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TECHNICAL DISCUSSIONS

HEALTH EDUCATION WITH PARTICULAR REFERENCE TO THE PRIMARY HEALTH CARE APPROACH

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Very few concepts or events in the history of public health have received so much universal support - even if not universal implementation - in such a short time as has the concept of primary health care. It is imperative, therefore, that one should consider the philosophy, mission and targets of this approach. There are two basic reasons why the primary health care approach has received such wide acceptance; one philosophical, and the other that it would seem to be the best and most practical way of providing health care to the multitudes of people who have thus far been deprived of their right to health.

In this paper an attempt will be made to look at the concept of primary health care from the philosophical point of view and to describe some of the health education premises. Although the premises which will be stated are not new - they have been accepted for several decades - they will become clearer when seen within the context of primary health care, which itself cannot be separated from other activities aiming at the development of man and the enrichment of life.

I THE PRIMARY HEALTH CARE APPROACH

It is safe to predict that the concept of primary health care will be considered as a turning point in the history of public health. For it is not just another alternative approach to the provision of medical care which is becoming fashionable, nor is it an interim measure. Although the problems and ways of dealing with them may change according to the time, space and culture in which the primary health programme is implemented, the very concept itself has introduced a new dimension, a new philosophy and a basis for the practices to follow. This philosophy changes the previous approach to medical care - an approach which was totally, or at least almost totally, vertical and individualistic, coming down from the top, unquestioned and unchallengeable, with the object of relieving pain or protecting the individual or community and with little or no reference to the other preoccupations and needs which determine the life and life style of the individual, the family and the community. Any plan for health care based on the idea of man, woman and child as "the central and interacting theme" within the context of the community needs and values is bound to become a landmark in the history of public health, and this is what the primary health care approach essentially is. It involves to a great extent the integration of "consumer-provider" as an inseparable part of the whole. It is within, and basically within, this context that one should look at health education.

The primary health care programme and WHO's role in this programme have been described in WHO's Sixth Programme of Work as follows:(1)

"Detailed objective

"To promote, within a comprehensive national health system appropriate to the conditions and needs of each country, the provision of primary health care to the whole population, ensuring that now underserved populations and high-risk and vulnerable groups are properly served.

"The targets should be to ensure that an adequate quantity and quality of health care is made available to all members of a community or all inhabitants of a country, as well as maximum coverage of underserved populations, and high-risk and vulnerable groups by primary health care.

"Approaches and activities

"WHO will promote the establishment of a primary health care system as part of a comprehensive health service. This system will comply with the following general principles:

"- It must be tailored to the customs of the communities concerned and must meet their actual needs;

"- It should be fully integrated into the national health service, or be supported at other levels by the work of peripheral units in areas such as technical backing, supplies, supervision and attention to patients requiring special care;

"- In the countries concerned, primary health care activities should also be properly integrated with other areas of community development such as agriculture, education, public works, housing and communications;

"- Most medical and health activities within the primary health care context should, as far as possible, be carried out at the most peripheral level of the health service by the staff best trained for the purpose....

"As far as developing countries are concerned, WHO will appeal for co-ordinated technical and financial assistance for the development of primary health care and for the training of first-line health personnel.

"It will participate in the collection, interpretation and dissemination of data for identifying health needs and priorities relevant to primary health care and for evaluating primary health care services.

"It will promote the active participation of the population concerned in the planning and implementation of health activities to ensure that such activities are properly adapted to local needs and priorities, and that any decisions on action to be undertaken should result from a continuing dialogue between the population and the officials of the various services.

"Primary health care services will be used, in particular, for the implementation of WHO's Expanded Programme of Immunization.

"WHO will define particularly vulnerable and high-risk groups and will identify their particular problems with a view to formulating policies for making primary health care available to such groups. Specific programmes will be developed..."

This concept of primary health care, as stated by the Director-General in his Report to the Thirtieth World Health Assembly on the Work of WHO in 1976[2], was that "prompted by the realization that conventional health services were not meeting the needs for essential health care, a search for new ways was initiated .... The Twenty-eighth World Health Assembly proposed a promising solution in 1975 by adopting the primary health care approach (resolution WHA28.88), on which further guidance was provided by the next World Health Assembly in 1976 (in resolution WHA29.74). The primary health care approach represents a reformulation of some of the basic tenets of public health:

"The approach aims at promoting the individual and community self-reliance. It implies that people should act to improve their own health rather than rely on others doing so for them".

This concept, this type of thinking, thus did not happen overnight. It resulted from an evolutionary process growing out of the dissatisfaction of men and women with conventional methods of health care services. It is not a "poor man's" health care system but a public health movement based on the potential capability of man, every man, to make a reasoned choice in order to improve his own lot and that of his fellow men. It is built on the premise that, biological determinants being taken for granted, man has a certain degree of freedom of choice, from among alternatives, for improving his own health, irrespective of his social standing or of "his ability to read or write a single message" - as literacy was once defined.

Nor does this emergence appear in the so-called developing nations alone. An indication of the emphasis being placed on the role of individuals in the prevention of

disease and promotion of their own health and even in their own treatment, heretofore reserved for a select élite, can be found in the number of books, papers and other publications appearing under the title of "self-care" or similar titles written during the past several years in the more developed countries. In fact, Fry[3], summarizing a few British studies, states that "without self-care any system of health care would be swamped". For example, the role of the individual and families in personal hygiene and improvement of nutrition, both highly essential in the prevention of disease and promotion of health, would not necessarily imply medical intervention if individuals were educated and motivated properly.

This development is fostered not merely by the fact that health workers and services cannot cater to the needs of all, but, more importantly, by the fact that no one can be made healthy and kept healthy against his own will or without continued involvement. "Health cannot be imposed; it must be attained"[4].

Whereas the idea of involvement of the individual in health and developmental work is not a new phenomenon, in the primary health care approach it takes a new and far more challenging slant. In the old ideology, "involvement" was conceptualized as an effort on the part of individuals to assist in the implementation of plans already made and targets set vertically. This kind of involvement prescribed passive acceptance of services and provision of support in cash or in kind, in providing money for a pump, digging a well for a water supply, or laying bricks for a health centre or a school. It was a means of cheap labour and was aimed mostly at rural areas. The dynamics of a changing society, however, require much more than mere acceptance, allegiance and unpaid labour. The new type of involvement required identification with the movement, which grows only out of involvement in thinking, planning, deciding, acting and evaluating, focussed on one purpose, namely socio-economic development, of which health is only one part - a major part nonetheless. It, indeed, is a mental process just as it is a physical one. But more important to the process is what this line of thinking implies. This is where health and education meet - i.e. in a continuing process of preparing people to make a "reasoned choice", their choice of areas for health improvement, so as to be able to cope with the ever-changing problems of a dynamic society.

This attention being given by governments to the formidable potential power of an individual to transcend himself is a point of no return in the history of health and, as stated before, not just another alternative. For here, man, in an awakening and changing society, becomes a person who reacts to the community and to the programme

and is subjectively involved in change, not merely the object of it. He will have to be helped to see his needs within a logical perspective - logical from his point of view and logical, reasonable and attainable from the vantage point of the community.

II HEALTH EDUCATION - PERSPECTIVES AND CHALLENGES

Success in the prevention and control of disease and in the promotion of health depends, inter alia, on an informed, motivated and involved individual and community - i.e. individuals and communities that are:

(i) adequately informed so as to be able to utilize available services and facilities, and

(ii) adequately motivated to demand additional justified services and to assume an active interest, participation and leadership in the protection and promotion of individual and community health.

Thus, a correctly informed and adequately motivated public is an essential component of a successful health service and development complex. It is on this premise that health education is based, and it aims at the voluntary and continuing adoption of good health practices by individuals and communities. Again, it is on this premise that a number of attempts, erroneous and non-productive at times and based on preconceived assumptions, have been made in educating the public. For in health education, just as in the general field of health, "too much emphasis has been given to the transfer of technologies and models of health development that have proven too uniform and in some cases counter-productive"(5).

Health education should be considered as an intervention and as an activity aiming at assisting people to participate actively in health matters relevant to their personal and community interest on a sustained basis. Not always, however, have such attempts resulted in success. Whilst successes - and there have been many on a large scale - have been taken for granted, the failure of a number of other attempts has caused some health administrators to look at health education with a dubious eye. But many of these attempts were doomed to fail even before they started, since they were based on premises not universally valid or not valid for the particular circumstances.

A main reason for the failure of health education to meet expected results has been the fact that many of the programmes have been superficially planned on the following two major assumptions:

(a) that a man's behaviour is rational, and

(b) that a positive high correlation exists between knowledge and behaviour. Thus, adoption of health behaviour becomes the consequence of the process of knowledge leading to attitude leading to practice (known as "KAP").

Although these two assumptions are valid under certain conditions, neither stands the test universally. The great diversity of social organizations and cultural values resulting from the interplay of different human attributes(6) with the immense variety of circumstances man encounters, makes a priori judgements and stereotypes in health education futile.

The KAP premise implies that knowledge leads to attitude change, which leads to change in behaviour. Hence, the failure in the output indicator (behaviour) is interpreted as the failure of the input (education), which would seem to be a logical deduction. Thus, the emphasis on sense-aid materials facilitating knowledge. Although, depending on the complexity of the problem, there are some cause-and-effect relationships between K, A and P, the process is not always a one-way one, and visual aids are not necessarily omnipotent, as they were once considered to be.

As the Regional Director stated as early as 1964 in his Annual Report:

"A gradual but very significant change is taking place in the method of approach to rendering health education services in most of the countries of this Region. Health education materials, long considered as potent change agents in health endeavours, are giving way to more direct communication with people. Audiovisual aids, such as posters, films, film-strips, pamphlets, radio and television programmes are still being produced but not on the mass scale production of some years ago. They are being continuously refined to meet specific purposes in terms of immediate or long-term health needs in the socio-ecological conditions. Mass gatherings and propaganda techniques are replaced by small group discussions, where a two-way channel of communication is established and the process of education becomes manifest.

"This movement is in line with modern methods of health education and in conformity with the outcome of the WHO Expert Committee Report on Health Education of the Public which defines the aim of health education as: 'To help people to achieve health by their own action and efforts'. Health education begins, therefore, with the interest of people in improving their conditions of living, and

aims at developing a sense of responsibility for their own health betterment as individuals, and as a member of families, communities or governments".

The KAP phenomenon, so popular, especially in the early days of family planning programmes, revived another premise which originally had proved effective in the field of agriculture - the premise of the adoption model. The model presupposes a sequential process starting with awareness of a method or the need, taking an interest in it, passing through a period of trial and evaluation, and finally, adoption. This process does not foresee failure or discontinuation if all steps are carefully followed. The model may be a workable one when one is adopting a new seed, a new fertilizer or a new agricultural technique. But transplantation of this approach to a delicate behavioural problem, and such an intimate one as family planning, without due consideration of all other intervening forces, has resulted in flagrant failure. Why? The main reason lies in the fact that although "change of attitude" had become common parlance, little consideration was given to that driving force in man which determines, shapes and reshapes his attitudes - that is, his values. For it is man's values, not necessarily his needs, that determine his behaviour.

There have been many studies on attitude and attitude formation. Some have developed mathematical formulae to predict one's attitude toward any given action or event.* No matter what other parameters are considered, there is unanimity amongst most investigators that values - social values - are determinants of behaviour in most cases, since, although values do not push a man towards an action, they nevertheless pull him, and man "is able to live and even die for the sake of his ideals and values"(8). Further, they all agree that a value stands behind every attitude, and a change in attitude does not take place without a change in values.

Health education activities, therefore, have a greater chance of success when they are based on value systems, i.e. making health a "valued asset"(9). For example, in matters dealing with parents in respect of the health of their children, if health per se is not considered a value - and it seldom is until it is lost - the parents' love for children can be used as a social value in dialogues with them. The fact that, in many countries of the Region, mothers often resort to giving alms when a child is ill is indicative both of their love for their children and of the lack of access to information on, or lack of trust in, the curative power of medicine.

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*For example: Rosenberg, Milton, J., in Cognitive Structure and Attitudinal Effect, and Matthews, C.M.E., in A Theory of Behaviour Change

This apathy and fatalism ascribed by some Westerners as being characteristic of people in this Region should not be considered as an insurmountable barrier to making innovations in health practices. Fatalism is not necessarily only a cause, but also can be an effect, of unmet health needs.

Even resort to magic is, according to Malinowski,(10) "to be expected and generally to be found whenever man comes to an unbridgeable gap, a hiatus in knowledge, or in his power of practical control, and yet he has to continue in his pursuit...Standardized traditional magic is nothing else but an institution which fixes, organizes and imposes upon the members of a society the positive solutions in those inevitable conflicts which arise out of human impotence in dealing with all hazardous issues by mere knowledge and technical ability".

This type of thinking continues the perennial chain of malevolent events which the public health workers of the 1950s termed the "vicious circle of ignorance - disease - poverty". Health education, when planned on an assumption of the integrity of man - any man - and his capability to cope with many problems of everyday life, can substantially contribute to breaking this chain reaction.

Dynamic health education should create both an understanding and a commitment - an understanding of the potentiality of man in solving the problem and his commitment to work toward what he aspires to be, in the knowledge, belief, hope and conviction that change is possible. This is nothing that can be imposed from above or by an outsider; it is an upward, not a downward, movement, which should start from the people - a mental process that can happen only when members of a community have determined on an aim and have decided to work together to achieve it. Basically, this type of education is either conditioning or deconditioning, or both. According to Paulo Freire,(11) "Although it is customarily conceived as a conditioning process, education can equally be an instrument for deconditioning... Education can be deconditioning - for man, essentially a conditioned being, is also, essentially knowing what conditions him, capable of reflecting on his action and behaviour and perceiving his perceptions".

As a simplified illustration, there is the new trend in anti-smoking campaigns. Cigarette manufacturers have always tried in their advertisements to associate smoking with popularity and elegance, by depicting artists and other famous personalities smoking cigarettes, and thus have conditioned youth to associate smoking with these two attributes, which are considered desirable. Anti-smoking campaigns, using the same techniques to try to decondition the public from past information, are nowadays

conditioning the younger generation to associate athletic success (which is an equally important value for them) with abstention from smoking. We are thus presented with pictures of athletic champions affirming that they do not smoke. Education in this way becomes a process enlarging the individual's capacities as well as his knowledge.

* * *

Health education, thus, does not imply the memorizing of an assembled group of words bearing a meaning characteristic of the didactic or traditional type of teaching(12). In didactic teaching, the emphasis is on listening, observing and reading, and the isolated elements, usually factual, have a "part to whole" relationship; they are teacher-selected learning activities, which fail to utilize the dynamic potential of the learner, as they discourage self-expression. This system of education is likely to produce a disciplined individual who has acquired only the isolated facts and skills needed to meet the requirements of a traditional society. Unfortunately, many attempts at health education, especially school health education, are based on this system, and it is no wonder that they are often unsuccessful.

This failure of the didactic system to meet the needs of a rapidly changing society gave rise to another system of teaching which was marked by a great degree of freedom, insisting on "learning by doing". The outcome was highly unpredictable, resulting frequently in socially ineffective personalities, unable to make the necessary personal and social adjustments. This laissez-faire approach to teaching definitely does not meet the needs of individuals in the changing and challenging world of today.

As opposed to the two approaches described above, progressive education involves wanting-planning-doing-evaluating; unlike the traditional school, which believed in "part to whole" relationships, this system stresses a "whole to part" relation. Once the development is seen in this light, the logic of the new trend towards regarding health planning as a part of the total socio-economic development, and not as a separate issue, becomes obvious.

Progressive education provides an excellent opportunity for mutually beneficial individualization and specialization of learning, and for guiding the learner towards increasingly effective self-appraisal,self-discipline and self-direction. This type of education does not automatically result from the demonstration of a film or explanation of a poster or talk, nor is it the outcome of "motivational manipulation", regrettably transplanted from the field of commercial advertising to human development.

Education, as stated before, is to create a commitment. It is only after such a commitment has been made that true health education can take place. In progressive education, the "teacher" and the "student" constantly exchange roles. This is one of the main reasons why, in the primary health care approach, the emphasis is on the use of local personnel - not only because they speak the same language but, more importantly, because they speak on an equal level and in a give-and-take situation, i.e. in true communication with one another. Furthermore, the fact that they are a part of the community and are constantly present in the area greatly facilitates effective communication with the people. Because this concept was not fully understood, many community development and extension workers of the 1950s failed to achieve their aims. At that time they were normally not a part of the community and were not involved with it nor identified with it. Like travelling salesmen, they went from village to village - alienated, detached and aloof, "helping people to help themselves" - to use a much misused phrase - spreading the seed of change that seldom bore fruit.

Education is thus a commitment resulting from identification with the community; a change from the "me" to "I" and the "us" to "we" concept, when the people and the communities are the subjects, not the objects, of health measures, and the developments conceptualized are "community-centred" rather than "problem-centred".

In order to achieve success, the role of health education vis-à-vis each particular health problem is unique. It might be described as consisting of the following seven complementary steps:

(1) analyzing peoples' values, interests and needs as they relate to health, especially within the perspective of other priorities as seen by them;

(2) determining the prevailing practices;

(3) defining specific behavioural objectives in health matters;

(4) identifying factors, positive or negative, which have an impact on health practices, such as culture, attitudes, other constraints, etc.;

(5) determining existing and needed resources;

(6) providing educational experiences based on the above five items; and

(7) evaluating the impact of education on health-related behaviour and modifying the attempts when indicated.

These steps would all be an essential part of any systems approach to the solution of a health problem.

What has to be accomplished - the change which should be introduced - is dependent on a knowledge of the existing practice and of the reasons for it, and also of the ways that behaviour might be modified or reshaped, or changes in personal or social values introduced.

III THE IMPACT OF HEALTH EDUCATION AND THE METHODOLOGY OF INCLUDING IT IN THE PRIMARY HEALTH CARE APPROACH

From the considerations brought out in the above two sections of this paper, a number of points will emerge:

1. Implicit in the concept of the primary health care approach is the necessity for having a workable short- and long-term plan for the health education component. Primary health care cannot be successful without community involvement and participation. Real involvement of the people and the community is achieved when, among other major activities, health education has been given due consideration.

Health education can contribute to the initiation and sustenance of activities at various levels: at the local level, by assisting the community in self-appraisal, by determining the needs and in working towards satisfying the needs; at the provincial level by providing the necessary support, especially with reference to the health education component of technical inputs, and at national level by influencing the decision-makers to give priority to the approach and to help to create a national will for development.

2. Whilst a workable plan of action for health education is essential, there are a number of other considerations. A joint UNICEF-WHO study on community involvement in primary health care[13], in which nine successful major programmes of community involvement located in ethnologically and geopolitically different areas of the world were examined, led to a number of conclusions, which were briefly outlined as follows:

"(a) Specific government policies to encourage community participation were found to enhance the extent and depth of participation.

"(b) Maximum community participation was achieved when limited local resources were complemented by external resources, especially those provided by the government.

"(c) Government administrative decentralization and regional planning appear to have given an impetus to community participation.

"(d) Specific government programmes for rural and urban development were found to favour community involvement in primary health activities.

"(e) Development programmes in specific sectors have served as an entry point for the introduction of comprehensive programmes, which have encouraged community participation in wider developmental activities.

"(f) Non-governmental organizations provided channels for community participation.

"(g) The capacity of communities to undertake projects was seen to be enhanced by the presence and ready accessibility of regional and national communications and other infrastructures.

"(h) The ability of the community to generate activities and participate in them was dependent upon the availability of local resources and the extent to which they could be mobilized.

"(i) Traditional structures formed the basis for expanded community participation efforts.

"(j) The community participation process was accelerated when there was readiness for change.

"(k) Awareness of the benefits of community participation stimulated further participation.

"(l) Projects and activities where children were the immediate beneficiaries were used as a starting point for further community efforts.

"(m) Ethnic and cultural homogeneity of the population and the absence of extreme factionalism or inter-group friction were observed in most of the communities studied.

"(n) The community participation activities observed covered a varied developmental range."

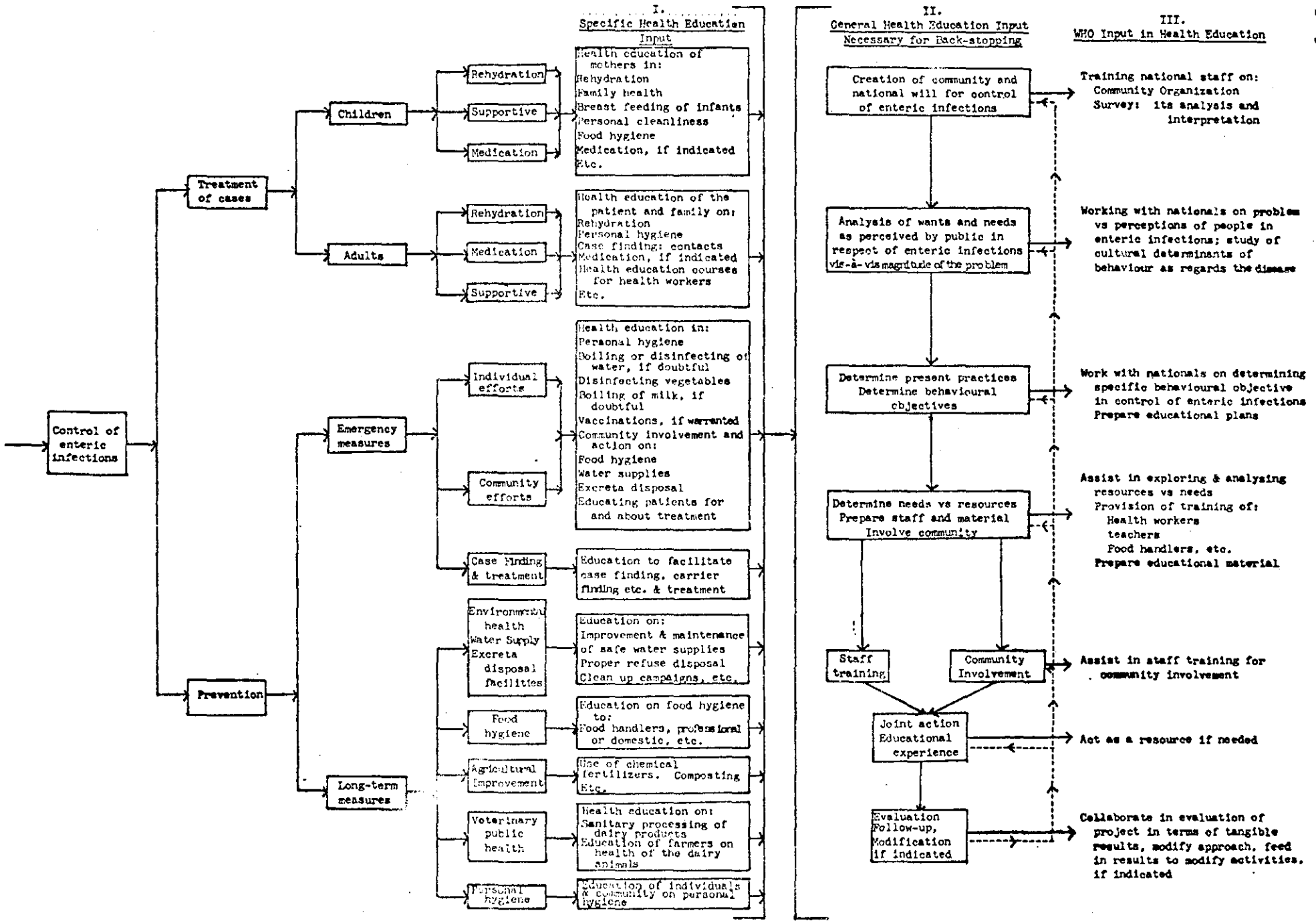
3. The health education problem should not be separated from all other issues within the life of individuals or of communities. In fact, as stated above, any successful attempt in education depends on a "whole to part" rather than a "part to whole" relationship. As an example, one might cite health education in the control of enteric

infections, which are the main cause of infant mortality in most countries of the Eastern Mediterranean Region. As can be seen from the accompanying diagram, their control depends upon two issues - treatment and prevention - and in each case a number of actions are simultaneously needed, some of which, such as the use of human wastes in the field of agriculture, etc., are not necessarily directly within the field of health. Thus, collaboration of all agencies is necessary in order to provide all of the components essential to deal with one specific disease. Furthermore, the health education aspect of each one of these components is listed and should be integrated into the entire activity and provided by the community health worker, along with his other activities. The community health worker, however, will need guidance as well as moral and technical support, both at the level of the province and at the national level. These should be provided by the health education specialists appointed. The integrated service that might be given by that time is shown in Column II of the diagram.

4. Health education at the local level must be carried out as a part of other activities; it does not operate within a vacuum, as has so often been stated. Recent studies, notably in Egypt[14], India[15], Iran[16], and Sudan[17], have indicated that programmes have a greater chance of success when they are carried out by a person from within the community who has received some training. Furthermore, a face-to-face, one-to-one relationship has also been one of the main reasons for success in health activities in a number of other countries, including China, where education and communication take place on a horizontal level as opposed to a vertical level of teaching and preaching. Studies in India suggest that an auxiliary nurse-midwife with some education can be really effective in health and family planning. Ronaghi,[16] explaining a primary health care approach programme in Iran, attributes the following successful activities to a group of men and women who had received six months' training following their primary education and who were employed in their own locality to work in the field of health:

> "...Within ten months of deployment, the number of family planning acceptors rose from 8 per cent to 21 per cent of the population at risk. Improvements to water supplies have been effected in 50 per cent of target villages. Sanitary improvements have been made to 35 per cent of the houses and 88 per cent of the toilets in those villages. Demographic characteristics, class, rank and place of residence of village health workers appear unassociated with village differences in levels of achievements. However, availability of material resources

HEALTH EDUCATION COMPONENT IN THE CONTROL OF ENTERIC INFECTIONS



and actual time spent by village health workers on the job may be factors influencing the differences in outcome between villages."

5. Any educational or development work on a community level should depend on the active involvement of women, especially mothers. It is an illusion to think that schools are able to undo the harm done at home. The formal educational system at present is based not on creation of a change, but on maintaining the status quo. Furthermore, even if a child attends school, by the time he reaches school age most of his habits are formed. As a case in point, nutritional habits, despite a strong input in nutrition education in schools, have, in most places not undergone a drastic change. Mothers, therefore, are the key to a successful health education activity.

6. There is a need for the people to make a choice from amongst alternatives or priorities in health services as they themselves see them. If they start to work on a problem to satisfy what they consider as their most important need, this will make it easier for them, later, to work on other, perhaps more difficult, problems, since accomplishment in one sphere motivates individuals to begin other activities. Different political systems may prescribe forms of community participation, but it is agreed that a certain degree of decentralization is necessary at the local level so that communities may base their programmes on felt needs and their own priorities and therefore identify themselves with the problems. Different communities also look at their needs from different points of view. For example, in Yugoslavia, where participation in community affairs is both a right and a duty, it is interesting to note that in seven contiguous communes in Cestica of the Varazdin area, each commune expressed a different felt need; each of them worked on its own felt need but they also collaborated with the sixty other communes of the Varazdin area in building a surgery ward which, incidentally, had not been suggested to them by the medical authorities(18).

7. The entry point in a developmental activity has a great degree of importance. Not only should the people's value orientation be carefully considered, but also the fact that the activity eventually decided upon will be more successful if it is something that does not require too long a time to reach a successful conclusion, and if it also makes some visible change in the socio-economic status of the people. In this connexion, reference is made to Dr Hydrick's work(19) in Indonesia in the 1920s, in which he stated that if such activities in collaboration with people were carried out in fields such as malaria or hookworm, two debilitating diseases, the action would result in an economically more viable population. The same logical approach has been adopted

by a number of other countries embarking upon the primary health care programme. Reference might be made, for example, to the programme in the Sudan, in describing which the following is stated:

"Line of action for change through the Primary Health Care Programme and related community development

"In selecting the various possible alternative aspects of health development an overall health plan needs to be worked out that recognized the wishes and needs of the vast majority of the people who live in small rural communities.

"These communities must become more articulated and socially better organized in the first instance before they can be understood by health planners. In the short term, this will mean the organization of an administrative structure at a very simple level so that community opinion can be systematically built up. Gradually, the promotion of village development committees becomes an essential asset in this process. Later, they become valuable in the transmission of information both ways, together with the SSU Basic Units. Thus, primary health care is developed as a result of the expression of rural needs and then the strategies are communicated back to the communities. The place of VDCs and SSU Basic Units in this avenue for change is essential and provided a greater understanding by all of the socio-economic problems involved.

"When it comes to implementation, a sense of urgency is required by everyone involved. Political, social and economic philosophies need explanation and discussion in order to provide motivation and then, more specifically, reorientation of all health workers is needed to new technical concepts and practical methods. The acceptance of simple buildings as a base for rural health work that are suited to the village environment within the economic framework of rural Southern Sudan requires explanation. In this way, limited resources are not squandered on a few prestige units but numerous inexpensive facilities provided and funds spent on the appropriate training of the staff to run them".

The very fact that in a number of countries of this Region one out of every five children born dies of enteric diseases, which can be drastically reduced by simple measures if people are adequately educated and motivated, stands as evidence of the lack or failure of dynamic health education. Malnutrition is another issue worthy of consideration. It is universally known that people, especially school-age children, suffer from this condition, which can even occasionally be spotted without clinical studies; yet even what they eat is consumed in great part by the helminths and is not absorbed

by the child. In a study in Africa,[21] for example, it was concluded that when students were routinely given three tablets of thiabendazole three times during an eight-month period, as opposed to a control group which received placebos during the same period, the weight gain in the group receiving the medicament was 19 per cent higher than in the control group. Helminthiasis is a disease that can be drastically reduced through simple measures such a personal hygiene, proper water supply and waste disposal, food hygiene, etc. - measures requiring neither medical attention nor sophisticated educational technologies. Much can be done to alleviate these conditions by correct health education, and there are no valid reasons why such attempts in health education are not made.

8. As implied above, the production, distribution and utilization of media are not the end points in health education. Materials are only a means of facilitating understanding. This subject has been extensively dealt with in the Regional Director's paper on "Trend of Health Education Services in the Eastern Mediterranean Region"[1], in which, for example, he quotes the following from his Annual Report for 1964-1965:

> "Individuals, nowadays, should play an active role in the promotion of the total health of the community in which they are a part, a link. This, however, consumes their efforts, time and financial resources. Time has now come for communities to take leadership in the recognition of their needs and in raising ways and means of meeting them. In parallel to already existing services, it will therefore be necessary to create new ones....."

9. Individuals and communities should not be motivated towards an aim which cannot be attained. For example, if an adequate amount of a vaccine is not available, the mobilization of all the mothers to have their children vaccinated will result in a loss of faith, and the implementation of the educational aspects of future activities will only become the more difficult. Obviously health education cannot replace other services, just as the other services cannot replace health education. They are linked in efforts toward the prevention of diseases and promotion of health. There have been many instances of communities having been encouraged to determine their own priorities and being given assurances that they would be assisted by higher levels, and then, when such assistance has proved not to be forthcoming, this failure to meet the expectations of the communities has acted as an impediment to any other innovations for some years to come.

10. Above all, it should be realized that primary health care does not replace the existing health services but only augments them, and this fact should be made very clear to the communities. The inter-action of a community which is participating and is being involved in developmental activities (including health) with an improved and improving health service will definitely make the community healthier and more progressive.

11. The actual input that should be expected as the health education component of primary health care can be considered under three main headings:

(a) Informing policy-makers about the primary health care approach, its value and its place within a socio-economic programme.
Such information should aim at stimulating these leaders to help create a national will for action on the national level, as well as acceptance and enthusiasm at the local level.

(b) Health education of other community members

(i) Education for involvement. A major function of the primary health worker at community level is to make it possible for members of the community to realize that change is possible, that many diseases and unnecessary suffering can be prevented and that such a change can be attained by the involvement of each individual and, in many cases, solely or mostly by the use of community resources.

(ii) Education on specific local problems. Education of the entire community on matters of common interest, and on alternatives which might be selected for meeting the problems, with due emphasis on the advantages and disadvantages of each option, and on the education of specific groups, such as mothers, on the issues related to infant care. In this connexion, reference might be made to the manual recently prepared in a collaborative effort by UNICEF/WHO/FAO/UNESCO in the Eastern Mediterranean Region on "Family Food and Nutrition, a Manual of Priorities for the Eastern Mediterranean Region"(22), the first part of which deals with messages for mothers for the purpose of improving nutrition of children. An interesting aspect of this manual is the extent to which culture of the area, availability of foodstuffs and the economy were taken into consideration in its preparation.

(c) Health education in the training of primary health care workers. This includes not only the health education input in training but also assistance in

the production of simple manuals, guides and other technical publications so that they will be not only technically correct but also pedagogically sound. Reference may here be made to two recent WHO publications, one on the "Treatment and Prevention of Dehydration in Diarrhoeal Diseases"(23), and the other, an experimental edition, on "The Primary Health Care Worker"(24). It is interesting to note that the latter publication has devoted an entire section to "Guidelines" for adapting the contents to various field situations. In addition, the primary health worker needs regular in-service training and on-the-job, of which health education should be a major component. Furthermore, when programmes are evaluated according to their output, the impact of health education should be appraised and the approaches modified, if indicated.

IV CONCLUSION

In summary, the paper presents the raison d'être for health education as part of the primary health care approach - an approach which has been adopted not only because it would seem to be the most practical way of tackling the problem of extending health facilities to the unserved populations but because of its value in encouraging people to participate and to be mentally involved in the promotion of their own health as a part of the enrichment of their lives. This concept of primary health care must be based on community participation, which, in turn, is totally dependent on systematic health education. Health education, in this context, is not an isolated exercise that is applied only occasionally, nor is it a substitute for other needed activities; it includes the whole spectrum of health education activities, each requiring its own specific inputs, which are determined by the needs, geopolitical situation and available resources of the country.

There are a number of educational aspects to consider in the primary health care approach, but most important of all is the conviction that very often man has a freedom of choice in changing his own destiny, and this he can do regardless of his social standing, educational level, financial status, etc., for, as has been observed time and time again, man has the remarkable ability to transcend himself when his values are at stake.