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Technical Discussions

Health educ. trends
Primary health care trends
Health promotion

NEW POLICIES FOR HEALTH EDUCATION IN PRIMARY HEALTH CARE

Report on the Technical Discussions

The Technical Discussions on the topic of "New policies for health education in primary health care" took place on 6 and 7 May under the chairmanship of Professor R Senault (France). The total number of registrations received was 305 and all six WHO regions were represented. In opening the first plenary meeting, the General Chairman stressed the dominant place now occupied by health education in the global action for health promotion and the need to develop new policies in full harmony with primary health care concepts, enabling individuals to take in hand their health destiny and that of their community.

The second plenary meeting on 7 May opened with reports given by each of the six Group Chairmen on keys issues highlighted by the discussions. The meeting was concluded by the Director-General who stated "I am personally convinced that primary health care will stand or fall depending on progress in the field of health education and I think, therefore, that the Technical Discussions this year have very particular importance."

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1. INTRODUCTION

Throughout the entire history of mankind, ever since its remote origins, social groups have felt themselves explicitely concerned by the state of health of their members all through their life, from birth to death.

In our own times, health, on account of all that is at stake in the many sectors of the life of nations, is unavoidably a factor in all strategies. Yet, one cannot help but be struck by the extent of the problems still to be solved. In one place poverty, in another affluence, alike give rise to an impressive series of somatic or psychosocial disorders.

The economic, social and cultural dimensions of health problems gave rise to the trends which became apparent several years ago. If we are to reduce inequalities with regard to life and death as the third millenium approaches, the policies which influence methods, means and strategies have to undergo a reorientation.

It would be untrue to say that we are right at the beginning in this matter. The Constitution of the World Health Organization announced to the principle that, inter alia, "informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people". The first Expert Committee on Health Education of the Public reaffirmed this principle strongly as early as 1953. A decisive stage was reached in achieving this ambitious goal, however, when at Alma-Ata, the International Conference on Primary Health Care sponsored by UNICEF and WHO at the invitation of the Government of the USSR, identified education as the first of the eight essential components of primary health care[1]. This was a natural outcome of the decision taken by the World Health Assembly the year before 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". Health education was put first in the Declaration of Alma-Ata because it was recognized to be fundamental to the attainment of all other objectives.

It is obvious that health - although unevenly distributed - constitutes part of the community's wealth and an aspiration of all men regardless of their ethnic origin, political institutions or ideological or religious opinions. This amounts to saying that all human beings have to come together to promote and protect the health of each of them, and that in order to do this they have to combine their efforts with those of the authorities and participate in improving communities' economic, social and cultural situation.

2. OBSTACLES AND CONSTRAINTS

The ideas of community involvement and appropriate technology are not new. They have been part and parcel of the earliest theories and concepts of health education and community development and they consistently make their appearance in the best projects and case studies and the most successful public health programmes. Why then haven't they been more widely and consistently put into practice? One major reason is, quite simply, that they have not been sufficicently supported by policy.

The reports sent by many countries in connection with the Technical Discussions show at least three ways in which policy has failed health education and consequently the primary health care approach. First, most policies, including World Health Assembly resolutions in earlier times, have limited their concept of health education to the idea that health education is a tool in the service of specific disease programmes. To be sure, that role of health education is not to be denied, but it has usually resulted in health education being assigned a subordinate role in such programmes. To be effective, however, health education needs to be placed at the intersection of all sectors.

The second way in which policy has failed primary health care is in its support for health education which has been too meager to permit achievements to match the expectations.

Thirdly, policies have created conditions where the planning and decision-making process required for primary heath care concepts to bear fruit was reversed. Typically, in most countries that have initiated community participation strategies, planning has been centralized, implementation has gone to the local level, and evaluation to the central level. Therefore, the whole concept of community participation has been misunderstood and reveals the little credence that health professionals give to the ability of people to decide on matters of health for themselves.

Several other factors have held back the formulation of clear policies in favour of health education, and in particular:

- the inadequacy of appropriate legislation;
- the difficulty that technicians have had in formulating appropriate health education policies for decision-makers;

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1 Alma-Ata 1978. Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. World Health Organization. Geneva, 1978 ("Health for All" Series, No 1)

- lack of understanding of the importance of health as a factor in socioeconomic development with the consequent neglect of the role of health education;

- inadequate demonstration of the results from numerous health education projects;

- the lack of or the weakness of national structures responsible for the organization and coordination of health education programmes.

But there is another issue which cannot be minimized: too often, in the past health education has not taken sufficiently into account the fact that people, in reaching health decisions, are influenced by factors often outside their control, such as working conditions, the marketing of consumer products in certain countries, the general educational level of the community, other economic and environmental factors, social norms and customs, and so on. The promotion components of health education policies must therefore provide not only for the "adoption of beliefs, attitudes and behaviour likely to further health" but press as well for an environment which supports the development of such attitudes and behaviour.

In fact, health must be regarded as a shared responsibility. Although health education is intended to help people assume greater responsibility for health, it should not lead to the belief that poeple's behaviour alone is responsible for their state of health. This would result in guilt-feelings, often unfairly.

These, then, are some of the problems which have slowed down and even blocked the effectiveness of health education.

3. EVOLUTION OF THE CONCEPTS

Awareness of these gaps and obstacles set in motion an evolutionary process which resulted in the formulation of new concepts of health education, both at the national and international levels.

Thus, policies for health education as articulated by the World Health Assembly over the past 30 years have shifted the emphasis:

- from centralized to decentralized planning;

- from singular (specific disease) to diverse objectives;

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

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

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

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

4. TYPES OF SUPPORT NEEDED TO ENABLE HEALTH EDUCATION TO ACHIEVE PRIMARY HEALTH CARE OBJECTIVES

Although a shift in the concepts has become evident, this reorientation would serve little purpose if it is not supported by political will and by the will of the people to translate these concepts into reality. This fundamental issue was the object of in-depth discussions within the six working groups that were organized in connection with the Technical Discussions. The present report summarizes the views expressed by the participants, both in the working groups and the plenary sessions.

From the start, two key points were highlighted. First, each country must set its own policy priorities with regard to health education. Policies must reflect variations within a particular society, especially urban and rural differences. But it is clear that in order to maximize the effectiveness of health education it is necessary for a policy to be evolved which rationalizes a plan, nurtures leadership and establishes a firm basis for evaluation. Second, it should be recognized that new policies are not entering a vacuum. They are building on long histories of educational practices in health, both formal and informal.

4.1 A political will

There are five main areas in which this political will can express itself.

4.1.1 Harmonizing national and local plans

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

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

This involvement is not without drawbacks. While there is a consensus with regard to the implementation of planned programmes - for which responsibility should be handed over as soon as possible to the local level, under the supervision of local health workers, with community commitment and with the technical and managerial support of the higher levels - opinions are less clear-cut when it comes to involving communities in the planning process.

One country for example has developed health care teams at the district level, composed of the local medical officer, nurses, community health aides, and other health workers. These teams are the basic planning units working in conjunction with lay members of the community. Plans then proceed "upward" through the system to the parish and national levels.

In contrast, other participants in the Technical Discussions indicated that community level planning and participation should not be "spontaneous" but rather a part of a structured and centralized system. Some communities, it was said, are not "cooperation-minded". It was observed that central decisions do not change situations locally unless local people are involved at every stage.

Generally speaking, however, participants agreed that the central level has an important role to play in integrating the opinions and contributions of local communities into the planning process.

In point of fact, this issue ought no longer to be a difficulty once the process of community involvement has been built up to the point of providing continuous guidance to national policy from the grass roots. National policy should even thrive on the input resulting from such community involvement. But initially, national governments must take the lead in setting policies that will legitimize, encourage and support local community involvement in health.

Seen in this perspective primary health care becomes a matter for everyone and all resources casn be mobilized - in the family, at work, in social groups, at school, and in training centres of all kinds - to ensure its promotion. Health education intervenes to enable everyone to recognize the importance for himself, for his family, and for his community of his taking part in collective activities for health.

4.1.2 Allowing for a diversity of objectives in formulating policies

Policies in health education have been most widely adopted by national governments during periods of mass campaigns against specific communicable diseases such as malaria or the immunizable diseases, or as a component of highly targeted programmes such as family planning.

As was pointed out in the preceding section, the very principles of primary health care make it necessary for national policies to find ways of taking into account in their planning, the more diverse objectives of communities so as to integrate the varied priority needs identified at the local level.

It is also important in this connection to recognize that certain objectives of national programmes may differ from the priorities or needs felt at the community level.

Another aspect of diversification of objectives is a consequence of a much more comprehensive definition of health. This resuits in many of the important objectives in today's health programmes being beyond the scope of physicians and other members of the institutional health system. It is necessary therefore that policies should recognize the need to involve many other sectors and disciplines in attaining these objectives, and that strategies designed to translate these policies into effective action should take that need into acccunt.

4.1.3 Facilitating intersectorial action

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

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

In addition, it appears from the discussions in the working groups that intersectoral cooperation is less of a problem at the local level where health concerns are perceived as an integral part of development generally. It is only as we proceed up the ladder of administrative jurisdictions that health concerns become disengaged from the overall development process. At these higher levels individual sectors often have fixed values, policies and administrative styles that act as barriers to intersectoral cooperation.

It has to be recognized, in regard to intersectoral cooperation at the national level, that sometimes there are outright conflicts of interest between different sectors. Further difficulty results from the inertia of the system in bringing together the many aspects of government and industry which need to cooperate, for example, over such matters as food hygiene or traffic accidents.

Another problem pointed out was that when other sectors did cooperate that often resulted in overlap or contradiction in goals or methods. This points to the need for a first step in planning cooperation, namely that of clarifying definitions and arriving at a consensus on intent or objective. Sectoral isolation at higher levels and lack of awareness of what other ministries are doing can lead to confusion and failure at field level.

The importance of intersectoral cooperation between health and education was unanimously stressed. Primary and secondary schools were viewed as major resources for health education and community development, for many reasons, and teachers were consequently identified as

essential partners in these efforts. It was strongly recommended that school health education curricula be strengthened. Indeed, health education aimed at children should make it possible for them to develop their physical and mental potential to the utmost, to appreciate the need to protect and promote the quality of life; and should help to prepare future generations to build a better, healthier world.

Teaching staff, also health workers concerned with schools and parent-teacher associations, all have a part to play in ensuring that health instruction is an integral part of the school curriculum and that proper learning experiences in relation to healthful living are presented to the children. This is too big and important a subject to be left to chance or the whims and fancies or the goodwill of individuals. There is an urgent need for policy decision at the highest level.

Among the other sectors in which health plays a vital role, agriculture and the work place were given first place. With regard to workers in industry, experience in training programmes undertaken jointly with labour unions and employers have yielded valuable data on methods and approaches leading to self-reliance in health. In agriculture, extension work with farmers has brought nutrition education and improved food production to rural areas. The communication sector, for its part, plays a crucial role in the promotion of health; section 5.2 is devoted to this subject.

One point stands out: the objective of health for all by the year 2000 can be attained only if health personnel combine efforts with those of personnel in all the other socioeconomic sectors. The effort must be a collective effort, and the personnel of other sectors - education, agriculture, communication, public works, industry and commerce, to mention only some - must all be made aware of the major health problems and know their main implications, so that they can participate intelligently in the search for solutions.

4.1.4 Using appropriate technology

Use of appropriate technology requires that the technology should be responsive to the needs and aspirations of the community concerned and should be compatible with local values and resources and local ability to use it. This points to the need for a policy that focuses first of all on existing resources and how they may be modified or adapted in developing technology. Effective technology may exist in the community and might be promoted and employed in a more deliberate manner. This technology may in practice be more useful than some technology that is developed centrally, which may be alien to local needs and values.

The choice of the appropriate technology for a given purpose largely depends on the audience - their literacy levels, traditions, accessibility to modern media, and similar factors. In this connection the need to take advantage of modern communications technology was recognized. It was also stressed however that traditional folk methods of communication, such as legends, songs, plays, drums, etc., can be very effectively used. The use of such media is often more effective than that of expensive and inappropriate equipment which contributes to the depletion of already scarce resources. Such equipment may also be difficult to operate and maintain, and breakdowns are frequent. Their use in such circumstances is not warranted in terms of educational objectives. Policies are therefore required which will ensure the utilization of appropriate technology in health education.

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

4.1.5 The structural framework

The positioning of health education has an important impact on its capacity to act effectively and to influence the integration of information and education with all aspects of health care, and with other sectors such as schools, agriculture and communications.

The structure responsible for health education may vary from country to country. Nevertheless it must be capable of assisting all the health services, preventive and curative alike, and the services of other development sectors and communities to plan, carry out and evaluate health education projects and activities.

Participants stressed the need for health education units at local, state and central levels of the health organization. Each of these units would be manned where possible, by a multidiscplinary team. The team would comprise workers specialised in health education, mass communication audiovisual techniques and behavioural sciences. To the extent health education units are well-organized, well-staffed and adequately financed, it is possible to develop meaningful information and education-for-health programmes in support of primary health care.

Such health education units would more particularly serve to: muster political will both for primary health care and health education as a part of it; support the planning, implementation and evaluation of health education at local, state and central level; harmonize health education activities at all levels; promote collaboration between health and non-health sectors; train other health workers, policy makers and administrators for health education aspects of their work; stimulate individual, family and community action; involve, where possible, traditional healers in health education activities; initiate educational activities to involve the individual families and their community at the grass roots level; and undertake research and provide data where necessary for various health education processes.

A last point: the institutional framework for health education must be capable of organizing a system for encouraging the various development workers engaged in activities to mobilize communities and help them achieve better health.

4.2 The will of the people

The will of the people to become partners in the protection and promotion of health expresses itself on the one hand, through their involvement, and on the other hand, through their capacity for action and self-reliance.

4.2.1 Community involvement*

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

Experience has shown that efforts to increase individual and community participation in the planning process have resulted in more successful programmes both in targeted disease prevention and in more general community development. Obviously, generating effective local participation involves a long term effort from which results might not be achieved quickly. Nevertheless the results might be more lasting and contribute more profoundly to community development than more dramatic external interventions which have immediate and highly visible effects.

For community involvement to be more than merely a temporary activity and achieve continuity, structures are required. Several participants mentioned that in recent years in their countries there had been considerable decentralization to local community organizations. In some countries there were village councils which were responsible not only for health development but for all general development efforts, including those in education, agriculture, sanitation, etc.

Such community participation and involvement implies a sharing of power and responsibilities - avoiding total abdication by the health sector on the one hand or domination and exploitation of the people on the other. It ensures a full partnership

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*Note: The term "community involvement" has been given preference today over "community participation" because "it is not sufficient merely to participate, which may be simply a passive response; there should be mechanisms and processes to enable people to become actively involved and to take responsibility for some decisions and activities jointly with health professionals".[1]

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1 Development of indicators for monitoring progress towards health for all by the year 2000. World Health Organization, Geneva, 1981 ("Health for All" Series, No. 4).

between all concerned in which a total trust relationship is developed, based on a sincere desire on the part of professionals to pay a great deal of attention to preserving the cultural and social identity of the population concerned. Engaging in dialogue with the population on its own terms, bearing in mind its own standards and frame of reference, is a factor of success.

Once communities have been sensitized and become involved in their own decision-making processes and in setting up their own priorities, they can proceed collectively to implement their local health programmes, using all available resources. It is important that such involvement should take place at all stages. Several participants gave examples of involvement of the communities themselves in evaluation, which can be an important motivating factor and a catalyst of social action. Such examples came both from developing countries and from industrialized countries.

Several participants questioned whether it was always possible to rely on the views expressed by the population when making the necessary community diagnosis and planning programmes. The importance of some serious health problems, such as schistosomiasis, may not be recognized by the community. It is necessary therefore to supplement the information available to, and the opinions received from, the community with epidemiologic, sociodemographic, medical and economic data. Furthermore, the priority needs expressed by individuals are not necessarily the same as those of the community, and someone may have to arbitrate.

Finally several participants stressed the fact that it was necessary to be very realistic and practical in collaborating with communities. Continued cooperation can only be expected if those concerned benefit from such cooperation. Apart from health benefits - which are not always evident in a first stage and only start to be felt on a medium or long-term basis - it would be useful to identify other incentives and motivating factors which could be used, where warranted, on behalf of the community.

4.2.2 Self-reliance

In fostering self-reliance it is important that health professionals should realize the importance of the approaches they use and the danger of becoming part of the cause of dependence. It is true that in many cases they are readier to give drugs than talk to their patients. Health professionals have to some extent taken responsibility for their own health away from the people; this is connected with the high technology of modern medicine, which the people often cannot understand.

That said, health education seems the approach par excellence when it comes to encouraging and enabling communities to identify their health problems, select solutions, set targets, and translate these into simple and realistic goals that they can implement and monitor. Health policies should be sensitive to opportunities for engaging ordinary people in determining health problems and in being active in their solution. For if people have the skills to enquire systematically into their conditions and health problems and to experiment with solutions, however simply, they will become less dependent on others and able to decide for themselves what their needs are and how these needs should be filled - among other things through training to develop appropriate skills.

In analyzing community needs it is essential to take account of prevailing values and concern for the quality of life, or of social problems as much as specific health problems. The problems identified will not necessarily correspond with formal epidemiological and socio-economic analysis. Furthermore needs will sometimes be expressed as health problems, "sick children" for example, and sometimes as social concerns. But health workers should be able to find the health issues underlying them, resulting from them or relating to them.

It is important therefore to conceive health education within a wide framework of efforts to train knowledgeable and independent citizens, capable of deciding their future for themselves. Within this overall framework all levels and all sectors of the population need to be made more aware of the importance of health in order that they may mobilize their energies for the common good. Thus local leaders (administrative and/or traditional), teachers, agricultural extension workers, women's associations, youth clubs, religious institutions, professional groups, trade unions, etc., should be involved, according to the circumstances.

5. IMPLICATIONS FOR POLICY MAKING

The measures required at policy making level relate to three key areas: manpower development, the use of media, and research.

5.1 Manpower development

Health care providers need to recognize that times are changing, people's attitudes are changing, our work and responsibilities are changing.

The best policies can be developed at all levels. But without trained people to implement them they will remain on paper. The first priority is therefore to develop skilled manpower. Here technical competence is not enough. The need is for personnel who will introduce the educational dimension in all the aspects of their work. It should be explained that the word "manpower" is used in its broader sense as including all those who have a role in or affect health education policies and practices. This includes legislators and policy makers who must be educated with regard to the importance of health education as a priority among local needs.

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

Thus reorientation of health education policies entails new roles in health education for all health care providers, including lay volunteers and mutual self-help groups. These new roles require in their turn new forms of training in line with new strategies for working with communities, and a more comprehensive and realistic appreciation of the demands of research and evaluation.

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

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

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

Even if the training curricula of health workers could be reformed in the near future countries cannot afford to wait until the present students become the majority. Reorientation of manpower now in service is essential. It must be practical and take place at the field level, and not merely be verbalized in the classroom.

Education of other key personnel besides health workers is extremely important, e.g. the village school teacher, religious and other community leaders, youth leaders, etc.

Special emphasis is needed for the education of women in order to help them to fulfil their role as the principal health care provider of the family and as a catalyst for community action. An important role of mothers is to be able to influence the maternal and child health and other primary health care services so that they genuinely answer the

family's needs. Women represent a social group too often neglected on account of various socio-cultural factors. Yet women need to be involved more closely in health education - which is one of their normal tasks as wives and mothers - for several reasons: their importance from a demographic viewpoint, their sense of personal responsibility, their leading influence in family health and their newly acquired roles in public affairs.

Another group that merits particular attention is the practitioners of traditional medicine. Several countries are endeavouring to bring about a dialogue with these practitioners by offering them supplementary training. Among the practical difficulties encountered are the fear of registration and bureaucratic supervision by the public authorities, the obligation to divulge their methods, and the loss of their prestige and/or clientele. Local situations will need to be studied, the importance of these practitioners within their communities being borne in mind.

Lastly, investment is needed in the training of educators in general to motivate them and stimulate them to re-examine their educational programmes, revise their handbooks, and make health education attractive and vital. This applies to general education, but it applies even more to those responsible for the training of health personnel. Health service officials will have to pay attention to the integration of health education into programmes that provide training in both the treatment and the prevention of diseases; they will have to attempt to change their own outlook and foster new life-styles.

With regard to the training of the specialist staff in health education, different views were expressed. Participants varied in the degree to which they appreciated the need for such specialized staff. While it is recognized that the categories of workers who have a role in health education are indeed numerous, yet "every one's job" often turns out to be "no-one's responsibility". Hence the need for specialized staff in health education, whose experience and qualifications are required at central and provincial levels for the training of other workers in health education and for the planning, implementation and evaluation of educational aspects of health programmes, including coordination of resources.

5.2 Media

In the history of education for health, attitudes towards mass media have varied from unrealistic expectations to a misunderstanding of their value. Experience shows that neither communication media nor interpersonal communication alone can have the total effect desired. They have different functions to perform, which mutually enhance each other's effectiveness.

There is a consensus regarding the main functions of information media. These functions are:

- to help strengthen political will by appealing to policy makers;
- to raise general health consciousness and clarify options concerning actions that have a strong bearing on health levels;
- to inform decision makers and the public about the latest developments and limitations in health sciences, and publicize relevant experiences for replication;
- to help deliver technical messages;
- to foster community involvement by reflecting public opinion, encouraging dialogue and facilitating feedback from the community.

The word media is currently used to refer not only to the print media, radio and television. It also covers traditional means of communications such as puppet plays or folk art.

Any action going beyond inter-personal communication, using mediated communication and reaching large numbers of people, is part of media work. It must also be stressed that media work is not limited to journalism and that there are many sectors in the press, radio and television which do not deal with news and with which health education can have much better cooperation.

It was agreed that we are in an epoch of complementarity in which each sector has special strengths that should be recognized and used. Properly used, the media can prepare the ground for health education efforts and maintain the kind of community action that is needed. The different forms of mass communication are therefore important for sensitizing and sustaining public opinion, but they must be supplemented by well-defined community activities.

What is necessary is that a balance should be struck between the mass media and other systems that reach people directly. The media should be used to bring out important issues, while at the same time their efforts should be harmonized with actions taken by the health sector that will affect health behaviour, thus leading to better results. In addition, health education should be sensitive to critical issues which are the concern of people, and collaborate with the mass media in arousing people's interest in these critical issues.

It was also recognized that in some of the developing countries people have little access to mass media, many of them not knowing how to read and having no radios and televisions. Yet even in these areas the media have much influence on a small but important segment of the population such as politicians and professionals. It was stressed that the media should be used in gaining support of politicians in the promotion of health.

The potential usefulness of television in the developing world should not be minimized however: the very fact that a high percentage of people are unable to read makes the printed word less effective than television. This medium has succeeded in reaching communities and families and has had a definite impact. Moreover in many countries, especially in developing areas, television is not commercial; this means that there is often a real opportunity to make proper use of this medium at little cost.

Lastly, it should be stressed that communication is one of the major instruments which should be employed in setting up and maintaining effective intersectoral collaboration mechanisms. Health education therefore should play a part in informing all concerned of the necessity and benefits of working together.

Taking the foregoing into account, appropriate policies need to be formulated to ensure proper and balanced use of media in health education. This implies:

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

(b) developing mechanisms to ensure a constant and free flow of information from the health sector to the communication sector;

(c) organizing in-service training programmes and seminars where professional personnel can meet; experience shows that workshops and seminars organized to that effect by many countries have yielded positive results;

(d) producing material for use by the media, utilizing the resources and skills of media professionals;

(e) emphasizing local programming with content closer to the interests and values of the people;

(f) making an effort to achieve greater coordination of media output with regard to agreement on consistency and appropriateness of content;

(g) going beyond the current practice of giving generous coverage to health education only during a health crisis.

General agreement was reached on the obvious influence of mass media. Communications technology has made rapid progress but not all health professionals have recognized its potential. Suggested policy measures should therefore aim at filling this void and ensuring effective and intelligent collaboration between the health and communication sectors.

5.3 Research and evaluation

Evaluation of services, activities and programmes in health education is necessary to their eventual improvement, but evaluation is only one part of a continuum of research needed to develop an informed policy and planning in health education.

5.3.1 Research

As people's participation in their health care has become their "right and duty", research needs to identify strategies that will make it possible to translate this concept into sustained practice.

Several important points were raised during the Technical Discussions:

- research in health education must be increasingly concerned with applicability - especially in the developing countries - and must be planned within the broader perspective of health systems research;

- as a part of health systems research, research findings must serve to facilitate the delivery of health services, i.e. establish a better dialogue between health care providers and potential users, propose innovative or more effective ways of providing information and facilitating education, and bring about more efficient involvement of individuals and communities in the improvement and maintenance of their own health;

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

- health service officials should be ready to question some of the assumptions upon which a number of activities in information and education for health have been based and should be capable of verifying their validity by experimentation;

- equal emphasis should be placed on training activities to provide more practitioners with research knowledge and more researchers with knowledge about practice: both are needed;

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

The groups noted that numerous simple research tasks and fact-finding endeavours could be undertaken by non-professionals. Although some areas of research need sophisticated methods of approach and expertise, that should by no means lead to a generalization. Much can be done - and should be done - by the community itself in terms of simple enquiries and observations, provided the people receive some training. Moreover, community self-studies are more likely to take into account values and social concerns.

While it is necessary to involve members of the community in identifying and defining their own problems, they ought also to have an opportunity to find or to seek solutions. In many instances they may need support of various kinds, especially expertise and technical guidance. Such assistance should be readily available in order to avoid frustration. So when a policy is announced it will be necessary to state that facilities and support for research are available not only for staff members but also for community members who are actively involved in community development as it affects health.

What are the fields in which research is most needed? Looked at from the point of view of health education goals - i.e. encouraging people to want to be healthly, to know how to attain health, to do what they can individually and collectively to maintain health, and so to seek help as needed - the issues requiring research are clear. They have to do with values, knowledge, ways of encouraging personal initiative and, lastly, relations between those giving health care and the individual.

Within this broad framework, several specific problems needing further study were given particular prominence. These include:

- the barriers to rapid implementation of research findings;
- the interplay of social, political and economic factors at the levels of planning, implementation and evaluation of primary health care programmes that include health education as an integral component;
- the integration of health education in formal, non-formal and informal community programmes at their earliest stage; and last but not least;
- the role of the health worker in helping community members to identify their health problems, to design solutions and take action, thus helping them to become their own agents for change.

While research should seek solutions to problems encountered in programme implementation, simultaneous efforts must be made to develop adequate mechanisms to ensure that findings can become operational as soon as possible.

In this connection it was emphasized that the values, customs and practices that may influence health are deeply embedded in the social and cultural aspects of life. As these may differ from country to country and even between communities in the same country, extrapolating findings from a specific cultural and political context into general rules tends to yield disappointing results. Research must therefore move away from concentrating on specific behaviours and recognize the importance of "lifestyles" in the prevention of disease and the promotion of health. It is within the context of lifestyles that adherence to certain health practices becomes truly meaningful. This is true in both industrialized and developing countries, but in different ways requiring different research.

The fact that the needs differ even from one part of a country to another or even within the same district, led one participant to stress the need for establishing a "geography of health". Clearly research is needed most urgently in developing countries where little is known about the health attitudes, beliefs, values, practices and relative effectiveness of health education strategies.

While it is important that research should provide the answers to numerous questions, it should also be recognized that a wealth of research findings exists which yet remains unused. Mechanisms must therefore be found to make these findings available so that they can help increase the effectiveness of health education in attaining the goal of health for all.

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

5.3.2 Evaluation

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

In such an evaluation, qualitative indicators are just as necessary as quantitative indicators. In this connection, the "short list of indicators" suggested for use in monitoring and evaluation of the global strategy for health for all by the year 2000 provides one indicator relating directly to health education policies. It concerns the degree to which mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning. These mechanisms include active and effective mechanisms of political parties and organized groups such as unions, women's organizations, farmers or other occupational groups; also measures to ensure that decision-making on health matters is adequately decentralized to the various administrative levels.

Many groups have drawn attention to the difficulty of evaluation, and to the resultant need for further socio-epidemiological research to provide a methodology and the necessary indicators to enable programme administrators to analyze results. It will be on the basis of these results that health education will be judged and will be able to be taken into consideration by the different structures, particularly in the difficult area of intersectorial cooperation. More sensitive measures of health education outcomes are needed so that the results of programmes can be detected within shorter time periods than is often the case in such evaluation.

Evaluative research should be focussed at three levels:

- evaluation of content (validity and appropriateness);
- evaluation of process (acceptance by providers and by target population);
- evaluation of outcomes (behavioural and other change).

This evaluation should be planned right from the start and in terms of clear and measurable objectives, with the participation of the beneficiaries.

As a first step in formulating more sensitive and specific criteria in relation to this and other indicators, countries might estimate the totals or percentage they would expect to achieve in connection with various types of participation. They might also outline short- and long-term plans of action with measures of progress indicated for each phase or year of the plans.

6. NON-GOVERNMENTAL AND VOLUNTARY ACTION

All the working groups emphasized the fact that health education policy should take into account non-governmental resources and were unanimous in their view that the role of NGOs is of vital importance in achieving health goals.

It was stressed that the concept of voluntary organizations should not be limited to structured groups such as NGOs or professional associations, service clubs, consumer associations, mutual aid societies and so on, which provide an effective platform for reaching the grass-roots; it should also embrace citizen groups or groups emerging spontaneously to cope with a pressing problem, and so on.

Non-governmental organizations provide a context that in many ways is ideal for involvement and for the growth and development of self-reliance, since they are an expression of the will of the people to use their own initiative in improving the quality of life.

It is a well-known fact in many countries that it was voluntary organizations, such as parents' groups or religious or charitable organizations, which pioneered important aspects of intersectoral health education and care. Very often it is only after such organizations have led the way that municipalities and government departments begin to accept responsibility for these health activities.

The WHO Seventh General Programme of Work specifically calls on non-governmental organizations to channel their resources for health at every level into support of the strategy of health for all, to develop joint action with governmental agencies through technical cooperation, and to broaden their involvement in the implementation of health programmes, ranging from accident prevention, leprosy, cancer, sexually transmitted diseases or cardiovascular diseases to research on human reproduction and drug policies. With regard to information and education for health, coordination is no less important in promoting acceptable self-care practices on the part of individuals and communities, also greater involvement in health promotion on the part of such groups as: the teaching profession at primary, secondary and university levels and in technical schools for agriculture and rural development workers, professional associations, media and labour unions, all of which represent important allies for health education.

Certain participants stressed the need for governments to coordinate the work of non-governmental organizations so that they supplement national action and do not enter into competition with it. In some countries this coordination already exists: the non-governmental organizations act within specific areas and on specific tasks fixed by agreement with the national authorities.

On the other hand other participants underlined the fact that in order to maintain the viability of the voluntary sector, official policy should be careful not to control it; the government's role is to provide a platform for coordination to encourage voluntary organizations, through financial or other forms of support, to encourage the community to take an active interest.

The concensus was that NGOs should bear in mind government programmes when carrying out their own functions, without involving controls which would limit their initiative.

In order to put into practice the political will to involve the non-governmental sector more closely in efforts to promote health, it was suggested that encouragement should be given to the creation of councils or federations of related non-governmental organizations, with the aim of facilitating their participation and avoiding duplication of effort.

In conclusion, three major types of support, usually provided by countries, need renewed commitment:

- formal recognition of voluntary associations through appropriate legislation;
- moral recognition of their key role through official involvement in coordination bodies concerned with planning, implementation and evaluation programmes;
- financial support through general subsidies or grants for specific programmes, whether these funds fully finance the actitivites concerned or supplement the funds provided by the voluntary organizations themselves.

7. THE ROLE OF WHO AND OTHER INTERNATIONAL AGENCIES

WHO, as the international coordinating authority for health, has the distinct role of coordinating, promoting, informing and cooperating with Member States, international agencies and NGOs in the field of health education, especially as an essential element of primary health care. The mandates given WHO by its Assemblies since 1949 in the form of resolutions relating to health education have indicated the types of activities with which it should be involved. These are mainly in the four areas of service, training, research and coordination.

In service, the role of WHO is to strengthen, upon request, health education services in the ministries of health and in other governmental services having health education functions.

In training, the Organization is requested to facilitate preparation in health education of all categories of health workers and workers in other related areas who have health education responsibilities. This, in collaboration with Member States might be accomplished through such provisions as fellowships, study grants, seminars, workshops, training courses and in-service training programmes. Continuing education could also take the form of dissemination of knowledge and skills on a regular basis through provision of manuals, guides, audio-visual material, etc.

In research, collaboration is needed between international institutions and organizations embarking upon health education research activities as part of health service research. Technical cooperation among developing countries (TCDC) needs strengthening to build a more generalizable scientific base for health education in those areas of the world.

In coordination, WHO has a leading role in collaborating with other UN agencies and NGOs in promoting the policies and activities needed for attaining the goal of health for all through primary health care. This, accordingly, necessitates the strengthening of WHO's collaboration with the agencies that have specific functions in health education. These include UNESCO, UNICEF, ILO, FAO, UNFPA and the World Bank. Among NGOs, special mention must be made of the League of Red Cross Societies, the International Union for Health Education, the International Council of Nurses, the International Council of Women and the NGOs concerned with specific diseases or health conditions.

8. SOME ADDITIONAL CONSIDERATIONS

To implement the political will to support health education several key issues need to be taken into consideration, in particular:

- the allocation of the budgetary and human resources is essential for the implementation of health education services;

- the support of political parties and of organizations connected with them at the national, provincial and outlying levels is conducive to the mobilization of potential resources and to coordination within and between sectors;

- the setting-up or strengthening of an institutional framework at the national level, responsible for coordinating the planning, implementation and evaluation of national health education activities, is essential;

- health education should not be used as a substitute for services that must be provided to the people, nor should health services be regarded as complete without an integrated health education component;

- poorly planned and non-integrated health education carries inherent risks of which health-workers must be aware;

- health education should avoid promoting in people an obsession with health; nor should it attempt to say what "normal" health behaviours are and thus make people feel "deviant" or guilty;

- intersectoral cooperation can only be successful when good intrasectoral organization exists;

- our responsibility is to go along with the people and to provide them with information so that they themselves can protect their health;

- research in industrialized countries can seldom be generalized to developing countries, so more research is needed in developing countries;

- the broadest possible involvement of traditional medical practitioners, community leaders, women's organizations, non-governmental organizations, trade unions, business organizations, and the like is needed; although primary health care calls for the involvement of these institutions, existing policies are not always able to accommodate them;

- there is a need to develop, through an interdisciplinary approach, a global conceptual framework which would facilitate implementing, evaluating and tailoring policy and programmes of health education to local needs;

- health education must develop along criteria different from those that have prevailed for a long time - based on a moralizing approach using "don'ts"; furthermore, health care providers have tended to encourage people to want what they themselves felt they should want; rather than attempt to understand the needs of the individuals and communities and helping them reach goals of their own choosing;

- an objective of health education is to promote an exchange between two cultures, that of the professionals, and that of the lay people, bearing in mind two things: firstly that this exchange occurs with people as they are and not as the health professionals would like them to be, and secondly that any progress in the field of health is relative;

- a new image of health education must prevail, thanks to new approaches and new technologies involving both professionals and lay groups;

- health education is an interdisciplinary and intersectoral process that has as its final goal the promotion of health in its broadest context, i.e. not merely as a health phenomenon but as a social and cultural, an economic and technical, and finally a political phenomenon;

- health education should not promise more than it can attain; that said, it must be realized that the WHO Seventh General Programme of Work covering the period 1984-1989 indicated that the role of information and education for health would be more prominent than ever before.

9. RECOMMENDATIONS

New policies for health education in primary health care must include clear, unequivocal recognition of the need for the active involvement of the community in health planning and in the implementation and evaluation of appropriate services and technology. Of the many recommendations suggested by individual participants, the following are the ones most generally applicable to policy everywhere, regardless of the stage of development. Even these few may need further adaptation to fit specific circumstances.

To fulfill its task effectively, health education should receive a strong mandate from national policies that:

1. facilitate that type of institutional framework and the economic and legislative supports that will bring about an environment in which people can exercise their "right and duty to participate individually and collectively in the planning and implementation of their health care"[1].

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

3. recognize that health is not strictly a medical issue, but environmental, cultural, biological, social and economic as well, and provide therefore for the research, training and intersectoral cooperation necessary to strengthen health education and self-reliance in all aspects of development;

4. assure that there is a central unit within the framework of health services, staffed by specialists in health education, with resources required to carry out its functions, and placed on the same administrative level as other essential health services, to permit access to all other units concerned with education for health;

5. provide for the integration of health education, including the effective utilization of communication media, at those stages of the health care process - from planning to monitoring and evaluation - where the effective involvement of people and their increased self-reliance requires additional understanding and skills;

6. give full importance to the coordination of public information and education for health with education in general, recognizing that these must be mutually supportive and that health education in the schools at all levels is essential to the future development of primary health care strategies;

7. assure that health education responsibilities are incorporated in the functions and training of all health workers, teachers and media personnel as well as related personnel in other sectors;

8. specify without ambiguity that the fundamental objective of information and education for health and of community involvement is to help each individual, each family, each community to exercise their right to achieve the harmonious development of their physical, mental and social potential;

9. recognize that this and other objectives of Health for All by the Year 2000 and primary health care, and consequently of health education, will not be achieved unless specific attention is given to the role of women in the promotion of health, and to their need for health education to perform this function.

For WHO, the recommendations made by the Technical Discussions reflect an endorsement of the new emphasis on information and education for health in primary health care by continuing and further strengthening activities in which WHO will:

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[1] Declaration of Alma-Ata. Alma-Ata 1978. Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. World Health Organization. Geneva, 1978 ("Health for All" Series, No 1)

10. collaborate with Member States in developing information and media that will heighten the sensitivity of decision-makers to the need for health education in promoting community involvement in primary health care, and help to strengthen the political will to support new policies on these matters;

11. cooperate with Member States in strengthening health education services so that they will be able to assist all other services in their public information and health education functions, recognizing that this will require the allocation of more resources within WHO staff;

12. facilitate community involvement in planning and evaluating primary health care programmes by developing guidelines, manuals and training materials disseminated to countries for adaptation;

13. strengthen intersectoral cooperation through continuing collaboration with UNESCO, UNICEF, FAO, ILO, UNFPA, the World Bank and other international and non-governmental organizations in further supporting health education in primary health care in all its aspects; and

14. regularly organize seminars, training programmes, workshops, and meetings on health education on global, regional, and national bases.

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