thereby building alliances that are sound and mutually beneficial.

WHO has long realized this need and has initiated media for health seminars, orientation programmes for media personnel and health inputs in media training centres. Press releases and fact sheets are useful ways of informing and stimulating the media to action. Radio
spots, videos and films on priority health issues are routinely made available to broadcast networks - although they have to compete for time slots with other topics including entertainment. The progress made in producing and screening “spots” and short films on health and social issues in some developing countries has proved very encouraging.

Providing support for such inputs must be considered as a priority issue by national authorities. The health sector has too often been reluctant and defensive in its relations with the media, perhaps fearing “exposés” that might undermine its professional credibility. Serious attention needs to be given to building up expertise within the health departments so that personnel develop the skills to work with the media sector.

Such regional organizations as the Asia Pacific Institute for Broadcasting Development (AIBD) and the Union de Radio et Television National d’Afrique (URTNA) offer valuable training schemes for media personnel. Health interests can be introduced into the training provided.

5. Advocacy Role of Universities and Research Institutions

Universities and similar institutions, where knowledge is both acquired and generated have responsibility for influencing the thinking of policy-makers. Many of them accept wider responsibility while others engage in purely academic activities, giving and acquiring knowledge.

A number of countries have national centres which undertake research on health, economic and social issues, and which study problems of interest. Many are autonomous bodies with the freedom to pursue scientific goals, and to collect information that will provide the bases for national plans. Their work on such diseases as malaria, schistosomiasis, onchocerciasis, leprosy and recently HIV infection, as well as on the harmful effects of certain practices, has focused on economic and social implications.

Thanks to the credibility established by individuals and departments through their research and teaching programmes, government departments frequently invite academics to provide advice and expertise in national planning. Those in health-related disciplines are often willing to share their experience with health practitioners. It is expected that their contributions will be based not only on facts respecting ethical, professional and scientific norms but also presented in a form understandable to policy makers and health administrators. The vice-chancellors of universities and the deans of health and related faculties have ample opportunities to provide leadership in promoting appropriate basic and applied research, disseminating the findings and advising national authorities and international agencies on matters that need action.

Another vital advocacy role that universities and institutions play is addressed to the students themselves, who will later have a part to play in shaping the destiny of the country. Teachers through their professional bodies, their teaching and their private lives have an important impact. Supporting the development of public policies that uphold equity and health can and must be part of learning at the universities. This can be achieved through appropriate curricula, effective methods of teaching - including community-based activities - and through the professional practice of the teachers themselves. The learning environment is not only in the classrooms; it also embraces the social interactions and culture that pervade the very life of the university community. Every country values the contributions made by its centres of excellence.
The role of universities

Since 1986, the strategy for developing the Nigerian National Primary Health Care Services has equipped local government areas to supervise and run the services. In addition, a concerted effort is being made to mobilize all agencies with the skill to design and implement the service. Under this plan, the 12 colleges of medicine and teaching hospitals in universities and the 20 schools of health technology have been drawn into a collaborative system.

Each of the colleges of medicine is helping a nearby local government to set up a PHC system which will also serve as the practice field area for the college during field assignments. At present, four medical schools already have a community-oriented curriculum for training the basic doctor. A recent meeting of the Ministries of Education and Health for African Countries in Abuja discussed the importance of effective training of doctors and nurses in improving PHC systems. The Abuja Declaration stressed the appropriate preparation of personnel to meet the needs of PHC programmes. This was strongly endorsed by the International Association of Medical Schools and the Confederation of African Medical Associations.

Every school of health technology is now mandated to have a practice area where community health extension workers are trained, and to revise the curriculum accordingly. The schools also provide expertise to set up the PHC services of local government areas of their choice.

The development of PHC systems within local government areas is a good example of a national initiative being supported by different international and bilateral agencies from outside the country (WHO, UNICEF, UNFPA, the Ford Foundation, the Christian Health Association, Rotary International, the Lions, etc.) and by academic, professional and voluntary agencies within the country. Each agency plays an advocacy role through their inputs to the national PHC services.


Universities have other opportunities for advocating for health. Seminars, summer schools and scientific and technical meetings on important health-related issues bring together policy- and decision-makers, health practitioners and the public with a view to inform, orient and influence action. This role is becoming increasingly important in developing countries. Joint documents and statements by academicians, professional bodies and practitioners can be valuable in shaping public policy.

Many universities in the developing world undertake projects of national importance that serve as demonstration centres and suggest ways and strategies for wider replication. Projects on primary health care delivery, maternal and child health, family planning, tropical disease control and so forth originate from many African, Asian and Latin American universities. Box 7 shows the involvement of universities in Nigeria in implementing PHC programmes.
Some countries recruit university students for national programmes in order to make up the manpower gap and accelerate action. Students then become advocates for health while working in communities. The role played by students in very successful literacy programmes in China, Myanmar and Tanzania is well-known, and their inputs in several national immunization campaigns have also been widely documented. Under the National Service Scheme, students from Indian universities participate in school and community health education, including activities to control diseases such as leprosy.

To this group of institutions may be added such professional bodies as the medical, nursing and other health workers associations. They have been successful in promoting new ideas and policies on health, or in bringing about the revision of others that do not meet the ethical standards of professional practice. These organizations must increasingly be involved in advocacy for healthy public policy both with the government and with their own members.

Convincing facts and figures strengthen advocacy and move international and national governments to action. An interesting example concerns smoking restrictions in public transport and on board passenger aircraft, both in developed and developing countries. WHO played a leadership role in creating global awareness of the effects of both active and passive smoking by presenting convincing scientific data, as well as pleading for the rights of non-smokers. In collaboration with the International Air Transport Association (IATA) and the International Civil Aviation Organization (ICAO), WHO collected information that helped to bring about legislative and administrative restrictions on smoking in public transport vehicles. Box 8 illustrates this advocacy approach and the policy outcomes.

Besides the efforts of WHO/IATA, a number of national authorities armed with research findings on the ill-effects of smoking and coupled with pressure from concerned groups in the community, have taken firm policy decisions on smoke-free public transport. Advertising of tobacco products is banned on board public transport in many countries, and administrative measures have been taken to ban smoking in these vehicles. Many national airlines have banned smoking on domestic flights and some are moving towards a total ban. These policy decisions are the result of a multipronged advocacy effort supported by convincing data against tobacco smoke.

6. Advocacy by international agencies.

The UN and its organizations with global mandates for health and development (such as WHO, UNICEF, UNFPA, UNESCO, UNEP, UNDP, ILO and FAO) play an important advocacy role by calling the attention of their member states to prime issues where joint action is urgently needed. This is done by organizing meetings of experts, publishing scientific and policy documents, setting up commissions on specific issues, holding global conferences and framing recommendations for action.

Some world level meetings on health issues that have either been organized in recent years or are about to be convened include:

(a) The Second World Population Conference held in Mexico City in 1984 sponsored by the UN, brought together UN agencies, countries and NGOs to assess progress and achievements since the First Conference was held in 1974 in Bucharest, and to make suggestions for the future.
(b) The Safe Motherhood Conference in Nairobi in 1987 was co-sponsored by the World Bank, WHO and UNFPA to consider the tragedy of maternal deaths.

(c) The International Conference on the implication of AIDS for Mothers and Children was held in Paris in 1989. The Seventh International Conference on AIDS will be held in Florence in 1991.

(d) The World Summit on Children in Bangkok in 1990 was co-sponsored by UNICEF and WHO to deliberate on the survival, protection and development of children.

(e) The WHO Commission on Health and Environment set up by WHO in 1990 assessed how major categories of economic activities of mankind, by altering the environment, have affected and will continue to affect human health positively or negatively, in preparation for the UN Conference on Environment and Development scheduled for 1991 in Brazil.

(f) Six World Conferences on Smoking and Health have taken place, the sixth being held in Perth in 1990.

(g) The International Conference on Nutrition, co-sponsored by FAO and WHO, is scheduled for 1992 to identify malnutrition problems and develop strategies for action.

(h) The World Summit on Malaria is to be held in 1992.

Such world conferences create awareness on priority issues, reflect collective decisions and advocate for global and national action.

The main thrust of the international organizations, equipped as they are with technical expertise, is to focus on the policy and managerial aspects of health actions with optimal use of national resources; they also provide technical support in designing strategies for dealing with national and regional problems.

The bilateral agencies (such as CIDA, DANIDA, SIDA, NORAD, USAID, etc.) play a somewhat similar role to that of the international agencies; the priorities of donor countries necessarily influence their activities in the recipient countries.

Some examples of advocacy for healthy public policy undertaken by international agencies and leading to substantial national programmes are discussed below.

The eradication of smallpox from the face of the earth, the success story of controlling yaws, the control of malaria and the expanded programme on immunization all illustrate what advocacy can do in mobilizing global and national efforts against death and disability.

In October 1977, WHO declared that smallpox was eradicated. Hitherto there had been 10 to 15 million cases of smallpox per year among whom about two million died. Eradication marked the end of the blindness, disfigurement and other disabling effects of smallpox; and it meant that countries could deploy resources previously used for smallpox control for other health purposes. It is estimated that a sum of US$ 1,000 - US$ 2,000 million has been saved as a result of eradicating smallpox.
Smoking restrictions in public transport

Advocacy approaches

- 1978   WHO Expert Committee on Smoking Control deals with exposure to tobacco smoke in indoor spaces
- 1978,1980  The World Health Assembly adopts five resolutions on combating the worldwide smoking epidemic
- 1986,1988  The 1986 Resolution pleads the case of the passive or enforced smoker and urges a non-smoking policy in public transport, workplaces and all indoor places.
- 1989   At a technical consultation held between WHO, IATA and ICAO, experts agreed that a complete ban on smoking should be considered on flights of short duration, particularly in planes with 30 seats or less.
- 1986,1987  Surveys were conducted with IATA into national legislation on smoking control.

Policy outcomes

- 1987  A WHO/IATA survey of smoking limitation policies in 150 airlines showed a positive trend towards allocating more non-smoking seats on aircraft. Only 13% of airlines had introduced smoke-free flights.
- 1988  A similar survey covering 755 airlines showed that 60% of them had recently introduced some kind of smoke-free services on domestic flights. Some were experimenting with a total ban on international flights.
- 1987  The International Foundation of Airline Passengers Association (IFAPA) in Geneva carried out a survey among 28,000 air travellers from 100 countries on attitudes to smoking restrictions on board aircraft. On the whole, 48% (60% in North America) favoured a ban on smoking on all flights (corresponding to 49% non-smokers and 20% smokers). About 80% of all non-smokers and - significantly - 49% of smokers thought a change was needed to improve cabin air quality.


Another early success story of WHO, with UNICEF collaboration, is the dramatic reduction of yaws with the availability of penicillin; one injection of procaine penicillin in oil cleared up the painful sores in one week. In 1950, there were believed to be around 20 million yaws cases worldwide. By 1965, campaigns were organized by WHO and UNICEF in 49 countries, and 46 million yaws patients were treated. The prevalence rate fell by as much as from between 20% and 30% to between 0.1 and 0.5%. It was easy to advocate for
yaws control; the dramatic results brought about by a single-dose treatment required no permanent health structure and little follow-up. Success was due largely to the recruitment and involvement of lay medical workers trained specifically for the campaign.

Another massive global programme initiated by WHO was aimed at the eradication of malaria. In the 1950s, the policy of worldwide malaria eradication was adopted by the World Health Assembly. Remarkable success was achieved in reducing the incidence of malaria. But by 1970 it was acknowledged that the initial impetus and success could not be maintained. Now, when malaria is emerging again in many areas, the need to reconsider policies and strategies is urgent.

Promoting the health of children through national immunization campaigns against the preventable diseases of childhood has been undertaken in several countries on a massive scale since 1984 (see box 9). The advocates for this mass action have been a group of international agencies (with UNICEF and WHO playing a leading role) working towards child survival. The approach of the international organizations was to involve both the heads of their own organizations and the heads of state of the concerned countries, and to seek their support for the campaigns during the planning and implementation stage.

Teachers, school-children, religious organizations, government departments and commercial organizations have all been involved in the campaign. Advocacy by international agencies focused on achieving immunization targets quickly by mounting three consecutive campaigns with massive mobilization of community and material resources. Advocacy inputs were reinforced by technical and other support to supplement national resources.

Advocacy directed at the highest level led to the formulation of state policy in support of this health issue. This set in motion a series of actions including the mobilization of various social groups as well as material and technical support for the programme.

The international agencies, led by UNICEF, arranged to bring groups of high officials from ten interested countries to Turkey to learn from its experience. Arranging the visits was a spin-off that was planned to advocate for nationwide immunization campaigns in other countries. All but two of the countries concerned subsequently organized nationwide campaigns within two years.

Other examples using a similar advocacy approach relate to national programmes on primary health care, family planning, nutrition and AIDS. Such advocacy approaches are rewarding when the health issue receives support at the top level and are accorded national priority. Advocacy for a particular health policy and action is more likely to be heard when the resources needed to translate policy into action are identified from both within and outside the country. For instance, a programme to strengthen primary health care in Nigeria was powerfully supported by a number of national, international and bilateral agencies (see Box 7).

International agencies also support global, regional and national research initiatives by suggesting areas for research and offering expertise, material and financial support. WHO, for instance, has taken the lead in such fields as tropical diseases, maternal and child health, environmental health, HIV infection and substance abuse including smoking. Another area where research findings have been used in advocating for health supportive policy is family planning and population control.
The 1985 Turkish national immunization campaign

Among the significant factors contributing to and supporting advocacy for the campaign were:

- The national health policy in the five-year development plan for 1985-1989 was recognized as crucial to the reduction of the infant mortality rate.

- In April 1985, a delegation of seven senior Turkish government officials and two UNICEF officers visited UNICEF Headquarters in New York and the Centers for Disease Control in Atlanta, and also observed the Colombian vaccination crusade.

- In May 1985, a tripartite agreement was entered into between the Government of Turkey, UNICEF and WHO for a five-year programme of cooperation for child survival and development, designed to strengthen PHC services and extend them nationwide.

- The Government of Turkey, in furtherance of its goal to reduce infant deaths, decided to launch a nationwide immunization campaign in September 1985 to immunize five million children and to spearhead the new, accelerated PHC approach.

- The campaign had the personal support of the Head of State. A visible demonstration of political will to reduce child mortality was televised, when the President and the Executive Director of UNICEF themselves immunized children with oral polio vaccine.

- The governors of the 67 provinces emulated the President and personally launched the campaign in each provincial capital - so did the 536 prefects in their respective districts.

- Team captains during a first division football match in Ankara appeared on television holding up infants and urged parents to immunize their children.

- An interministerial coordination committee of relevant non-health sectors was set up to mobilize support.

- The campaign strategy included a high degree of social mobilization. Advocacy to mobilize different social groups to be involved in transport, in delivery of services at convenient locations and in convincing people to bring their children were important aspects of planning for the campaign.

- A spin-off of the campaign was advocating through demonstration and providing first-hand experience to a number of interested countries on how to organize a successful campaign.

- This national exercise illustrates a number of advocacy inputs in addition to those made by international organizations - by the President of the country, by the Executive Director of UNICEF, by the governors of provinces and prefects of districts, by football team captains and by the campaign itself to visiting representatives from other countries.

Empowering People for Health Action

Health education of the public had its beginning as a discipline of public health in the 1930s, and it received further impetus during World War II when added emphasis was placed on efforts to inform people about better nutrition and related health problems. Today the need is widely recognised for education of the public on health matters, so that they take better care of their own health and initiate health support actions for their community.

The process started initially by offering publicity and information about such matters as diet and personal hygiene, then gradually progressed towards more comprehensive health education directed towards fostering behaviour change and community action for health. In the beginning, such efforts in developing countries were focused on specific health problems, for example hookworm control projects in the 1930s, safe water and basic sanitation projects in the 1940s and 1950s, and family planning in the later years until the advent of AIDS. It was only gradually over the past decade or so that health education programmes started taking a holistic view of health and received the needed attention and support; WHO’s new Inter-Health programme aimed at a cluster of lifestyle-related diseases illustrate this point.

Initially, health education efforts were largely limited to the use of printed materials, posters and audio-visual aids, and inter-personal communication was confined to home visits and patient education in clinics. The situation has dramatically changed over the
years. Multi-faceted strategies have been designed and applied, with emphasis on community organization, group discussion and public debate, often involving the mass media (TV/radio/press). At the same time, the scale of operations of health education has expanded. Earlier experiences were mainly limited to scattered, small-scale projects in local communities.

Today there is a need to accelerate, intensify and expand projects to the point where the leadership at national level and in all sectors of society can be mobilized in support of health. Already health education is showing positive trends towards engaging all societal forces and establishing a productive partnership across sectoral lines in favour of health education and community involvement for health.

The nature and scope of the role that communities are expected to play in the health development process have also undergone a healthy change. Instead of mere compliance and acceptance of health advice, there is now much greater involvement and true partnership in planning and managing health care. Furthermore, there has been increasing realization that knowledge alone is not enough for behaviour change; society must make it possible for people to live healthy lives.

### Box 10

**Audiothèques for non-literate communities in Mali**

The first audiothèques (or sound libraries) in Mali were created in 1982 to provide communities with more information. These “libraries for the non-literate” consist of cassettes recorded in vernacular languages. They work as centres both for the production and dissemination of knowledge and of rural extension.

In rural communities, audiothèques are the responsibility of a committee generally headed by the chief of the village. The committee, in permanent consultation with the population, decides on subjects to be treated and recorded. If the subjects relate to traditional knowledge (such as the history or geography of the community, traditional pharmacopoeia and medicine, knowledge of herbs, etc.), they are mostly dealt with by people in the community. In matters of “modern” knowledge produced elsewhere (such as problems of health, non-traditional medicine, agriculture, education or habitat), competent professionals and cadres prepare the cassettes. Many communities have already collected in their audiothèques information on topics of particular relevance to such health problems as oral rehydration therapy, controlling infectious diseases, hygiene, and water and sanitation. These “sound books” are discussed by the villagers at regular public meetings under the palaver tree. Audiothèques already number 60 in Mali, and are connected to a central audiothèque which not only keeps a copy of all the cassettes but promotes oral knowledge at the national level.

Evaluations by UNDP and Unesco have confirmed considerable interest by the populations in this new cultural instrument. Because of their low cost and adaptability to people’s own needs and conditions, audiothèques have already been called “the living school of the bush” (“l’ecole vivante de la brousse”). The interest in audiothèques seems to stem from the fact that, unlike other methods of transmitting non-written knowledge, they allow a community: to choose the subject of interest to it; to obtain the required knowledge very quickly in its own language; and to be able to use any information of interest at any time under the most suitable conditions.

Empowering people, therefore, aims not only at fostering healthy lifestyles but also at enabling them to mobilise social forces and to create conditions, including health supportive public policies and responsive systems, that are conducive to healthy living. The challenge before us all, therefore, is how to empower people to become active advocates of health.

**Multimedia support to health education in Indonesia**

Mothers and children under five in Indonesia receive services at the village level post-immunization, oral rehydration therapy (ORT), nutrition education and growth monitoring.

An intensive multimedia health education programme has been mounted in 11 out of 27 provinces in the country selected for this project. All districts and villages in the 11 provinces are covered. The World Bank is supporting the project for an initial period of five years which will end in 1992.

The health education component of this project uses the mass media - radio, television, graphic and print to communicate a well-planned set of messages. National, local government and private broadcast systems are used. Listener, viewer and reader groups are being organized by community level workers to enhance learning through the mass media, and to facilitate discussion. Further reinforcement through interpersonal, two-way communication is also provided.

The success of the programme is being measured through the increase in peoples' awareness on immunization, ORT and nutrition, acceptance of immunization and growth monitoring and improved nutrition practices.

Earlier, an Indonesian project on nutrition, communication and behaviour change showed on a fairly large scale that education alone - without the provision of food supplements - could improve the nutritional status of children in the target group. The project used carefully designed messages that were behaviour-specific, practical and applicable to the daily lives of rural Indonesian women. Messages were transmitted through various channels of communication including village volunteer workers, radio and posters. Children in the target group had better growth than those in the control group. Food intake of children in the target group was greater, reflecting the mothers' ability to make better use of the family food for feeding children.

**Source:**
(1) Verbal Communication from Dr I.B. Mantra, Chief, Health Education Centre, Ministry of Health, Jakarta, Indonesia.

(2) Mantra, I.B. et al, Indonesia Nutrition Improvement Programme.

1. **Reaching Communities**

Today a major educational effort in the developing countries is being directed towards preventing and controlling communicable diseases. There is much stress on the important role played by personal hygiene, safe water and safe disposal of wastes in controlling diarrhoeal diseases, a major cause of ill-health.

Over-crowding, poor ventilation and poor personal hygiene cause respiratory infections, another common malady in the developing world. Vector-borne diseases, particularly malaria, constitute a major concern in most tropical countries.
Much attention has been directed at clients, patients, families and others to ensure the early diagnosis and complete treatment of diseases such as tuberculosis, leprosy, guinea worm, and schistosomiasis - diseases for which effective technology and treatment schedules exist.

Educating people to accept immunization for children and mothers against preventable diseases is a major activity of WHO's Expanded Programme of Immunization, now endorsed by every developing Member State. Nutrition, safe motherhood, family planning, smoking and substance abuse are some of the other key issues which underline the importance of health education of the public.

**Family planning in Thailand - an NGO's initiative**

In the early 1970s, family planning in Thailand was restricted to medical channels and mention of the subject tended to cause social embarrassment. Today, public discussion of, and advertisements for, family planning methods have become commonplace. This change has largely resulted from the activities of a nongovernmental organization, the Population and Community Development Association (PDA), which has shown impressive achievements in promoting social awareness of family planning and the widespread adoption of contraception.

The Association is a non-profit and largely voluntary organization with over 300 staff members and 16,000 village volunteers working from five offices.

A new understanding of social motivation, combined with a large measure of humour and audacity, has resulted in a wide range of culturally adapted strategies, implemented through the PDA programmes. Between 1974 and 1981, one of the programmes, the Community-Based Family Planning Services (CBFPS), grew from a pilot undertaking into a network of local self-help schemes reaching over 16,200 villages in 158 districts with a population of 17 million. Its consumer-oriented approach has been adopted within the National Family Planning Programme to extend coverage and maintain high user rates.

Since the inception of the programme, the main message has linked population growth to low standards of living, on the one hand, and family planning to economic advantages on the other. This message is conveyed by creative use of virtually all possible communication channels, leading to a high level of public awareness of family planning and of the PDA programmes. Face-to-face education is undertaken by the village distributors, using the information, and motivational and publicity materials with which they are provided.

In addition, television and radio broadcasts are made on issues related to family planning, and many programmes of general interest close with reminders about using contraceptives. In school, children learn about family planning and may be taught, for example, a song describing the hardships resulting from having too many children.

Troupes of traditional itinerant entertainers perform puppet plays containing family planning messages in villages all over the country. T-shirts and other promotional materials carrying family planning messages have been distributed at formal state dinners and sent to foreign heads of state, emphasizing the legitimacy of the programme and the support of the government.

To convey the message through the various communication channels, it was necessary to overcome the taboos surrounding birth control techniques and the social embarrassment at discussing them openly. In Thai culture, humour and joy were found to be the best means. Carnivals, games, raffles, village fairs and weddings serve as occasions to promote family planning joyfully. Inches and centimetres are printed on contraceptive pill packets so that they can be re-used as rulers. Sheets, pillow-cases, piggy banks and business cards are all printed with family-planning catchwords.

A variety of approaches have been tried and tested in reaching the people effectively with health messages. Some of these approaches are designed specifically to meet the needs of non-literates, as in the case of audiothèques introduced in Mali (see Box 10). Others provide information through different media and channels of communication. Multimedia approaches used in Indonesia and Thailand are described in Boxes 11 and 12. Because of low literacy levels, the spoken, graphic and broadcast media, together with interpersonal communication, are particularly effective. However, there is plenty of evidence that shows that such information carried through the media needs follow-up discussion and action.

What has really made it possible to reach people at the grassroots level has been mobilising millions of community-level workers in the family planning, nutrition, water and sanitation and disease control programmes. Training these peripheral workers for educational tasks including the use of various techniques and educational aids has received attention from both government and non-governmental agencies. National guidelines have been drawn up for the trainer and the grassroots-level practitioner, and audiovisual aids are being developed to complement face-to-face communication. Locally-made aids have been encouraged. Nevertheless, education tends to be seen as secondary in the daily routine of the community-based health and related workers. Monitoring and supervision of educational activities need to be much more intensive. The cooperation of community groups formed by mothers or religious leaders, for example, will be vital in ensuring social support as well as in bringing about community action. There have been both successes and failures in this field. However, at times advice on accepting contraception or nutritional and weaning practices has been resisted. In order to overcome such resistance, much ground work has been undertaken by health workers, who have gained valuable experience in the process.

Facilitating interaction in groups in traditional societies is not always easy at first. Age, class, caste and other factors play a significant role in building interactive communication - asking questions and making comments. This social situation is undergoing a process of positive change. Sensitive issues such as family planning, eating habits and maternal care are being discussed more freely and acted upon.

2. Empowering Specific Population Groups

Certain population groups such as women, youth, school-age children, the work force and disadvantaged communities have specific health needs and problems which require appropriate educational and enabling inputs to bring about individual and collective action. National and international agencies have made efforts to address these specific groups in developing countries.

The declaration of the UN Decade for Women: Equality, Development and Peace (1975-1985) drew the attention of countries to the needs of women, their contribution to society and their full integration in all facets of national life. WHO’s response was to plan and undertake “women, health and development” activities directed at improving women’s health status, facilitating their roles as health carers and promoting equality in health development. The goal was to meet the health needs of women and enable them to contribute fully to the health of the family, community and nation. A number of world, regional and national conferences were convened during the decade, and several countries established ministries and departments to deal with women’s affairs.
In developing countries, women are often disadvantaged not only because of their low social status but because of ignorance, poverty and ill-health. Mobilizing women to form groups, then empowering and educating them for health and development action has been the focus of a number of national government, and NGO programmes.

Spreading literacy among women and enrolling girls in schools figure high on the agenda of the education sector in developing countries with powerful backing from UNESCO. That a mother's educational level has a bearing on her family's health is illustrated in Box 13. Involving women in water and sanitation programmes has shown the importance of women in development. Dramatic results in reducing deaths from dehydration achieved by educating mothers about oral rehydration are presented in Box 14.

### Box 13

**Mothers' education level and its relationship to family health**

In South India, education has fundamentally affected women's attitudes to child care and their ability to provide it. An educated woman is more likely to fight for the right to identify her child's sickness and to be able to take early and, in her view, appropriate action. And she is more likely to be accorded this right by her mother-in-law and husband. The evidence shows conclusively that mothers notice a child's sickness at an earlier stage and feel more strongly about taking action.

Most illiterate women will not draw attention to the situation until their mother-in-law or husband identifies the child's problem, and very few will take action on their own accord. The educated woman's attitudes and changed decision-making situation have ramifying effects. She is more likely to give equal consideration to her children and the adults in the household when providing meals, and to treat sons and daughters alike. This may often result from the family eating together. She is more likely to demand that food be bought for children's needs when supplies run low. She tends to provide a more balanced diet. She is more likely to excuse a sick child from work. There is an element of common sense in her child care, which is probably an education-induced attitude of responsibility. Certainly, she acts more decisively to prevent accidents and to ensure her children's hygiene.

This aspect of child care was identified over 50 years ago on Tyneside in north-east England and related there at least partly to education. The World Fertility Survey evidence from Ghana, Nigeria, and Sudan suggested that maternal education went a long way to overcome deficient water and toilet facilities.


The Baldia Project in Karachi, Pakistan, the story of barrio women in Tegucigalpa in Honduras, and the actions of women in El Puyo, Ecuador, are encouraging examples of what women can do for their communities. These stories are told in Boxes 15 and 16.

There are other good examples of how women, when educated and empowered, can organize themselves and play a highly useful role in the nation's development. Success stories about women, health and development from Fiji and the Republic of Korea are related in Boxes 17 and 18, while Box 19 describes a nationwide programme initiated in Nepal to mobilize mothers for development action.
Teaching village women about ORT

In 1977, Honduras reported that nearly a quarter of all infant deaths resulted from dehydration due to diarrhoeal disease - the single greatest cause of infant mortality. The non-formal education programme focuses on those most at risk - small children under the age of five. The educational strategy using mass media combined with systematic training programmes for community health workers focused on teaching village women about oral rehydration therapy (ORT) and how they could use it at home. Preliminary results of this project have been dramatic; deaths resulting from diarrhoeal dehydration among young children have dropped by 40% within 18 months.

In Gambia, after only eight months of a non-formal education programme, two-thirds of the mothers in the target area already had a good understanding of, and were beginning to use, home-administered oral rehydration therapy.


Women’s initiative for safe water and sanitation in Pakistan and Honduras

(i) The Baldia project in Karachi, Pakistan, is an example of a successful attempt to improve sanitation in a slum area, which relied heavily on the initiative of women. Since the project was launched, 70% of the households built soakpit latrines. The initiative for latrines often comes from women. It is women who most suffer inconvenience when there are no toilet facilities in the home. It is also women who have to take care of the needs of their children and any aging household relative. Almost half of the work of constructing latrines was undertaken by women; and all the health committees formed have women representatives among their most active members.

(ii) In Honduras, at the suggestion of a women’s legal society in Tegucigalpa, barrio women enlarged their group into a community-wide action committee headed by women. They made a formal request to the city authorities to get four standpipes installed in their hillside slum. They put two standpipes near the top of the hill and two near the bottom, protected by little wooden shacks. One of each pairs is open five hours a day in the morning, and the other five hours in the afternoon. A community woman, usually from a female headed household, is hired by the committee on a rotating basis to be in charge of the standpipes, to collect set fees for water and to keep the water sites clean.

A cooperative project involving women in Ecuador

The Popular Unity Cooperative in El Puyo, the main town in Ecuador's Amazon Region, undertook a low-income housing project involving three phases. Women were not admitted to the first or the second phases, which required manual lifting of 40 to 50 kilograms per person.

However, in the third phase, 70% of the membership in the cooperative were women, and the programme remained under their control. From the start of the programme, women were especially active not only in organizational tasks but also in the heaviest work such as site preparation and the production of foundation components, as well as actual building. Apart from the production of foundation components, they also made blocks for the fire-resistant walls. This then became the starting point for a small block production firm of which the women were in charge.

The way in which the group was organized was in complete contrast to that of the men. While the latter's building components, workshop, construction and assembly teams were of the traditional hierarchical type (manager, supervisor, foremen, etc.) the women established a horizontal form of organization. Responsibilities were shared equally, both in the administration of the workshop and actual physical activity. Income grew and the small firm expanded. The construction of their own homes, a day nursery and a social centre showed the women the purpose of their own contribution to these activities. This led to the start of group training by the women themselves. From the training and their practical experience, members saw that they were involved in a productive activity which could possibly provide a source of income and stable employment.


Another population group given increasing attention in today's world, including the developing world, is youth. (WHO defines adolescence as being between the ages of 10 and 19 years, and youth as between 15 and 24 years). Many young people have no opportunities for formal education in developing countries. A good proportion of those who do go to school drop out after three to five years. While some join the workforce supplementing family incomes, others with no hope of employment drift along or sometimes engage in anti-social activities, exploited by organized crime groups.

Young people, those below 25 years, form about half the population in developing countries. Though the age group 15-24 years has relatively low mortality rates, the very specific health problems that young people face call for education and support. Of particular concern are accidents (30 to 50% of total deaths in Asia), maternal mortality (young women aged 15 to 19 years have from a 20% to a 200% higher risk of dying during pregnancy or delivery than those who are older), and problem behaviour including alcohol and drug abuse, cigarette smoking and sexual precocity. Although providing support to young people is necessary for development, youngsters must be educated and empowered to take and act upon personal decisions with health consequences for the present and future.
A women’s group promotes community health in Fiji

Sogosogo Vaka Marama i Tankei (Non-Sectarian Women’s Society) is a national society in Fiji founded in 1924, which has a powerful influence on promoting community health. The emphasis is on doing things together by organizing and establishing village communities for health. The Society has 20,000 members and reaches out to very remote parts of the main islands as well as outlying small islands (a total of 332 islands).

The major thrust of the Society’s activities are directed to:

(a) preparing and encouraging Fijian arts and crafts;
(b) providing instructions in looking for and using Fijian foodstuffs;
(c) assisting in child welfare work;
(d) improving standards of living in the home and community; and
(e) promoting family life education.

The Society has 500 active health workers, who have been identified and trained to work in rural areas on improving health and sanitation conditions. They work closely with village representatives.

Certain standards have been set for homes; each house must have a sleeping room, a kitchen with a smokeless stove, a rubbish pit, a soak pit toilet; a bathroom, drainage and a kitchen garden. Village competitions are organized by the society to assess achievements in improving sanitation in the homes.

The Fijians thrive on community activities - they love to do things together, working, singing, feasting and merry-making as well as learning through talks, role-plays and discussions. The influence of the Society on families has been recognized, and the UNFPA has granted them funds for family planning activities. The 1984 review of primary health care in Fiji noted the significant contributions made by the Society.


With teenage and unwanted pregnancies among young girls on the rise in Africa and Latin America, and with an increase in the prevalence of STDs and AIDS among young people, youth groups are increasingly being contacted by concerned agencies to help solve these problems. In addition to educating and empowering these groups, they are being persuaded in turn to undertake educational activities among young people and to help establish behavioural norms that prevent such situations. An example of such action in Tanzania is presented in Box 20.

Some youth organizations are politically motivated while others are non-sectarian, concerned with youth development and mobilizing young people for nation-building activities. Ministries or departments addressing youth issues exist in practically all countries, and many have set up national youth councils.
Women show the way in the Republic of Korea

Historically, the woman's status in the Korean family has been low. Concepts of male superiority and traditional values discouraged the wife from voicing her opinion. All decision-making was made by the husband and his parents.

In 1968 an effective network of mothers' clubs was started with assistance from the Population Council/Agency for International Development (PC/AID) and the Swedish International Development Agency (SIDA). The Planned Parenthood Federation of Korea (PPFK) was asked to organize clubs in each of the 16,868 villages. During the first year, 17,000 village clubs were formed, and the network expanded to 27,292 clubs by the end of 1976 with the help of family planning organizers. Each club had 10 to 15 members with the focus on family planning. Village clubs formed township groups and these in turn got together to form the Country Federation of Women's Clubs. Mothers' Banks were set up to meet the clubs' financial needs.

The Saemaul Undong (New Village) Movement, which was started in the 1970s, was strengthened in 1979 as a pan-national activity for improving the life of the people through cooperative endeavours. From a top-down programme, it became a bottom-up people-led programme - a nation-building movement to construct new communities from traditional villages. It focused on spiritual reform, social development and economic development through voluntary participation of the whole nation. All existing women's organizations at all levels were merged into the Saemaul Women's Association (SWA) under the supervision of the Saemaul Undong Headquarters. The Movement, after 1979, became a truly dynamic activity with roots in the lives of people and propelled by the people. The SWA now has over two million members and is actively involved in community development.

The women's clubs have changed the status of women and made an impact on their lives. From being "inside persons" in the family, the women are now increasingly involved in decision-making on family matters, and not least on sensitive family planning issues.


Health education through Mothers' Clubs in Nepal

In collaboration with the National Women's Organization (NWO), the Ministry of Health of Nepal has launched a programme to reach mothers through mothers' clubs using female community health volunteers. A professional health educator has been assigned to help plan and organize the health aspects of this new national campaign. The programme is under way in Central and Mid-Western Regions in 27 Districts and about 14,000 female volunteers have been trained.

The club's activities respond to the development agendas of local communities and existing situations rather than to the donor-formulated targets and objectives of specialized programmes.

Source: Background country report, Intercountry Consultation on Health Education Strategies in South-East Asia, December 1990, New Delhi.
Addressing school drop-out due to pregnancy

The Dar-Es-Salaam Youth Centre in Tanzania provides services to young women forced to discontinue their formal primary school education because of pregnancy. The backbone of the Centre is a well-rounded curriculum to allow the completion of school requirements, but it also provides courses on topics related to general health and hygiene, parenting, family life education and income-generating skills. Day care is available for the infants and this is the only facility of its kind in Tanzania for infants under the age of three.

The counselling services include individual and group sessions that emphasize the development of self-esteem and self-reliance, assess the individual needs of the young women, and provide information. Home visits have been useful in uncovering the degree to which mother and infant illnesses prevent participation. Maternal and child health services were introduced in the Centre, and a good referral system has been developed with local government health and family planning services. Absenteeism has been reduced and the overall health status of the young women has improved.

It remains to be seen whether such a resource-intensive, multidisciplinary approach could be replicated on a wider scale, and it is too early to assess whether repeat pregnancies are avoided and the young women have improved their economic futures. What has been demonstrated is increased self-confidence among the participants in their abilities as students, income-earners and mothers.


Some examples of national youth organizations undertaking health and welfare activities are the Unoja Wa Vijana (The National Youth Council) in Tanzania, The National Independence Party Youth League in Zambia, the Socialist Working Youth League of Mauritius and the Jatio Tarun Sangua (JTS) in Bangladesh. The work of the JTS is summarised in Box 21.

Young volunteers for health in Bangladesh

The Jatio Tarun Sangua (JTS) (National Youth Organization) of Bangladesh has 15,000 branches all over the country and supports government programmes from village to central level. The activities are run by young volunteers, some of whom are qualified doctors and teachers. They focus primarily on health education and are particularly active in the areas of water and sanitation, nutrition, safe motherhood and child survival, family planning, school health, alcohol and drug abuse. At the grass roots level, the JTS involves youth in agriculture, horticulture, fisheries, literacy, sports and income-generating activities.

Young people in and out of school (age range 15 to 25 years) form another target group for education; subjects include hygiene and sanitation, good eating habits, late marriage and family planning, anti-smoking and anti-alcohol campaigns. The volunteers organize sporting and cultural activities, as well as providing family planning and health services in some areas.

The Organization works closely with village and religious leaders, seeking their support for community activities. Health promoting practices are given credibility by relating them to what is written in religious texts.

WHO has long recognized the potential of youth in health action and, in collaboration with the World Assembly of Youth and UNICEF has organized regional workshops in Africa and Asia on youth involvement in health development. A similar project in the Caribbean is now under way. "Facts for Youth", a booklet on health facts that youth should know, is under preparation to meet a need expressed by youth organizations. Local youth groups with sports and recreational interests have also made useful contributions to promoting health by taking part in community action related to sanitation, smoking, substance abuse, immunization, and so forth.

Global movements like the World Federation of Scouts and Guides, Junior Red Cross and the Young Women's and Men's Christian Associations undertake development, health education and action programmes in communities. The activities of the scouts in Egypt and India and of the YWCA in the Caribbean are highlighted in Boxes 22, 23, and 24.

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**Box 22**

**Boy scouts and girl guides work for health**

(1) In recent years, members of the Egyptian Federation of Boy Scouts and Girl Guides have been bringing health education and supplementary services to villages in seven governorates. Small groups of well-trained Scouts and Guides, some from medical schools, establish themselves in existing community and youths centres for several weeks and make visits to homes. They inquire into the health needs of the children, identify those who somehow were missed by the national immunization teams, or refer them to the centres where basic care can be provided.

Their activities have now expanded to include subjects identified by themselves as relevant to their own health concerns. Posters have been made and distributed on the dangers of drug and alcohol use; sports competitions are organized between teams of smokers and non-smokers; surveys are being undertaken to enquire about the needs of other young people for information about sexual development and family planning; and accident prevention strategies are being developed.


(2) The Bharat Scouts and Guides in Delhi, India, adopted an action plan to improve the health conditions of their city by carrying out construction and upgrading work as well as promoting sanitation. With help from UNICEF, they set up demonstration sanitation units, and produced a sanitation promotion book which offers guidelines for individuals and for troops. Several groups dug borehole latrines in poorer areas as part of their activities. Rangers and Rovers from all over India helped to level roads, clear away rubbish, provide or improve drainage, and make soak pits. They also went from house to house speaking to the residents about sanitation and other health matters.

Scouts in Mexico, supported by other Girl Guide and Girl Scout organizations, helped a community which suffered serious damage during the September 1985 earthquake. Many homes in the community of Delicias were either destroyed or so severely damaged as to be uninhabitable. The Guides have undertaken plans to help rebuild the neighbourhood with larger communal areas, improved sanitary conditions and more light and space.

Besides empowering such groups which are involved in positive health action, it is necessary to network with them and build effective alliances to bring about concerted action for community well-being.

### Indian Scouts help to control leprosy

The Bharat Scouts and Guides in India are actively involved in leprosy control activities. The Gandhi Memorial Leprosy Foundation trains scout leaders in leprosy work in various camps and centres, who in turn train the scouts for action. The result is 1,200,000 youngsters prepared to work for controlling leprosy.

The scouts inform and educate the public about leprosy being a curable disease which needs to be identified early and treated adequately to avoid deformities. They also try to remove the fear and stigma associated with the disease. Early detection of cases in the school and community is part of the work of the scouts. They work closely with health personnel and help in ensuring complete treatment and rehabilitation.

During community visits, the scouts also provide education on personal and environmental hygiene. These Indian scouts can earn a leprosy badge which gives them an additional impetus to be active in leprosy control. The Leprosy Relief Organization in Munich, Germany, supports this nationwide programme by funding low-cost educational material designed to meet local needs.

**Source:** A talk by Mr Ranga Rao, Director, Bharat Scouts.

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*School-age children* number about one billion throughout the world. A large proportion of those in developing centres are not in school. Spurred by UNESCO, efforts are being made by countries to meet the basic learning needs of their citizens, both children and adults. Health education programmes must be envisaged not only for children in the school system but also for those outside it.

Educating *school children and teachers* for health action concerning themselves and the community constitutes a very important area of promoting health. This falls within the responsibility of the ministries of both education and health.

Health education in schools, though often perceived as limited to health teaching in the classroom, is far more effective when augmented by the many other opportunities that the school offers for health learning. This includes the school environment, the buildings and grounds with sanitation and other facilities; the school health services, including the early detection of health problems by teachers or health staff, referral for correction and treatment, and the handling of health emergencies; meals at school, whether supplied by the school or brought from home; a social environment encouraging good relationships among the staff, the students and the parents; and recreation activities such as gardening, sports and group activities like clubs, scouting and camping. In addition, relationships between the school and the community contribute to health learning and health action.
Regional surveys on school health education have been undertaken during the last decade in a number of countries of Africa, Asia, the Caribbean area, and the Middle East. The findings showed some common inadequacies. Health education was seldom a separate subject in the curriculum but was sometimes integrated with other subjects, with varying degrees of success. Teacher preparation and motivation were not as they should be, while teaching methods were mostly didactic and teaching material was meagre. Health teaching in primary schools was easier to implement than in secondary schools, where the curriculum is overloaded.

An encouraging outcome of the surveys is that serious regional and national efforts are now being made to develop a meaningful health curriculum. While some of these aim at comprehensive teaching of health so as to meet the particular needs of different age groups, others are focused on priority health issues such as population education, child survival and development, malnutrition, smoking, drug abuse, water and sanitation, the prevention of cardiovascular diseases, and AIDS. Some of these efforts at educating schoolchildren are initiated and supported by health, nutrition and population programmes sponsored by such concerned agencies as WHO, UNESCO, UNFPA and UNICEF. A few of these notable regional and country initiatives are mentioned below.

In 1983 and 1984 in Africa, WHO organized two sub-regional consultations for decision-makers in the health and education sectors, to review school health education in 23 countries and to make recommendations. Subsequently, action has been initiated in a number of countries to improve school health education.

WHO and UNICEF assisted in developing a prototype action-oriented school health curriculum for primary schools in the Eastern Mediterranean Region. Seven Arabic-speaking countries have tested the curriculum and are in the process of adapting and implementing it.
In a number of countries in Asia and the Pacific, the ministries of education and health have jointly revised and developed comprehensive health curricula for different age groups as well as for teachers. India, Indonesia, Malaysia, Papua New Guinea, the Philippines, the Solomon Islands, Sri Lanka and Thailand are among the countries involved in this activity. WHO has supported these efforts through workshops, consultant services or training fellowships, and by providing educational material and equipment.

A nationwide programme in Columbia to promote the healthy development of children provides an encouraging example. The national programme, called SUPERVIVER, aims at lowering child mortality. It is coordinated by the Ministry of Health in collaboration with the mass media, the education system, and voluntary and community agencies. In 10,000 rural schools, teachers have organized evening classes for over 300,000 parents on ways of promoting their children’s health. A child health component has also been added to the curriculum at all levels, from the primary school level to the university. In urban areas, an innovative approach has been made towards teaching schoolchildren and then giving them responsibility for community health. This is described in Box 25, while Box 26 reports on the “Little Doctor” programme in Indonesia - another national effort to involve children in health action.

Box 25

"Health Scouts" in Colombia

An outstanding school health education programme has been conducted in Colombia since the mid-1980s, as part of an innovative nationwide “Escuela Nueva” (New School) programme. Elementary school classrooms in both rural and urban schools contain health learning centres where children receive health and nutrition messages. These they are encouraged to take home and share with parents, brothers and sisters. Schools are also used as focal points for programmes of immunization, distribution of oral rehydration salts and other preventive health activities in communities lacking a health centre, as part of a national childhood survival and development initiative.

A second innovative element in Colombia is the “Vigias de Salud” (Health Scouts) programme for young people aged about 14 to 17. In Grades 8 and 9, they receive basic instruction related to the six major health problems which exact the heaviest toll among the country’s young people. Then in Grade 10, they carry out 30 hours of community practice. This includes gathering health data on their own and neighbouring families before they become, in effect, health guides or health monitors for their families on disease prevention, nutrition and child development. The young people work closely with both school and health service authorities in their communities.

Source: Marilyn Rice and Elizabeth Rasmusson, Healthy Cities In Developing Countries, PAHO (1988).

In Uganda, all the primary schools have integrated basic health knowledge and skills into the science course. The new syllabus was tested in 20 schools and covers such topics as nutrition, safe water, sanitation, immunization, the treatment of common diseases, the prevention of accidents and AIDS. Teachers use specially developed teaching materials, and children are encouraged to share what they learn with friends and the family.
The Little Doctor or "Dokter Kecil" programme of Indonesia

In Indonesia, non-curricular health education called "Penyuluhan Keshehatan" is carried out as an integral part of school health services. An important input to this is the "Dokter Kecil" or Little Doctor programme, which has the personal support of the President. The programme uses a group of students to serve as prime movers and motivators for changes promoting better health in the school, home and community. Children from grades IV to VI are selected by teachers to serve as little doctors based on leadership potential, willingness to help others and observance of good personal hygiene.

The responsibilities of the little doctor include: setting a good example by following a healthy life-style, observing good personal hygiene and avoiding health risk behaviour; active participation in improving environmental conditions with reference to disposal of sewage and refuse, protecting safe water sources and food storage, and cleanliness of rooms; communicating messages on diarrhoea prevention, immunization, mosquito control, etc.; monitoring personal hygiene, growth, eyesight, oral health, scar survey (BCG) and deviations from health such as skin and eye infections; informing teachers about children needing attention; providing simple treatment including first aid and referral of cases; maintaining a health log book/diary; writing personal reports; and presenting health facts using graphics.

The little doctors are given initial training which includes 20 lesson hours. Problem solving and active participation are encouraged. The training is evaluated through tests, essays, skill assessment, role play and group discussions. The work of the little doctor is monitored, and the impact on the school and the community is observed.

After ten years, this programme which started as a pilot project now exists widely in the country. Schools with little doctor programmes show improvements in sanitation, personal hygiene and in the health awareness of parents. Reports from various provinces show that little doctors have been instrumental in popularizing ways of getting rid of man-made mosquito breeding places in their communities. Similar programmes have also been initiated in Kenya, the Philippines and Thailand.


What is encouraging is that many countries have taken action in the past decade to improve health teaching. Some have been supported by priority health programmes such as the WHO Expanded Programme on Immunization, the Diarrhoeal Disease Control Programme (through oral rehydration therapy), the WHO Global Programme on AIDS, and the UNICEF Programme on Child Survival and Development. Innovative methods are being tried and tested to teach health and encourage student action.

In Swaziland, 2,000 children in 16 primary schools were taught about immunization. Eight radio programmes of 15 minutes duration were developed to instruct children on the subject. Each programme started with an immunization song followed by a story by Uncle Elijah, who soon became a popular figure. Children were also given workbooks on the six childhood killer diseases. They listened to each of the eight programmes once a week.

The Child-to-child programme, designed primarily for children in developing countries, especially for those in rural and peri-urban areas, is based on the understanding that in these countries, older children often look after their smaller brothers and sisters. The programme is for children both in and out of school and has been reviewed with enthusiasm in more than 70 countries. More details are found in Box 27.
Child-to-child programmes

The concept of Child-to-child is based on a reality common throughout large areas of the world: in many societies, it is often not a parent who looks after the young child, but an older sister or brother.

It followed logically that children in primary schools were an untapped source to care for other children. Older sisters already carry babies and care for them throughout most of the day, and young toddlers are left in the care of older children. It was felt that child-minders will perform their roles better if they understand what they should be doing, if their tasks are made easier and more enjoyable, and if they are given praise and encouragement - in other words, formalizing what has been practised for centuries all over the world. This can be done by placing the Child-to-child contact firmly within the community settings, giving it support from teachers, parents and health workers.

Since 1979, the Child-to-child programme, designed primarily for children in developing areas and particularly for poorer countries in the more remote rural areas and peri-urban areas, has spread throughout the world. It has taught and encouraged older children to concern themselves with the health and general development of their younger siblings and other younger children in their community.

The channels for this teaching have included the formal school system, particularly the primary school, and youth groups of various kinds. The programme is for children both in and out of school and has been reviewed with enthusiasm in over 70 countries. Activity sheets, teaching material and teacher guides are available in different languages, and cover topics related to the young such as feeding, immunization, caring for a sick child, accidents, safe water and diarrhoea. A series of attractive primary health readers has been developed for school children in Africa, India and Latin America, to be used as an integral part of other subjects like science and home economics.

The five broad areas identified in which children can help other children were: eating well, improving health, teaching good habits, recognizing diseases early and monitoring growth, providing a safe environment, helping them to grow up physically and mentally, and stimulating younger children by playing with them.

The Child-to-child programme is a popular one, and national and international agencies including many NGOs, UNICEF, UNESCO and WHO strongly support this initiative.


It is important to foster links between the school and the community to address health issues. In many countries, the school premises are used as temporary health posts and health teaching centres where teachers and students provide outreach education to the community.

Schoolchildren and teachers frequently participate actively in national immunization campaigns and in promoting oral rehydration therapy (ORT). In Senegal and Syria, thousands of children have made house-to-house visits to enrol children for and inform parents about immunization sessions. In Turkey, 70,000 school teachers helped motivate parents to have their children vaccinated during a national campaign in 1985 (see Box 9).

In Bolivia, thousands of school teachers have organized oral rehydration teaching and treatment centres in schools for parents and children. In Tanzania, school children were taught how to use oral rehydration therapy, and one of their homework assignments was to
teach parents. A survey showed that the percentage of parents who could correctly prepare the rehydration solution rose from 13% to 65%. In the Ivory Coast, teachers and students have formed a theatre group and perform sketches on immunization and ORT. In a low-income area in India, poliomyelitis immunization coverage increased from 20% to 90% when school children assumed responsibility for bringing their brothers and sisters to the vaccination post. In Ecuador, 34,000 teachers and 150,000 secondary school students provided families with information about child health. A follow-up showed that 50% of families had used ORT, and more than half of these said they had learnt about it from a secondary school student.

We have already mentioned teaching school children about six communicable diseases - diphtheria, measles, pertussis, poliomyelitis, tetanus and tuberculosis - the target diseases of the WHO Expanded Programme on Immunization. Over the past two decades, much effort has gone into teaching people about communicable diseases that are endemic in tropical countries, and have a debilitating and often fatal effect on children. WHO has supported research and action projects to develop the teaching content and educational material, and to integrate them with other school subjects.

Malaria, guineaworm, onchocerciasis and schistosomiasis have been on the priority list in Africa. A well-illustrated textbook for school children in Portuguese-speaking African countries was prepared, dealing with endemic infectious diseases. The book builds on traditional beliefs and uses everyday experiences to show how people contract such prevalent infections as schistosomiasis, malaria, amoebiasis and tuberculosis.

AIDS education in schools arouses much attention and receives significant resources in North America, Australia and Europe. WHO and UNESCO have global plans for school health education on this subject. A school guide to education on AIDS and sexually transmitted diseases has been prepared. WHO supports the Documentation Centre on Educational Materials for AIDS Education in Schools, based at UNESCO in Paris. Before launching national AIDS education programmes in developing countries, WHO and UNESCO are supporting pilot projects in Ethiopia, Jamaica, Mauritius, the Pacific area and Sierra Leone. Tanzania and Venezuela have initiated projects, and others are planned for Argentina and Uganda.

Project activities include developing curricula based on the existing knowledge, attitudes, behaviour and concerns of children - curricula that are sensitive to local culture and acceptable to parents and teachers. Educational techniques include using such media as drama, art and song. AIDS booklets and material form part of the project.

Nutrition education in schools is an area that attracts the continuing interest of governments. Nutrition assessment of school children and their dietary habits have been studied in several places.

Nutrition education in primary schools in the Caribbean area has received significant support. A handbook prepared in 1984 for Caribbean teachers had the aim of incorporating food and nutrition into specific subject areas in the regular school curriculum for children aged between four and seven. A project undertaken by the Ministry of Education in Jamaica with USAID and UNESCO support is presented in Box 28. This project developed a Nutrition Magician Reader for use in primary schools, with the dual aim of improving reading skills and nutrition knowledge and behaviour. Clear messages are conveyed in stories, poems, comic strips and illustrations - all ways of stimulating pupil activity. Teacher guides and supplementary material were also made available. The promise is that
children will become “nutrition magicians” if they adopt the behaviour recommended by the reader, and indeed improvements in dietary habits have been recorded. The reader is now available in every fifth-grade classroom in Jamaica.

**Learning about nutrition and health in Jamaica**

The Jamaican Ministries of Education and Health have shown how teachers, parents, and local resource people can develop a locally relevant nutrition programme for primary schools. Using specially designed posters, reading primers and other materials, the goal is to improve reading skills and promote nutrition and health-related behaviour changes.

The programme comprises seven steps: designing, collecting and analysing basic data on reading ability and nutritional understanding; examining dietary attitudes and practices of students and their families; establishing community-based workshops that apply research findings to the development of teaching materials; obtaining the support of teachers and parents by integrating teaching materials into the regular curriculum and assigning as homework the surveying of home food habits; informing parents what role they can play in the project; evaluating project impact on students and their families; and finally, a proposed national conference to put the project into wider use.

Source: UNESCO.

In Zaire, nutrition education is provided, with WHO/UNICEF support, in all primary schools, where several suitable textbooks are available. Nutrition projects are also under way in a number of other developing countries such as Fiji, Malaysia and Papua New Guinea.

**School sanitation: learning in a clean environment**

In Jordan, a school-based health programme, supported by WHO, the United Nations Relief and Works Agency for Palestine Refugees, UNESCO and the Department of Health, has upgraded school facilities and sanitary conditions and, more recently, has expanded and improved health education programmes. All new students are medically examined and given any necessary immunizations. Health records are kept, and children are screened periodically for specific conditions such as hearing and vision problems. Sanitary conditions of schools and school yards are periodically checked by health personnel.

Each school selects certain teachers - usually science teachers - for a one-year in-service health education course, which trains them to become health tutors and to assume responsibility for organizing health education. School health committees work with them and with outside advisers to identify specific problems amenable to change through education. Once a problem has been identified, each school prepares a school health action plan covering the teaching-learning activities to be carried out over the school year. Health topics are worked into science, home economics and other courses, and include monitoring of the cleanliness of classrooms, toilet facilities, canteens and school yards, visits to local health centres and meetings with community health workers.

Source: UNESCO
Teaching about sanitation in Paraguay

Schools in some rural areas of Paraguay are now teaching basic sanitation in primary schools using various materials, including poems, slides and films. The local water board, school superintendent, health educator, headmasters, teachers, parents and students work together in teaching how to ensure good drinking water, control parasitic diseases and dispose of waste. Teaching materials are worked into other subjects: for example, health statistics become arithmetic, and examining slides of water-borne life under the microscope becomes biology.

Children have been encouraged in several projects to find answers to questions such as: How many children under five years of age have died recently, and why? Where do people obtain water for their homes? Is the water supply sufficient, and is it of good quality? Plays, poetry and artwork were among the means used to illustrate their findings, and prizes were given to schools and children by a "communal committee" in which families, the church, the school, the health centre and local officials took part.


Water supply and sanitation, along with personal hygiene, are subjects introduced early in primary school health education in developing countries, often as part of a programme for providing water supply and latrines in the school and community. International, national and voluntary agencies have taken the initiative both in providing the facilities and in developing the curriculum. However, many schools today, even though they give instruction on personal hygiene, have inadequate water or sanitation facilities.

In Africa, the schools of Kenya, Lesotho, Liberia, Uganda and Zimbabwe have hygiene education. In Mozambique, Nigeria, and Zambia some activities are under way. In Kenya, the government and nongovernmental organizations have contributed towards developing a syllabus and materials that include books, teacher guides, comic strips, puzzles and contests; they share this programme with Uganda. In Lesotho, a ten-point educational programme emphasizes the use of toilets, and teachers involved in school and community hygiene use posters, slides and printed material. Zimbabwe has an extensive hygiene education programme that develops school hygiene booklets, teacher reference material and provincial competitions in poems, songs, essays and drama. The experience of Jordan is given in Box 29.

In Asia, Bangladesh, Bhutan, India and Indonesia are among the countries that include hygiene education in schools. CONCERN, an Irish nongovernmental organization, has active hygiene education projects in selected primary schools in Bangladesh. In Bhutan, guidelines for training teachers in low-cost sanitation and health education have been developed and are in use. Teaching materials have been produced in India and Indonesia by government and nongovernmental organizations. UNICEF has produced technical publications in India to improve school sanitation.

In Latin America and the Caribbean area, several countries have hygiene and sanitation education programmes in school. The Ministry of Education and Culture in Bolivia has a programme supported by UNICEF, which includes drawing up attractive educational material and a training manual for teachers. Teaching about sanitation in Paraguay is
described in Box 30. Carefully designed and tested educational materials have been prepared in Honduras. The International Water and Sanitation Centre in The Hague, a WHO Collaborating Centre, has valuable information on the subject.

**Box 31**

**Children learn about urban development in La Paz**

An innovative programme to educate Bolivian school children on urban problems and solutions has been launched in La Paz to facilitate student understanding of the urban development problems faced by their city. Children are encouraged to have a greater sensitivity for the challenges presented by environmental conditions in their city. Project activities promote a critical but motivated attitude that will stimulate students to develop concrete solutions to the problems they face in their urban environment. Consciousness-raising activities parallel educational efforts that are already being carried out in schools.

One of the main strategies to promote greater awareness is to transport the students by mini-bus round the city, concentrating on areas with major urban development problems. After the trips, students discuss the problems seen and propose solutions.

Another strategy is to present students with an audio-visual expression of their urban reality through photographs, videos and models. Again, problems and potential solutions are debated. Discussions focus on issues such as proper waste disposal and the supply of clean water. Food services are another topic; such issues as the production, preservation, storage, transport and sale of food are important to a city such as La Paz, where much food is prepared and sold on the street. Children also discuss ecologically sound and structurally safe housing facilities.

Yet another strategy used is to bring children to specific park areas set aside for their recreation. During a full-day session, the children discuss the factors that damage their environment, such as air, water and land pollution, and suggest preventive measures that could be taken to stop the destruction. Students are encouraged to do their own research to identify urban problems and solutions, as well as to inform and educate their families, friends and neighbours.

Source: Rice, Marilyn and Rasmussen, Elizabeth, *Healthy Cities in Developing Countries*, PAHO (1988).

Concern for the environment is another area that is being introduced in schools. A community-oriented teaching-learning experience introduced in La Paz, Bolivia, is presented in Box 31.

Recognizing the importance of food safety education in schools, WHO has recently published a guide for primary school teachers on food, environment and health.

Schools all over the world have dental health programmes. Brushing teeth, oral hygiene and proper eating habits are emphasized, and there are many examples of innovative methods of persuading children to develop good oral habits, including brushing teeth under teacher supervision in primary schools. Singapore has had success with a comprehensive programme in this domain. Dental health education in schools, along with dental care services and fluoridation of water, has registered dramatic results in reducing tooth decay and loss in many countries.
Family life education in schools evolved over the last three decades in a large number of developing countries. In the 1960s this was a major concern of Asian countries in the context of population control. With massive support from international, bilateral and private agencies, family life education curricula were developed for different teaching levels. Schools in Africa, the Americas and the Caribbean area include the subject with the additional aim of preventing teenage pregnancies. A school health and family life education project supported by WHO and the Carnegie Corporation is now under way in three Eastern Caribbean countries. Its goals include better health and sex education in schools. In some 100 countries, population and family life education are incorporated into school curricula at different levels as well as in out-of-school programmes. In 1988, UNESCO developed a training package to prepare teachers and other community educators. It covers both contents and methods of teaching, with the accent on an interdisciplinary approach.

**Youth to youth: reducing alcohol use**

The use of peer leaders as facilitators for alcohol abuse prevention with adolescents has proved to be an essential component of successful programmes. A WHO collaborative study on alcohol education and young people compared a peer-led programme to a teacher-led programme and to no programme at all in 25 schools in Australia, Chile, Norway and Swaziland.

The educational programme emphasized "refusal skills for alcohol use" among eighth and ninth graders in the four countries. The peer-led educational programme appeared to be efficacious in reducing adolescent involvement with alcohol across a variety of settings, economies and cultures. Peer leaders are unique in their ability to influence behaviour because they are members of the peer group, credible role models and disseminators of social information, and they use the same language as their peers. Peer leaders can be trained to modify environmental, personality and behavioural factors that are predictive of alcohol use among adolescents, and so become a viable alternative to teachers and adult leaders.


The increase in the use of drugs, alcohol and tobacco among young people is now a concern of developing countries as well as the industrialized world. Educational programmes to tackle this problem in the school and community are being initiated. Projects conducted as part of the school curriculum are combined with out-of-school reinforcement through the mass media and support from parents and youth clubs. An important part of the programme aims at increasing self-esteem, improving decision-making, teaching how to say no, and developing the ability to cope with psychological stress in other ways than by using drugs and alcohol. Programmes on smoking and its dangers have started in schools in some developing countries.

The ASEAN Centre for Drug Abuse Prevention Education in the Philippines has been tackling the drug problem for over two decades through health education in schools. Box 32 gives an account of WHO's programme on alcohol education in 25 selected schools in Australia, Chile, Norway and Swaziland. The emphasis was on teaching eighth and ninth graders when to say no. A comparison of peer-led and teacher-led programmes showed that peer-led programmes appeared to be more effective in some situations. This endorses the view that trained peer leaders can serve as alternatives to teachers and adult leaders.
School health education is vital if developing countries are to encourage lifestyles that minimize the risk of cardiovascular disease. Many developing countries now seek to educate and empower school children and teachers for such action. The outcomes have been encouraging. But what are needed are nationwide programmes that are long-term in nature and part of a comprehensive school health education programme.

Children today are increasingly exposed to the mass media, the press and television. Little control can be exercised over what they read, hear and see, and frequently what is taught in school and at home is in conflict with the messages from the media. Children can, however, be taught to handle the messages in an intelligent way. Understanding advertisements and dealing with conflicting messages are skills to be encouraged by school health education projects.

On the other hand, the great potential of the media in teaching health must be fully utilized to complement what is learnt at school. A number of countries use the broadcasting media to teach school subjects. Educating Children through the Media is a project in India that includes health communication aimed at urban and rural children from 10 to 14 years of age, in and out of school. Prototype material (mainly video with some audio and printed material) is produced after research on the audience and the content. It includes one to five-minute spots and longer 20-minute programmes on various topics.

School-age children not in school comprise - according to UNESCO estimates in 1985 - some 105 million school-age children (aged 6-11 years) who do not receive formal education. Of them, 70% were in the least developed countries, and 60% of these were girls. If this trend continues, by the year 2000 the number of out-of-school children will almost double to around 200 million.
In accordance with the Universal Declaration of Human Rights in 1948, nations set targets to ensure that everyone's right to education became a reality. Primary school enrolment in 1970 and 1980 exceeded the projections made at UNESCO's regional meetings - yet universal education has not been achieved. Total enrolments during the 1950s and 1960s were phenomenal, but could not keep pace with the rapid increase in population.

**Alternative primary education in Bangladesh**

For children in Bangladesh, as in many countries of the world, schooling is likely to be little more than a moment that ends too soon: 50% of youngsters of primary school age are actually enrolled in school but fully three-fifths of the youngsters in first grade leave only two years later, without basic literacy or numeracy skills.

The Bangladesh Rural Advancement Committee (BRAC), is trying to change that by educating children - especially very poor rural children - who cannot be reached by government schools or, once reached, do not stay in school. In 2,500 villages throughout Bangladesh, youngsters between the ages of eight and ten study under the BRAC Alternative Primary Education programme. In the equivalent of first to third grades, they learn to read and write, to work with numbers and are taught science, social studies, health, and hygiene.

More than 95% of students enrolled in the BRAC programme actually attend classes and more than 98% of those who enroll in the first year complete all three years; almost all continue their education in government schools. Sixty per cent of the BRAC students are girls, just as 60% of the teachers are women (compared to 8% of the teachers in the formal school system).

The Alternative Primary Education programme offers a curriculum appropriate to rural culture and needs, one that can be taught by para-professionals recruited from the community and that parents are eager to support with their time and labour. The learning environment does not alienate rural children: school hours are adapted to local conditions, and parent groups supervise the organization and management of each school centre.

The success of the programme shows that para-professionals can be trained effectively, provided they are given sufficient support. Although BRAC teachers are paid one-quarter of the average formal school salary and receive no benefits, they gain a sense of accomplishment and are respected in their communities. Fewer than 2% of teachers leave each year (mostly because their families are moving from the community).

The programme currently costs about US$15 per student per year, but the per-pupil cost will drop when the system expands to 3,500 schools in 1991 (although some donors have urged that expansion be speeded up). It is not yet clear whether BRAC should simply replicate its successful programme or continue to try new ideas aimed at reaching those still without schooling.

BRAC's success has fired demand, as people see the possibilities for their children and their villages, but complete success would depend on a radical restructuring of national priorities and educational objectives.

While Asia achieved significant gains in the 1980s in the total number of children with access to schools, in sub-Saharan Africa the least developed economies faced a period of stagnation and some failed to meet the declared goals. After four decades of significant progress in primary education in terms of the absolute numbers with access to school, children not at school continue to increase in number. As a result there is a continued accumulation of unmet needs for basic knowledge and skills. The formal primary school systems in many countries do not have the capacity to meet these needs. Unless significant changes are brought about, many nations will not be able to improve access to education, still less improve its quality; indeed, some must face the possibility of deterioration in the decade to come.

Given these circumstances, the health sector in the countries concerned, as it pursues the Health for All goals, must work out ways of meeting the health education needs of the vast number of children who are not at present in the school system and, in all probability, will continue to remain outside it for years to come. Countries need to identify the population groups who are not at school, determine why they are not, and design or adapt appropriate educational programmes to meet their specific conditions and needs. The Out-of-school children (age groups 6 to 11 years and 12 to 15 years) are often underprivileged children; many of them have never attended school and others may have dropped out.

**Box 35**

"**Earning and learning**" for young women in Indonesia

DIKMAS is the Community Education Division of the Ministry of Education and Culture in Indonesia. Its programme of combining employment with oriented skill training closely linked with literacy efforts has helped Indonesia to move from about a 60% literacy rate to nearly 80% over the past decade, while also providing earning opportunities for unemployed out-of-school youth.

"Learning and Earning" opportunities are being offered by the Kejar Paket A literacy and Kejar Usaha small enterprise programmes for women in Indonesia. Using such facilities and activities as village learning groups, reading courses, rural newspapers and preparation for primary school equivalency examinations, the programmes aim to eliminate illiteracy especially among women; to increase participation in child survival and development activities; and to enable women to increase their income through loans for small businesses. Most learners are poor, illiterate girls and women between the ages of 13 and 44, with no fixed occupation. The community provides tutors and a venue for classes, while a village task force manages funds for the programme.

In 1987, a midterm review found that Kejar Usaha group members had been able to increase their income by as much as 34% a year, and Kejar Paket A learners raised theirs by 20% a year. The Kejar Paket A scheme has also become an alternative to formal schooling for primary school dropouts, who form 46% of learners. One innovation of the Kejar Usaha programme is that loans are being extended through the Bank Rakyat Indonesia (BRI) on collateral furnished by UNICEF and the government. This offers group members a chance to learn to deal with banks, and frees civil servants from having to keep detailed accounts of payments and repayments. A total of 5.6 million illiterates will be reached by the programmes during Repelita V, the country's next five-year development plan.

Support for out-of-school training

In the mid-1970s, several developing countries began, simultaneously, to improve techniques for disseminating information from centre points to the grass roots. Service centres sprang up to transfer information and training and - even more important to many educators - to help community groups develop methods for identifying problems and acquiring the information and resources for solving them.

Several centres began with little or no outside help; for example, in 1974, the Lesotho Distance Teaching Centre was blessed with more talent than money. It began selling materials and training services to other organizations, using an agency that still brings it income. Nepal’s Literacy Section of the Ministry of Education had an excellent series of teaching materials but virtually no budget for administering a literacy programme. By providing teaching materials at cost to various public and private development organizations, the Literacy Section has succeeded in linking literacy with the core development needs of thousands of Nepalese.

Service agencies in other countries were designed to meet identified deficiencies in out-of-school training. In order to save its new integrated rural development programme, the government of Ecuador created the National Institute for Campesino Training (INCCA), which addresses the need to develop human resources. INCCA strengthened the extension and training programmes in all ministries involved, and it links training more closely to the country’s research establishment.

In The Gambia, the government drew on a study of the literacy and numeracy needs of entrepreneurs in the informal sector to design its Nonformal Education Services (NFES). NFES staff cooperate with virtually all government departments to improve the effectiveness of training programmes, using a broad range of instruction technologies and techniques in order to teach subjects as disparate as ox-ploughing and holistic development theory.

Nongovernmental organizations also function as service agencies: the Bangladesh Rural Advancement Committee has a Training and Resource Centre (TARC) that trains landless peasants, government employees and field staff of other nongovernment organizations. TARC has been in operation since 1976 and is larger than many government programmes.

In Venezuela, the Centro al Servicio de la Accion Popular (CESAP), in operation since 1974, annually offers hundreds of courses for development-related organizations and members of grass-roots groups; about 60% of its budget comes from service income.

All the service centres have managed to accomplish what development planners have long urged: working across sectoral boundaries, they improve the quality of life for people at the grass roots.


Countries are grappling with this problem in different ways. Box 34 tells the story of a voluntary agency (BRAC) in Bangladesh with its non-formal primary education programme, including health teaching.

Underprivileged children in urban areas who struggle for survival with their families often do not value schooling, nor can they afford it. There has been an alarming increase in the number of poor urban families because of the growing migration from the countryside to the cities. Large numbers of children either become street children exploited for antisocial activities or are employed as cheap unskilled labour, living in slums.
Street children in Brazil

For seven million children, the streets of Brazil's cities and towns are workplace and even home. The youngsters are everywhere: shining shoes, washing taxis, guarding parked cars, sorting through garbage for plastic bottles. But people would rather not acknowledge their existence and the authorities treat them as delinquents or misfits.

Throughout Brazil, hundreds of community-based organizations sponsor programmes to reach out to street children and try to find ways of helping them to earn a living and, at the same time, to mature intellectually, socially and emotionally. In 1981, UNICEF, the government of Brazil, and the National Child Welfare Foundation began the Brazil Street Children Project to pool the knowledge gained by these diverse programmes. They also hoped to increase public awareness of the children by broadening community involvement and making government responses more effective.

The 70 programmes directly involved in the joint project have different philosophies, objectives and activities, but they share several features: each seeks to gain the child's confidence and to build a solid bond between child and programme, providing meals, income-generating activities, health care and discussion groups. Some programmes also offer more formal training or employment. From their inception, the educational methods being used have placed the primary emphasis on the child as decision-maker.

A 1986 evaluation of the Brazil Street Children Project, using such indicators as social skills, career skills, personal growth and moral values, found that programmes are most successful when they respond to the children's own needs, the first of which is for income. For example, the Salao do Encontro in the city of Betim, Minas Gerais, produces a complete line of home furnishings and employs more than 350 young people. The production process is labour-intensive and emphasizes the use of local resources. Besides manufacturing the products, young people actually manage the enterprise. Salao do Encontro tries to build self-esteem among street children, believing that confidence creates a secure foundation for personal growth and development.


Bangladesh is countering this problem through an enterprising programme aimed at providing schooling for these boys and girls and later training them in technical skills and assistance to find employment. Social services to ensure the cooperation of families and employers in rehabilitating such children form part of the programme. Some 20 schools in three large cities are taking part, with a total enrolment in 1989 of nearly 11,000 children aged 10 to 12 years, about one-third of whom are girls. A condensed primary curriculum is followed, using non-formal methods of teaching in which a student can complete up to grade 8 in four years. The children stay in school for two to three hours a day and continue to work, with no appreciable loss of earnings.

Predesigned lessons focus on learning skills and are taught by specially trained teachers who also look after the pupils' social needs. In addition to languages and mathematics, the children learn about the social environment and hygiene. Similar programmes are found in other countries, and ensure that the hygiene component includes carefully selected messages and skills that help to develop healthy behaviour.
Another programme for girls in Indonesia which includes learning and earning is described in Box 35. Distance learning centres in several countries are explained in Box 36. In every country, the health sector needs to identify such programmes and integrate into them health teaching appropriate to the requirements of the children. Health educators and experts in curriculum development must introduce an appropriate health component and identify methods of teaching that appeal to the children.

It is estimated that there are 30 million street children in the world, victims among other things of polluted water, strife, loss of parents, and poverty. Half of these children are in Latin America, where the numbers continue to increase. Seven million children live on the streets of Brazil’s cities and towns alone, and the streets are their home as well as their place of work - if they have work. Community-based organizations have programmes reaching out to these children, and are finding ways to help them earn a living and at the same time to mature intellectually, socially and emotionally. UNICEF, the Government of Brazil and the National Child Welfare Foundation initiated the Brazil Street Children’s Project in 1981 (see Box 37).

Brazil’s programme for its street children shows how it is possible to meet the health needs of similar groups elsewhere. Educating these children on health matters is a challenge that needs taking up. The physical, mental and social health needs of street children require special study; a sound health programme with an appropriate health education component can then be planned. The lessons learnt from programmes like that of Brazil highlight the need to allow the children to make their own decisions about their health and lifestyle. Providing them with knowledge and skills and an appropriate environment wherein to make wise health choices should be the responsibility of the health education and health services. Innovative approaches using group activities, the media, peer pressure and role models can bring health dividends.

Box 38

Singapore: health education where people work

Health education where people work is indeed a priority in Singapore. Health educators cooperate as widely as possible with management and safety officers, as well as with medical personnel if a company employs them. If not, involvement is sought from staff welfare and sports committees, as well as from union leaders, personnel managers, and industrial relations officers.

Managers are encouraged to give active support by sponsoring elements of the programme, offering competition prizes or free refreshments, and allowing employees paid time-off to attend sessions.

Among the 80 companies is Singapore Airlines, where 7,000 employees were the focus of an anti-smoking campaign. For a month before it began, airline staff were reminded of the campaign theme “No more butts - quit smoking” by posters, stickers, messages on payslips, and health jingles played over public address systems.

The central part of the programme was a week-long exhibition, and a no-smoking day. Doctors were on hand to spell out the harmful effects of the habit, and Singapore Airlines introduced a policy to ban smoking in its meeting rooms, recreation centre, and library. Smokers on the airline’s staff were offered courses to help them give up.

However, a large majority of young people aged 15-24 years who were never or are not now at school are not covered by any of the programmes mentioned above. Some of them are employed, others are looking for jobs or undecided what they should do. This period of life is one of struggle with difficult problems - choosing an occupation, learning to interact with the opposite sex, developing an identity, achieving independence from the family. It is also a time of crisis, that of dealing with bodily changes and striving to achieve intellectual, economic, and emotional autonomy. This growing-up process in adolescence carries the risks inherent in experimentation and exploration. The origins of many of the health problems of these young people are behavioural in nature - poor dietary habits, cigarette smoking, drug and alcohol abuse, irresponsible sexual behaviour, and carelessness on the roads leading to accident and injury. Caught in the turmoil of societal change, young people come under the kind of stress that promotes mental instability.

India: Adult education for health and development

K.V. Kuppam block is one of the most underdeveloped communities in Tamil Nadu, India. Its literacy rate is 32.94% (male 52.77% and female 12.77%). In 1980-1981, 30 centres were selected to cover 9,000 people in an adult education programme focusing on people aged 15 to 35.

A variety of innovative approaches stimulated and maintained interest, including social and cultural events (drama, film shows etc.) related to life situations, such as family planning and population education, health and nutrition, immunization, disease control, values and traditions, and economic development. Times and meeting places were adapted to the learners' needs, but several formidable constraints were encountered, such as seasonal employment at harvest time, temporary migration to places with better employment opportunities, and the heavy work load. Some upper class residents also showed hostility to the rising awareness among the poor. Three centres in all were forced to close by various means.

Nevertheless, assessment of the programme against criteria established by the education authorities revealed that real progress had been made. In relation to literacy and numeracy, 24% of the participants were rated high on a three-point scale, 34% medium, and 42% below average, scores that correlated with hours of attendance. Use of primary health care facilities showed a marked increase, and 80% of learners supported the family planning programme and subscribed to the small family norm (having appreciated the socio-economic benefits of smaller families), although 15% feared the effects of the methods used. Only 5% clung to the belief that many children were a form of social insurance for old age. All displayed greater awareness of individual responsibility within both family and community, but putting this into practice was hindered by poverty. Nearly 90% believed that reading and writing skills would help them to advance in life, that the programme should be continued, and that efforts should be made to provide another opportunity for drop-outs. Neighbouring villages also requested adult education programmes.

As for functional learning, about 45% acquired facilities for poultry or dairy production, small businesses, self-employment or jobs in the public or private sector. The fact that only 5% secured loans for housing - and 12% for small businesses caused much disappointment. Others complained of corruption among petty officials, and of their lack of collateral; but 28% had entered saving schemes, and 25% had put electricity into their homes. Their awareness of social position and self-confidence increased to the degree that they began to demand their rights and organize themselves, to the dismay of the upper classes. The evaluators recommended that the project be continued and developed, taking into account the knowledge gained in the first year.

Source: Christian Medical College Hospital. Rural Unit for Health and Social Affairs (RUHSA), mid-course evaluation, Tamil Nadu, 1983.
Young people outside the formal educational system have few programmes addressing their special needs. They need information about health hazards, skills to avoid them and a supportive environment. Outings, exhibitions and so forth, to sensitize and inform the young about healthy lifestyles and to help them gain peer approval need to be arranged. Community and religious groups should be encouraged to take up activities that promote health. For the young, the media are a favoured channel of communication - one that must be used wisely and should form part of any strategy for educating youth on health.

Another important target for education is the workforce including the management in offices and factories. Farmworkers also form a large group in developing countries. Education on safety at work is a big issue, and much has been done in this direction in the industrialized countries. Trade unions are increasingly involved in worker education programmes to help workers to achieve a better quality of life at home and in the community. The International Labour Organisation is encouraging such initiatives. One interesting story on promoting health in the workplace in Singapore is cited in Box 38.

**Empowering disadvantaged communities** is of particular importance to developing countries, which suffer from a great imbalance between their needs and their resources. While they have 75% of the world’s population, they have only 17% of the world’s gross

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### Organizing communities to help themselves

In Rio de Janeiro, in the heart of one of its poorest neighbourhoods, a community association called “Asociacion Rocinha” has united a community of roughly 80,000 persons and has initiated a wide spectrum of activities, ranging from establishing a system of garbage collection to organizing kindergartens. By dividing themselves into working committees for sanitation, health and education, the residents of the Rocinha neighborhood have learned how to work together as well as how to work with the local bureaucracy to accomplish group goals. They now know how to negotiate with bureaucracy, to get the material they need, and to carry out the project.

The groups’ activities address many of the urban problems. In the area of education, teacher training programmes help to improve the quality of education the children receive, while a building renovation project works to improve the actual school buildings. Kindergartens have also been started. An information system helps to educate residents on health topics, while the sanitation committee works to improve environmental health conditions like rebuilding an open water and sewer system, and installing spillways for the waste from higher areas of the neighbourhood. The work is done voluntarily by community members, many of whom are construction workers. The Rocinha policy is based upon community opinion and participation. Key policy elements include trust in the decision-making ability of the community, recruitment of local residents for part-time work, and a commitment to serve as coordinator between community groups and governmental bodies.

The “Rocinha model” was so successful that it is now being used in other poor neighbourhoods of Rio de Janeiro. The community of Morro da Dona Marta, in the hills near Rio, has built a new 7,000 litre water storage tank, which now provides water to dozens of neighbourhood residents. The work was organized by the “Bloco Carnavalesco Imperio de Botafogo”, a samba song and dance group that normally devotes itself to helping the community prepare for carnival festivities, but which is now becoming involved in a growing number of community activities.

*Source:* Murphy, Tom (1983) “*Son los pobres los que hacen que se lo que es*” Noticias del Unicef, No. 115, pp 14-16
national product, 5% of science and technology, 15% energy consumption, 11% of education spending, 18% of export earnings, 8% of industry and 6% of the health expenditure.

Box 41

Bangkok slum dwellers pioneer a land-sharing plan

Like thousands of other slum dwellers in Thailand’s capital city, the people of the Sengki neighbourhood faced eviction when real estate developers sought the land on which they lived. After a fire swept through the neighbourhood, owners cancelled leases, turning residents into squatters.

The condition of Sengki residents is not unique for Bangkok - of more than 1,000 slum communities in the city, over 200 were threatened with eviction in 1988. Rehousing residents in a new area is a costly solution for the government and developers, and often not acceptable to many residents. Rather than move from their neighbourhood, residents of Sengki have developed an arrangement called “land-sharing”. This system divides the slum into two parts, one for the landowner to develop as he wishes, while the other is leased or sold to residents who organize themselves into a cooperative to build new homes. Landowners experience immediate financial gain, avoiding long and costly confrontations with tenants, while tenants gain small but secure plots of land for their homes.

In the Sengki neighbourhood, a commercial loan was obtained by the neighbourhood housing cooperative for a down payment on part of the land. This land was then sold to residents at less than half of its market value. Owners will now be able to build new homes on their plots, choosing from various models proposed to them, or building whatever type of home they wish. Residents’ involvement in their neighbourhood will be encouraged through an election process, after which much of the administration will be handed over to the community itself. Support for the project came from the United Nations Development Programme and the UN Centre for Human Settlements (Habitat). Both of these organizations see land-sharing as a model for future slum clearing. At present, five other land-sharing projects in Bangkok are in various stages of completion.


Government efforts for development, in spite of external assistance, are not able to cover entire population groups in many countries. Government attitudes and resources allocated to address the problems faced in the Third World countries preclude really striking advances.

Nevertheless, it is heartening to know that there are innumerable examples of the poor and disadvantaged doing more for themselves than the government has been able to do for them; with some inputs from concerned groups, they have shown self-determination and self-reliance. Examples cited earlier, for instance in Boxes 2 and 15, also illustrate what the poor have done to improve their own conditions.

In empowering the disadvantaged to action, especially in traditional societies, some important constraints must be kept in sight. After generations of neglect and subjugation, many communities become apathetic and resigned to their lot, with little or no hope of betterment. Most of them are shy to come forward and are doubtful of their ability to take individual and collective action in areas they believe to be beyond their scope and purview.
The resources required to bring about the needed action are not readily available to these people. They fear and distrust the social and state systems when they have had negative experiences in the past. They are often unable to read or write and have not dealt with formalities required for development action.

**Interactive radio instruction: on the right wave length**

Interactive Radio Instruction (IRI), an innovative use of broadcast radio for improving the quality of primary school education, is applied by teachers in Asia, Latin America and Africa. More than a half-million children worldwide are now learning through IRI.

During IRI lessons, children are asked to respond to the radio every few seconds by answering questions and performing spoken and written exercises. Subjects offered include mathematics, reading, English as a second language, reading and writing in Spanish, science and health. In Lesotho and Honduras the programmes operate on a national scale, with more than 95% of schools participating. In the Dominican Republic, IRI is particularly valued where the difficult terrain has made it impossible to establish regular primary schools.

Does IRI improve student learning? Over the past 15 years, evaluations have consistently shown a strong impact on student achievement - even greater than gains produced by introducing textbooks or in-service teacher training. A typical result: in 1988, second grade children in Honduras using radio maths programmes scored 66% on final exams, compared with 47% scored by children in traditional classes.

What makes IRI effective? Its strength comes from a combination of excellent curriculum design and lessons based on proven educational principles - the most important of which is the active participation of children throughout the broadcast. The radio typically calls for five or six responses every minute. What does IRI cost? Annual recurrent costs typically range from 25 cents to one dollar per student.


It is into this type of community that many educators and enablers have moved, and have succeeded in bringing about changes, using innovative approaches to stimulate and maintain interest. Groups and agencies who work with such communities are invariably committed to a cause, believe in people irrespective of their socio-economic background, and have empathy for their fellow beings. The work undertaken by a unit attached to a teaching hospital in India is outlined in Box 39. Though the prime interest was the health of an underdeveloped community, adequate attention was given to literacy, income generation and saving schemes.

Another example of a very poor community in Rio de Janeiro in Brazil is illustrated in Box 40. A community association rallied about 80,000 persons to take part in a wide spectrum of activities to accomplish neighbourhood goals. And Box 41 describes how slum dwellers in Bangkok came to an understanding about land sharing and building new homes.

While these are examples from isolated communities, the national experiences of progressive rural development in China, Singapore, the Republic of Korea, Thailand and other countries are well-known. Motivating communities to action can be achieved by committed and sustained leadership. The power of the people must be neither underestimated nor neglected as a means of solving problems and ensuring well-being.
3. The Media's Role in Empowering People

The role of the print and broadcast media in health advocacy with policy makers as well as with the people has been discussed earlier. In the developing countries, the media, whether modern or traditional, are being used to inform and empower people in many development fields. Handwritten village newspapers, interesting radio spots and documentaries, stories, folk drama, songs and street plays are being used innovatively to educate and empower people for health.

Much has been said about educating and empowering people, specific population groups including disadvantaged communities to take action for health. A multi-channel and multi-media approach has brought about good results in terms of transferring information. Educational approaches including the use of the media have proved successful, as illustrated in Boxes 11, 12, and 14.

Environmental education - the Thai Magic Eyes concept

Environmental destruction is advancing so swiftly that there seems to be hardly enough time to wait for the next generation to be environmentally educated. Fortunately, reaching children effectively can be a means to reach adults, thereby changing the behaviour of two generations at once.

The Thai Environmental and Community Development Association (TECDA) a non-governmental organization, began five years ago with the aim of educating people to be environmentally aware. It was hoped that awareness would lead to action - initially in the individual's own domain, and then to participation in developing the community and the country as a whole. The ultimate aim was to develop a respect for, and attachment to, the environment, so much so that the individual would no longer quietly allow others to pollute it and would encourage others to conservation efforts. It was important to present complex environmental problems simply and to show how they affected individuals.

TECDA's basic mass education began with the Magic Eyes campaign. This was a series of cartoon advertisements on television directed at children - persuading them to put rubbish in its proper place, and encouraging them to "police" adults and see that they do the right thing with the words, "magic eyes see you." From this anti-litter campaign TECDA has expanded to deal with problems of water pollution and forest destruction.

This unique and joyful approach to educating Thais to improve local environmental conditions has been tremendously successful. Annually, the number of people who participated in TECDA's various programmes - including school children, government officials, market vendors, private company employees and other community residents - grew from 15,000 in 1984 to over 400,000 in 1988. A public sector advertising survey found that 89% of those surveyed said the Magic Eyes campaign contributed "quite a lot" to society.


Box 42 describes experiences of several countries in Interactive Radio Instruction. The inclusion of science and health in this programme is encouraging. Box 43 outlines how Thailand successfully used a television series for environmental education.
Modern communication for family life education

Education in the 20th century is being reshaped by the interaction between modern communications and the growing understanding of how knowledge, behaviour and human health are interrelated. For the first time in history, technology reaches millions in a single moment, and it is possible to educate people to prevent or treat disease. Changing attitudes to lifestyle diseases have sensitized society to a new kind of education that strengthens schools, clinics and hospitals and empowers people to a degree never before imagined.

Diseases related to lifestyle decisions are among the most expensive and deadly killers in the world, accounting for the vast majority of health care costs, premature death and disease morbidity. Each can be altered by knowledge and, to that degree, is linked to education.

Effective educational communication stresses facts and skills development; it motivates people to want to change their own behaviour. Evidence that it does so is based on scientific research from various disciplines and professions.

More than 16,000 radio stations and more than 1,000 million radio receivers are in operation around the globe. Television is now found in every nation on earth; in India, Brazil and the Middle East viewership has expanded as a result of three decades of creative rural programming. Thanks to satellite transmission, video recording, durable transistors, miniaturization and a vast supply of batteries, people in even the poorest villages have access to a wealth of information.

A revolution in programming technology has expanded opportunities to teach and persuade. In Mexico, a rock video motivates adolescents to delay sexual activity, a lottery in The Gambia teaches thousands of rural women about a new remedy for diarrhoea, and a mass campaign in Turkey increases immunization coverage. Listening groups, public service announcements, interactive radio in schools, mass mobilization campaigns, educational soap operas, rock videos and instructional cassettes are only a few of the new mass education technologies emerging around the world.

Health professionals have learned to involve audiences in programme design, to target messages to specific kinds of behaviour, to integrate mass media and interpersonal support, and to mobilize health services to meet increased demand. Wherever behaviour inhibits human progress, mass education is now a powerful tool for health and learning.

Source: Background document, World Conference on Education for All, Jomtien, Thailand 1990

Many developing countries have experience in using the media for family life education - see Box 44. There is a greater tendency today to use such traditional media as folk songs, drama and puppets as they still have great popular appeal. The story of Jochim Chacha is told in Box 45; being a puppet he is free to say things that people would not dare to say otherwise. So his messages strike the mark. The story presented earlier in Box 12 also refers to the use of traditional media.

Television is still a rarity in some rural communities but many of them share a communal TV set and arrange listening and viewing groups to discuss issues which concern them. Box 46 describes how villagers in Thailand keep themselves well-informed through shared radio sets.
Jochim talks, people listen

Jochim Chacha is much in demand in the small communities of Rajasthan (India). When a handpump is to be installed, he settles disputes about location and payment. Appealing to people with local jokes and expressions, he puts across messages on the evils of money-lending and bureaucratic insensitivity. If higher castes are practising untouchability where handpumps have been installed, he is dispatched to settle the problem amicably.

Jochim Chacha is the name of a puppet (a revered 300-year-old Muslim) who makes children go wide-eyed with awe. The creator of this puppet keeps his ears open to local gossip and disharmonies, and then uses them in the puppet’s dialogue. This delights villagers, who are amazed that Chacha should be so aware of their problems. He weaves real personalities around themes that have a direct bearing on the villagers’ everyday lives. Messages that would take months to absorb through radio and television - if absorbed at all - are conveyed through a puppet show in one evening. Shows have been given in over 100 villages. With donations of 10,000 rupees, people from other states are now being trained to follow this approach.

India and other countries have many people whose communication skills could be used to reach the rural poor. Half of the 600,000 villages in India already have roving theatre groups, puppeteers, oral historians and minstrels who can reach people and convey ideas simply at little cost. The question is how to get to these people and train them - or rather, persuade them to be trained.


*Chacha = Uncle

The village broadcast system in Thailand

The Health Education Division in Thailand encourages villages to establish their own information system through radio broadcasts. A village, or sometimes two villages together, will mobilize resources to buy the hardware - radio receiving sets, tape recorders, amplifiers, speakers, microphones and antenna. Funds are usually collected from the local members of parliament, the temples and from village resources.

When the hardware has been acquired, the provincial Health Education Section is informed and a village team comprising the village leader, the chief monk and village volunteers, including teachers, is trained to handle the equipment and to produce radio programmes that inform village people on issues concerning their health and welfare. The radio also provides information about other areas of community interest.

The Provincial Health Education Section teaches the village team how to broadcast health messages. Guidelines on such training have been drawn up, and other departments provide training on their subject areas. The government has allocated a budget for providing training.

Helping village people to own their local broadcast system and take responsibility for information dissemination to improve their quality of living has proved to be a success. At present, a third of the villages in Thailand, about 20,000 in number, have their own radio broadcast systems.

Source: Verbal Communication, Dr Thong Chai Thavichachart, Director, Health Education Division, Ministry of Public Health, Bangkok, Thailand (1990).
Developing Support Systems and Building Alliances

Adequate knowledge and desirable attitudes about health are not necessarily followed by appropriate practices. The gap between knowledge and practice is well recognized. Other factors play a significant role in bringing about desirable behaviour conducive to health. The approval of society is valued by most individuals and our actions are guided by societal norms. New practices become difficult to sustain when there is social disapproval. Behaviour change and acceptance of new practices become easy and possible when there is material and human support from the community. Help from neighbours, friends, relatives and from voluntary agencies and groups can make action easy. In addition to informal support, the state-provided support through the health and welfare infrastructure facilitates the change process.

_The support of society_ is an important factor in making choices for action. Certain practices recommended for improving health may be contrary to existing customs in a society. Early weaning and the introduction of solid foods in the diet of infants, use of animal foods, antenatal examinations, hospital deliveries and use of contraception are some examples of actions that are not socially acceptable in certain communities.

Young mothers and couples face the disapproval of mothers-in-law and religious leaders, relatives and neighbours if they accede to some of the behaviours recommended by health workers. So it is important when planning educational programmes to target those
individuals and groups in society who influence health-related practices. Maternal and child health, nutrition and family planning programmes have learnt that they must address groups in the community which have the power to influence people. Designing educational programmes for each influence group requires careful study of what beliefs and practices exist, the basis for those beliefs and practices, how strong and deep-rooted such beliefs are and how they are perpetuated.

Box 47

When eggs and milk were taboo amongst the Zulus

A case study documented about four decades ago showed that most Zulu families had fowl and eggs in plenty, but they were rarely eaten. Though it was considered uneconomical to eat an egg, it was also considered a sign of greed, and eggs were even thought to make girls licentious. None of this was very deeply felt and, with patience over a period of years, it was possible to overcome this aversion to eggs. Today eggs form a common article in the diet of infants.

The question of milk proved more difficult and complex. Apart from being in limited supply, milk was associated with deep-seated and powerful customs and beliefs. Only relatives of the head of a household can use milk produced by that man's cattle. Among the Zulus, cattle are intimately connected with veneration of ancestors and valued norms of human conduct. The link between a man and his masters is his cattle. No family could supplement its milk supply from another family outside the kin group, and the situation was more complex for women. During her menses or when pregnant a woman is thought to exert an evil influence on cattle and may not pass near a cattle enclosure or partake of any milk. This applies to her own home. It is therefore customary for girls to drink no milk after puberty.

In the face of deep-seated beliefs, merely convincing people of the nutritional value of milk cannot be expected to bring about a change. This became a real barrier to improving the nutritional state of mothers. Fortunately it was possible to overcome this difficulty to a considerable extent by introducing powdered milk. Even the most orthodox of husbands and mothers-in-law had no objection to this form of milk, and over the years a large number of families bought milk powder to supplement the amount received from the health centre.


To weigh these factors against arguments for accepting recommended practices is an educational task that must be undertaken with care. Convincing facts and examples that support action have to be brought forward. Suitable visits and demonstrations must be arranged and case studies presented in support of the desired health action. During the past four decades, there have in fact been remarkable changes for the better in social approval for health practices. Improvements in educational status, greater efforts in health education and the exposure of traditional societies to modernity are some of the factors that have modified social control. A few examples in Boxes 47 and 48, some referring to traditional communities 40 years ago, illustrate the power of societal norms. Indeed, all too often, people risk social stigma because they accept practices that are not approved by the society.
Beliefs that inhibit health action

(1) A 1942 case study of a cholera epidemic in a village in the Yunnan Province of China pointed out that the stricken community preferred its native “fairy water” to Western anti-cholera injections. The villagers relied on elaborate and costly prayer meetings to please the gods. Ironically, the vaccine appears to have been considered as another kind of fairy water, an unwitting instance of magic offered in a scientific package.

(2) Smallpox and chickenpox are believed, in India, to be caused by the goddess Sitala. An attack of these diseases had to be accepted because the goddess was manifesting herself in the patient. Special prayers are even today offered to propitiate the goddess at a certain period during the year. The introduction of preventive vaccination against smallpox posed problems in some communities, because the priests of the goddess felt that this would interfere with the rituals connected with honouring the deity.

In view of the strong religious beliefs, it was necessary to involve Sitala’s priest in the vaccination campaigns and assure him that he could continue with the special prayers and offerings to the goddess in addition to supporting the vaccination.

(3) Even after four decades of a nationwide programme of family planning, including a fairly strong educational component, a great many Indians feel an obligation to beget sons in order to fulfill the traditions of society. Male sterilization continues to be viewed with fear because it is seen as entailing a loss of virility. Many families continue to believe that children are the gift of God and any interference in the process of child bearing goes against God’s wishes.


People belong to different groups; they are part of a family, a caste, a neighbourhood, a religious group, a friendship or gossip group, a work group and so forth. In traditional societies group ties are strong, and in most developing countries, especially in rural areas, almost everything revolves around social interaction. This means that much behaviour is decided by the accepted patterns of the various groups in which people move in their daily lives. Under these circumstances it is essential that a social climate be created in which various groups in society accept the health practices recommended, and thus make it easier for individuals to make wise choices. The acceptance of such health practices as immunization, infant feeding and contraceptives have been made possible in developing countries because of group acceptance.

Young children and youths are influenced by peer behaviour; for them it is vital to win acceptance in groups that are important to them. Risk taking on the roads, smoking, alcohol and substance abuse, eating habits and the use of study and leisure time are areas where peer behaviour can influence a young individual’s action. Recognising this, educational programmes often resort to using young people to educate other young people, and address them in groups rather than as individuals. The story cited earlier in Box 32 highlights the use of peer groups in alcohol education.
Lesotho's low-cost sanitation programme has two separate but complementary parts, the Urban Sanitation Improvement Scheme and the National Rural Sanitation Programme. Both have the same guiding principles - coordinating major decisions and promoting the same latrine designs. The key elements of the programme are:

- an affordable and acceptable ventilated improved pit (VIP) latrine of national design.
- a comprehensive programme of latrine promotion - health and hygiene education.
- latrine construction by the private sector with the government providing training, follow-up supervision and assistance to the builders. No subsidies go to the householder.

Lesotho promotes and markets latrines so that people want them and are prepared to pay for them. The VIP latrines have been designed using a wide range of materials so people can choose a suitable material according to available resources. In urban areas a credit system is available from the Lesotho Bank, to which offers 60% loan to be paid back over two years. The client proves commitment to the scheme by a "deposit" of collecting blocks and sand, and by digging the pit. There is no means-testing and anyone can apply for the loan. In some towns, up to 30% of the latrines have been built under this scheme and repayment records are good.

Source: Dialogue on Diarrhoea, issue 43, December 1990.

If we look at how certain practices grow into becoming accepted behaviour in society, we see that most people observe what an elite group does and then imitates it. When one of the States in India was introducing latrines, a study of why people installed latrines showed that the fact that influential people accepted them was a significant reason for putting up a latrine and using it. This underlines the need to identify and direct attention at this group of potential innovators who will be the first to accept a healthy practice. The mass media have played a leading role in reaching the innovators who are often more exposed to the media than others in the community.

Social support for certain health practices is sometimes difficult to obtain because they impinge on other more important aspects of life. For instance, DDT spraying to control malaria was also killing creatures such as lizards that protected the thatched roofs of houses from insects; family planning recommending one or two children encountered the problem of a preference for sons.

In many parts of the developing world, there is a revival of faith in religion and in the practices recommended by the holy books. It is therefore important to know these practices and to see how they can be incorporated in health education. Initiatives have already been taken in this direction. For instance a paper on "Health in Islamic jurisprudence" has been prepared by staff at WHO's Eastern Mediterranean Regional Office in Alexandria which highlights areas related to healthy lifestyles.

The support from society for health action is an important dimension that requires timely attention. Health programmes addressing issues of national importance like family
Box 50

Sri Lanka’s Sarvodaya Shramadana Movement*

The Sarvodaya Shramadana Movement is a nationwide non-political voluntary organization drawing on the philosophy already present in the religious and rural life of Sri Lanka. It had its beginnings nearly 40 years ago, when a group of teachers and students worked together on social development projects involving the community in villages that were economically depressed and difficult to reach. Villagers and trained leaders identify the most urgent needs of the village that can be met by physical labour and local resources - like building an access road, repairing a water tank or creating an irrigation scheme. After working in the fields, everyone in the village joins together for discussion, meditation, sing-songs and to participate in folk dances. This breaks down barriers of caste, creed, race and colour. The Movement first focused on village awakening and then moved on to national awakening and hopes for world awakening.

Various training courses have been set up for village people in agriculture, carpentry, metal work, bamboo and rattan work, batik-making, printing, photography, running pre-school care centres, village kitchens and creches. Children's libraries, cottage and small industries are also run by the Movement. Large and small cooperative farms around the country are used for training courses for youth, youth settlement schemes and marketing. The creches, pre-school and community kitchen projects have a positive impact on children’s health, and are supported and run by local families.

The Movement has the active participation of school children and youth who undertake such activities as helping families in need and participating in village improvement projects. Though the philosophy of Sarvodaya was inspired by Buddhism, it has adapted to and been adopted by other religions. Sarvodaya groups have been established in such countries as Belgium, Canada, the Netherlands and the Philippines.

The work of the Sarvodaya Movement supports the programme activities of the government at the community level; it is recognized as a valued voluntary agency, and has attracted external funds.

* Sarvodaya - welfare of all; Shramadana - sharing one’s time, thought and energy for the benefit of all.

Kenya: Tototo Home Industries

When the Mkwiro Women's Group decided to start a boat service from their island off the southern coast of Kenya to the mainland, they needed to earn money for community development projects and to provide transport to the health clinic that served their children. Four years later, the ferry was still afloat, but the business was sinking.

Tototo Home Industries, a nongovernmental organization in Mombasa, was ready to help the women to keep both boat and business running. Women in Mkwiro, and in 46 other groups along the coast of Kenya, had already received training in group organizing from Tototo's Rural Development Programme. Now Tototo would train them and offer technical assistance in business management.

Organized in the early 1960s by the National Council of Churches in Kenya, Tototo initially marketed handicrafts produced by women in the town of Mombasa; in 1986, a new director saw that this did virtually nothing to change the quality of rural women's lives. She began to work with them on community development and income generation. By 1987, Tototo's community development programme had reached more than 1,200 women within a 200 kilometre radius of Mombasa, offering training in group organizing and leadership, a revolving fund for loans, assistance in health and family planning, and a savings club.

According to a 1985 study, the businesses established by the groups were barely viable; as in Mkwiro, the groups lacked the skills to maintain them or the ability to work creatively within the economic, social, and cultural constraints imposed on them as women.

On the basis of these findings and its knowledge of women's groups, and of the barriers they face, Tototo created a business management training programme. This enables women to translate knowledge of household enterprises into the basic practices needed to operate a group business. One key was a pictorial accounting system that allowed non-literate members to read project accounts and understand the allocation of dividends. The new accounting system permits the women of Mkwiro to track their actual expenses and to allocate profit more effectively; as both business performance and dividends improve, the women tackle other projects for community development.

Tototo staff began working with eight groups in 1986; the following year, the women of Mkwiro were selected for training. Research shows the effectiveness of training: on average, dividends in the 1986 groups increased 500 per cent between the first and the second year of training, while gross revenues doubled. Those groups paid an average of US$700 in dividends to their members in 1986 and more than US$3,300 in 1987. Although the 1987 groups did not experience such dramatic increases, their gross revenues and dividends have improved significantly. Tototo has now begun to teach its training programme to agents in Swaziland and Malawi.

India: Child development services

India's Integrated Child Development Services (ICDS), the largest programme of its kind in the world, illustrate the power of political commitment to achieve significant rates of coverage in integrated programmes targeted at children up to six years old, with important effects on health and education, and at a reasonable cost per child.

Beginning in 1975 with 33 experimental projects, ICDS had grown to almost 2,000 projects in 1989, reaching 11.2 million children under six years of age. The overall goals of the programme are: to provide a comprehensive range of basic services to children, expectant and nursing mothers, and other women aged 15 to 45; to create a mechanism at the village level by which the services can be delivered; and to give priority to India’s low-income groups, including the underprivileged tribes and castes.

The integrated package of ICDS services works through a network of Anganwadi (courtyard) Centres, each run by an Anganwadi Worker (AW) and helper, usually selected from the local village. The AW undergoes a three-month training in one of more than 300 training centres run by voluntary and government agencies. Support is provided to the AW by a supervisor (1 per 20 AW), and by a Child Development Programme Officer (1 per 5 supervisors) who is directly responsible for carrying out and managing each ICDS project.

The programme uses the existing services of various governmental departments and voluntary agencies. Overall administration lies with the Department of Women and Child Development, within the Ministry of Human Resource Development. The annual unit cost per child per year is estimated at Rs. 115 (about 10 US dollars).

Although the programme often operates at a minimum level of quality, it has nevertheless had important effects on the under-six population. A review of some 30 studies of the nutritional impact reveals unanimous results documenting a positive outcome. A 1984-86 comparative study made in a number of locations showed ICDS/non-ICDS infant mortality rates of 67 versus 86 in rural areas and 80 versus 87 in urban areas. A comparative study of effects on schooling found that those with ICDS backgrounds had a higher primary school enrolment rate (89% versus 78%), were more regular in primary school attendance, performed better academically, and scored significantly higher on a psychological test than non-ICDS children. Furthermore, the difference in enrolment rates was accounted for by higher enrolments of ICDS girls. Another study found that primary school dropout rates were significantly lower for ICDS versus non-ICDS children from lower and middle caste groups (19% versus 35% for lower castes, and 5% versus 25% for middle castes).


The importance of social, community and systems support for community health action has too often been ignored or underplayed by health administrators. The blame for failure to comply with recommended health practices has been placed squarely on people’s ignorance resulting from ineffective educational inputs. What is underscored in this section is that - quite apart from the individual’s knowledge and understanding - other outside factors have a significant role to play in bringing about desirable practices to promote health.

While developing countries suffer from limited resources for health and development activities, many of them have made innovative and committed efforts to solve the problems they face. A need that is being increasingly recognised is for building alliances between and networking with the many groups and agencies that work for and influence health and
welfare. More and more government and non-governmental agencies are seeking to build bridges between these various groups for health. Activities in this direction include convening meetings of concerned persons, establishing joint committees, publishing periodicals and newsletters, organizing joint programmes and field activities, sharing experiences and providing information.

Education for the disabled in Zambia

Zambia has demonstrated that commitment to the education of the disabled can go beyond rhetoric. The government officially recognized the educational needs of the disabled for the first time in its Second National Development Plan (1972-1976). In its Third National Development Plan (1977-1980), it made pre-service and in-service teacher training and the establishment of new schools and units for disabled children a priority. In 1980 it simultaneously received assistance from Sweden to set up a special education system and launched its National Campaign for Disabled Children.

The immediate objectives of the National Campaign were to raise public consciousness of the special needs of disabled children; to establish provincial registers of disabled children; to lay the foundations of nationwide health and educational services for disabled children; and to supply technical aids and prosthetic devices to as many of them as possible.

District Ascertainment Teams consisting of a local primary school teacher, a medical assistant or nurse, and a community development worker set out to identify disabled children and to design home-based intervention programmes. The nationwide campaign used 3,000 reporting centres in 57 districts. Ascertainment officers examined 11,000 children, identifying 7,247 as severely disabled. Of these, 3,209 were physically impaired; 1,549 visually impaired; 1,390 hearing impaired; 626 mentally retarded; and 473 multi-handicapped.

As the Ministry of Education assumed responsibility for the education of the disabled, the University of Zambia added special education to its curriculum for the Associate Certificate in Education, and the National College for Teaching of the Handicapped was established in Lusaka, enrolling 69 students in its 1984-85 two-year programme. At the central level, a special education inspectorate has been formed, with three special education inspectors devoted to staff development. By 1985, there were 35 institutions serving 2,095 disabled students at the primary level, more than double the number served in 1980.


The work that the Voluntary Health Association of India is undertaking in building alliances is illustrated in Box 55.

Professional bodies such as national public health associations and international health federations play a role in building alliances and networking with groups that share a common health interest. Conferences organized by these bodies provide a forum for sharing experiences and supporting each other. External donors supporting health programmes can facilitate this process.
Reaching adolescent girls in Brazil

Special programmes have been functioning in two of Brazil's maternity hospitals to address the problem of unplanned, repeat pregnancies among adolescents. At both of these hospitals, staff had noted that one-quarter to one-fifth of their cases were adolescents under 20, present for childbirth or complications of induced abortion. Specially-trained staff visited these young women and invited them to discuss their concerns, including those about contraception.

Previous attempts at community outreach to adolescents were not successful; young women who had never been pregnant were unwilling to use family planning services at the hospitals. However, those who had been patients and received services or talks from staff returned for follow-up services and, after some time, girls from the community began to appear. This has been attributed to word-of-mouth referral from those young women, apparently satisfied with the services, encouraging their friends to attend.


But there is still a great need to further strengthen the building of alliances for health in developing countries. Mechanisms to bring this about must be evolved and governments must take the lead. It will be important to create and update an inventory of concerned groups and agencies, and record their health-related activities. Such efforts will need the maximum support and encouragement to make Health for All a reality.

Building alliances between social action groups - an Indian experience

There are about 5,000 organizations in the field of health care throughout India. At least 7,000 to 8,000 others are involved in development work in areas other than health care, e.g. social action, the environment, agriculture extension and income generation, women's needs and so forth. Through a series of three-day workshops and orientation programmes, the Voluntary Health Association of India (VHAI) is exposing these groups to health issues and to each other's activities, so that there is a broader outreach of health action throughout the country. VHAI has concentrated on the most needy states of Bihar, Madhya Pradesh, Uttar Pradesh, Orissa and the North-Eastern region, where the health situation is extremely unsatisfactory. Over the last year, VHAI held 15 workshops involving about 500 social action groups.

Some of these groups are gradually moving towards launching modest but relevant health programmes. Most of them have become participants of various health campaigns in which VHAI is involved.

The Association hopes to strengthen this activity further, particularly in the most needy pockets of the country, and it is developing active follow-up mechanisms. A newsletter in Hindi called PATHIC has been started to encourage networking with these groups.

4 CHALLENGES FOR FUTURE ACTION

The concept of health promotion offers challenging opportunities for application. The three principal strategies of health promotion have already been applied in varied forms and with varied degrees of success in many developing countries.

The examples cited earlier illustrate the experience gained in developing countries in applying the strategies underscored by health promotion. However, much still remains to be tried and tested. For instance, how do we heighten the interest of policy-makers and the public in health, and how do we mobilize societal forces so as to accelerate progress in health development?

The commitment of all nations to the primary health care approach provides the potential for devising comprehensive strategies which will involve all sectors of society in actions for health. Social and political action for health and health education initiatives must therefore be viewed as a challenge with a long-drawn-out time frame. Future strategies must be planned to strengthen existing initiatives and to involve non-governmental agencies as well as the public and private sectors in pursuing strategies underscored by health promotion.

The focus should be on strengthening advocacy for health; improving efforts to empower people; and influencing social, community and people-centered systems to support health action.

Having discussed the three major strategy areas, some issues crucial to making health promotion operational in developing countries are presented below. Inherent in these issues are the future challenges addressing actions for health promotion.

1. What can be done to mobilize public attention, strengthen national policy and political commitment favourable to health, and obtain adequate resources?

What kinds of advocacy can be applied to translate popular statements into reality and mobilize resources so as to move from philosophy to action?

Health authorities should indeed take the lead in championing, together with their allies, the cause of health, and shall be vigorous in competing for their appropriate share of resources. How can expressions of national policy and political commitment that are favourable to health, and that emphasize social justice and equity, be generated and supported by adequate resources?

The challenge calls for all sectors of society at all levels, but particularly at the highest level, to be mobilized in support of health.
Sound data that support the value of health in national development should be collected and presented in a persuasive manner to policy-makers. That health is indeed an economic and political asset must be made evident to decision-makers and resource allocators. Mechanisms to facilitate advocacy for health should be evolved and acted upon.

2. How can political action and health supportive public policies become major instruments for safeguarding health in the context of industrial and economic development plans?

Poverty must be eradicated and the process of economic development accelerated.

There is much evidence that economic progress has a positive impact on health. However, at times, health and economic development are at cross purposes with each other. When industrial and economic policies and programmes are being formulated, safeguards must be established to protect the health interests of the community.

How do we achieve an acceptable balance between health and industrial development? This can only be done by public policies based on enlightened public opinion. Such policies for balanced development will be adopted and implemented only when the public is made aware of the problems, motivated to demand constructive action and skilled in pressing for such action.

3. How can partnerships be strengthened and alliances built with organizations and institutions that can be influential allies for health promotion?

Social, political, and professional groups capable of influencing national policy need to be enlisted in the cause of health promotion. How can we be more pro-active in establishing productive partnerships with these influential groups? How can we encourage them to bring pressure to bear upon governments for policies and for resource allocations supportive of health?

A number of non-governmental organizations undertake health and welfare activities at the grass roots level. They need to be identified and good working relationships established with them. Effecting linkages between these agencies serve more than one purpose: recognition and support for each agency's work, avoiding duplication and ensuring complementarity of services, sharing experiences and exchanging methodology and materials, and facilitating concerted actions for health.

4. How can true intersectoral collaboration be achieved in order to activate community interest and social support for health?

Lip-service is often paid to the importance of intersectoral collaboration for health yet, in practice, health systems have found it difficult or have remained reluctant to enter into productive partnership with the mass media, education, agriculture, or other sectors that clearly can contribute to the attainment of health goals. Whose responsibility is it to actively initiate such collaboration, and what practical first steps can be taken? What coordinating mechanisms are needed at national, intermediate and local levels to sustain and strengthen intersectoral collaboration?
Favourable national policies may not result in better health of the population unless concrete actions are taken at the community level. How can such actions be initiated with the participation of the community? How can community involvement in health and socioeconomic development programmes be generated and sustained?

5. **What are the critical needs for strengthening and developing national capabilities to implement health promotion strategies?**

Health promotion and education programmes will be successful only when there is national commitment and capacity (infrastructure, manpower and resources) for planning, implementing, managing and monitoring these programmes.

Commitment from the highest authorities to place and keep health issues high on the public agenda is a prime prerequisite.

Another input is the preparation of manpower in ways that will emphasize the application of social skills in advocacy, building partnerships and alliances, and in networking with allies so as to initiate social and political action for health.

Also, mobilizing adequate resources for health is crucial to accelerating progress in health.

6. **How do we improve efforts to empower people for health action?**

Past perceptions of health education dealt largely with personal health actions through messages related to good health habits and the avoidance of risk behaviour. Though these kinds of health messages remain important today and cannot be neglected, equally important is education for collective actions on behalf of health. Empowering people to function as enlightened health citizens is a challenge that has to be met.

Collective action enhances societal and political commitment for health. People must be prepared and strengthened to act collectively at local levels and beyond. Conditions need to be created and reinforced to make people live healthy lives.

Efforts to mobilize community organizations and local leadership need to be further strengthened. Collaborating with the media to influence leaders and the public for health action can be crucial in empowering people.

All these activities are among the many issues which will have to be considered when devising strategies and actions for health promotion. The approaches must be pragmatic and action must be specific to gain the greatest possible success. There is no single model or blueprint that can be universally applicable. However, it is important that each community and nation working towards achieving the HFA goal should prepare its own plan of action, taking into consideration priority needs and available resources, and applying innovative approaches that actively involve institutions and people at all levels from the very early stages of the planning process.
ACRONYM LIST AND GLOSSARY

EC  European Community
FAO  Food and Agriculture Organization of the United Nations
ILO  International Labour Organisation
IMF  International Monetary Fund
IUHE International Union for Health Education
NGO  Non-Governmental Organization
OECD Organization for Economic Co-operation and Development
UN  United Nations
UNDP United Nations Development Programme
UNEP  United Nations Environment Programme
UNESCO United Nations Educational, Scientific and Cultural Organization
UNICEF United Nations Children’s Fund
WHO  World Health Organization

1. Documents and major international conferences

A Call for Action

A summary statement of the Working Group on Health Promotion in Developing Countries convened by WHO in October 1989 to review health promotion concepts and principles and to recommend specific steps for translating them into action in developing communities.

The Adelaide recommendations: Healthy Public Policy

The final document from the 2nd International Conference on Health Promotion: Health Public Policy, held in 1988 in Adelaide, Australia. The recommendations define the conditions for a health-oriented public policy and establish the need for clear public responsibility for health, particularly emphasizing support for women’s health, food and nutrition and curtailing tobacco and alcohol consumption. These goals are to be achieved by creating supportive environments for health, developing new alliances and making global public health, based on international cooperation, a top-priority issue.
Brundtland report

The World Commission on Environment and Development was appointed in 1983 and chaired by the then Norwegian Prime Minister, Gro Harlem Brundtland. The final document of the Commission, our common future, published in 1987, contains a proposal for coordinating economy and ecology to achieve sustainable development. The work of the Commission was followed up by the UNEP report, Environmental Perspective to the Year 2000 and Beyond.

Declaration of Alma Ata

The final document of the International Conference on Primary Health Care held in September 1978 in Alma Ata, the capital of the Soviet republic Kazakstan. The conference was jointly arranged by WHO and UNICEF. Major principles and guidelines were formulated for the implementation of a global health for all strategy. The conference is referred to as a milestone in the health for all movement (see below).

Eco 92

(See UNCED 92)

Environmental Perspective to Year 2000 and Beyond


Health for All

World Health Assembly resolution WHA30.43 from May 1977 states that “the main social target of governments and WHO in the coming decades should be the attainment by all 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”.

Ottawa Charter for Health Promotion

Adopted at the First International Conference on Health Promotion in Ottawa in 1986. This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. The Charter constitutes a framework for health promotion and points out major areas for action,
one of which is to create supportive environments. It was the first WHO document to include the concept of a stable ecosystem and sustainable resources as prerequisites for health.

Our Common Future

(See Brundtland report)

UN Conference on Human Environment, Stockholm 1972

In May 1968 the Swedish Government made a proposal to the UN that environmental issues should be put on the UN agenda. The purpose of the conference was to encourage and provide guidelines for actions undertaken by governments and international organizations, in order to protect and improve the human environment and prevent its destruction. A total of 1,350 delegates representing 113 countries took part in the conference.

Targets for Health for All

The WHO Regional Office for Europe developed the overall strategy for Health for All by the Year 2000 more precisely in 38 quantitative sub-goals. These targets were adopted by the 33 Member States of the European Region in September 1984. The goals are grouped in five sections - health for all, lifestyles and life to health, a healthy environment, appropriate care and research and policies supporting the health for all strategy. A major principle is to ensure equity in health, by reducing the present gap in health access and status between and within the European countries.

UNCED 92

In 1987 the Swedish Government proposed that, within five years, the UN should arrange a global conference to follow up the UN conference held in Stockholm in 1972. In 1989, the UN General Assembly decided to develop a United Nations Conference on Environment and Development. The conference will take place 1-12 June 1992 in Rio de Janeiro, Brazil. Eco 92 has sometimes been used as an acronym for the conference. The conference aims to achieve formal commitments between states on actions for sustainable development. Heads of states and governments are expected to attend the conference and to sign international agreements.
2. **Glossary of Terms** (all definitions in the context of health promotion)

**Community development**

The process of involving a community in the identification and reinforcement of the aspects of everyday life, culture and political activity that are conducive to health. This might include support for political action to modify the total environment and strengthen resources for healthy living, as well as reinforcing social networks and social support within a community and developing the material resources available to the community.

**Ecology of health**

A scenario for a positive concept of health based on personal and social responsibility for health, by providing a health-promoting environment.

**Environment**

**Economic environment**

Economic factors beyond the immediate control of individuals that affect health and healthy lifestyles.

**Physical environment**

The physical, chemical and biological factors within home, neighbourhood and/or workplace beyond the immediate control of the individual that affect health. Among the most important factors will be: air and water quality, noise, waste management (domestic, industrial, hazardous, toxic), other sources of harmful substances (such as heavy metals and persistent chemicals), radiation, housing and other buildings, open spaces, natural or wild areas, global structures (such as ozone layer and carbon cycle).

**Political environment**

Whether a society is open or closed politically, participative or authoritarian, secular or religious, democratic or undemocratic, at peace or at war, significantly impacts the possibilities for health promotion. Thus, issues such as human rights, constitutional structures, the nature of political parties and other representative institutions, freedom of or access to information, all have a bearing on health and health promotion.
Resource environment

The amount and availability of resources to individuals and communities is clearly a key determinant of the possibilities for health. Among the resources needed to create a supportive environment for health are: financial resources, which may be available from public, commercial or personal sources; infrastructure resources, which range from the literal physical infrastructure, roads, sewage systems, etc., to the legislative, regulatory and administrative infrastructure (e.g. power, laws, inspectors, etc.); information resources, both formally and informally transmitted, are clearly essential to creating a supportive environment for health; and personal resources, the individual’s own skills and capabilities.

Social environment

The social environment consists of the norms, values, customs, fashions, habits (which might include work), prejudices and beliefs of a society. These vary enormously from society to society, but in each society their profile will be more or less supportive of health. They are modulated through the mass media, thus raising the question of the role played by the means of communication in creating supportive environments for health. They are institutionalized in the family, the community (which may be defined ethnically as well as geographically) and the country.

Total environment

All identifiable aspects of the social, economic, and physical environment that may influence the health of individuals or groups.

Health

WHO defined health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. However, as one might expect, this all embracing and idealistic description has sometimes been viewed as unattainable and largely irrelevant to lives of most individuals. Within the context of health promotion, health has been considered less as an abstract state and more in terms of the ability to achieve one’s potential and to respond positively to the challenges of the environment. In these terms, health is seen as a resource for everyday life, not the object of living; it is a positive concept emphasizing social and personal resources as well as physical capacities.

The basic resources for health are income, shelter and food. Improvement in health requires a secure foundation in these basics, but also information and life skills; a supportive environment, providing opportunities for making health choices among goods, services and facilities; and conditions in the economic, social and physical environments (the total environment) that enhance health.
This inextricable link between people and their environment constitutes the basis for a socioecological concept of health that is central to the concept of health promotion. Such a view emphasizes the interaction between individuals and their environment and the need to achieve some form of dynamic balance between the two.

**Health policy**

A formal statement or procedure within institutions (including government) that gives priority to health or that recognizes health goals. It involves health services and sectors outside health services that affect health. These include in no particular order: agriculture, energy, transport, industry, trade, aid, social welfare, environment, education and science.

**Living conditions**

The standard of housing and material resources within the physical environment in which an individual lives. Differences in living conditions usually reflect a wide range of inequalities between different socioeconomic groups within societies. The overall impact of living conditions on health is sometimes difficult to untangle from the combined influence of individual lifestyles and social and cultural norms.

**New public health**

Professional and public concern with the effect of the total environment in health. The terms builds on the old (especially nineteenth century) public health which struggled to tackle health hazards in the physical environment (for example, by building sewers). It now includes the socioeconomic environment (for example, high employment).

**Positive health**

A state of health beyond an asymptomatic state. Concepts of positive health usually include the quality of life and the potential of the human condition. Notions of positive health may include self fulfillment, vitality for living and creativity. Positive health is concerned with thriving rather than merely coping.

**Quality of life**

The perception of individuals or groups that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfillment.
Self empowerment

The achievement of personal autonomy through the development of and use of life skills.

Social inequality

The existence of unequal opportunities and rewards for different social positions or statuses within a group or society. Social inequality in health often refers to the unequal influence on health of the different social positions or statuses. The fundamental aim of health for all is to reduce inequalities in health both between countries and within countries.

Social movement (popular movement)

Various forms of collective action by a group of individuals aimed at social reorganization. In general, social movements are not institutionalized but arise from spontaneous social action directed at specific or widespread grievances.

Sustainable development

Sustainable development in the sense of environmentally sustainable economic development has become one of the key issues in the present environment and health policy debate. There is now a widespread recognition that our current form of economic development and the way to deal with our natural and social resources touches not only on borders of their depletion but also on critical borders of our global ecosystems that endanger our living and survival.

Hence, the call by the report of the United Nations World Commission on Environment and Development for a form of sustainable development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

It is important to add that the Commission defines needs including the “essential needs of the world’s poor to which over-riding priority should be given”. It also recognizes the “limitations imposed by the state of technology and social organizations on the environment’s ability to meet the present and future needs”.

In essence, sustainable development is a process of change in which the exploitation of resources, the direction of investments, the orientation of technological development, and institutional change are all in harmony and enhance both current and future potential to meet human needs and aspirations.

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"Action for Public Health - Creating Supportive Environments" is the theme of the 3rd International Conference on Health Promotion that will take place in Sundsvall, Sweden, June 1991. Sundsvall will be a working conference with a focus on practical action. Half of the time will be devoted to workshops to discuss practical issues and to examine how to create supportive environments. The workshop discussions will be based on Briefing Books which cover major sectors and which propose alternative solutions. The sectors will be food and nutrition, energy and transportation, education, work and unemployment, and social care and housing. Discussions will also consider community environments and the issues pertinent to developing and developed countries.

This briefing book on Health Promotion in Developing Countries underscores the importance of the Health for All goal and brings into sharp focus the contribution that health promotion strategies can make towards the achievement of this goal in the spirit of social justice and equity. The health promotion concept during this century has evolved from a somewhat restricted interpretation - that is to say, within the framework of an interlinked chain of promotive, preventive, curative and rehabilitative health care - to a broad-based concept of social and political actions for health. It aims at creating conditions and fostering lifestyles that are conducive to health and well-being for all.

The book builds upon a three-fold action strategy for health promotion; advocacy for health-supportive public policies, empowerment of people and social support for health. These three principal strategies are highlighted in the Call for Action, a summary report of the WHO Working Group on Health Promotion in Developing Countries held in Geneva in 1989.

Recognizing that many activities relevant to the above strategies have already taken place in health and development programmes in the developing countries, WHO considered it useful to examine these experiences and to derive lessons from them. Fifty-five stories from a variety of documents that illustrate social and political actions for health have been selected and included in the book to support the text on different components of health promotion strategy. An attempt has been made to categorize these activities under the three strategy areas, in the hope that readers may benefit from these experiences in transforming concepts into realities.

The future of health promotion in developing countries offers a challenge which calls for effective and innovative societal action in the field of health development.

Health promotion is a process of activating communities, policy-makers, professionals and the public for health-supportive policies, systems and ways of living. It is manifested through acts of advocacy, empowerment of people, and building social support systems that enable people to make healthy choices and live a healthy life.

World Health Organization