FINAL REPORT

WHO/UNICEF REGIONAL WORKSHOP ON INFORMA
EDUCATION AND COMMUNICATION ON HEALTH

Manila, Philippines
17-23 March 1981
WHO/UNICEF REGIONAL WORKSHOP ON INFORMATION, EDUCATION AND COMMUNICATION ON HEALTH

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FINAL REPORT

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NOTE

The views expressed in this report are those of the consultants, temporary advisers and participants in the Workshop and do not necessarily reflect the policy of the World Health Organization.

This report was prepared by the World Health Organization Regional Office for the Western Pacific for Governments of Member States in the Region and for participants in the WHO/UNICEF Regional Workshop on Information, Education and Communication on Health, held in Manila, Philippines, from 17 to 23 March 1981.
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1. INTRODUCTION

A joint WHO/UNICEF Regional Workshop on Information, Education and Communication (IEC) on Health was held in the Conference Hall of the WHO Regional Office for the Western Pacific Manila from 17 to 23, March 1981.

1.1 Opening statements

The workshop was opened by Dr S.T. Han, Acting Regional Director of the WHO Regional Office for the Western Pacific. He stressed that the attainment of WHO's goal of health for all by the year 2000 would demand the utmost dedication and concentration of skills from the information, education and communication sectors. In his address, Dr Han said that delegates had before them the proceedings and recommendations of the first (1979) Workshop on the Promotion of Health Information. While it was necessary to assess progress since then, it was even more important to determine future goals and ways of achieving them. Dr Han stated that WHO was most pleased that UNICEF had again joined WHO in sponsoring the workshop.

The opening remarks of Mr S.H. Umemoto, UNICEF Representative, were presented in his absence by Miss Bituin Gonzales of UNICEF. In his remarks, Mr Umemoto noted that information, education and communication were at the core of the concern with primary health care. He stressed that any primary health care approach necessarily involved a host of new education and communication requirements, as compared with the needs of conventional health services.

Mr Umemoto observed that there must be stronger channels of communication between health planners and those sections of the population which they sought to serve.

He also emphasized that communication must be a two-way process, if communities were indeed to help shape their own health care. He suggested that some attention might have to be given to the scope and nature of the flow and communication within the community itself.

1.2 Workshop objectives and outcomes

In the workshop orientation which followed the opening addresses, Mr Jose C. Abcede, WHO Regional Information Officer for the Western Pacific and operational officer of the workshop, stated that the workshop was the second of its kind to be convened in the Western Pacific. The workshop aimed to strengthen health information, education and communication activities in the Region. He reviewed the workshop objectives, which were:

(1) to review the activities undertaken as a result of the 1979 workshop;

(2) to identify the scope of activities in the national health information/education programmes in the context of recent trends in communication and media reporting;

(3) to further expand and strengthen the role of the mass media in propagating the concept of health for all by the year 2000 through primary health care.
He proposed that participants should deal with three major questions relating to the strengthening of IEC programmes:

(1) Where are we now? (assessment of the situation)
(2) Where do we want to go? (formulation of objectives)
(3) How do we get there? (plan of action)

He noted that background papers had been prepared to stimulate discussions on these and other issues.

1.3 Workshop agenda

Delegates approved a provisional agenda prepared by the Workshop Steering Group (Annex 1).

Working groups were organized to discuss three main issues as follows:

<table>
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<th>Date</th>
<th>Topic</th>
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<tr>
<td>Wednesday, 18 March</td>
<td>Current status of national IEC programmes and development since the 1979 workshop.</td>
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<tr>
<td>Thursday, 19 March</td>
<td>Goals and objectives for IEC programmes by 1983.</td>
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<td>Recommendations for accomplishing the above goals and objectives.</td>
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The composition of the working groups changed from day to day to enable each delegate to interact closely and work with all other delegates.

1.4 Participants

A total of 21 participants from 16 countries attended. All were information, education or public health officers associated with health education or information ministries (Annex 2).

1.5 Election of officers

The participants elected the following officers:

Chairman                     - Mr Christopher Wong Kwan-ming (Hong Kong)
Vice-Chairman                - Mr Gordon Benjamin (Australia)
Rapporteurs                  - Ms Rene K. Silverwood (New Zealand)
                            - Mr Eliki Bomanii Momoivalu (Fiji)
                            - Mr K. Mariappan (Malaysia)
                            - Mr Ezekiel Kikiolo (Solomon Islands)
2. CURRENT STATUS OF IEC PROGRAMMES/COUNTRY REPORTS

2.1 Country reports were provided by 16 countries (Annex 3). It was apparent that, as at the 1979 workshop, there is within the Region a great diversity of health problems, health systems and IEC systems. Many countries, however, share a number of common problems and developments. The mass media approach to dissemination of health information has been adopted by all the countries depending on the media methods available. An extensive use of radio as a means of reaching outlying groups is common to many, while increasing use is being made of television where the medium is available.

Organizational approaches to mass media vary. For instance, some IEC units are an integral part of the health ministry; in other countries such services are provided by the information ministry. A variety of IEC activities are conducted within the Region. These include seminars on primary health care, mass media programmes aimed at promoting healthful living and lifestyle, training of public health staff in IEC techniques, and the development of health promotion policy. Examples were also given of two-way communication systems, such as question and answer columns in health publications. The role of other health staff in IEC programmes was noted, such as public health nurses, sanitarians and community workers.

A number of negative aspects were also noted. These include the lack of policy in support of primary health care and/or IEC activities, problems of physical isolation, lack of transportation/shipping, language and literacy difficulties, lack of manpower and training resources, and the uncooperative attitude of some mass media to health and health news.

The value of the 1979 workshop was evident in that there appears to be progress in many of the countries represented at that time. Health promotion and education have been strengthened but there have also been setbacks. There was also a consensus that government infrastructure for health promotion exists in all participating countries.

In summary, the participants identified two main problems:

1. how to most effectively utilize existing IEC resources;

2. how to develop and strengthen current weaknesses in IEC in support of primary health care.
3.1 Information, education and communication in primary health care

This paper was presented by Professor Benjamin V. Lozare, Institute of Mass Communication, University of the Philippines.

The full paper is attached as Annex 4. Professor Lozare discussed the current state of knowledge regarding IEC from a research perspective. He explained that the communicator's problem is not just to get stimuli across, or even to package his stimuli so they can be understood and absorbed but rather to understand the kinds of information and experiences stored in his audience, the patterning of this information, and the interaction resonance process whereby stimuli evoke this stored information.

Professor Lozare noted that while there are no certain answers to a number of questions about IEC support for primary health care, there are some available insights based on research and experience in related fields. Professor Lozare identified a number of specific groups in and outside the health care system for which specific IEC objectives could be defined.

He suggested that, rather than concentrate specifically on the implementation of IEC activities, it may be useful to consider a four-stage model of primary health care programmes in relation to IEC. The four stages are:
- policy formulation and clarification;
- programme research and planning;
- organization and training;
- implementation.

Source, message, channel and receiver are important communication variables. Professor Lozare noted that insights based on research findings and experience in several countries in the Region suggest a few factors which may be considered in designing effective IEC programmes.

(a) Sources

(1) Interpersonal communication is most effective in changing behaviour, especially when combined with mass media.

(2) An effective source generally has:
- credibility
- communication skills
- dedication and sincerity
- sociability
- positive character and mental traits
- peerness
- availability
- authority position
- positive physical attributes
(b) **Messages**

1. Effective messages are generally based on clearly defined communication objectives.
2. Effective messages are generally based on a hierarchy of importance.
3. Effective messages usually have minimum contradictions.
4. In most cases, appeals to individual interests are more effective than appeals to social or national interests.
5. Pretesting messages and communication materials can save costs and enhance effectiveness.
6. It is useful to package information in an entertaining way.
7. A distinct symbol or logo to identify information campaigns can be useful in establishing the coherence and organization of multiple messages.

(c) **Channels**

1. Multi-media combinations are more effective than single medium use.
2. Field workers must be supported by other channels.
3. Radio is extensive and popular but at present greatly underutilized.
4. TV and film are also at present underutilized.
5. Print remains the backbone of communication due to:
   - reader's control of exposure
   - possibility of repeated exposure
   - easy storage and retrieval
   
   But there are problems of:
   - illiteracy
   - distribution
6. Folk media can be effective tools of communication.

(d) **Receivers**

1. There is a need to identify specific audiences and establish priorities.
2. Communication effectiveness is influenced by the amount of participation allowed by audiences.
3. Group membership and group pressure influence communication processes.
Professor Lazare concluded with the following key points:

(1) Since many things cannot be changed overnight, and since certain things have to be done first before others, there seems to be a need to think in terms of a multi-stage approach to information, education and communication.

(2) The magnitude of the task (bringing about health for all by the year 2000) is perhaps larger than what most people think.

(3) IEC support for primary health care requires planning a campaign, not a skirmish.

(4) More than anything else, it is perhaps more prudent to plan before one acts on a major scale.

Plenary discussion of Professor Lazare's paper reinforced his point that greater emphasis needed to be given to planning and organizing IEC programmes.

3.2 Renewed efforts for old problems

This paper was presented by Armando J. Malay, Training Director of the Press Foundation of Asia. The paper discussed desirable goals for IEC in the promotion of primary health care (Annex 5).

Professor Malay referred to the 1979 workshop on the promotion of health information. Although the objectives and agenda for both workshops were similar, he felt two further dimensions had been added:

(1) an increasing role for IEC programmes combined with a declining availability of resources;

(2) the urgency of meeting primary health care goals by the year 2000.

Professor Malay suggested that more attention should be given to immediate pressing problems, setting aside for the moment longer-term problems. An immediate problem, he noted, was the development of adequate, trained manpower. Training programmes need not be elaborate or expensive and could, potentially, be funded by a variety of agencies.

Other problems identified by Professor Malay included:

- organizational problems;
- lack of resources and facilities;
- value orientations and traditional beliefs contrary to sound health practices;
- lack of cooperation among agencies;
- multiplicity of languages in some countries.

Many of these problems can be overcome by working together and perhaps even with the use of existing resources.

The plenary discussion focused on the need for trained and effective information workers in most countries.
3.3 Information, education, communication and Health for all by the year 2000: the need for action

This paper was presented by Mr Donald F. Treadwell, Chief Health Education and Information Officer, New Zealand Department of Health (Annex 6).

Mr Treadwell discussed ways in which IEC programmes could be strengthened to meet primary health care goals. He put forward two propositions:

(1) that because of the magnitude of the task, IEC personnel must develop a "multiplier" effect, that is, they should strengthen the capacity of other health workers to undertake IEC programmes.

(2) that there is an IEC "poverty cycle", which must be broken at some point to allow IEC to develop more fully. He suggested ways by which this might be achieved.

Mr Treadwell drew attention to a number of WHO documents which identified a role for IEC in primary health care programmes. He pointed out that WHO was quite specific about this in many respects - WHO had suggested roles and activities for the mass media and education, had suggested issues and topics which the media could focus on, and had suggested standards for media reporting. He said the media could be used in three ways to promote primary health care:

(a) promoting the concept of primary health care;

(b) providing the information and skills required for self-reliance in health;

(c) more effectively linking health care providers and consumers.

There are a number of specific tasks the mass media can undertake to promote primary health care. Some of these are already accepted by IEC personnel; others require development, for instance, training of health professionals in IEC skills, IEC research, developing two-way communication methods, and assisting specific groups to develop their own information activities.

Mr Treadwell identified areas in which improvement or development would lead to more effective IEC programmes. These are:

- development of national or agency media policy;
- identification of specific "pay-off" areas for IEC;
- audience identification and analysis;
- specific goal setting;
- development of distribution systems;
- monitoring of IEC standards;
- coordination;
- training;
- research;
- IEC organizational restructuring as necessary.
In plenary discussion, emphasis was placed on the research element: finding out more about target audiences, measuring communication effectiveness, and stimulating the interest of the research/academic community in health promotion.

3.4 What the mass media can and cannot do to promote primary health care

Mr Alberto T. Rous, Science Editor of the Times Journal, presented the fourth background paper "What the mass media can and cannot do to promote primary health care" (Annex 7) to the participants and a panel of discussants composed of Mr Antonio R. de Joya, Chairman of the Asian Federation of Advertising Associations, and Col Honesto C. Isleta, President, Association of Philippine Broadcaster (KBP).

In his presentation, Mr Rous stressed the following points:

(1) "Selling" the concept of primary health care is an exciting challenge that requires a partnership between media, government and communities.

(2) The task calls for an all-out sustained information drive using all forms of media to reach every community. Radio, television, periodical write-ups, editorials, health columns, advertisements, periodical displays, travelling shows, puppets and stage presentations, traditional or folk media, sermons in church pulpits, planned home visits, etc., all have something to contribute in the promotion of primary health care.

(3) Since the task relating to information, education and communication on health matters is so big, the private (media) sector needs to cooperate with the government media in such activities.

(4) There is a need for public information officers to be appointed, particularly in health ministries, to facilitate information, education and communication activities.

(5) There is also a need to set up national councils or information centres to facilitate these information, education and communication activities.

(6) Good rapport and linkages between the government health agencies and the mass media are necessary.

(7) The mass media can help the government in several ways, e.g. preparing the right kind of information, education and communication materials on health for the government health departments; conducting courses for health personnel and media personnel in health reporting, conducting health education, information and communication activities, and having technical and medical terms translated into simple terms so as to enable the public to understand them.
There are also certain things the media and the government agencies cannot do, e.g. the government agencies/personnel should not give the impression that the government is losing interest in the health care aspects of villages (and depressed areas) in promoting the primary health care concept; the government agencies/personnel should avoid antagonizing the mass media or the indigenous media; the mass media or government media should avoid ridiculing the traditional health practices or otherwise, and there should be no violation of advertising and media promotional regulations.

In conclusion, Mr Rous reiterated that the mass media (both private and public) can be used to launch crusades to spur action with a view to achieving the primary health care objectives.

Panel discussion

The advertising perspective

Mr Antonio R. de Joya, one of the panel discussants, spoke briefly on the objectives and purpose of the Asian Federation of Advertising Associations, which has 18 Asian countries as its members. He informed the participants that the purpose of the Federation is to upgrade the practice of advertising and marketing and to harness advertising in the effort to promote national development.

Mr de Joya expressed the view that the Asian Federation of Advertising Associations could certainly contribute towards strengthening information, education and communication activities supportive of primary health care programmes. This, he felt, could be done by providing necessary information, education and communication materials and inputs to the Federation, who could assist by securing free space or time for such materials in local or regional media such as Time or Newsweek. He was confident that dissemination of health information carried out nationwide through the print media and broadcasting media could help create awareness on health-related matters among the general public. He also suggested that workshops and national advertising congresses could be used as forums by health agencies to foster better cooperation, understanding and working relationships between the health agencies and the mass media. He also felt that organizations such as WHO and UNICEF could contribute towards achieving these objectives.

Based on the AFAA experience in development communication, Mr de Joya noted that approaches/methods which combine entertainment and development communication such as dramas on radio/television and comics seem to be more effective in securing support from advertisers than dull documentaries.

The broadcast media perspective

Mr Honesto Isleta, President of the Philippine Broadcasters' Association, noted that the broadcast media such as the radio and television have largely contributed towards attitudinal and behavioural changes relevant to the development of the community and countryside.
Mr Isleta observed that both the public and private broadcasting agencies could contribute significantly in the promotion of primary health care programmes. Although the private/commercial broadcasting media are usually profit-motivated, Mr Isleta noted that they can certainly make positive contributions in the promotion of primary health care through integration of health messages in radio-TV dramas and in commentaries and news programmes. Governments can help the broadcasting media by giving them encouragement instead of merely dictating to them on what they should do. Incentives in the form of tax exemptions for broadcasting equipment purchased, etc. should be given to encourage the private broadcast media, to participate in information, education and communication activities in the primary health care or other health programmes.

3.5 Strengthening government information, education and communication programmes in health: the need for coordination and training

In her paper, Mrs Natividad Nuguid, Officer-in-charge of the Inter-Agency Projects on Agricultural and Rural Development, National Media Production Centre, focused on the need for coordination and training in government information, education and communication programmes in health (Annex 8).

Mrs Nuguid pointed out that governments should plan out their information, education and communication campaigns thoroughly, define their objectives and audiences, and at the same time take stock of the resources available. She noted that planning must involve the community and its leadership.

Media play a vital role, not only in disseminating information, but also in crystallizing opinion about development and in galvanizing a community to action.

However, in many less developed countries, media have a limited reach in isolated rural areas. Low-cost IEC materials may therefore be useful in relieving the health worker of some of the burden of explaining health programmes.

Mrs Nuguid stated that coordination is vital in the orchestration of IEC efforts so that messages will not be cancelling out each other out; so that unnecessary duplication will be avoided and therefore greater economy effected; so that information may be given in the right doses, at the proper time and to the right audience.

She observed that extension workers, who will bear the brunt of the work of introducing primary health care, will certainly need all the training they can get in communication skills, in organizational skills and in the subject of primary health care itself.

Other key points which Mrs Nuguid made included:

(1) The need to view health in the light of the total development programme.

(2) The need to involve people in the total development process.
(3) The need for feedforward and feedback mechanisms to ensure full participation of people in planning health programmes.

(4) The need to avoid "a revolution of rising frustrations".

(5) The need for use of non-technical language and comprehensive symbols, images and goals.

(6) The need for government to resolve or minimize inequalities in communication facilities.

Panel discussion

Mrs Leonor Zamora, Health Adviser, Office of the Minister, Ministry of Health of the Philippines, reinforced the observations of Mrs Nuguid regarding the need for coordination and training in health programmes.

She also stressed the need for careful planning of training and IEC programmes. Planners should be more realistic and recognize the constraints faced by most government programmes.

Mr Lino Atienza, Chief, Regional Operation Division, National Media Production Centre of the Philippines, also supported the remarks made earlier on the strengthening of intersectoral linkages.

Mr Atienza noted that complementation in the efforts of various extension workers would strengthen the government's "assault" on problems of communities.

He suggested the organization of speakers' bureau to maximize the use of human resources and the reorientation of extension personnel to see themselves not only as community extension workers but as community organizers who should try to "xerox" or duplicate themselves by training or organizing the leaders of the community to take more responsibility in the development effort.

Mr George Dorros, Management Development Officer, General Programme Development, WHO Regional Office for the Western Pacific, concurred with the opinions expressed by Mrs Nuguid and the other two panel discussants.

Mr Dorros pointed out that the concepts of primary health care call for a rethinking of basic ideas concerning health. The first component in the health system that requires modification is the health profession itself, which needs fundamental reorientation and restructuring towards the basic principles of primary health care. The second component that requires changing concerns people and communities, to include their perceptions and behaviours relevant to primary health care. A basic redefinition and rethinking of the concept and requirements of technical information concerning health is also perhaps useful.
Other discussion/reference papers

In addition to the background papers, "Communication: Operational arm for health development," a paper contributed by the Division of Information at WHO Headquarters, Geneva, to the workshop, also served as a reference and guide for discussion. Likewise, the "Revised Report on Regional Policies and Strategies for Health for All by the Year 2000", originally issued as a working document for the thirty-first session of the WHO Regional Committee for the Western Pacific, held in Manila in September 1980, was also used as a reference paper for the workshop.

4. SUMMARY OF WORKING GROUP DISCUSSIONS

4.1 First Working Group day (18 March) - Annex 9

Delegates were asked to identify progress in their countries towards the goals identified in the 1979 workshop, other developments in information, education and communication, and current constraints on information, education and communication at national level. The specific questions put to delegates were:

1. Attached is a summary of the recommendations of the 1979 workshop on the Promotion of Health Information (Annex 10). To your knowledge, what steps have been taken to realize these recommendations in your respective countries?

2. What other steps along the lines of information, education and communication have been taken in your country to promote primary health care since 1979? Please assess the status of information, education and communication support of primary health care in your country. The following outline may be used as a guide to your discussion:

(a) development of IEC policies and plans
(b) development of IEC programmes
(c) development of IEC strategies
(d) development of resources:
   (i) people - number and skills;
   (ii) IEC support materials, e.g., posters, brochures, leaflets, slide - tape presentations, etc.;
   (iii) IEC facilities and hardware;
   (iv) IEC linkages with other related sectors and institutions.

3. What constraints/problems, if any, hamper IEC support to primary health care in your country?
4.2 Second Working Group day (19 March) - Annex 11

Working groups identified goals for information, education and communication in promoting health care by 1983. Participants were asked:

"What should information, education and communication accomplish in promoting primary health care within the next two years? Please state in clear and measurable terms information, education and communication goals and objectives for 1983 in both national and regional contexts. Please specify information, education and communication goals and objectives in terms of specific target audiences and their respective priorities."

Reports from each of the three working groups were provided and are summarized as follows:

- All three groups emphasized the need for political support and commitment at a high level. They felt that strong support for both primary health care concepts and information, education and communication programmes was essential.

- The important role of health personnel was also emphasized. A top priority was considered to be training of health personnel in primary health care concepts and in appropriate communication skills. Various mechanisms were suggested for this, including national, WHO regional and sub-regional workshops.

- Improvements in media coverage of primary health care/information, education and communication programmes. Training is considered essential for this as is motivation of mass media personnel and closer liaison by health authorities.

- Discussion groups also identified the community as having a key role in primary health care/information, education and communication promotion. Problems of community motivation were discussed, together with the need to attend to cultural minorities in communities. To supplement current IEC resources, it was felt that the private sector/voluntary organizations, community leaders and influential groups could be more fully involved in IEC programmes.

- The problem of inadequate IEC resources was common to all groups. To make best use of such resources, priority targets were identified for the Region. These are:

  (a) control of population growth;
  (b) control of infectious diseases, including venereal diseases;
  (c) eliminating malnutrition;
  (d) reduction of chronic and degenerative diseases;
  (e) reducing the incidence of smoking, drug abuse and excessive alcohol intake;
  (f) control of environmental pollution.
The need to strengthen coordination of IEC projects was emphasized and mechanisms such as inter-agency councils to strengthen linkages in IEC were suggested.

Groups noted the need to improve literacy and education levels and to overcome superstitious beliefs and misconceptions about health.

Finally, the need to continuously monitor and evaluate IEC programmes in all member countries/areas was also stressed.

4.3 Third Working Group day (20 March) - Annex 12

Groups discussed specific actions that member countries could take, individually or collectively, to meet the goals identified in the previous workshop discussions (19 March). Working groups were provided with all working group summary papers from the previous day. They were asked to:

"(1) Write (or rewrite) the important goals your group identifies in order of priority.

(2) Beneath each goal, write the recommendations that will help achieve this goal. Specify who should act on each recommendation."

Each working group identified five or six major goals and specific conclusions in support of each goal. Specific goals identified by the three groups included:

- Orientation of governments, health service workers and mass media to primary health care concepts
- Establishment or development of coordinating bodies for IEC programmes on primary health care.
- Better planning of IEC programmes
- Increased funding and other resources
- Training of all involved personnel to develop communication and other relevant skills
- Commitment of all relevant sectors and levels to primary health care
- Motivation of the mass media to increase coverage on primary health care
- Research and evaluation of IEC programmes.

Specific conclusions were developed by each group in support of these objectives. These are discussed and summarized in the following section.
5. SUMMARY AND CONCLUSIONS

The workshop in plenary session agreed on five major conclusions and a series of specific conclusions in support of each of these. In all countries within the Region:

(1) There should be greater political and policy commitment to primary health care and to IEC support programmes.

(2) The organization and resources for implementing IEC programmes should be strengthened.

(3) Training of health and other relevant personnel in primary health care concepts and IEC skills should be developed.

(4) IEC planning and research should be strengthened.

(5) The mass media promotion of primary health care and support of IEC programmes should be encouraged in as many ways as possible.

5.1 Conclusion 1

There should be greater political and policy commitment to primary health care and IEC support programmes:

**Regional**

1.1 The conclusions of this workshop and of the 1979 workshop should be considered at the next WHO Regional Committee Meeting and if possible also at the next meeting of the World Health Assembly.

1.2 The WHO Regional Office for the Western Pacific should organize a meeting of health ministers of countries or regional representatives of WHO should visit the countries to discuss with ministers of health and political leaders with the aim of securing greater political and policy commitment to primary health care and IEC support.

**National**

1.3 National health authorities should establish policies and/or introduce legislation as appropriate to promote primary health care and IEC support.

1.4 Ministries of health of the member countries should ensure that policies/legislation to promote primary health care are clearly understood by programme staff, media, community and other related agencies/groups at all levels.

1.5 Health and information workers should seek to influence support from community leaders for primary health care policies and IEC support.
5.2 Conclusion 2

The organization and resources for implementing IEC programmes should be strengthened.

Regional

2.1 The WHO Regional Office for the Western Pacific should set up a regional coordinating council/centre to monitor all information, education and communication activities on primary health care and strengthen inter-agency linkages to promote sharing of information, education and communication materials and expertise.

2.2 The WHO Regional Office should identify the problems, requirements or needs of information, education and communication activities at the regional level and suggest appropriate corrective measures, if necessary.

2.3 The WHO Regional Office should explore the possibility of financial support for IEC activities from international agencies/foundations to carry out activities such as training, production and distribution of IEC materials, procurement of IEC hardware, and logistic support.

National

2.4 Health ministries should set up multi-sectoral, multi-agency coordinating councils to plan, implement and evaluate IEC programmes for primary health care.

2.5 Information, education and communication workers should take stock of existing resources of information, education and communication programmes to determine whether existing resources are being used efficiently or whether a re-ordering of priorities is necessary, and to assess future needs.

2.6 Where appropriate, financial assistance should be sought from United Nations organizations and other international agencies for specific IEC projects.

2.7 Health ministries should actively involve service clubs or civic organizations, e.g. rotary clubs, lions' clubs, women's clubs, church groups, etc., in sponsoring and financing specific information, education and communication projects. Similar support should be sought from professional and voluntary associations such as medical associations, anti-cancer associations and the Red Cross.

Similar action should be taken in respect of business firms and industrial organizations, such as life insurance and pharmaceutical companies.
2.8 IEC workers should, within the existing framework, seek to persuade governments to allocate a larger share of available resources for information, education and communication programmes. Such persuasion should be based on the presentation of realistic evidence of the value of specific information, education and communication projects and programmes to primary health care programmes.

2.9 Governments should allocate to IEC activities specific percentages of revenue from health-related sources of income, e.g. national health insurance schemes, taxes on alcohol and cigarettes sales and other sources of revenue such as lotteries.

2.10 Where appropriate, federal/central governments should cooperate with local/state governments to help finance information, education and communication programmes.

5.3 Conclusion

Training of health and other relevant personnel in primary health care concepts and IEC skills should be developed.

Regional

3.1 WHO should provide funds and facilities within the framework of its budgetary resources, for training key health, media and other related personnel in carrying out the management of IEC activities. Workshops, seminars, fellowships, study tours, consultation, observation attachment, training in media production and resource centres should be organized for such selected key personnel.

3.2 WHO should explore the possibility of securing assistance from appropriate international agencies, e.g. Colombo Plan Bureau, Asian Mass Communication Research and Information Centre (AMIC), etc. to support training programmes for IEC.

3.3 WHO should provide technical advice to countries in need of such advice in formulating and implementing IEC training programmes.

3.4 WHO should serve as a clearing house to coordinate and collect information relevant to IEC training programmes for neighbouring countries or countries with similar training requirements.

National

3.5 National coordinating bodies concerned with primary health care should assess training needs and formulate policies and programmes to meet these needs.

3.6 Ministries of Health should provide adequate funds and facilities for IEC training programmes for all health-related personnel.

3.7 Health ministries should encourage communication training institutes to provide assistance for key personnel to attend courses in mass communication and journalism.
3.8 IEC training programmes as appropriate should include communication skills on public speaking, interviewing and listening techniques, counselling techniques, use of audiovisual aids, health reporting, advertising, public relations, research and evaluation techniques.

5.4 Conclusion 4

IEC planning and research should be strengthened.

Regional

4.1 WHO should provide technical assistance for countries who wish to strengthen their IEC research and planning activities.

National

4.2 National IEC coordinating councils should establish national guidelines on IEC programmes and develop specific IEC programmes for different target audiences.

4.3 National IEC coordinating councils should develop IEC programmes adopting the participatory planning process.

4.4 National IEC coordinating councils should determine IEC national needs in terms of manpower, research and other resources.

4.5 Health Ministries should regularly evaluate IEC activities on primary health care at all levels within the country and institute appropriate measures as necessary to improve programmes.

4.6 IEC workers should establish the needs of communities and individuals so that IEC may be appropriately directed and continuous monitoring and evaluation undertaken.

4.7 IEC workers should identify obstacles and resistance to IEC programmes, e.g. superstitious beliefs and misconceptions, and determine methods to correct them.

Conclusion 5

5.5 The mass media promotion of primary health care and support of IEC programmes should be encouraged in as many ways as possible.

Regional

5.1 WHO should sponsor and organize regional and national seminars and workshops for media practitioners to promote awareness of the primary health care strategy to achieve health for all by the year 2000.

5.2 WHO should seek the cooperation of international media organizations (e.g. Asian Federation of Advertising Associations, Pressa Foundation of Asia, etc.) in urging their members to promote primary health care through the media.
National

5.3 National coordinating councils/ministries responsible for health and development should initiate activities to gain the cooperation of the media and the private sector. Dialogue sessions, workshops, seminars, brochures on primary health care, forums, briefings, orientation tours could be developed and organized to instil in the media and the private sector their moral obligation and role to promote better standards of health.

5.4 National coordinating councils should establish mechanisms for two-way communication among the various sectors involved in health promotion.

5.5 Health ministries in each country should establish personal rapport with national organizations of media practitioners, e.g. journalists' unions, broadcasters' associations, press clubs, etc., and with individual practitioners, especially at the district level.

5.6 Health ministries should provide incentives to improve reporting on health matters, e.g. through giving of national awards for health reporting, and provide assistance in improving the knowledge and abilities of media employees in reporting health matters, etc.

6. CLOSING STATEMENT

In his closing remarks, Dr Hiroshi Nakajima, WHO Regional Director for the Western Pacific, thanked the participants for their diligence and industry during the workshop. He also congratulated the workshop consultants and temporary advisers and the workshop chairman and vice-chairman on their respective contributions. Dr Nakajima expressed his appreciation of the proposals and recommendations formulated by the workshop and assured the participants that WHO would consider every suggestion carefully.
PROVISIONAL AGENDA

Monday, 16 March

Arrival of participants

Tuesday, 17 March

8:00 - 8:30
- Registration

8:30 - 10:00
- Opening ceremony
- Address by Dr S.T. Han
  Acting Regional Director
  WHO Western Pacific Region
- Address by Mr Stephen H. Umemoto
  UNICEF Representative
  Manila
- Workshop orientation
- Self-introduction of participants,
  representatives, observers, secretariat
- Election of officers
- Adoption of agenda

10:00 - 10:30
- Coffee break

10:30 - 12:30
- Statements by participants on the current
  status of information, education and
  communication in health in their respective
  countries

12:30 - 1:30
- Lunch break

1:30 - 2:30
- Presentation of Background Paper I -
  "Information, Education and Communication
  in Primary Health Care"

2:00 - 2:30
- Plenary discussions

2:30 - 3:00
- Presentation of Background Paper II - "New
  Directions for Information, Education and
  Communication on Health"

3:00 - 3:30
- Plenary discussions
Annex 1

3:30 - 4:00  - Coffee break
4:00 - 4:30  - Presentation of Background Paper III - "Information, Education, Communication and Health for All by the Year 2000: the Need for Action"
4:30 - 5:00  - Plenary discussions

Wednesday, 18 March

8:30 - 9:00  - Presentation of Background Paper IV - "What the Mass Media Can and Cannot Do to Help Promote Primary Health Care"
9:00 - 10:00  - Panel discussion with representatives from the print and broadcasting media and from advertising
              - Plenary discussion
10:00 - 10:30  - Group photograph and coffee break
10:30 - 11:00  - Presentation of Background Paper V - "Strengthening Government Information, Education and Communication Programmes in Health: The Need for Coordination and Training"
11:00 - 12:30  - Panel discussion with representatives from WHO, government health and information ministries
                 - Plenary discussions
12:30 - 1:30  - Lunch break
1:30 - 3:00  - Working Group Sessions
3:00 - 3:30  - Coffee break
3:30 - 5:00  - Working Group Sessions
5:00 - 5:30  - Film Showing - "Our Village, Our Future"
Thursday, 19 March

8:30 - 10:00  - Working Group Sessions
10:00 - 10:30  - Coffee break
10:30 - 12:30  - Working Group Sessions
12:30 - 1:30  - Lunch break
1:30 - 6:00  - Field Trip - Times Journal National Media Production Centre, Maharlika Broadcast System Building, Quezon City Institute of Mass Communication, University of the Philippines, Quezon City

Friday, 20 March

8:30 - 10:00  - Working Group Sessions
10:00 - 10:30  - Coffee break
10:30 - 12:30  - Working Group Sessions
12:30 - 1:30  - Lunch break
1:30 - 3:00  - Working Group Sessions
3:00 - 3:30  - Coffee break
3:30 - 5:00  - Plenary Session - Reports of Working Groups

Saturday, 21 March

8:00 - 5:00  - Visit to a rural health centre, the University of the Philippines, Los Baños, National Arts Centre, Mt. Makiling

Sunday, 22 March

Free Day

Monday, 23 March

8:30 - 10:00  - Plenary Session - Presentation of Draft Report of the Workshop
10:00 - 10:30  - Coffee break
10:30 - 12:30  - Evaluation of the Workshop
- Closing Statements
First row: Mr Jose C. Abcede, Mrs Natividad Nuguid, Professor Benjamin Lozare, Mr Christopher Wong (sitting) Kwan-Min, Dr Hiroshi Nakajima, Mr Gordon Benjamin, Mr Donald F. Treadwell, Professor Armando J. Malay and Mr Alberto Rous.

2nd row Mrs Rebecca Santos, Miss Rene K. Silverwood, Mrs Esperanza Santos, Dr Chan Wai-Man, (standing) Mr Tosiaki Takagi, Miss Ana Hoff, Mrs Justina Langidrik, Miss Kairabu Kamoriki, Mrs Lilia Juarez, Mr Eliki Domao Momovalu, Miss Susana Liava'a and Mr Valentin Loyola.

3rd row Dr Keiji Tanaka, Mr Ezekiel Kikiolo, Mr K. Mariappan, Dr Yii Kie Mung, Dr Weng Mingqing, (standing) Mr Francisco Sungino, Mr Antonio Eustaquito, Mr Geniemo Bayron and Mr Zulkarnain Hassan.
PROVISIONAL LIST OF PARTICIPANTS, CONSULTANTS, TEMPORARY ADVISERS, OBSERVERS AND SECRETARIAT

1. PARTICIPANTS

AUSTRALIA

Mr Gordon Benjamin
Director of Public Relations
Australian Department of Health
P.O. Box 100
Woden, A.C.T. 2606

CHINA

Mr Weng Mingqing
Tianjin Information Centre of Medical Science
Tianjin

COOK ISLANDS

Ms Ana Hoff
District Nurse
Public Health Division
Health Department
P.O. Box 109
Rarotonga

FIJI

Mr Eliki Bomani Momoivalu
Information Officer
Ministry of Health
Suva

GUAM

Mr Antonio M. Eustaquio
Public Information Officer
Department of Public Health and Social Services, Government of Guam
P.O. Box 2816
Agana

HONG KONG

Mr Christopher Wong Kwan-ming
Principal Information Officer
Medical and Health Department
Lee Gardens, Hysan Avenue

Dr Chan Wai-man
Medical and Health Officer
Medical and Health Services
Lee Gardens, Hysan Avenue
Annex 2

JAPAN

Mr Toshiaki Takagi  
Chief, Office of Public Information  
General Affairs Division  
Minister's Secretariat  
Ministry of Health and Welfare  
Japanese Government  
1-2-2 Kasumigaseki  
Chiyoda-ku  
Tokyo 100

Dr Keiji Tanaka  
Deputy Director and Medical Officer  
Tuberculosis and Chronic Disease Division  
Public Health Bureau  
Ministry of Health and Welfare  
Japanese Government  
1-2-2 Kasumigaseki  
Chiyoda-ku  
Tokyo 100

KIRIBATI

Ms Kairabu Kamoriki  
Community Worker  
Ministry of Health and Community Affairs  
P.O. Box 268  
Bikenibeu  
Tarawa

MALAYSIA

Mr K. Mariappan  
Health Education Officer  
Office of Director of Medical  
and Health Services  
Kelantan

Mr Zulkarnain Hassan  
Head, City Broadcast/RTM  
Ministry of Information  
Kuala Lumpur

NEW ZEALAND

Mr R.K. Silverwood  
Senior Health Education Officer  
Department of Health  
P.O. Box 5013  
Wellington

PAPUA NEW GUINEA

Mr Geniembo Byron  
Chief, Health Information Officer, OIC  
Health Planning and Research Division  
Department of Health  
Konedobu
PHILIPPINES

Mr. Valentin C. Loyola
Officer-in-Charge
Division of Information
Ministry of Health
Manila

Ms. Esperanza N. Santos
Training Officer
Office of Health Education and Personnel Training
Ministry of Health
Manila

SINGAPORE

Dr. Yii Kie Mung
Head, Programme Operations
Training and Health Education Department
Ministry of Health
Singapore

SOLOMON ISLANDS

Mr. Ezekiel Kikiolo
Health Education Officer
Ministry of Health and Medical Services
P.O. Box 349
Honiara

TONGA

Ms. Susana Liava'a
Health Education Assistant
Ministry of Health
Nuku'alofa

TRUST TERRITORY OF THE PACIFIC ISLANDS

Mr. Francisco Sungino
Health Educator
Macdonald Memorial Hospital
P.O. Box 39
Koror, Palau

Ms. Justina R. Langidrik
Health Educator
Department of Health Services
Amner Ishoda Memorial Hospital
Majuro, Marshall Islands
Annex 2

2. CONSULTANTS

Professor Benjamin V. Lozare
Assistant Professor and
Institute Secretary
Institute of Mass Communication
University of the Philippines System
Quezon City, Philippines

Mr Donald Francis Treadwell
Chief Health Education and
Information Officer
Department of Health
Wellington, New Zealand

3. TEMPORARY ADVISERS

Professor Armando J. Malay
Press Foundation of Asia
Manila, Philippines

Ms Natividad Nuguid
Officer-in-Charge
Inter-Agency Projects on Agricultural
and Rural Development
National Media Production Center
Quezon City, Philippines

Mr Alberto Rous
Health and Science Editor
Times Journal
Manila, Philippines

4. REPRESENTATIVES

UNICEF EAST ASIA AND
PAKISTAN REGIONAL OFFICE
Bangkok

Mr E. Wilfred D'Silva
Programme Officer
UNICEF/Manila Area Office
Manila

UNITED NATIONS
INFORMATION CENTRE
Manila

Mr Hisashi Uno
Director

5. OBSERVERS

DANGEROUS DRUGS BOARD
Manila

Mrs Lilia E. Juarez

Mr Toribio Medina
UNIVERSITY OF THE PHILIPPINES
Ms Elena Samonte

NATIONAL MEDIA PRODUCTION
CENTRE, Manila
Mrs Rebecca Santos

DEPARTMENT OF PUBLIC HEALTH
AND SOCIAL SERVICES
Agana, Guam
Mr Anthony Santos

6. SECRETARIAT

Mr Jose C. Abcede (Operational Officer)
Regional Information Officer
WHO Regional Office for the Western Pacific
Manila

Mr H.S. Dhillon (Co-Operational Officer)
Chief, Human Resource Development
WHO Regional Office for the Western Pacific
Manila

Mr George L. Dorros
Management Development Officer
General Programme Development
WHO Regional Office for the Western Pacific
Manila
COUNTRY REPORTS

COUNTRY REPORT - AUSTRALIA

by

Gordon Benjamin

In the two years since the previous workshop, there has been a significant move forward in Australia in the use of the media for promoting better health. In particular, the Australian Federal Government has sponsored a test programme which encourages people to accept responsibility for their own wellbeing and to help themselves to a better level of health.

But before I give details of this and other programmes, may I explain briefly the organization of health services in Australia - an explanation which, I think, will help put my other information in proper perspective.

Responsibility for providing health services is shared by the Federal Government, the Governments of the six Australian States and the Northern Territory, by local government bodies (that is, city and shire councils), by voluntary organizations and, of course, by private enterprise.

The state governments and local government bodies are largely responsible for 'basic' health matters - that is, the provision of hospitals, child care clinics, community health centres and the like, together with the conduct of essential public health programmes like immunization, tuberculosis control, etc.

The Federal Government provides funds to the States to help pay for a number of these services and programmes, and in addition has responsibility for certain national programmes like quarantine control, health insurance, the provision of medicines at a fixed price, and approval to import and market newly-developed drugs. But it does not have any direct responsibility for health education that has traditionally been the clear responsibility of the state governments which firmly maintain their rights in this area.

Thus, the approach to health education and promotion is fragmented in Australia, and each state health authority has its own philosophies and practices and cultivates its own relationship with the media. And, as was emphasized by my colleague Peter Moyle at the 1979 workshop, this fragmented approach makes the development of a cohesive national strategy for dissemination of health information via the media a most difficult problem.

Nevertheless, with or without cohesion, much has been happening in the past two years at both state and federal levels with the emphasis generally on relatively sophisticated health promotion programmes.
As I mentioned at the outset, the Federal Government has entered the health promotion field, and in so doing has stepped somewhat boldly into the traditional area of responsibility of the state governments.

The Federal Department of Health, to which I belong, has felt for some time that it had a national role to play in trying to encourage all Australians to help themselves to better health. And last year, it persuaded the Federal Government to provide funds which were sufficient to undertake a pilot health promotion programme which, if successful, might form the basis of an ongoing major national campaign.

The Federal Minister for Health, in launching the programme, expressed its aim in this way:

'We will not be asking people to become Olympic runners and swimmers or food faddists. But we will be pursuing an innovative approach aimed at encouraging Australians to make more informed decisions about their own health and to help them act on those decisions.

'In the past, the emphasis has been on treating illness. The more positive side - maintaining health - has been virtually ignored. We should be changing the meaning of the word "health" back to its original meaning, with its connotations of "wellbeing".'

In our basic thinking on the programme, the Health Department had decided that the media would be used for the major role. But the type of role and the nature of the messages to be used were not determined until an expert research company carried out an exploratory survey to see what people thought about health and what they rated as health priorities.

Time will not permit me to give full details of the results of the survey, but the major finding was that two out of three people admitted to suffering from some degree of stress. Thus ways of reducing stress and tension became a major part of the messages to be conveyed during the campaign.

Other areas of concern highlighted by the survey were smoking, drinking and dietary habits, and these were also covered in campaign messages.

With the help of the Federal Government's own advertising experts, two leading commercial advertising agencies were engaged to develop the campaign - one to devise the overall media strategy and the other to undertake the creative work of developing advertisements for the press, radio and television and to produce associated products - a booklet, posters, car stickers, T-shirts and the like. The common theme adopted for the campaign was 'Help Yourself to Better Health'.

A brilliant series of television commercials - devised with all the care that goes into making the most sophisticated television programmes - was produced and programmed to run in three test areas in a concentrated five-week campaign.
The test areas - chosen because of their diverse nature - were a large State capital, Adelaide, with a population approaching one million; the Federal capital, Canberra, with about 200,000 residents; and a country town, Goulburn, with about 40,000 people.

Although the same media advertisements were used in each centre, variations were built into the associated support programmes so that differing approaches could be evaluated.

In each centre, the local health authority was invited to participate, and health educators were encouraged to devise supportive activities which drew attention to, and encouraged people to respond to, the advertisements and the literature.

Most importantly, personal approaches were made to the media to urge them to participate actively by reporting on local 'help yourself' initiatives - not merely to carry paid advertisements. As anticipated, this drew a mixed response, with some media outlets paying very little attention to the campaign (while at the same time enjoying the advertising revenue).

At the end of the five-week test period, a post-evaluation survey was carried out in each area - and the results both surprised and delighted my Department and the many other people involved. For example, the survey showed that:

- seven out of ten people recalled seeing one or more of the television messages;
- six out of ten had read the associated 'Help Yourself' booklet;
- nine out of ten thought the programme was an 'excellent' or 'good' idea;
- one in five saw, or participated in, specific promotional activities.

Those are the sorts of results which would delight any advertising manager or director of public relations. Of course, they only point to awareness - they do not (nor could they be expected to after only one isolated five-week campaign) point to any long-term change in attitude or fitness level.

But the Department was enormously encouraged to feel that perhaps a national campaign along these lines might have the potential in the long term to influence behaviour and to steer people into a new awareness of their personal lifestyle and its effect on health.

Of course, it is only right to emphasize - and these thoughts are pertinent to the theme of this workshop - that this type of programme which makes heavy use of media space and time is extremely expensive to mount.
I have no doubt that the use of sophisticated media advertising, marketing and research techniques will successfully impress any message on the minds of the people, whether it be to urge them to drink more Coca-Cola, or take part in an immunization campaign, or help themselves to better health.

But in these days of economic stringency in every country of the world, it is likely to become increasingly difficult to persuade governments that such programmes are well worthwhile, and likely to produce better long-term results than merely continuing to increase spending on the provision of hospitals and on other curative measures. Indeed, the Australian Government has yet to provide any follow-up funds for an ongoing campaign.

Nevertheless, I hope my brief description of our 'Help Yourself to Better Health' programme may be of some interest to other participants, and I will be pleased to provide further details later if any delegates are interested.

May I spend my remaining time in briefly mentioning two other developments in the health education and information field in Australia in the past two years.

In addition to the 'Help Yourself' programme, my Department has also conducted a national publicity programme on quarantine. This seeks to increase the level of awareness in the community of the need to observe quarantine laws to safeguard not only human health but also the health of Australia's livestock and plants which provide such a substantial part of our national income.

This programme was also based on media advertising, but with one important extra - the advertising and associated publicity activities were centred around a 'presenter', a television personality who has an exceptionally high credibility rating throughout Australia.

This man is not only featured in the campaign's press and television commercials, but he also undertook a national personal tour to meet and talk to public groups and, of course, the media.

It is interesting to record that media interest was extremely high, and the campaign captured much free press space and radio and television time, undoubtedly because of the personality of the presenter. Perhaps that thought might be of interest for further discussion during the workshop.

One other programme - this one conducted purely at local level by a regional division of a State health authority - will, I believe, be of specific interest.
The 'Healthy Lifestyle' project, as it is called, seeks to assess the effectiveness of various approaches to health education and promotion in influencing behaviour. This is to be specifically measured by the results of the programme in persuading people to reduce smoking, increase exercise, and reduce their intake of saturated fats.

Three moderately-sized country towns are involved. In one of them a paid media advertising campaign has been accompanied by vigorous, well-organized local support activities which have actively encouraged participation by all members of the community.

In the second town the same volume of paid media advertising has been used but there had been no specific support activities. And in the third (control) town, there has been neither media advertising nor any other specific activity.

Evaluation of the first two years of the programme is now underway and the results are awaited with keen interest.

May I conclude with a brief comment on the quality of media coverage of health matters in Australia. There has been little change from the position outlined by my colleague at the 1979 workshop.

Medical politics, health 'gimmickry' and scare stories are still the favourite topics of health reporters. In spite of the efforts of one or two individuals, there is little sign of any change of direction towards regular, serious reporting of health issues. The smart headline and catchy introduction is still the norm in the great majority of Australian media outlets.

Sadly, my Departmental colleagues and I are reaching the conclusion that, by and large, the media can best be used in health education and promotion by paying it large sums of money to present paid advertising.

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A BRIEF INTRODUCTION TO THE DISSEMINATION OF HEALTH INFORMATION IN TIANJIN, PEOPLE'S REPUBLIC OF CHINA

by

Weng Min-Qin

As Tianjin is one of the three largest cities of the People's Republic of China with a population of seven and a half million, thus our duty on health information is of great importance.
Active propaganda to the masses on health policy, such as prevention of various diseases, integration of Chinese traditional medicine and western medicine and family planning have been disseminated to the public not only through the publication in the *Tianjin Daily News* but also over television and radio. Besides the above, other steps regarding the common knowledge of health and popular science have been taken as necessary measures of propaganda information media so as to enhance the population's health condition, promote medical and health knowledge, enable people to thoroughly understand the approaches to avoid diseases and to eliminate harmful infections and contagious diseases.

The professional institutions of health information are the Health Educational Propaganda Service, Family Planning Office, Patriotic Health Movement Committee, etc.

Our various media services are as follows:

I. **Printed matters**

A. "The Popular Science of Health" - a half-monthly issue, the object of which is reaching the great masses, its contents are under the categories of: elimination of diseases, health for women and children, health care in schools, family planning, traditional medicine and medicinal herbs and so on. Circulation is 60,000 copies and copies are distributed to readers in Tianjin city as well as the cities of other provinces.

B. Pamphlets on different subjects are also published with about 10,000 - 20,000 words each, some with illustrative pictures. Some of the subjects covered are "Harmful Effects of Smoking", "The Prevention and Treatment of Carcinoma of Breast", "Nutrition and Health", "Some Technical Problems on Family Planning" and "A Common Text on Family Planning", etc.

C. Advertisement pictures including pictures on detailed explanations of public health, together with Chinese folded fans, New Year drawings and sketches (with style of famous Yangliuqin work) and calendars are also used. Such pictures are printed in 30,000 copies.

D. Slides (film strips) or films showing the contents of health propaganda. Such slides and films are to be projected on the screen prior to a regular show in the cinemas. Such films are made and produced under the following topics, e.g. "Health Care in Foodstuffs", "Prevention of Food Intoxication", etc.

Booklets, all materials, slides and films presented to rural and urban institutions of health organizations are free of charge.
II. Broadcasting

A. The "Popular Science Programmes" which popularizes medicine knowledge are broadcasted once a week, each taking 15 minutes. Subjects in such programmes give fundamental knowledge on: liver and pulmonary function, common diseases, coronary heart disease, neoplasms, biomedical engineering and newly developed subjects and techniques in medicine.

B. The "Serving the Great Masses with Medicine Programme" is a countrywide daily broadcast of 500-1000 words on every aspect of daily life in which health care is considered, e.g. information on infectious diseases and nutrition.

III. Television

There are more than 400,000 sets of television in the city with millions of people watching television everyday.

Daily health propaganda programmes are as follows:

A. The "Health Programme" with typical programmes like "Maintenance of Environmental Health", "Labour Health", "Family Planning" "How to Discover the Breast Tumour", "Alopecia", "Harmful Effects of Smoking" and "Drugs", etc.

B. The "Post Box on Health" is set up for the purpose of replying to problems put forth by letters from the public, such problems as "Which kind of disease can be cured by certain drugs" and so on. The above programmes are irregularly broadcasted one to three times in a month, each taking 15-20 minutes. Listeners are so fond of such programmes that they often write hundreds of letters requesting re-broadcast of such programmes or for copies of these programmes.

Furthermore, the other approaches to health propaganda include posters on the walls of the clinic, posting of pictures and names of drugs and instruments relevant to family planning, prevention of various diseases, etc.

At the end of 1980, a meeting was held on health and popular science propagandizing in Tianjin to assess the present experience and to award advanced workers in this field.
COUNTRY REPORT
DISSEMINATION OF HEALTH INFORMATION IN THE COOK ISLANDS

by

Ana Hoff
Public Health Nurse

General information

The Cook Islands are a group of 15 islands, situated between 8° and 23° latitude south and 156° and 167° longitude west. The total land area is 91.2 square miles spread over 75,000 square miles of the ocean. The capital and seat of Government are on Rarotonga Island. The population of Cook Islands is 18,000. Half of this population live on Rarotonga.

Current status of dissemination of health information

Dissemination of health information are carried out by all public health nurses in weekly maternal and child health clinics and visits to schools.

Community-interpersonal communication

Health information are also given at the hypertension and diabetic clinics, outpatient clinics and also at the Child Welfare Association's monthly meetings. Home treatments and visits provide another effective mode of health education in the Cook Islands.

Mass media (radio)

Besides individual and group talks, we have our weekly radio health programme, which is played during peak evening listening hours and repeated the next morning during breakfast hour the broadcast messages are reinforced by public health workers in the clinics during the week.

The response from the public relating to our radio health programmes are favourable to the extent that health talks have been repeated many times. We have been invited to talk and answer questions on health on the favourite and popular "Women's hour radio session" and at the same time explaining the misconceptions on family planning and other health issues. We had hope to print the radio health talks in the daily local press, but due to lack of resources this was not done. We have no television in the Cook Islands.
Our Outer Islands Community Network System was started June 1980. These transceivers are installed in hospitals on other islands and in the Resident Agent dwelling on each island. These telecommunication networks are used for public health staff inservice training, information and emergency health issues. The network system is not only effective in the educational sense, but also serves as a morale booster for the health staff in the outer islands as they are isolated from the capital.

Health education activities are carried by all staff of the Division of Public Health under the general supervision of the Director. There is however a lack of printed materials, posters, charts and of other audiovisual aids for teaching of health practices.

COUNTRY REPORT: FIJI

by

Alex B. Momoivalu

This report will basically give participants an opportunity to have an idea of what progress, if any that has been made in the field of health information dissemination in Fiji during the two years that have transpired since the first workshop here in 1979.

My aim will be to review our activities in health information dissemination and, in this regard, pay particular attention to the basic outline of a report given to the first workshop by a representative from my Ministry who attended the 1979 workshop.

I would like to begin by informing the workshop of the considerable progress that has been made in promoting public awareness in all aspects of primary health in Fiji. This has been particularly the case in our rural communities. Fiji still has a predominantly rural population and current statistics indicate that more than 75% of our 655 000 people still live in rural communities.

A major thrust of our Government's development policy is therefore targeted at our rural people - the eventual aim being to improve the living standards of our rural population.

The Ministry of Health has an important role to play in the achievement of this particular policy.

The Ministry had long recognized the benefits that a sustained and carefully orchestrated primary health care programme can bring to our rural communities. Primary health care has now been an integral part of our national health programme for well over six years.
Annex 3

The promotion of primary health care is both a centralized and decentralized process. While our Ministry of Health headquarters is primarily responsible for the preparation, coordination and provision of wide-ranging advisory services, the bulk of primary health care work is the responsibility of each of the country's four medical divisions or regions.

In fact, our 'agents of change' in so far as primary health care is concerned, have been our divisional, subdivisional or district corps of doctors, nurses, medical assistants and other health-related personnel. Information dissemination and the promotion of the virtues of ongoing primary health care programmes has been mainly done through a person-to-person medium which puts the doctor/nurse/medical assistants in the forefront of our promotional programmes.

Every field worker in each of the four medical divisions is expected to impart, distribute or channel information (the information covers all aspects of primary health care and can be instructive, informative, explanatory, etc. in nature) to every community in their respective health constituencies.

I know of a specific case in the Central (medical) Division where concerted efforts have been during the past five years to fully and effectively promote primary health care. This has been done through the staging of regular workshops, seminars and informal meetings at the village and settlement levels. This approach has now been emulated in the other three divisions and there now exists some semblance of a national primary health care programme focused entirely on the health needs of rural Fiji.

Health education in general has also been an important aspect of primary health care. A health education unit was established in the early 1960s to coordinate and strengthen health information dissemination and education activities. The unit is actively engaged in all aspects of health delivery systems and it is now also working very closely with divisional primary health care programmes.

The unit is responsible to the Permanent Secretary for Health through the Director of Preventive Medical Services and is responsible for all components of health education, the most important of which is the dissemination of health information.

Presently, the staff of the Unit consists of a Senior Medical Officer with postgraduate training in Public Health and Health Education, a Senior Health Sister with similar training and a Health Inspector who has been earmarked for training in health education. Further expansion to this unit in terms of staff is envisaged as family health has been incorporated into it.

To fully appreciate our health information dissemination system, one needs to have a general overview knowledge of our Health Service Organization.

The Health Education and Family Health Unit is a part of Headquarters administration.
For administrative purposes, there are four medical divisions, each headed by a Divisional Medical Officer assisted by a Senior Health Sister, a Senior Health Inspector and backup clerical staff. Divisions are further divided into subdivisions and further still into Medical Officer areas each with a health team of a composition similar to that at divisional level. At the periphery are the district nursing zones staffed by a single district nurse who either operates from her nursing station or from a health centre. The district nurse performs all facets of primary health care with a heavy leaning towards promotive and preventive services. It is at this level that we achieve the greatest contact between health personnel and the people and it is this contact that provides us with the greatest opportunity for disseminating health information.

Current approaches to health information dissemination and their relevance to our Health Service Organization

Our current approach covers a wide variety of activities ranging from personal discussions between health worker and client to film production.

Person to person approach

This is our main channel of information dissemination. District nurses on home visits, in maternal and child health clinics and doctors in health centre outpatients and special clinics exploit these opportunities of contact to advice clients and for clients to inquire about all components of health care for themselves, their families and their community.

Group approaches

Various community groups serve as a means of disseminating information and exchanging views. These include Mothers' Clubs in villages and settlements and in urban and semiurban areas, service clubs, youth clubs and religious groups.

Doctors, nurses and health inspectorate staff establish close contact with these groups and utilize informal meetings with them for discussions about family health and community health problems and related needs; for passing on information and for obtaining ideas and information from the groups.

Contact on an official basis is also made with more formal groups such as village and provincial councils, Rural Development Committees, etc. Opportunities provided for in these more formal settings are exploited to the full as contact at this level is of vital educational importance as a means of interpreting priority health problems and the need for family health services to both policymakers and financial authorities.
Annex 3

Approach through our educational system

The primary school curriculum includes health as a separate subject and the subject content is planned jointly by officers of the Ministries of Health and Education and covers mainly the preventive aspects of health.

In secondary schools, health teaching is incorporated into the biological sciences.

School visits by school health teams also utilize these visits to disseminate health information.

Approach through the organized sectors - employer organizations and trade unions

Two Seminars on Family Welfare for the Organized Sectors, organized and funded by ILO, expressed strong support for positive action from Trade Unions and Employers' Organization on Family Welfare. This support is presently only vocal but this is a potential avenue for the dissemination of health information and needs to be seriously explored.

Mass information approaches

This is the direct responsibility of the Family Health and Health Education Unit.

The only mass media services in Fiji are the press and radio. Radio has a much greater reach and it surmounts the problem of illiteracy in the population. Cost is the major constraint to its fuller use, but the Fiji Broadcasting Commission which runs the only radio station in Fiji does allocate time for health broadcasts as part of its service to listeners.

Radio broadcasts on health matters has been a rather varied life but I will only dwell on the present state of health broadcasts and these fall under the following categories:

Radio talks: Lasting several minutes is a weekly broadcast session, and the contents are broadcast in the three major languages in Fiji. A programme is drawn up for the whole year. Scripts are prepared by specialists in the various medical specialities and in public health and are channelled through the Health Education Office.

Radio spots: These come on daily in the morning. Scripts are prepared by health workers and again channelled through the Health Education Office.

Women's programmes: This consists of daily sessions and often features interviews with nursing personnel.

Radio news releases: These feature in the News Sessions whenever the need arises usually in emergency situations such as epidemics, threats of epidemics and natural disasters and whenever there is an untoward trend in disease patterns and, or there arises any major development in the health services, etc.
Panel discussions are not as yet a regular feature and we have not as yet ventured into serial radio plays.

The use of the press has been limited to press news releases in the same situations that I have outlined for radio news releases. A weekly health bulletin run by one of the dailies has since lapsed.

All radio and press news releases are channelled through the Ministry of Information after scrutiny by the Permanent Secretary for Health.

Problems and constraints

There have been setbacks in our efforts to effectively promote primary health care. But we have not lost sight of our objectives and goals in so far as primary health care is concerned.

The aim of our Ministry of Health in the immediate future will be to:

(a) expand an existing primary health care infrastructure and ensure that it effectively serves the needs of the communities it will deal with;

(b) extend primary health care to areas of the country that have not been exposed to it.

Our problems in a nutshell are lack of financial resources, manpower and perhaps effective organizational capability to a degree needed for maximum services/output, etc. in our primary health care programmes.

COUNTRY REPORT: GUAM

by

Antonio M. Eustaquio

Description

Guam is known as where "America's Day Begins", the first American Territory, West of the International dateline. Guam is the southernmost island of the Marianas Islands chain and is located approximately 1500 miles south of Japan and 1500 miles east of the Philippines.

As an unincorporated territory of the United States, Guam has a locally elected Governor, unicameral Legislature, and non-voting representative to the United States House of Representatives. Guam is divided into nineteen geographic districts each of which has an elected commissioner.
The 1970 census reported a total population of 86,000. Current estimates now place the total population at 120,000. Approximately 20% of the population consist of US military and their dependents.

Many cultural groups are represented with the majority of people being of Chamorro (the indigenous population) descent. English is a second language for most of the population.

The educational system is patterned after the American system. School attendance is mandatory up to sixteen years of age.

A community college is available for vocational training and a four-year university offers undergraduate studies and professional training in education, social work and business, and other fields.

Mass media resources

The island has:

A. Two newspapers of general circulation
B. Three television stations
C. Four radio stations

The daily newspaper is a publication covering international, national, and local news and has islandwide circulation. Usually one of the reporters is assigned to cover health-medical news. Public service announcements are readily accepted as space permits. The other newspaper concentrates on Asian/Pacific news, and is printed once a month.

One television station is a cable service to which people subscribe and pay a monthly fee. A second television station provide commercial broadcast service reaches the entire island. The third is a public broadcast station and is received by almost two-thirds of the island residents.

The television programme generally consist of the United States programmes but these are supplemented with local news, weather, and sports. The public broadcast station does the most local programming. Public service announcements from the United States as well as those that are locally-produced are used between regular programming and/or commercials as time permits.

The radio stations primarily provide music and news. Because of federal requirements, all station managers are quite receptive to receiving and airing public service announcements in the interest of the people.

Use of the media

Various government, private and voluntary health organizations are involved in disseminating health information to the public. These organizations, especially those that are government and voluntary, vie among themselves for free newspaper space and public service time on television and radio.
Within the Department of Public Health and Social Services, the Public Information Officer is responsible for the collection and dissemination of health information for release to the mass media. Dissemination of health information usually serves two purposes:

(1) To increase the public's awareness of health problems and to suggest corrective of preventive actions, and

(2) To increase the public's awareness of health services and community resources.

Commencing 1979 and continuing to the present, the Health Education and Nutrition Section of the Department of Public Health and Social Services produces a monthly hour-long health programme which is aired over public television and the commercial television station.

In 1979 a Health Education Task Force was organized with representatives from various health-related agencies for the purpose of:

(a) improving communications among the "providers";
(b) updating members as to available community resources;
(c) fostering coordination and cooperation; and
(d) developing island priorities and objectives in health education on an annual basis.

Some government agencies have the technical expertise and equipment for videotaping and/or production of audiovisual materials. These agencies have been amenable to assist other government agencies in producing local public service announcements and/or media programmes.

At present, the Department of Public Health and Social Services utilizes the media for public service announcements and press coverage and arranges for television and radio programming time during specific health projects or campaigns.

I am thankful for the opportunity to briefly share with you what we are doing in Guam and hopefully would learn from your experiences. Thank you.

COUNTRY REPORT - HONG KONG

by

Mr Chris K.M. Wong

Visitors to Hong Kong have often wondered how the territory, with one of the world's highest population densities and located geographically at the centre of a region plagued by epidemics of varying kinds, could ever manage to maintain a clean record of major communicable diseases for almost a quarter of a century.
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This tiny city of more than five million inhabitants, right in the crossroad of east and west, with a total land area of less than 1100 square kilometres, is grossly overcrowded, to say the least. The overall density is 4480 people per square kilometre, but in most of the urban areas, the density is in fact close to 25 400 people per square kilometre.

High population density, overcrowding, humid and warm climate, all combine to make the territory susceptible to the spread of communicable diseases.

Yet against this background of unfavourable conditions, the people of Hong Kong generally have been enjoying good health, even by western standard.

To back up with some statistics, it is significant to note that Hong Kong's general standard of health compares favourably with most advanced countries, as exemplified by its low infant mortality rate and maternal mortality rate, which are internationally recognized health indices.

The infant mortality rate has now dropped to 11.8 per thousand live births from 37 in 1961 and the maternal mortality rate also came down to 0.05 per thousand total births last year. These rates are comparable to those of the United Kingdom and America. Due to stringent control measures, Hong Kong has been free from all quarantinable diseases except cholera, which occurs only in sporadic outbreaks occasionally.

The absence of common childhood diseases such as diphtheria and poliomyelitis is another major achievement of the health authority in Hong Kong. As for other communicable diseases, there have been a few malaria cases all of which are imported while tuberculosis among children is now rare.

This remarkable achievement is partly due to the comprehensive primary health care provided by the Government through its maternal and child health service as well as a full range of clinic services which place special emphasis on prevention, immunization and early detection of diseases.

It is also due in no small measure to the contribution of health education made by various Government departments and professional bodies in the medical field as well as voluntary agencies in the last decade or so.

Health education is the dissemination of health knowledge with the aim to improve the health of the individual and the community. In Hong Kong, health education is an onerous task simply because of the complexity of the population's ethnic and cultural background. Hong Kong is where you find people turning to a neurologist or a cardiologist after failing to get satisfaction from traditional herbal medicine or vice versa. To educate the public health under such peculiar situation will require a multiple approach, deploying all forms of media - from mass communication to interpersonal interaction.
There are 114 registered newspapers, of which five in the English language and 46 in the Chinese language are published daily. In addition there are 326 periodicals.

Readership is among the highest in Asia with 350 copies of newspaper printed to every 1000 people. Undoubtedly, this printed medium is a useful tool for dissemination of health information.

The electronic media occupy an equally important place in the mass communication world. There are two enfranchised commercial TV broadcasting stations in Hong Kong, both providing Chinese and English language services with a daily broadcast of 60 hours.

Television viewing has become one of the regular past time for the public. More than 90% of all families possess at least one television set, and the size of daily audience is estimated to be over three million people.

In addition there are nine radio channels, five of which are operated by a government-financed station providing almost 600 hours of air time weekly. Three other services are run by a commercial radio which also has a large following.

Ostensibly, such a wide range of media provides a good instrument for imparting health knowledge to the public and the medical and Health Department has been making full use of these channels in its health education efforts.

Responsible for health education are a Public Relations and Information Unit which is under my supervision and the Central Health Education Unit of the Medical and Health Department. Both units, while performing different functions, complement each other in the course of fulfilling their respective role.

The Public Relations and Information Unit regularly issues feature articles for publication in the newspapers and periodicals on various aspects of health. Last year alone 98 press releases averaging eight stories each month were issued for the print media.

The Unit also arranges interviews for the news and public affairs programmes on radio and television to drive home the health message, supplemented by spot announcements which are repeated over radios and televisions at regular intervals.

Apart from these, health features are also tailored to fit in programmes of different nature, such as variety shows, children's programmes, women specials and youth's time.

A half-hour weekly radio programme on health has been running for the past few years specially designed for easy comprehension by housewives, domestic and industrial workers, a programme that is to prove extremely popular and effective.
Annex 3

Maternal and child care topics are also being aired once a week in a women's special over a Chinese TV network.

Where possible, assistance is given to television stations in the production of special features. Topics of such programmes include health of the elderly, eye care, kidney care, cancer, hypertension and maternal and child health which the majority of the public find of special interest.

On the other hand, the Central Health Education Unit since its establishment in early 1978, is responsible for coordinating all health education programmes and organizing the department's own activities, often in conjunction with voluntary organizations and professional bodies.

In the short span of its existence, the Unit has organized several exhibitions to promote health care for the elderly, maternal and child care, anti-cancer and anti-smoking, all of which have been very well attended. Through these displays of visual materials, the public are made to be aware of their health. This Unit also provides professional advice and assistance to many voluntary organizations and schools to hold their own health campaigns or exhibitions.

In support of the immunization programme and other health activities run by the Medical and Health Department, the Unit maps out a yearly programme of health education to tie in with the department's immunization campaigns against tuberculosis, rubella, polio, measles and so on. Very often in order to hammer home the message of a particular campaign, posters and pamphlets are put up in market places, bus stops, piers and in schools, housing estates, community centres, etc. Pamphlets written in simple language and illustrated at times are distributed free to the residents for whom the campaigns are intended.

Apart from that, the Central Health Education Unit also produces slides, tapes and other audiovisual materials for special target groups. Altogether a total of 27 posters and 54 pamphlets covering a wide variety of health subjects have been prepared and distributed.

For some specific subjects, the dissemination of health information to a special target group must be supplemented by a personal approach. In this respect, the role played by health visitors and community nurses is most essential. Their contribution in disseminating information to patients, their relatives at maternal and child health centres, social hygiene clinics, eye clinics, school dental clinics, chest clinics and at their homes has been invaluable. They have proved to be an effective tool in conveying the message put through the mass media.

Despite the wide variety of information channels available to us, health education is no easy task and increasingly so in recent years, more for political reasons than anything else.

Firstly, the press in Hong Kong is absolutely free and the publication of health education information is entirely at the mercy of newspaper editors.
As there are so many newspapers each striving to promote its circulation, vying for a larger share of the readership, competition is extremely keen. Health information items, which are, by nature non-sensational, except in an emergency situation brought about by epidemics, do not always get into print.

Competition is equally keen among radio and television stations. In the news programme, ordinary reports on health education often give way to other spot news and sensational stories. This trend must be indeed worrying to those who are dedicated to public health education.

Let me illustrate this by quoting an example. The Hong Kong Medical Association used to run a column in 13 Chinese newspapers answering questions from readers about personal health. The column was quite well received and continued for about five years until 1977 when seven of the newspapers decided to drop the column simply because they wanted it to be exclusive to them. The column has since been suspended.

Secondly, health educators in Hong Kong are facing a problem seldom found elsewhere: the problem of influx of immigrants from Viet Nam and other Asian countries.

The influx of Vietnamese Refugees began in May 1975 when a Danish container ship arrived in the Victoria Harbour with 3,743 people from Ho Chi Minh City. This was followed by streams of boat people coming from Vietnam and at the end of 1979, a total of 73,700 had arrived in Hong Kong.

The Vietnamese Refugees who came from a war-torn territory have gone through years of hardship and they inevitably adopt a different set of health habits. The majority of them arrived undernourished, and were generally not in the best of health.

They have been put up in transit camps awaiting settlement overseas. Their health becomes the concern of the Medical and Health Department and voluntary bodies dedicated to health services. As part of the department's health prevention measures, health visitors are assigned to carry out immunization programme in all the camps, especially for the children. Talks and seminars in the media of Cantonese and Vietnamese are conducted to educate them on personal health and environmental hygiene. Our job has been made rather difficult because of the language barriers.

Another area of concern to the health educators is the upsurge of immigrants from various Asian countries who are not accustomed to our rules of personal and environmental health.

Coming from less affluent societies, they are less informed as far as health knowledge is concerned, and have a different attitude to health and environmental hygiene. Health educators find that it is more difficult to reach these immigrants than their Vietnamese counterparts as they do not live in designated accommodations. It is however gratifying to note that their pattern of disease is not significantly different from that of the local population.
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Whatever our difficulties, we shall continue our efforts in the very important field of health education, with increased momentum. We are absolutely convinced that a slight slackening in our efforts will lead to a decline in the standard of health. The task before us is enormous, but we are looking forward to meeting the challenge with renewed vigour and above all, confidence. There is no doubt that in the week ahead we shall be able to benefit from the experience and expertise of the participants in this workshop.

COUNTRY REPORT - JAPAN

by

Mr Toshiaki Takagi and Dr Keiji Tanaka

Health education programme in Japan - Present and future

(1) At the national level, the Community Health Division of Public Health Bureau (Ministry of Health and Welfare) is responsible for planning and implementation of the national health education programme. The main role of the Ministry of Health and Welfare is to stimulate the health education activities conducted by prefectural governments. Every year, it holds the National Convention of Health Education under the auspices of the Ministry of Health and Welfare. In this occasion, a variety of events are performed, for example, refresher training for personnel, awarding of prizes for persons who have shown devotion to health education, exhibitions and competitions of slides for health education.

In addition to these activities, a number of divisions in the Ministry of Health and Welfare implements specific health education programme relating to maternal and child health, chronic diseases, tuberculosis, mental health, nutrition, health for the aged.

In 1978, the national government adopted the policy of health promotion, and for that purpose the Foundation of Health Promotion was established and has been actively carrying out its activities on a nationwide scale assisting the work of the health agencies.

National government publicity on health and welfare fields is arranged by the Office of Public Information. Almost everyday it distributes many materials for journalists and organizes press conference with the related division of the Ministry of Public Health and Welfare when necessary.

(2) As for the prefectural government level, each prefecture has varied conditions concerning health education. Some prefectures have independent health education centre with many special staff, but usually each prefectural government has a few full-time staff in charge of health education and they are not specially educated. There are only two graduate programmes that offer training for health education specialists (Juntendo Medical College and Tokyo University Medical School). But every public health administrator, public health nurse, nutritionist, doctor, dentist, food sanitation inspector perform health education activities.
Health education is also carried out on a specific item by every division as follows:

- Mothers' class
- Pre-marriage class
- Pregnant women's class
- Health college
- College for the aged
- Home care for the aged class
- Nutrition class
- Prevention of tooth decay class
- Soya bean soup class (salt reducing)
- Self-examination for breast cancer class

Health education activities are carried out at several health institutes, such as Health Centre (855), Community Health Centre (104), Health Centre for Mother and Child (682), Health Promotion Centre (12), Welfare Centre for the Aged (1024), and other community meeting places.

(3) At non-government level, there are more than 300 voluntary organizations (authorized by Ministry of Health and Welfare). For example, Japan Anti-tuberculosis Association, Japan Cancer Society, Japan Heart Foundation, Japan Family Planning Association, etc. They are involved with health education.

Recently, these groups have been working under coordinated efforts to make their activities more efficient and effective, and also to learn from each other concerning health education technique.

Many community groups have been voluntarily practicing health education through lectures or films. Of course, people can also obtain health information from a doctor at a clinic, and they can also read popular health magazines or elementary family medicine books.

People mainly obtain health information from newspapers and television. These information are classified into descriptive news and explanatory articles. The latter is usually longer than the former.

(4) I have introduced two topics among many activities in health education and information in the last two years.

The Health Promotion Foundation was established in 1978. It is the first specified health education organization in Japan. Annual budget is 1.0 to 1.2 billion yen (about 5 to 6 million dollars).

The activities of the Foundation are as follows:

(a) To produce television and radio programmes on health, for example, "Travelling for Health Towards the North and the South" (every Saturday, 15 minutes), "Health Europe - health promotion projects in Europe" (every Saturday, 30 minutes).
(b) To promote meetings on "Let's walk".
(c) To publish magazine "Health Promotion" (50,000 copies monthly).
(d) To make and distribute leaflets about health.
(e) To organize symposiums or lectures, surveys about health attitude.

We have just started these projects and have not yet evaluated their effectiveness.

The second topic is the anti-smoking campaign started in 1980. At first, non-official advisory committees were organized and oriented with policies. It has summarized many reports (WHO and U.S. NCI's, etc.) on smoking and health, legislation and about smoking. It is now studying about smoking attitudes and behaviour in Japan.

Secondly, national government acted as follows: issuing statement of the Director-General (Public Health) about smoking and health (it encouraged health education and distributed some materials to local government), holding symposium about "smoking or health" on World Health Day, giving many courses for health practitioners.

Thirdly, voluntary groups worked actively. JATA, JOS and JHF had conferences, and they made posters and leaflets, held competitions on anti-smoking slogans. Medical doctors, Japan Cardiovascular Disease Association, Japan Public Health Association and Tokyo Health Insurance Society also have attended the campaign. Many surveys about smoking attitude were conducted by newspapers and statistics bureau, etc.

These activities and materials were released actively to press club. Many news about "smoking or health" were adopted or newspapers and television programmes.

(5) In general, people are provided with adequate health information. But they are not satisfied with these information which sometimes are not timely provided and which sometimes do not match with individual demands. Quality matters more than quantity. Also, effective retrieval systems which means specialization of health information are therefore necessary. People in Japan know much about health but they behave contrary to sound health practices. Enough information do not always change attitudes or behaviour. Every media should be utilized and every medical resource have to be mobilized for this purpose. The above means comprehension of health information. Future health education is going to aim at two different directions, specialization and comprehension.
1. **Background information**

(a) **Location and topography**

Kiribati consists of 33 atolls spread over an area of about two million square miles of the Central Pacific Ocean around the point where the International Date line intersects the equator. They represent a total land area of about 264 square miles.

Only 21 of these atolls are inhabited.

**Population**

The population, according to the 1978 census, was enumerated as 57,313.

Kiribati is a developing country and about 68% of the population live in rural areas where subsistence farming and fishing form the main livelihood of the community. The remaining 32% live in Tarawa which is the capital of Kiribati and which is urban in development.

**Sex distribution** is about 50:50 for males and females.

(c) **Political structure**

Kiribati is a new independent which has a Parliament called the "Maneaba ni Maungatabu". The members of the "Maneaba ni Maungatabu" are elected by the people via constituencies and men and women are equally eligible to be candidates. Kiribati has adopted a Constitution which favours democracy and honours human rights.

**Health education**

Health education is not a new idea in Kiribati. It was learned by our ancestors in different forms and different manners and it seemed to be part of our traditional customs in Kiribati. Our ancestors believed that a real I-Kiribati (Gilberties) must be healthy and strong and fit to be able to face hard tasks and live longer than others.

And because of the many changes in the society and customs, many problems occurred and health is one of them. Our grandparents nowadays always said, "The young generation is weak and unhealthy because they neglect our own food and especially our own way of living.

The Government and churches are aware of these health problems and work hand in hand to overcome them.

In the Community Affairs Division, the Women's Interests Section started teaching women in the villages and make people aware of health and health problems since 1973, with the idea that women who are mothers or mothers-to-be understand how to look after their family, especially their young children.
Annex 3

There are six community workers (girls) who always go out to all villages and teach women on health education in nutrition and good health:

- Family Planning
- Cooking Demonstration, Balanced Diet
- Child Development
- Sewing
- Budgeting.

The programme was carried out by these community workers in collaboration with Health Education Section.

The Education Department include health education in the curriculum in both primary and secondary schools all over Kiribati. Community workers are usually invited to schools on a special day called "Education Week" to give talks on nutrition and what they should expect from their mothers. The idea behind this is to make children aware of the right food to eat especially health food and protein and always remind their mothers not to give them rice and bread and other starch food. Radio is used as the only source of mass media throughout the islands.

As I have said, the Government is fully aware of these healthy problems especially the population problem and is taking steps to correct these problems. Just before I left Kiribati, it was officially announced on the radio that family planning is now a top priority of the Ministry of Health and Community Affairs.

Thank you all.

COUNTRY REPORT - MALAYSIA

by

K. Mariappan1 and Zulkarnaian b. Hassan2

1. Introduction

Information, education, communication is increasingly being utilized as a tool in health programmes to promote self-determination and self-reliance among the public on health matters. The logic behind this approach is that a well-informed public will be more motivated to utilize the health services and also adopt the desired health practices. As such it is important that activities related to information, education and communication in health be intensified.

This paper includes discussions on two aspects, namely, (a) the present status in dissemination of information on health and (b) strategies/activities adopted for the improvement of health information promotion in our country. The discussions are as follows:

1Health Education Officer, Ministry of Health, Malaysia.

2Programme Organizer, Public Affairs Division (Radio), Ministry of Information and Broadcasting, Malaysia.
2. The present status in dissemination of information on health

Currently, information on health is disseminated through various media available in the country. The main approaches used are the interpersonal approach and the mass media approach.

2.1 Interpersonal approach

The interpersonal approach is the main approach used by the health workers. Extension workers of other ministries such as the Ministry of Information and teachers from the Ministry of Education do also employ this approach in disseminating information on health to the community.

(a) By health workers

Health education activities are carried out as a routine by all categories of health staff in the clinic or health centre-settings and in the homes of members of the community. Similar activities are also carried out in schools and community organizations. Information on health is continuously disseminated by the health workers both "formally" and "informally".

In our country, especially in Peninsular Malaysia, there is a good network of hospitals, health centres and community* and midwives' clinics, which provide health care under the rural health services. The rural health services are manned by health personnel such as the medical officers of health, medical and health officers, nursing sisters, public health nurses, staff nurses, public health inspectors, hospital assistants, trained assistant nurses, community nurses and midwives. Their services reach the remotest possible village areas in the country. A substantial portion of their time and efforts are spent on informing and educating the community on health related matters. For example, under the maternal and child health services, health education activities such as talks and demonstrations on health topics such as antenatal care, postnatal care, child care, breastfeeding, nutrition for mother and child, immunization, prevention of home accidents, etc. are carried out. Dissemination of such information does not only take place during the attendance of mothers in health facilities but also in the home-setting when the nursing personnel visit the homes in the community.

Under the Environmental Health Programme, health education activities are carried out by the health inspectorate staff such as the Public Health Inspectors, Public Health Overseers and other extension workers. The topics discussed are mainly on preventive measures of communicable diseases, personal hygiene, food hygiene, environmental sanitation, sanitary water supply, vector control, etc. Their activities are usually in the form of house-to-house campaigns, dialogue sessions with the numbers of the community, talks/discussion during prayer meetings, informal discussions and the like.

*Community clinics are rural clinics (Kelinik Desa) manned by community nurses (Jururawat Desa).
Annex 3

Programme staff of other national 'vertical' health programmes such as the National Tuberculosis Control Programme, National Leprosy Control Programme, National Family Planning Programme, Malaria Eradication Programme and Filariasis Control Programme do also carry out information/education activities for their respective programmes.

(b) By the staff of other Government Departments

(i) Ministry of Information

The extension workers of the Ministry of Information such as the field officers, through their network of mobile units all over the country, assist the Ministry of Health in disseminating health information to the public. Their active participation in the dissemination of health information is intensified during endemics or epidemics and during special health campaigns. They assist the Ministry of Health in organizing dialogue sessions, civic courses and other similar activities for the purpose of health education/information. There are 251 such mobile units in West Malaysia.*

(ii) Ministry of Education

Teachers with schools under the Ministry of Education disseminate health information to their pupils all the time. Such communication takes place during the physical training sessions in the classrooms and during health science classes. There are teachers who are specially trained and appointed to supervise health related matters in all the schools.

(iii) By other Government agencies

Other government agencies such as the Community Development Organization ('KEMAS') under the Ministry of Agriculture do also disseminate information on health to the members of the community through their home-science sessions, kindergartens and such other activities.

(c) By other agencies

Agencies such as the family planning associations in the various states conduct courses, family-life education sessions, nutrition education, breastfeeding campaigns, sessions of antenatal, postnatal and child care, etc.

Organizations such as the Red Crescent Society and St. John's Ambulance do also carry out dissemination of health information to a certain extent.

*West Malaysia - 165 units; Sabah - 41 units; and Sarawak - 45 units.
2.2 Mass media

Mass media is another major approach that is used for disseminating health information in the country. This could be categorized into the (a) print media, (b) broadcasting media and (c) other media.

(a) Print media

(i) Newspapers and magazines

Malaysia's population is made up of a multiracial society. There are about 57 newspapers (inclusive of daily newspapers) and magazines in more than about 7 major languages in Malaysia (including publications in East Malaysia). The total circulation of these newspapers and magazines is estimated to be around 2 million copies with a readership of about 3 persons per copy. Almost all the newspapers and magazines are privately owned.

In West Malaysia alone, there are daily newspapers in the four main languages, that is, in Bahasa Malaysia, English, Chinese and Tamil.

Health information in the form of news items on epidemics or endemics, health warnings, health advice on preventive measures and feature articles on health are published periodically and as and when there is a request from the Ministry of Health for such coverage. Such health information is carried out by all the vernacular newspapers.

Magazines such as the 'Wanita', 'Her World', 'Keluarge', 'Dewan Masyarakat', Urasan Pelajar', Mingguan Kanak-kanak' are published monthly and carry articles on health topics. Some of the magazines also carry a "Doctor's Column" in which questions pertaining to health matters from the readers are answered.

Apart from these, there are also other publications such as the 'Sinar Zaman' (Ministry of Information), 'Sihat' (Ministry of Health), 'Pembangunan Masyarakat' (The Prime Minister's Department), 'Bulletin Keluarga' (The National Family Planning Board) and several others which are published monthly and distributed free-of-charge to the public. These publications carry health information in the form of short articles and questions and answers.

(ii) Pamphlets, posters and booklets

The Health Education Unit in the Ministry of Health produces pamphlets, posters and other such educational materials on various health topics and distributes to the members of public, schools and other agencies through its State Medical and Health Departments. Materials are also obtained by agencies direct from the Health Education Unit.

Agencies such as the National Family Planning Board, the Federation of Family Planning Associations, Malaysia, do also produce educational materials on health and distribute through their existing network.
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(b) Broadcasting

This is another major mass media through which information on health is disseminated to the public.

(i) Radio

There are four language networks which extend their broadcasts to cover the entire country. There are also other local radio broadcasts such as the Capital City Broadcast (Kuala Lumpur), FM Stereo Broadcast and Aborigenese Broadcast. In addition to these, there are three other regional broadcasts which cover the northern, southern and eastern regions of West Malaysia. The regional broadcasts are done between 3 p.m. and 7 p.m. daily to cater for the regional listeners. About 15% to 23% of the radio broadcasting time is allotted for information/education on all issues. A reasonable portion of this time is utilised for disseminating health information. The radio programmes are said to reach about 85% of the population. The advent of transistorized radio-sets has enabled people even from the remotest areas to listen to radio programmes.

The approaches employed in disseminating health information through radio are the (a) straight/direct messages, (b) indirect messages. These are broadcast in all the main languages of the population.

Health messages are broadcast in the form of:

- Children's programme (health)
- Women's programme (family health)
- Youth programme
- Talks
- Radio Doctor (questions and answers)
- Magazines
- Interviews with medical/health personnel
- Forum
- Special feature programmes
- Comic sketches
- Spot announcements
- Promes/jingles
- Titbits on health
- Capsulization, etc.

The dissemination of health information is carried out by the Broadcasting Department as a regular activity and also on the request by the Ministry of Health. Broadcasting of health information is intensified during certain campaigns such as the Anti-Dengue Campaign, in the Control of Communicable Diseases, during epidemics and so on.

There are also local radio broadcasts carried out by private agencies such as the rediffusion to cater for the needs of city dwellers in Kuala Lumpur and Ipoh. A short duration of their broadcasting time is also allotted disseminating health information.
(ii) Television

Television Malaysia has a national network with 35 hours of telecast-time a week. Networks 1 and 2 of the Television Malaysia have 28 hours and 44 hours of telecast-time respectively. Network 3 which links up the national network to East Malaysia has a telecast-time of 20 hours a week. About 10% to 30% of the telecast-time in the various networks is used for programmes related to information/education. A reasonable percentage of the telecast-time is allocated for disseminating health information. Like in radio, the approaches used are both direct and indirect approaches.

Health information are telecast in the form of:

- Interview/discussion programmes
  - Fokus (Bahasa Malaysia)
  - Scope (English)
  - Tumpuan Minggu (Tamil)
  - Lembaran Minggu (Chinese)
  - Kesuma - Women's Programme
  - Titbits in dramas/comic sketches
  - Drama programme (e.g. Drama Minggu ini)
  - Film trailer/jingles
  - Spot announcements
  - Etc.

(b) Mass approach by Government departments and other agencies

(i) Ministry of Health

There are mobile health education units operating under the Health Education Units of the State Medical and Health Departments in the country.

These mobile units visit the villages, schools and other areas on a routine basis and carry out health education activities. They visit areas which are identified by the district level health staff and provide all the technical assistance that is required by the local staff to carry out health education activities in their respective areas. Films on health topics are screened and talks, discussions/dialogue sessions with community leaders are held during such visits. Pamphlets and booklets on health topics are also distributed during these visits. Each mobile unit is able to cover between 120 and 200 villages and schools in a year.

(ii) Ministry of Information

The Ministry of Information has a fleet of mobile units in the country. Almost every administrative district in the country has a mobile unit. There is a total of 251 Information Department mobile units in Malaysia.
These mobile units make regular visits to the villages to disseminate information on all aspects. During such visits, the field officers disseminate information on health as well. Films on health are screened during such visits.

The talking points are usually provided by the Ministry of Health (national level) and by the State Medical and Health Departments (State and district levels).

The mobile units are actively mobilized during special health campaigns, during epidemics and at other times according to the needs of the Ministry of Health.

(iii) Other agencies

The National Family Planning Board, the Ministry of Agriculture and a few other agencies do also have information mobile units. These mobile units are also used to disseminate health information.

(c) Health exhibition

Health exhibitions are held in all the states by the State Medical and Health Departments on health topics which are determined by the departments concerned. Exhibitions are also held to disseminate health information on specific topics for campaigns such as the Rural Environmental Sanitation Programme, Malaria Eradication Programme, Anti-Drug Abuse Campaign, Breastfeeding campaign and so on.

Exhibitions are also held on World Health Day themes. During the year 1979 and 1980, these exhibitions were organized by the Health Education Unit at the Ministry of Health and were held on a rotation basis in all the states.

(d) Other media

Health information is also disseminated to the public through folk media such as "Dikir Bare" (in the State of Kelantan), and "Boria" (in the State of Pulau Pinang).

It is important to note that the foregoing account of the media/approaches is neither complete nor exhaustive. There are numerous other channels of communication that exist for the dissemination of information on health to the public in our country.

3. Strategies/activities adopted for the improvement of health information promotion

3.1 Restructuring and reorienting the health information/education setup

Positive attempts have been made to strengthen and improve the present system of communication linkages among the various media for disseminating health information to the public.
Annex

3

(a) Workshop on dissemination of health information

The Ministry of Health has initiated activities to achieve this objective. In line with this, a Workshop on the Dissemination of Information on Health and Development (Primary Health Care) was held in Kuala Lumpur (Malaysia's Federal Capital) from 1-4 December 1980.

The objectives of the workshop were:

(i) General objective

To strengthen and increase effectiveness in the dissemination of information on health and development (primary health care).

(ii) Specific objective

(1) To identify problems related to the dissemination of information on health and development to the public.

(2) To define the role of the various agencies responsible for the dissemination of information on health and development and to recommend ways of expanding the role of the mass media channels in informing the public on health matters.

(3) To identify activities that would facilitate the dissemination of health information to the public.

Fifteen participants from the Ministry of Health (composed of Health Education Officers; a Press Officer, a Public Relation Officer and Dental Officers), 3 participants from the Ministry of Information and Broadcasting, and 10 participants from the National News Agencies (BERNAMA) and all the National Daily Newspapers and the Malaysia Press Institute attended this workshop. Mr J.C. Abcede, the WHO Regional Information Officer, Western Pacific Region, was the resource person and adviser.

Several recommendations were made by this workshop to the Ministry of Health and the media (press and radio and television) in order to improve and promote the dissemination of health information to the public. Some of the recommendations were:

(a) to facilitate and promote the flow of information on health and health-related matters and activities of the Ministry of Health to media services.

(b) The media services to serve as a link between the Ministry of Health and the public.

(c) The Ministry of Health to set up unit or responsible officers who could help provide the information on health-related matters that are required by the press.

(d) The Ministry of Health to strengthen the communication skills and health education techniques and capabilities of its officers.
Annex 3

(e) To encourage the print media to have reports/writers specializing on health-related subjects.

(f) The print media to carry more feature and other articles on health and health-related matters.

(g) The radio and television to introduce more health education materials in their programme and to integrate health messages in their programmes.

(h) Training courses in health reporting to be held for journalists and other mass media people - with collaboration from the Malaysia Press Institute, Kuala Lumpur, WHO and other related bodies.

(i) To provide specialized training programmes for health personnel in mass media requirements, advertising, scriptwriting, film-making, and in other relevant areas.

The recommendations of the workshop are being studied by the Ministry of Health for implementation.

Meanwhile, the Malaysian Press Institute, Kuala Lumpur, has set up a pro-term committee with representatives from the Ministry of Health, Ministry of Information and Broadcasting, the Press and other related bodies to develop a training programme for the journalists in health reporting. It is hoped that this training will be conducted in the near future.

(a) Other activities

Apart from the workshop, the Health Education Unit of the Ministry of Health is intensifying its activities to enable a better flow of health information to the media. For example, the Health Education Unit has arranged for the broadcast of regular health talks to the Broadcasting Department. At least 14 major topics on health were included in the radio and television broadcasts in the year 1980. The unit has also facilitated the flow of information on health-related topics to the print media and other interested agencies.

At the State level, the State Medical and Health Departments have also intensified their health education activities through their respective State Health Education Officers. The health staff of the various health programmes have been mobilized to this effect.

Better collaboration has been established with other agencies in the State such as the Regional radio station, Information Department, News agencies (through the Information Department), Community Development Department (KEMAS) etc., to facilitate information flow on health-related matters to the public. Existing facilities such as the information mobile units, extension workers and the like are fully mobilized for this purpose.
3.2 Training of information, health and health-related personnel in disseminating information on health

Attempts have been made to this effect and much is expected to be done in this area.

Health Education Officers who undergo the 'Postgraduate Course in Health Education' are given a short training to prepare themselves for producing radio programmes at the Tun Abdul Razak Institute of Broadcasting in Kuala Lumpur.

All categories of health staff particularly the paramedical personnel such as the nurses, public health inspectors, hospital assistants and auxiliaries such as the trained assistant nurses, community nurses, public health overseers and midwives under the Ministry of Health, have been and are being trained in health education skills and techniques, by way of basic training programmes and in-service training programmes. The State Health Education Officers carry out training of the staff in the State in the related subject.

3.3 Collaboration and coordination among organizations concerned with health information/education

Currently there is good collaboration among the various organization concerned with health information/education in the country. The Government departments, concerned with health information/education activities such as the Ministry of Health and the Ministry of Information and Broadcasting and other agencies such as the press have established a good working relationship. Attempts are being made to further improve this cooperation among the organizations so as to enable a better flow of information, education and communication in health at all levels, that is from the national level to the state, district and village levels.

4. Conclusion

Activities related to information, education and communication in health are planned, implemented and coordinated by the Ministry of Health. Mass media such as the Radio and Television Malaysia, the Press and the Ministry of Information play a very vital role in the actual dissemination of information on health to the public. It is hoped that with better collaboration between these agencies and with improved facilities and channels of communication and better information/education techniques, a better informed public can be created. This would augur well for achieving a higher standard of health by the people.
Dissemination of health information in New Zealand: 1981

Ladies and Gentlemen greetings,
Best wishes from the land of the long white cloud.

1. Introduction

New Zealand has a multicultural society comprised mainly of European race with a growing Maori and Pacific Island population. Recently there has also been added an increasing number of Vietnamese citizens to the population. I opened my report with a Maori greeting. Maoris are the original settlers of New Zealand and today very few speak only Maori although there has been an encouraging revival of the language. The Pacific Island community on the other hand comprise mainly first generation immigrants who for the purpose of good verbal communication are happiest in their own island tongues of Tongan, Samoan, Cook Island Maori, Niuean and Tokelauan. The Vietnamese new New Zealanders find themselves in the same situation as the Pacific Islanders. English is the main language so all forms of written and spoken communication are primarily in English.

The population of just under three million is widely scattered throughout the country but with a greater concentration of people living in the north island than in the south as can be seen in the map which is provided.

Education is free and compulsory from age 6 years to 16 years and most children start in school at age 5 years. There is also a free preschool education available and a high proportion of children attend these schools from 3 1/2 years of age.

2. Promotion of health and safety

Teaching health is a shared role in New Zealand. As would be expected health education is a primary responsibility of the Department of Health but other government departments and voluntary organizations play a very active part in specific areas some of which are as follows:

(a) Department of Education

Health education was officially introduced into the school syllabus at junior level in 1969. Publication of a handbook for school teachers jointly written by Dr M.B Joel, Department of Health, and Mr I.W. Phillips, Department of Education, marked the beginning of health as a compulsory subject for this age group of 6 to 12 years.
It is hoped that shortly health will become a compulsory subject for children at secondary level - 13 to 16 years. At present, it is taught to this age group according to each school policy and is carried out as an extensive programme in some schools but a very small one in others.

To support the health education in schools, the Department maintains a Health Education Resource Project (HERP) which acts as a backup to school based programmes. HERP has a limited term of 5 years to function and is funded jointly by Department of Education, Heart Foundation and Alcohol and Liquor Advisory Council. For some students added funding is provided by Department of Health, Cancer Society and Accident Compensation Corporation. The project is committed to preparation and supply of kit sets for use in schools. They also keep a resource catalogue of available health publications as a reference for teachers.

(b) Ministry of Transport

Promotion of road safety is on a continuing basis through radio, television, press and production of posters and pamphlets. The programmes are aimed at specific groups such as the teenage driver, the drinking driver and parents on the subject of child restraint.

(c) Other Government departments

In a similar manner to Ministry of Transport where health information is appropriate programmes are implemented.

(d) Accident Compensation Corporation (ACC)

An ad hoc corporation funded by levies from employers and for the non-worker government funded; the promotion of safety is of prime concern of this body. ACC produce a wide range of resource material in the form of booklets, pamphlets, posters and such like for the use of their own safety consultants who work in the community and in industry. Much of this printed material is also freely available to government departments and other groups similarly involved in promoting safe behaviour.

(e) Voluntary organizations

Heart Foundation, Cancer Society, Red Cross, the Order of St. John and many other voluntary groups are actively engaged in the provision of information for the people.

3. Department of Health

All medical and paramedical staff employed by the Department of Health are expected to promote health and safety as an integral part of their work.
Annex 3

(1) **Health Education and Information Unit**

In February 1981 all sections of this unit were brought together in one building. Previously the scattered nature of the unit made communication within its own ranks disjointed. In the month following the coming together of all sections from three separate buildings, there is an obvious improvement in coordination of effort.

The unit consists of:

(a) health education training section, responsible for inservice health education training of Department of Health personnel;

(b) the publications section, responsible for departmental publications and written resource material;

(c) an artist;

(d) an audiovisual section, responsible for audiovisual resource production, display and advisory service to departmental staff;

(e) an audiovisual lending library for the use of departmental officers and selected health promoting groups and individuals;

(f) clerical, administrative support staff.

(2) **Film production**

To promote child and family health care six 14-minute films were produced during 1979-80. The subject matter which was closely monitored by a Department of Health steering committee covers the child from conception to 6 years of age. Designed to inform parents of health promoting behaviour during pregnancy and early childhood they are intended as educational films. An unusual approach to health has been used in producing the films. They are lighthearted, entertaining, often funny with a serious health message. Planned to catch and hold attention they were first shown on television and are now available through our audiovisual library for community education use.

(3) **Programme promotion through the media**

According to planned objectives, resource material is produced in support of departmental priorities:

(a) printing of pamphlets and posters;

(b) production of a quarterly magazine "Health".

(4) **Use of advertising**

Supporting planned programmes:

(a) radio - short commercial spots;

(b) television;

(c) magazine and press.
(5) Community service of television and radio broadcasting

A supplementary service by New Zealand broadcasting service is provided by a generous extra showing of television and radio advertising.

(6) Translation for immigrant groups

Although it is not practical or necessary to produce all handout material in other than the English language, selected translation is undertaken. For example, rubella immunization information is translated into five leaflets in Pacific Island languages, with English text on the reverse side of each leaflet.

Translation into Vietnamese is now being undertaken for separate and selected purposes.

4. Choice of method for health promotion

Experience has taught over the years that a careful analysis of method, level of understanding, and media choice is essential before production of information to be used in any programme.

Evaluation of the effectiveness of health-related information is very difficult but good pretesting of written material with a small sample of the community who will be using it, before printing, has proved invaluable. All pamphlets are treated in this way.

So often the most important factor in acceptability is how information is presented and who presents it.

COUNTRY REPORT - PAPUA NEW GUINEA

by

Byron K. Geniembo
Officer in Charge, Health Information Unit

Department of Health

An internal arrangement was made in March 1979, when the Department of Health had assured the setting up of a Health Information Unit.

Although still understaffed to date, the unit continues to progress in its activities of informing people about health services in the country. In the meantime, a basic document for the promotion of health information in the country has been prepared which includes annexes on many of the relevant guidelines and recommendations from the first WHO/UNICEF Regional Workshop on the Promotion of Health Information in the Western Pacific Region, held in Manila from 6-12 March 1979. It is anticipated that the said document will serve as a useful purpose for planning and implementing full national health information programmes as soon as the unit is established properly.
Annex 3

Health information services, however, is the role the Department of Health has to play in contribution to the total information and communication services system of the country.

Review by Government

During the past several years, the Government of Papua New Guinea has become increasingly aware of the need for developing its communication resources and systems. Consistent with that concern, the Government established the Information Review Committee in mid-1979 to survey communication needs as well as to recommend proposals for communication development.

The Committee submitted its report by the end of 1979, and on 23 January 1980, the National Executive Council "approved in principle" the majority of its recommendations.

The implementation of these recommendations was to be accomplished by the establishment of high level Task Force "to ensure an orderly and effective transition from the present communication system to more suitable forms".

Change in Government

A change in Government in March 1980 produced a decision in April to 'suspend indefinitely' the previous Government's approval of the communication recommendations. The Communication Task Force, however, was retained, and they presently are at work to upgrade the existing Office of Information. Evidence has been gathered to warrant a more effective centralized government communication system. It is likely that information service of a wide variety will be amalgamated into a Department of Information. Included will be functions such as greater support of provincial efforts, extension liaison, and translation services.

Television

Television as a mass medium has been considered for introduction into Papua New Guinea for some time. Due to its costs and the lack of infrastructural services required by it (e.g. power supply and production capacity), it is likely that its introduction will be deferred for the near future.

Government resources, however, will be used to upgrade both print media and radio broadcasting. In September of last year, a significant milestone was reached when the last province of the nation received its own provincial radio service.

Awareness of the crucial role communication plays in development has increased at all levels of the national community and in the Government. Careful planning is taking place to ensure that our investments will be used to the greatest possible good.
The Information Unit of the Department of Health has had an increasing responsibility since March 1979 in disseminating health information through print media, press and radio in the country and through correspondence and print media abroad. There is a bright future for improvement of Health Information Services in Papua New Guinea, but its expeditious performances will depend very much on the availability of funds and qualified staff.

Further to our brief progress report in general above, an appendix on the review of health information and education services in 1979 is included. The review indicates the Department's achievements and failures and suggests ways for improvements, changes and developments in certain areas of information and education programmes.

APPENDIX

REVIEW OF INFORMATION SERVICES IN 1979

Response of the Department of Health to questionnaire (omitting irrelevant areas).

1. Print media

The Department of Health mostly use posters, wall charts (or teaching charts), booklets and pamphlets for educational purposes and health bulletins for information. These are printed by either Health Education Section or elsewhere which are in English and some in Motu and Pidgin.

The present printing facilities/arrangements within the Department is not adequate for our needs. There is indication of big demand for the print media from the Department but owing to the inadequate facilities and manpower resources, we have never been able to meet this demand.

Doctors and other specialists write handbooks for various categories of health workers such as nurses and health extension officers from time to time which are printed by private companies and other government printing organization. This, however, have continued to be an expensive exercise.

We would like to see a more frequent issues of health bulletins, pamphlets and booklets for both information and educational purposes by the Department of Health. We also would like to have more handbooks published for educators, health extension workers and communicators.

2. Radio

All the provincial radio stations have fixed weekly programmes on health education covering various health and disease topics. Other programmes of the radio such as the "TOK SAVE" is also used to inform people on movements of health workers in the areas. We use radios in the events of epidemics and in the campaigns against certain diseases to educate and inform the public on proper control measures. News releases have been a common practice by our Department over the National Broadcasting Commission.
Annex 3

We have found the radio programme throughout the country to be very effective. The staff of the National Broadcasting Commission elsewhere have been cooperative. However, it is felt that since the National Broadcasting Commission in Papua New Guinea is often understaffed, one of its roles should include training of officers from other Government Departments and organizations at the cost of the relevant Departments or organizations in radio knowledge and techniques, and in journalism. These officers then would be seconded to National Broadcasting Commission for full-time programme producers over the radios.

The Health Department realizes the "Education News" and "Man on the Land" programmes of the Education Department and Department of Primary Industry respectively and feel that there is no reason why we should have similar opportunity to produce health programmes. The languages for broadcast should continue to be English, Motu and Pidgin and one or two of the major languages spoken in the area at the provincial radios.

3. Video

We do not use video, but if we were to use it then it could be best used only at the training institutes for instructional purposes to students and trainees.

The standard should not be established for video programming. However, the video machinery should be unified so that the models of the machinery and their accessories are selected to suit the tropical conditions, and that they will be a reasonable price to Papua New Guinea economy.

It can be said that the role of video in development can be twice as much or more to that of the radio.

4. Film

We have used 16mm, movie films and film slides in training and in health education talks. They are found to be quite effective particularly the film slides as the educator has control on the media to explain things which gives time for audience to understand well.

However, it is felt that the Government should encourage and support for development with departments and agencies 8mm film equipment which are much lighter and portable and are less expensive.

The films can be easily produced by a person without much training. Compared to other media, movie films are probably the most accepted form of audiovisual aid in communication. Evidence has proved that people can learn skills, information and sometimes change their attitudes from films alone without the aid of a teacher, provided they are prepared to learn.
Movie films are important because they:

1. Arouse interest.
2. Combine sight, sound, movement and inflection to a very high degree.
3. Can be approximated to reality better than any other media.

5. Photographs

All photographs used by the Health Department are black and white most of which are produced at the expense of Provincial Health Officers themselves or other specialists. These photographs are used mainly for the Department's annual reports. Some of the photographs are produced by the Health Education Section, but others such as for passports are provided by the Office of Information.

The Health Education Section have the equipment and facilities for producing photographs, and they produce a lot of photographs each year and often half the number of photographs are of the polaroid type which are sometimes in colour.

Most of the Health Education photographs are used for pasting on the Health Study Certificates.

The Government facilities are inadequate as well as a time consuming process for our present photographic needs. However, if we did have a better access for it in the future, the photographs would be best used on pamphlets, booklets, newsletters and brochures to inform the general public and people of other countries what health services is all about in Papua New Guinea.

Such media could be produced by Health Department and distributed through the Office of Information for International Exhibitions, and through the Office of Tourism for visitors to Papua New Guinea, etc.

6. Small group media

The Government could make better use of this communication form by establishing a training institute where youngsters could be trained in general traditions, and later choose specialized fields such as health education, primary industry, politics, etc. The performances could also be filmed or recorded for radio programmes.

7. News

We realize the problem of shortage of staff in the National Broadcasting Commission and Post-Courier. We also realize that Post-Courier have made available a space in the paper for the Health Department for its weekly news items and other programmes. However, there has been a breakdown in communication between the Post-Courier and Health Department Headquarters to be able to utilize this opportunity of disseminating health message. Secondly, there has been no trained and full-time officer with the Health Department to deal with news and other information programmes constantly on weekly basis.
In 1979, the National Broadcasting Commission initiated the formation of the National Broadcasting Commission Coordinating Committee made up of representatives from various Government Departments and Agencies. The role of the Committee was to draw up guidelines on major national problems for National Broadcasting Commission Support Programmes. However, we feel that this does not solve the needs for our Department in dissemination of health information. We do realize the interests of mass media and their emphasis between the "hard" and "soft" news but, at the same time the role of the mass media should include constant, liaison with various Government Department such as the Health Department to study their needs for types of news for communication. Even though the mass media may think that health news are "soft news", we feel that with the new concept of primary health care, health news are just as important information as other "hard news" to communicate with people.

**The informing function**

Through their news stories, the mass media can make aware of the various components of primary health care.

**The interpreting function**

Levels of awareness and knowledge about primary health care matters can be increased by means of in-depth, interpretive reports in both the print and broadcast media.

**The instruction function**

The mass media can do this through "how-to-do-it" type reports.

**The motivative function**

The mass media can often persuade the Government, other agencies as well as the public to act on certain health problems in the community. This could be done through motivational articles in the form of editorials and columns.

**Providing opportunity for dialogue**

The mass media can provide opportunity for dialogue between and among medical practitioners, auxiliary health workers, interested reading public, etc., and between these groups and media practitioners.

**Participating in special campaigns**

Special health information campaigns undertaken locally by the Department of Health or other agencies during specific weeks or months should receive support from communication media in terms of expanded coverage of the specific topic concerned during the period of the campaign.
Assisting in health law enforcement

Through sustained projection in the mass media, both print and broadcast enforcement of legislation and/or policy relating to specific components of primary health care can be facilitated.

Undertaking action programmes

Newspaper writers and editors should continue and be more active in governmental organizations and other agencies which promote community welfare projects.

Many, if not all of the hints made above are the existing roles of mass media in Papua New Guinea. However, taking points into consideration, it is obvious that there is much room for improvement in communicating primary health care via the mass media.

8. Development communication

Unfortunately, we do not employ anyone with skills in "development journalism" in our organization to do this.

9. Communication training

There are no trained or skilled communicators in the Department of Health. However, the Health Department should be interested and consider seriously in practical in-service training for health educators with emphasis on news reportings and radio programme producing and basic journalism.

10. Coordination of communication

There is poor cooperation and no coordination within the Health Department in the area of communication, in that each section of the Department puts out its own little newsletter. This encourages each section to look upon itself as a separate body and not as a part of one organization. For this reason, the Division of Health Planning and Research under the guidance of Dr Benjamin Taukuro prepared and put in a submission for establishment of National Health Information Unit on 5 February 1979. It is understood however, that the submission is being withheld at National Planning Office pending total review of Government's communication services and activities which is currently carried out by Information Review Committee. One of the major roles of the proposed National Health Information Unit would be to coordinate information and communication activities of all the divisions and sections of Health Department through one channel as one organization. This unit then would endeavour to improve the image of Health Department within the country and overseas as well.
Annex 3

11. Access to information

The Department of Health up to this stage has been providing information internally and interdepartmentally through extension workers such as health educators, literature and radio. Nevertheless, it has always been difficult because one has to seek for the right office, and often there is no information readily available, etc. There has been no contact point at Health Department for other people seeking information on health. There is no flow of information to people and vice versa. Again this was another big reason for our proposal for establishment of National Health Information Unit. The Information Review Committee may be well aware of our need for setting up a health information centre as they keep our submission as mentioned earlier in question No. 10.

12. Postal services

No comment.

13. Translation

With our submission for establishing National Health Information Unit in mind, our need for translation in the future can be expected to be great. Health information brochures, pamphlets, booklets, etc. are not only expected to be translated into Motu and Pidgin, but also into other foreign languages such as French, German, Chinese, Japanese, etc. A centralized translation service would not only be useful, but would be less costly to us and other government departments and organization.

14. Communication research

We have never conducted any real research in communication other than the perception test and pretesting of new posters or wallcharts before using them. In 1967, a survey was carried out in the Central Province to find out people's concept of the world "HEALTH" which had been interpreted as "HELP". However, it is strongly felt that we would benefit very much from research into specific communication forms such as the traditionally accepted channels of communication in villages and communities what form of message people value best, radio-message or personal by extension workers, etc. so that the medium of communication can be determined for certain people in the areas, etc. The student of communication studies should do this research under the guidance of their tutor or a consultant.

15. Extension services

It will be fair to say that the field workers of the Health Department do make use of some form of communication in their extension services. On the other hand, most of our field workers are not properly trained to do this. They do not have the technical-know-how, and often do not have the right tools, materials or aids to carry out extension programmes.
Health Education Officers are the only field workers who are able to carry out extension services. Besides their wide range of activities in education and training in schools, colleges, other categories of health workers and other formal groups in urban areas, they are able to get out to rural areas to carry out extension programmes. Health Education Officers must be commended. However, this does not mean they do not need support. Their great need for support would be in terms of money, transport, portable generators and movie film projectors. It is experienced that most communication programmes in villages and communities is best carried out in the evenings when people return from gardens and work.

16. Communication policy

We would appreciate the following areas of communication policy to be drafted:

1. Decentralization Policy - Decentralizing communication policy not only to the provinces but to various government departments and agencies.

2. Coordination Policy - between ministries and the respective departments and agencies.

3. Research and Evaluation Policy.

4. Participation and Feedback Policy.

5. Manpower and Training Policy.

6. Cultural Integrity and International Exchange Policy.

We feel that all of the areas mentioned here should have equal priority as they would also be of greatest concerned to most other organizations.

Finally and very briefly, we wish to suggest that the Government should consider establishing a national information and communication centre with its branch offices at various Government departments and agencies. The branch offices then should be staffed by "communication professionals as well as the communication generalists" who are expert in the subject matter to be informed or communicated.

COUNTRY REPORT - PHILIPPINES

by

Valentin C. Loyola
Officer-in-Charge, Division of Information

The accelerated development of mass communications in the Philippines has made the dissemination of health information easier and more effective.

In the development of the mass media, the most significant in recent decades was the advent of the transistor radio.
The Philippines being an archipelagic country - composed of over 7000 islands - reaching the rural dwellers by newspapers and magazines on time is still a problem and will be a problem for a long time to come. The major newspapers printed in Metropolitan Manila are distributed by aircraft only to the major airports and delivered to the communities around it. The provincial subscribers get their copies by interisland and shipping and after much handling and traveling finally reach their destinations. It is only in the urban centres near airports that provincial readers get their newspapers on time.

But the transistor radio has bridged the straits and channels separating the hundreds of inhabited islands. Information from the news centres of the nation reach the fishermen while at sea, the farmer while he is in the field or the wife while she is doing house work even in remote islands.

Considering that some two-thirds of the population live in rural areas, many of them isolated, radio broadcast has simplified the dissemination of health information.

There are 287 radio stations and 44 television stations in the Philippines, many of them broadcasting in the provinces within the range of all inhabited islands. What has been called "transistor revolution" has of course not diminished the importance of the newspapers and magazines.

In fact, newspapers and magazines have themselves become some of the richest sources of information for radio. Finding their way to libraries and barangay training centres at the grassroots level, they have become even more useful because of their detailed and specialized reporting and, of course, because of the retentive quality of their contents.

Metro Manila has eight English and four Pilipino dailies. In addition, there are 12 weeklies. All over the country, there are 98 community newspapers. There are 110 magazines including those illustrated in the style of comics. There are eight provincial magazines.

These are all registered with the Publishers Association of the Philippines, Inc. (PAPI).

It is safe to say that there are house organs, trade papers and other regular publications not registered with PAPI. A number of them are health-oriented and, therefore, carry useful health information.

Health-oriented media

There are other significant factors that have helped to make the dissemination of health information more substantial if not more vigorous. One is that the mass media has become more health conscious or health oriented. The other is that the level of health consciousness among the masses of the people has been raised to a level where they demand more health information. Of course, the mass media have played invaluable role in the raising of the level of health consciousness among the people. Since the public demands more health information, the mass media meet this demand.
Today, all major newspapers in Metro Manila have assigned reporters to cover the Ministry of Health. They produce on-the-spot news or do specialized reporting. Even the two better known business newspapers in Metro Manila have assigned reporters on the regular health beat. In addition, radio and television reporters cover the health ministry.

Health reporters from the print and broadcast media also cover medical, dental and allied associations and societies. All of these professional groups disseminate useful health information to the general public.

**Health Ministry Information Service**

The Ministry of Health has a division on information. The 12 regional health offices also have their equivalent of an information division manned by public information officers (PIOs).

Among other things, the PIOs in the central headquarters and in the health regions issue press releases of general interest. They also engage in other forms of information activities such as the production of color slides, pamphlets, leaflets, posters and regional periodicals with newspaper format. Of course, they maintain close liaison with the working press, from the print and broadcast media.

The Division of Information help make available specialists for radio and television interviews.

**Training Arm**

The Ministry of Health has the Office of Health Education and Personnel Training (OHEPT). It is the training arm of the Ministry. It also produces health information materials.

Each regional health office has a health education adviser who also disseminate health information.

In the pre-service and in-service training of field health personnel, it is emphasized that every field workers is a health educator able to disseminate the more basic health information depending on his category and training.

The World Health Organization Western Pacific Region is doing much to improve the quality of health reporting. Periodically, the WHO Manila information office invites health reporters on observation trips to the provinces to acquaint them of health projects. For example, it has afforded some health reporters an insight into the mechanics of the primary health care (PHC) concept by taking them to Leyte to observe how PHC works.
Annex 3

Information, education and communication (IEC) programme

It is in this atmosphere that the information, education and communication (IEC) programme as a component of primary health care has been developed.

The programme recognizes that IEC is a necessity especially for field health workers. In the health system, there are settings wherein IEC as a tool for the health worker can be fully utilized. These include maternity wards, prenatal and postnatal clinics, nutrition wards, mothers' classes, mothercraft centres and the homes.

Besides these, there are other opportunities to utilize the IEC programme to reach other segments of the population such as the youth and the leadership groups. Such an opportunity is offered by schools. The Ministry of Health IEC programme calls for a full cooperation with government and non-government agencies such as the Population Commission (POPCOM).

The IEC component addresses itself to problem areas, namely, poor nutrition especially of mothers and children, the decline of time-tested breastfeeding, low family planning acceptance and mothers' discontinuation of family planning measures, inadequate levels of immunization, high maternal and infant mortality rate, lack of safe drinking water, poor waste disposal and high prevalence of communicable diseases.

The thrust of the IEC component is to equip the Ministry of Health field staff and volunteers in their face-to-face communication with the various segments of the community. This will be done by increasing the capacity of the Ministry of Health to design, produce and distribute IEC materials; to supervise field workers in the utilization of IEC and to evaluate IEC activities. For the production of IEC materials, the programme calls for a printing section. Equipment and skilled personnel will be provided.

The IEC component of primary health care is expected to perform a useful role in the attainment of "Health for All by the Year 2000".

COUNTRY REPORT - SINGAPORE

by

Dr Yii Kie Mung
Dental Officer
Training and Health Education Department

The new concept of health promotion is to motivate full participation of the individual and the community. Towards this end, health education and health information are two important means to achieve the goal. In this way, the individual and the community are armed with useful knowledge to promote their own well-being and health.
In Singapore, systematic health educational activities aimed at specific health problems are organized. A multi-media approach is taken, utilizing print, broadcast and interpersonal means to inform and motivate the public. Participants from governmental, statutory and private organizations are coordinated to complement the efforts of the Ministry of Health.

The Training and Health Education Department is responsible for health education activities to the public and specific target groups through its regular programmes, publications and campaigns. Audiovisual materials for health education are developed and produced by the Department. It also provides training for nurses and teachers to conduct health education. In addition to generating publicity and information over the mass media, health education is also provided through talks, slide and film shows, exhibitions, seminars/workshops and a host of other means (see Appendix 1).

With rapid industrialization and urbanization, patterns of social behaviour have changed, influencing also health and disease patterns. Of concern is the growing incidence of chronic and degenerative diseases associated with harmful lifestyles. In view of this, a National Health Campaign was organized in September 1979 and continued into 1980 which focused on five diseases - lung cancer, heart attacks, high blood pressure, diabetes and mental health, which can be collectively described as diseases linked to stress situation or self-imposed by cultivating harmful lifestyles which place a person at risk. Campaign activities consisted of exhibitions, mass media publicity, competitions, dissemination of educational and promotional materials and seminars. These were sustained by follow-up activities which included mobile exhibitions, talks and film shows in community centres, schools, military camps and other establishments.

Recently, a campaign on "Smoking and Disease" was launched in response to the increasing morbidity and mortality due to smoking-related diseases. This was also in line with the WHO theme for 1980 - "Smoking or Health - The Choice is Yours". The campaign is specifically targeted at young people - students, vocational trainees and national servicemen - to educate them on the harmful effects of smoking.

One way to improve the Department's health information service would be to train the professional staff to acquire skills in effective writing in journalistic style. Training and Health Education Department intends to implement this in progressive stages.

Family planning IEC activities

Information, education and communication (IEC) activities are necessary to generate and sustain demand for family planning services and to promote the small family concept, in particular, the two-child norm. Soon after the Singapore National Family Planning and Population Programme was launched, increasing emphasis was put on the IEC aspects of the programme. This culminated in the award of the Max Lewis Trophy for the best Public Service Advertising Campaign in Asia, at the 8th Asian Advertising Congress held in Bangkok, November 1972.
Annex 3

The IEC programme consists of a wide variety of mass media channels as well as face-to-face, group and individual motivation (see Appendix 2). The main messages disseminated in recent years continue to be the promotion of the two-child family concept and discouraging early marriage and childbearing, and the promotion of spacing with a three-year birth interval.

Under the ASEAN multi-media project in support of population programmes, Singapore's contribution consisted of developing a range of audiovisual materials and media which were pretested and used in a family planning campaign for young factory workers. The materials include exhibition boards, posters, pamphlets, a comic book, family planning songs and a documentary (done in a human drama or soap opera (film style) on the problem of teenage marriage. The family planning songs have been recorded into cassette tapes for distribution to schools, factories and popularized through radio and the cinemas.

Health and family planning educational services will continue to play an increasingly important role in national development. As society becomes more affluent and educated, demand for health services will reach even higher and more sophisticated levels. Wider dissemination of health information will not only generate further demands but if channelled constructively towards the preventive aspects, can also serve to reduce the strain on our health care delivery system. The promotion of health through education should therefore be given high priority and go hand-in-hand with national development.

Dissemination of health information by radio and television and the press

Radio and Television, Singapore, previously a government body, has been reorganized and is now a statutory board named the Singapore Broadcasting Corporation. As such, it is far more difficult for the Health Ministry to have access to the Corporation's radio/television outlets. The Health Ministry has to pay full commercial rates for air/viewing time. However, SBC on their own initiative continue to disseminate health information in their weekly programmes for women and consumers. Television continues to show documentary film originating from both local and foreign sources on health. They also take an active part in national health and related campaigns in making available publicity services.

Newspapers regularly publish feature articles on health. Although the Health Ministry maintains a cordial relationship with the press, it is felt that sensitivities among the reporters/journalists which make them refuse to allow health authorities a chance to have a glance at their write-ups before they go into print, often result in misreporting and much embarrassment to both sides.
Appendix 1

HEALTH EDUCATION ACTIVITIES

Mass media

1. Radio and rediffusion spot announcements and programmes
2. Television announcements, slides, filmlets, documentaries and programmes
3. Newspaper and popular magazine advertisements and articles
4. Educational and publicity print materials - posters, pamphlets, souvenir items, etc.
5. Wall slide projections
6. Bus panels
7. Illuminated posters

Publications

1. "Health Educator" newsletter - general health articles for the lay public.
3. Miscellaneous health education items, e.g. comic, colouring book, seminar proceedings, etc.

Exhibitions

1. Permanent health exhibition at Training and Health Education Department
2. Static campaign exhibitions
3. Mobile exhibitions at community centres, shopping complexes, work places, schools, etc.

Others

1. Talks
2. Slide shows
3. Film shows
4. Seminars/workshops
FAMILY PLANNING IEC ACTIVITIES

In addition to the usual range of mass media activities, other motivational activities include:

1. Post-partum and post-abortal contact service
2. Family planning/sterilization telephone information service
3. Family planning talks and film shows at MCH/family planning clinics
4. Talks for statutory and other bodies such as the People’s Association (at community centres), trade unions, national servicemen and uniformed groups, voluntary organizations, etc.
5. Talks for the newly weds on family planning methods/services
6. Talks to schools on the population problems, human reproduction and responsible love, marriage and parenthood
7. Seminars on Family Life and Population Education for secondary school teachers, held in conjunction with the Ministry of Education and Ministry of Health
COUNTRY REPORT - SOLOMON ISLANDS

by

Ezekiel Kikiolo
Health Education Officer

Introduction

The Solomon Islands is an independent State since 7 July 1978, and it proudly takes its stand among the neighbouring countries of the South Pacific Region and the great family of the Commonwealth of Nations.

The Solomon Islands consist of 10 large islands lying in a form of a double chain, extending over nine hundred miles of ocean, stretching to north-west to south-east.

The main large islands are New Georgia, Kolombangara, Rendova, Vangunu, Vella-La-vella, Choiseul and the Shortlands.

They are enclosed in area from approximately 5 degrees south latitude to 12 degrees east longitude.

Land maps

The total land area of the Solomons is 11,500 square miles or 28,446 kilometres. To the north of the main Solomons group is the Ontong Java group, and to the east is the Santa Cruz Group including the Duff, Reef Islands Group, Tikopia and Anuta.

Population

The population of the Solomon Islands for 1981 is 232,936 people most of whom are indigenous, and about 2/3 of the population are not educated and illiterate. The capital of the Solomon Islands is Honiara and is situated on the island of Guadalcanal, well known for its battle fields from World War II in 1942-1945.

Health education activities

During the year 1980 and also early this year 1981, we have been holding and conducting quite a number of courses for village health aides, community health leaders and other medical workers working in hospitals and rural clinics throughout the nation.

Community health leaders, we believe have very high social standings, reputation and leadership potentials in their own respective communities, and because of this, we (MHMS) try as much as we can to equip them with basic knowledge of health hoping in the end, they will preach the good news of health.
Annex 3

Workshops

During 1980, women's workshops had been successfully held throughout the country, and MHMS had been asked to provide some inputs on health education and as well as providing health educators. Health educational films, slides, posters and charts were provided.

PROVINCIAL ASSEMBLIES

The Independent State of the Solomon Islands has seven provincial assemblies, each is responsible for the dissemination of health services as well as other social services. The most heavy populated province is Malaita province which has over 60,000 people.

Communications

The Government of the Solomon Islands has recently increased its shipping fleet aided by some private shipping firms. We have also the Solair, the national regional airline. All these helped to play a big part in the dissemination of health education activities to the remote areas of the country and things are much easier now than in the previous years.

Malaria

Malaria still remains a major health problem throughout the nation, though health and administration services have been decentralized in the last two decades. Since 1979 malaria cases were found to be increased due to the parasites building drug resistance, both to DDT and some malarial drugs.

The Solomon Islands Government has changed some of the old methods of tackling this and introduced a new insecticide.

Press

Since the resurrection of the Health Education Division, we plan to submit some health education activities columns in the government and private newspapers for our news readers and the general public.

Health lectures in Government institutions

One of the ways of health dissemination in our country is this periodical submissions of health lectures to the two main Government institutions, namely, Honiara Technical Institute and the Solomon Islands Teachers College and these are ran by the health staff of the Ministry of Health and Medical Services.
School health education

School health education curriculum is planned and formulated by the Health Education Division and the Solomon Islands Teachers College Curriculum Development Officer aiming to equip students with health knowledge in simple personal hygiene, sanitation, family health, etc. Both school teachers and staff of Health Education Division work together in health teaching.

Besides, school health service and inspection are also carried out by community health nurses and tackle on the spot any health problems present.

Students are also vaccinated against communicable diseases, such as tuberculosis, polio, tetanus, whooping cough, etc. Treatment of minor ailments are given on the spot.

Maternal and child health services

Clinics have been established in all the provinces to cater for health needs in antenatal, postnatal and child health care. These clinics are manned by capable and qualified nurses. The effect of these services has played a very remarkable increase in our health population.

In the national census in 1976, the population was 193,823. This year the estimated population is 232,936 peoples. There are home visits to follow-up all postnatal, antenatal defaulters, and as well as treatment defaulters.

Radio broadcast

We have a weekly health radio programme over the Solomon Islands Broadcasting Corporation. In our radio programme also, we have interviews from primary health care course participants held throughout the country.

Under the Health and Population Radio Programme Project, we work jointly with the SIBC to plan some series of small dramas with health inputs and aims.

Personal contacts

Health education staff and other medical workers such as registered nurses and doctors, from time to time meet and discuss with rural people health problems in their communities, causes of these problems and find possible solutions to these problems. This is one of the ways that led us to organize an effective course for the rural leaders in their own villages.

Health educational posters and charts

Most of our health educational materials are ordered overseas especially from the Papua New Guinea Health Education Unit, because we have no health educational productions unit established permanently.
At the moment, we have one of the staff from Health Education Division attending an Audiovisual Technique Course at the SPC Audiovisual Training Centre in Suva, Fiji.

I must say that we still need a person specialized in the field of health education. This Division of Health Education in the Solomon Islands is at the moment still understaffed, but we hope to create more posts in future for its expansion.

Projects relating to health education of the nation

The Government of the Solomon Islands, together with the United Nations Fund for Population Activities Visiting Team to the country, had initiated two proposed projects and are financed by both. The two projects are aimed to educate the nation as a whole on sanitation, nutrition, child care, personal hygiene, maternal health/family spacing, malaria and herbal contraceptives on different aspects of communications:

(a) by holding courses in rural areas for villages health aids and village leaders;
(b) by using radio/broadcasting programmes weekly;
(c) by training health educators for each province in the Solomons.

COUNTRY REPORT - TONGA

by

Susana Liava'a
Health Education Assistant

General information

Tonga consists of 150 islands, of which less than 30 islands are inhabited. The total land area is only 269 square miles. Although the land is so small, the islands are scattered over a comparatively wide expanse of the South Pacific Ocean between 15° and 22° south latitude and 173° and 175° west longitude.

Population

In 1976, the population was 90,128. Tonga has a very young population with approximately more than 50% in the age of 1-20 years.

Language

Tongan and English are the main languages, while English is the second language for the daily use.

Health service organization

The overall organization of the Ministry remained the same as in past years, with the Minister of Health being responsible for the formulation of policies and liaison with the international agencies in matters related to
health. The Director of Health, as professional head of the Department, is responsible to the Minister for the implementation of the health policies, programmes and projects and the daily administration of the department. As a whole at the headquarters, the administration is divided into five divisions, namely, Medical Services and Public Health Services, Dental Services, Nursing Services and Administration Services. Each division is headed by senior medical officer, who is directly responsible to the Director of Health for the administration of his/her division. These heads of division, together with the Director of Health, constitute the members of the National Health Planning Committee which is chaired by the Minister of Health. This committee is responsible for the development programmes of the Ministry, its planning, implementation and evaluation, organizing school leavers programme on family health education to all secondary schools, seminars for school teachers and youth leaders and also inservice training for the health personnel and the traditional birth attendants.

Current status of dissemination of health information

Because this section really want to achieve its objectives, it takes part in planning, organization and implementation of public health programmes and the related activities, by using all the available methods of communication, such as radio and newspaper and interpersonal communication.

(1) Mass media

Broadcasting is perhaps the most effective channel of communication for health information dissemination among the mass media in the Kingdom for it reaches a high percentage population coverage. But because there is only one radio station in Tonga, we only have four 30 minutes regular programmes since 1979. But in early 1980, the Cancer Society in Tonga sponsored a 24 fifteen minutes extra radio programmes added to the regular radio health talks. So instead of 4 30-minute programme divided into various field of health, i.e. Monday evenings last for 10 minutes, Tuesday evenings last for 15 minutes, Wednesday morning last for 5 minutes, Thursday mid-day last for 5 minutes and Friday evening for 10 minutes.

(2) Newspaper

There is only one weekly paper named Tonga Chronicle which is under the Government control. We also contribute articles whenever necessary. But in the Ministry, we produced leaflets, pamphlets, posters and calendars, booklets on health and distribute them among the people. We also produce the Ministry of Health Newsletter every two months.

There are four private clinics in the Kingdom owned by our retired Medical Officer which are all situated in the main town of Nuku'alofa, which is the capital. Traditional medicine and faith healing is being practised by traditional healers and religious leaders.
Annex 3

For administrative purpose, Tonga is divided into 12 health districts, according to the location of the 4 district hospitals and 8 rural dispensaries or health centres. There are also 23 district maternal and child health/family planning clinics in the Kingdom which are located separately in densely populated areas and islands staffed by a public health nurse.

Health Education Section

This section was under the charge of the health education officer and being assisted by two health education assistants and one Peace Corps Volunteer. This section is an essential component of the Public Health Division in all its health programmes, in planning, organizing and implementation.

During the year, this section took part in the planning and organization and implementation of the following public health programmes and related activities throughout the year:

1. Strengthening the immediate post-partum health education approach and health talks in the maternity and paediatric ward, outpatient department, antenatal clinic, schools and villages to establish the idea of family planning and better family life.

2. Teaching of health education as a subject in the school to enable the trainees to acquire knowledge and skill in various methods, approaches and tools used for effective education of the public.

3. Continuation of meetings with men in their villages throughout the Kingdom to seek the cooperation of men in health problems.

4. Participating in the agricultural show - displaying posters and billboards emphasizing the WHO theme and other posters on the current public health programmes, leaflets on family health and family planning were also distributed to the public.

COUNTRY REPORT - TRUST TERRITORY OF THE PACIFIC ISLANDS
(MARSHALL ISLANDS)

by

Ms Justina Langidrik
Health Educator

Marshall Islands is one of the groups of islands in the Trust Territory of the Pacific Islands. There are 34 atolls - 16 in the Ratak (sunrise) chain and 18 in the Ralik (sunset) chain. These islands are scattered or separated by the ocean; and so in order to reach other islands, one has to go by the ships. Nowadays, though one can go by two Nomad airplanes that fly to the islands that have airstrips once a week, the Government of the Marshall Islands is making efforts to build airstrips on all atolls in the near future.
Office of Health Education

Health education is new in the Marshall Islands. It started in 1977 with only one health educator. There was no funds for the Office of Health Education, and so the programmes that were set up were not fully recognized or supported by the community.

The Office of Health Education is located in the Department of Public Health. The health educator works with the divisions in the hospital as well as other agencies to set up health programmes.

Health education programmes

The following are the health education programmes that the only health educator carries out:

1. Public health

Classes are held in public health weekly during prenatal and post-partum clinics and well baby clinic. Individual counseling is also done for family planning, hypertension, obesity and malnourished cases.

In addition, the hypertension clinic is in the Department of Public Health so the health educator helps with the "high blood pressure hunt".

2. Wards

Classes are held in the maternity ward, the paediatric ward as well as the other wards. Demonstrations are also done on how to prepare balanced diet, how to bathe a baby, etc.

3. Schools

Since there is no health education curriculum in the schools (only elementary schools are trying to develop H.E. curriculum), the health educator also teaches health education class in the elementary schools once a week.

4. Community

Since health education has no money to hold workshops and training programmes, sometimes the community groups would organize workshops and invite the health educator to get involve in such programmes.

5. Other agencies

Health education, although new, is being recognized by other government agencies. Health education helps other agencies set up workshops for the community (not financially).
(6) **Mass media**

Since the islands are scattered, the only means of communication and reaching the entire population on health matters is through the radio. Health education has a weekly radio programmes, spot announcements and riddles.

There is only one weekly newspaper and health education articles are printed also.

**Materials**

Since we do not have funds to print materials, we do not have many printed materials to give out, but we do make our own posters and translate other booklets into Marshallese.

**Health education funds**

Last year, a proposal was written by the health educator, a Peace Corps Health Educator and an intern health planner to our Government to support health education programmes. The Government accepted the proposal and now health education has a small fund to run its own activities and programmes.

Although a small sum was given to support health education activities, it is an indication that the Government has recognized the fact that health education has an important role to play in the well-being and welfare, perhaps development, of the Marshalls. It is with hope that health will also be considered as the number one priority in the development of the Marshalls.

Although the Marshalls is far from the other groups of islands in the Trust Territory, all the health educators in the TTPI have a monthly satellite conference in which ideas are shared and the health educators have a chance to talk to their colleagues and find out what they have been doing in their works and so on. Annual health education workshops are also held for all the groups of islands in the TTPI.

Although TTPI was represented in the 1979 WHO workshops, not all the groups of islands received reports and information on primary health care, I hope that WHO will help coordinate health education activities in the TTPI as well as in the region.
Perhaps the biggest single change in thinking about our basic philosophy to achieve an acceptable level of health throughout the world is the increasing awareness that we were riding in the wrong vehicle, and worse, that we were traveling on the wrong road.

Although this description may be a slight exaggeration, there is no doubt that the shift of our attention from the highly sophisticated level of hospital based medical care to primary health care which rests on promotive, preventive, curative and rehabilitative services achieved through self-reliance is a much welcome change.

What is of interest to us in this workshop is to know where we are in understanding the role of information, education and communication (IEC) in promoting primary health care, to define what new directions or strategies we can consider to make information, education and communication activities contribute more effectively to the effort of promoting primary health care and lastly, to identify concrete steps/actions that we can take to realize a more effective information, education and communication support to primary health care programmes.

This paper is far from being a definitive one. It simply seeks to stimulate discussion and thinking on these questions and to share some insights and lessons that have been gained from experience and research concerning information, education and communication support to primary health care programmes.

Terms of reference

Since definitions of concepts vary with time as well as with the manner and circumstances under which they are used, it may be necessary at the outset for us to arrive at a common understanding of the key concepts central to this workshop.

*Assistant Professor and Institute Secretary, Institute of Mass Communication, University of the Philippines System, Quezon City, Philippines.
Information, education and communication are not easy to define. Although hair-splitting definitions can be attempted, it is clear that these concepts greatly overlap and in fact, oftentimes, these concepts are used interchangeably. All three are concerned with establishing "commonness of ideas, feelings or opinions" and in practicing the art or science of "transferring meanings". At present, the dominant information, education and communication model is that of a transmission-belt one where movement of information constitute the central problem.

I would argue, however, that information, education and communication involve not only the art of understanding and applying the spectrum of media techniques, nor merely the production process involving the systematic development of information, education and communication materials but that information, education and communication also represent basically the sum of relationships between sources and receivers on the basis of which signs, symbols are given meanings.

To focus on a relational model of information, education and communication has some added advantages. Indeed, the "message" point of view in the transfer of messages model of communication ceases to be meaningful when receivers are overloaded with information, or when new messages contradict existing beliefs and feelings. Awareness of the "relationship" dimension of information, education and communication on the other hand, makes us more sensitive to information patterns that are already possessed by target audiences and to the capacity of communication receivers to screen select, process, evaluate and give their own meanings to messages received.

The "relationship" perspective also highlights the point that oftentimes what we do is more important than what we say. The communicator's problem then is not just to get stimuli across, or even to package his stimuli so they can be understood and absorbed but rather to understand the kinds of information and experiences stored in his audience, the patterning of this information, and the interactive resonance process whereby stimuli evoke this stored information (Lozare, 1980).

For the purpose of this paper, we may use the following working definition of information, education and communication:

"information, education and communication are systematic processes through which signs, symbols, messages are shared by people brought together in a relationship. These signs symbols and messages may be shared by interpersonal means or through the mass media".

Primary health care is likewise a multi-dimensional concept that is not easy to define for several reasons. One, is its encompassing and all-embracing scope. Another is that in practice, it exists in many
different forms throughout the world since its operational definition is left to communities who are involved with it. Perhaps an initial working definition of primary health care may be stated as:

"Essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their participation and at cost that the community and country can afford". (Alma-Ata International Conference on Primary Health Care, 1978).

These proposed working definitions may turn out to be inadequate as our discussions unfold but perhaps they would suffice as acceptable starting points.

Where are We Now in Understanding the Roles of Information, Education and Communication in Promoting Primary Health Care in the Western Pacific Region?

There are several reasons why this question is not easy to answer.

One reason is the fact that although there exists a body of knowledge that incorporates varied research findings and experiences in the Western Pacific region, the area is basically more of a geographical category than a socio-cultural one. There is, therefore, the question of determining the validity and limitations of generalizations based on socio-cultural specific findings and experiences. It may be noted, however, that intercountry differences within the region are not necessarily absolute nor are they necessarily permanent. The differences may also be in kind but they may also be differences in degree.

Another reason is that although there are grounds for mutual learning between countries within the region, there are limitations in making cross-cultural comparisons since there have been very little full scale nationwide primary health care communication campaigns that have been systematically analyzed and evaluated. What exists are mostly pilot project/programme level campaigns that are limited in scope and reach and which are often characterized by scanty resources as reflected in "compromise budgets", lack of communications personnel or lack of policy support. At present, we do not have certain answers to questions like what would happen if resources for communication components of primary health care programmes are doubled or tripled, or if they are cut in half? (Schramm, 1971; Lozare, 1980).

On the other hand, we do have certain answers to smaller but no less significant questions based on research done on pilot or experimental programmes. We also have some data and insights from basic and applied information, education and communication research conducted in other related fields such as population, health, nutrition, and agricultural extension which could be used as starting points for research and action concerning information, education and communication support programmes on primary health care. (Lozare, 1980).
In view of these difficulties, it may perhaps be useful to outline in specific terms what exactly we want to achieve with information, education and communication support to primary health care programmes. Bearing in mind intercountry differences, the following behavioural objectives relevant to primary health care were culled out of the report of the 1978 Alma-Ata International Conference on Primary Health Care and other related literature.

<table>
<thead>
<tr>
<th>Unit of analysis</th>
<th>Desired behavioural change/objectives which could be influenced by IEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Actors who manage or work within the health service system</td>
<td></td>
</tr>
<tr>
<td>a) policy-decision makers (heads of state and other national authorities)</td>
<td>01) Develop a strong political will committed to the achievement of the goal of health for all by the year 2000</td>
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<tr>
<td></td>
<td>02) Adopt a broader approach to health development which will bring together the community and all government sectors concerned in a partnership effort to promote health</td>
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<td></td>
<td>03) Give preferential allocation of resources to primary health care</td>
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<td></td>
<td>04) Restructure and reorient existing health systems to provide support for primary health care</td>
</tr>
<tr>
<td></td>
<td>05) Institute policy guidelines that would promote the basic principles of primary health care such as:</td>
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<tr>
<td></td>
<td>a) community-government partnership</td>
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<tr>
<td></td>
<td>b) decentralized planning</td>
</tr>
<tr>
<td></td>
<td>c) use and development of appropriate technology</td>
</tr>
<tr>
<td></td>
<td>d) use and development of existing community resources</td>
</tr>
<tr>
<td></td>
<td>06) Recognize that people are the most important resource of any country.</td>
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<tr>
<td>Unit of analysis</td>
<td>Desired behavioural change/Objectives which could be influenced by IEC</td>
</tr>
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<td>---------------------------------------------------------------------------------</td>
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<tr>
<td>b) planners and managers of health programmes</td>
<td>07) Institute legislation required to facilitate the development and implementation of primary health care programmes</td>
</tr>
<tr>
<td></td>
<td>01) Provide central planning, managerial expertise, logistical and financial support to primary health care programmes</td>
</tr>
<tr>
<td></td>
<td>02) Develop multi-disciplinary planning and approaches procedures</td>
</tr>
<tr>
<td></td>
<td>03) Develop capabilities of people in intermediate and community levels to plan primary health care programmes</td>
</tr>
<tr>
<td>c) community and professional health workers and traditional medical practitioners</td>
<td>01) Acquire new or strengthen present skills in management, planning, coordination, information, education, communication, and team operations</td>
</tr>
<tr>
<td></td>
<td>02) Establish effective linkages with different levels of the health system</td>
</tr>
<tr>
<td>02. Actors outside of the health service system but who are in a position to help promote primary health care</td>
<td>01) Recognize a much higher priority for health information and news and consequently devote more space and time for such material</td>
</tr>
</tbody>
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### Annex 4

<table>
<thead>
<tr>
<th><strong>Unit of analysis</strong></th>
<th><strong>Desired behavioural change/objectives which could be influenced by IEC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>b) advertising practitioners</strong></td>
<td>02) Provide support in moulding public opinion favorable to the concept of primary health care, e.g. lobby for strong political will committed to the achievement of the goal of health for all by the year 2000, preferential allocation of resources for primary health, policy guidelines and legislation that would facilitate the development and implementation of primary health care programmes, greater community and individual involvement in the effort to provide essential health service, etc.</td>
</tr>
<tr>
<td></td>
<td>03) Ensure greater accuracy and fairness in media coverage of events and developments related to health</td>
</tr>
<tr>
<td><strong>c) community leaders, local officials</strong></td>
<td>01) Integrate health-oriented messages in their advertisements when possible</td>
</tr>
<tr>
<td></td>
<td>02) Increase their awareness of messages in advertisements which may contradict sound health practices</td>
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<tr>
<td></td>
<td>03) Share their knowledge and expertise in communication with information, education and communication personnel in health action programmes</td>
</tr>
<tr>
<td></td>
<td>01) Take an active role in organizing communities to develop community primary health care programmes</td>
</tr>
<tr>
<td></td>
<td>02) Develop their capabilities to assess their communities' health situation and to improvise and innovate solutions to their communities' health problems</td>
</tr>
</tbody>
</table>
**Unit of analysis**

**Desired behavioral change/objectives which could be influenced by IEC**

d) education policy-makers, education planners and managers, and school teachers

01) Integrate primary health care principles in school curricula for all levels

e) Scholars in various disciplines, e.g. communication, education, sociology, anthropology management, psychology, economics, etc.

01) Conduct basic and applied research on development, operation, control and evaluation of primary health care programmes

f) policy-decision-makers of non-governmental funding institutions

01) Provide increased financial and technical support to primary health care programmes (e.g. fellowships, research grants, pilot programmes, etc.)

g) policy-makers, planners and managers concerned with supportive services in other sectors

01) Provide necessary infrastructure supportive of primary health care, e.g. adequate supply of safe water, housing, environmental protection, anti-poverty measures etc.

03. The public

01) Recognize that they are equally responsible as the government in looking after their own health

02) Place a higher value on their health status

03) Observe basic health practices especially in the areas of proper nutrition, sanitation, maternal and child care, family planning, immunization, prevention and control of locally endemic diseases, treatment for common diseases and injuries

04) Volunteer their services for various health actions, including the development of local water supplies or part-time service in the delivery of health care
Two points need to be considered in discussing the objectives presented above.

One is the obvious assumption that these objectives cannot be achieved overnight. Some can perhaps be achieved in a relatively short-term but others would require a long time before they can be realized.

Second is the fact that some of the objectives described above have already been achieved in varying levels in some countries within the region. The answer to the question of where we are now therefore may vary from country to country.

It may be useful, therefore, to consider a general conceptual framework which is broad enough to consider intercountry differences and yet provide us with a measure of gauging where we are now as far as information, education and communication objectives and roles are concerned.

A four-stage model of primary health care consisting of policy formulation and clarification, programme research and planning, organization and training and implementation may satisfy the requirement of identifying the sequence and priority of information, education and communication support activities. In diagram form this may be presented as follows:
### Annex 4

#### FIGURE 1. STAGES OF PRIMARY HEALTH CARE PROGRAMMES AND INFORMATION, EDUCATION AND COMMUNICATION ROLES

<table>
<thead>
<tr>
<th>Stages of Primary Health Care Programmes</th>
<th>Policy formulation and clarification</th>
<th>Programme research and planning</th>
<th>Organization and training</th>
<th>Implementation</th>
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<tbody>
<tr>
<td>+Evaluation and feedback</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Information, Education and Communication Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) <strong>Facilitator and catalyst</strong> - promote communication and understanding between people involved in this stage.</td>
</tr>
<tr>
<td>2) <strong>Initiator</strong> - focus attention on primary health care, lobby for resources, legislation, reorientation and restructuring of health systems to support primary health care.</td>
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<table>
<thead>
<tr>
<th>-Facilitator-</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Facilitator</td>
</tr>
<tr>
<td>2) Linker - help people define and articulate their problems, needs and priorities, help planners identify priorities of target audiences and key messages</td>
</tr>
<tr>
<td>3) Persuade - sell primary health care programme and information, education and communication plans to people at all levels.</td>
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</table>

<table>
<thead>
<tr>
<th>-Organizer-</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Facilitator</td>
</tr>
<tr>
<td>2) Organizer - help mobilize people and resources for primary health care programmes</td>
</tr>
<tr>
<td>3) Teacher - provide information, education and communication support to primary health care training programmes</td>
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</table>

<table>
<thead>
<tr>
<th>-Communicator-</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Facilitator</td>
</tr>
<tr>
<td>2) Communicator - help disseminate information relevant to primary health care</td>
</tr>
<tr>
<td>3) Motivator - help motivate people to observe basic health practices, volunteer their services for various health, etc.</td>
</tr>
</tbody>
</table>
A. Policy formulation and clarification

1) The role of information, education and communication as facilitator and catalyst -

Primary health care is a broad concept and there are numerous agencies, both private and public, who work for its realization.

The challenge to organizational and management communication, therefore, is how to weld these agencies into a force that would maximize the use of scarce resources, minimize competition, correct overlapping functions and reduce irritants and conflicting interests. Contradicting messages emanating from various sources lacking in policy directions are not only wasteful but also confusing to target audiences.

It is therefore vital that maximum communication and understanding between people involved in promoting primary health care be achieved at the earliest stage as well as in all other stages.

Information, education and communication activities relevant to this role may include seminars, conferences, workshops, briefings for and dialogues between the people involved in policy formulation and clarification.

Information, education and communication support materials may come in the form of briefing notes, audiovisual presentations, visual aids, brochures, etc.

2) The role of information, education and communication as initiator -

Gearing up for more effective communication activity requires above all policy direction. The development of a strong will to communicate and the provision of adequate resources to carry out information, education and communication activities are important lessons learned from experience. Indeed, organizing an effective communication activity requires above all management or policy commitment - a commitment of adequate resources and commitment of purpose and intent without which no communication activity has been found to succeed (Parkinson and Rowe, 1977).

It is therefore an important role for information, education and communication to focus the attention of the political leadership on primary health care, to lobby for preferential allocation of resources, for necessary legislation, and for reorientation and restructuring of health systems to support primary health care programmes.
Information, education and communication activities in this respect may involve a media campaign in the form of editorials, in-depth reports, and new stories that would call for clear policy guidelines on primary health care.

B. Programme research and planning

1) The role of information, education and communication as linker -

Through the concept of feedforward which is defined as a conscious and systematic attempt to identify people's perceptions of their problems, needs and priorities before action programmes are planned and implemented; information, education and communication can serve as an important link between planners, implementors and target audiences. In contrast with feedback which is usually given a reactive and minor role in fine tuning messages, feedforward is an aggressive attempt to base plans and programmes not just on planners' perceptions and theories but also on target audiences' perceptions and felt needs.

In this context, dialogues, seminars, workshops, and information, education and communication research activities constitute the most important tools of the information, education and communication planner and manager.

However, some research issues relevant to primary health care are now emerging and they merit mentioning here:

1) Many research studies are simply on the level of programme reporting. There seems to be a lack of systematic evaluative studies particularly on cost-effectiveness of communication strategies and techniques.

2) The adult individual is often the unit of analysis in most information, education and communication studies. Families, groups or communities on the other hand, are rarely studied.

3) Although communication is usually defined as a process, there seems to be a lack of process-orientation in most communication research. Many existing studies are one-shot cross-sectional surveys and there are only very few longitudinal studies that consider changes over time.

2) The role of information, education and communication as persuader -

Planning is a very complicated and difficult business. It is also a very human process since it involve working with all levels of people and deciding in advance what a number of people will do. In effect, plans have to be understood by and "sold" to people in various levels.
In some situations, the "selling" of the plan may involve "mutual education" for planners and decision-makers. Since all planning implies change and all change is threatening to somebody, planning always occurs in a power struggle. Further, since not all planners are good politicians nor are all politicians good planners, we can perhaps speak of "mutual education" which involves "teaching the plan about the larger system and teaching the larger system about the plan" (Churchman, 1968).

In this role, we can envision information, education and communication activities to focus on consultative meetings, dialogues, and perhaps on the use of conflict management techniques in these activities.

C. Organization and training

1) The role of information, education and communication as organizer

To implement a programme before one is fully organized is a classic management error. Yet this costly mistake is a common one. Since action is always more appealing and early achievements are very rewarding, the drudgery and difficulties of organization work oftentimes lead programme planners and managers to leap into implementation too early.

The challenge to information, education and communication is how to integrate the contribution of diverse public and private agencies concerned with the promotion of primary health care. At the same time, information, education and communication is tasked with determining how to tap the vast human resource that exist in the Region and transform these large but unorganized mass of people into an efficient machinery for promoting primary health care.

There have been much talk in the past decade of teaching people to help themselves but with the exception of the Chinese experience, we still have to see a large-scale mass organization of people harnessed to the goals of national development and health welfare.

Specific information, education and communication activities supportive of this role may include all forms of mass media support as well as posters, leaflets, brochures, streamers, billboards, car stickers, messages in T-shirts, etc.

2) The role of information, education and communication as teacher

One, perhaps, should not just pay attention to existing resources but also - the manner in which resources can be increased, e.g. through training and education of personnel.
Primary health care requires the development of skills in management, planning, coordination, research and development, information, education and communication and team operation for personnel at different levels.

Information, education and communication support relevant to this role, therefore, may include the development, production and pretesting of training materials, syllabi, references, and teaching aids, e.g. slide-tape presentations, film strips, films and video cassettes, and other audiovisual aids.

D. Implementation

1) The role of information, education and communication, in disseminating information intended to change people's perceptions, knowledge, attitudes and behaviours relevant to primary health care

The dissemination of information has always been seen as the major role of information, education and communication support programmes. For this reason, much of what we know about information, education and communication based on research findings in single-purpose health action programmes (e.g. nutrition, family planning, etc.) concern the diffusion of informative and motivational messages. Using the source, message, channel, and receiver framework, we can summarize some of the key findings in research to establish where we are now in understanding the diffusionist role of information, education and communication.¹

A. Source

1) In general, research has shown that personal communication especially when combined with mass media sources are still the most effective form of communication (although we lack studies relating cost effectiveness of personal sources with mass media services). The doctor, the health worker, the extension worker, the volunteer worker, etc. have the advantages of immediacy of feedback, ability to fine tune messages suited to the particular needs of audiences and the capability to enhance behavioural changes without necessarily instilling convictions.

¹Most of the literature reviewed here are discussed in greater detail in "Communication and Child/Family Welfare", a paper presented by this author in a seminar on Communication and Child/Family Welfare held in October 1980, Singapore, at the Asian Mass Communication and Research Centre.
2) The factors that contribute to the making a good source which have been identified by researches conducted in the Philippines, India and Korea include: credibility, communication skills, dedication and sincerity, sociability, positive character as well as mental traits, peerness, availability, authority position and positive physical attributes (Alfonso, 1973; Schramm, 1971; Ocampo, 1973; Lacson, 1976; Mercado, 1973; Abaya, 1972).

B. Messages

1) Both research and experience point to an important principle of communication, that is, messages must be based on clearly defined communication objectives. Unfortunately, to know how to reach somewhere, we have to know with some accuracy where we are at present and oftentimes we just guess this, and not surprisingly, we usually guess wrong (Parkinson & Rowe, 1977).

2) Both research and experiences in Thailand, Malaysia, Singapore and the Philippines point to the need to identify a hierarchy of messages, from the key message points to the less important ones. Knowing what is the logical sequence and priority of messages, makes it easier to package key message points in different forms for repetition and reinforcement.

3) If key messages are to be received well, research has also indicated that contradictions in the communications environment must be minimized if not totally avoided. In the Philippines, for instance, family planning messages encourage smaller families while at the same time commercial advertising of household goods show large Filipino families in their ads. Similarly, in many countries in the region, ministries of health try to encourage breastfeeding but their efforts ran counter to advertisements of milk products that discourage the practice (Lozare, 1980).

4) The chief appeals used effectively thus far in health programmes are those that emphasize individual interests rather than social or national ones (except in Singapore and People's Republic of China). In many family planning campaigns, for instance, the basic themes of personal health, happy families, economic welfare proved more appealing than the themes of national and social development (Schramm, 1971).

5) The importance of pretesting messages and communication materials with a sample of the intended audience before resources are invested in a major communication campaign is shown by research and experience. It has been observed that oftentimes, most materials are produced as part of "crash programmes" with insufficient attention being paid to planning, preparation and testing. Although pretesting does not guarantee the production of perfect communication materials, simple pretesting methods can be effective cost-saving devices (Mercado, 1974; Feliciano, 1974; Schramm, 1971; Glatthbach, 1977).
6) Research also show that to communicate well, especially with people who are not highly motivated to learn, it is useful to package information in an entertaining way and in terms and context that are familiar to target audiences (Ong, 1977). Perhaps a good guide to consider is the acronym S-P-E-E-D which stands for the essential characteristics of effective communication materials; e.g. that they should be:

1. Simple
2. Practical
3. Economical
4. Effective
5. Duplicable (Valbuena, 1980)

7) Experience show that a distinct symbol can be an effective communication tool, and in large or major campaigns, a distinct signature color or logo provides unity to various communication activities. Private sector communications have long relied on developing "brand image" to achieve mass consumption of goods and indeed, no organization or movement is complete without its own logo (Glattbach, 1977; Schramm, 1971). So far, it seems that no distinct symbol or logo for primary health care has been drawn up for international use.

C. Channels

1) Multi-media combinations, e.g. radio combined with listening groups and forums, radio-TV programmes combined with telephone information services and mailings mass media plus home visits, have been found to be significantly more effective than single media use (Glattback, 1977; Schramm, 1971).

2) Although the use of multi-media has always been the advice of communication researchers, the media situation in most Western Pacific countries, however, seems to be such that the problem is often not the making of right choices between a number of media but of utilizing in the best possible way whatever media are available.

Since resources are usually inadequate to buy media space or time on a continuing basis, the strategy that has often been used is to make full use of "free space or time" through radio-TV plugs, press releases, reports or articles on research findings, integration of health messages in radio-TV dramas, comics and other entertainment media.
3) Research show that the effectiveness of field workers are greatly enhanced if they are closely supported by other channels of information and persuasion (Schramm, 1971). The experience in most countries highlights the importance of prompt and continuous distribution of support materials in the field and the provision of clear instructions regarding the use of such materials (Varona, 1972). Synchronizing the efforts of field workers and the mass media have greatly enhanced the effectiveness of communication programmes.

4) Radio is undoubtedly the most extensive and popular medium in the region. As such, radio has been widely used in promoting family planning, nutrition, health and agricultural extension in many less developed countries (Unesco, 1972).

Some of the major lessons we have learned from research regarding the use of radio include the following:

01. Selecting broadcast time appropriate to intended audiences is crucial to the success of any radio programme.

02. The compartmentalization of radio programming into talks, dramas, music, news, etc. should not deter the use of radio for development and social welfare programmes. The opportunities to "infiltrate" development messages into all programmes can be easily seen if we perceive all programmes as educational.

03. Thus disc jockeys, scriptwriters, directors and producers, news commentators, song composers are all potential carriers of primary health care messages (Quarmyne, 1976).

04. Localization of messages and programmes is crucial especially in areas where there are large cultural and social differences (Adhikarya and Radel, 1975).

D. Television and film

Although these two media have been associated with urban and upper class audiences, both have been noted to be significant sources of information on health. The most significant fact about television is perhaps not so much its great power but its rapid growth.

High movie attendance noted in countries like Hong Kong and the Philippines also suggest the huge potential of this medium. However, a UNESCO meeting in 1972 reported that film is not fully exploited for development purposes due to problems of content, distribution, hardware expense and maintenance. Against these, the potential of film is recognized in terms of the following: it is mobile and therefore can penetrate deeply into rural areas, it is repeatable and can also be easily "plugged in" to television (Glattbach, 1977).
E. Print media

1) The advantages of permanence, reader's control of exposure (which allows repeated exposure), easy storage and retrieval, make print still the backbone of communication.

Limitations due to low literacy and difficulties in distribution especially for archipelagic states still plague the use of print but these have not deterred the print orientation in many countries in the region. Feature stories, special articles, editorials, news columns, photography, cartoons, special supplements are still the basic tools of the information officer.

Although print is generally regarded as primarily a channel for reaching elite audiences, the use of comics in the Philippines to promote family planning, nutrition and health has shown the potential of print to reach audiences from lower income levels.

F. Folk media

Some studies show that behavioural change directly attributable to mass media varies from 10 to 15 per cent and this percentage goes up to 54 per cent when mass media is integrated with extension work. Experience in the use of folk media such as folk songs, dances, mimes, shadow and puppet plays and folk theater shows that change could well be increased further if folk media is also integrated with the two (Mathur, 1974; Glatthbach, 1977).

G. Receiver

1) Careful identification of receivers into primary, secondary and tertiary audiences is an accepted communication principle. However, there is some research evidence that a great number of communication materials are still produced for a "nebulously defined general public". Perhaps for reasons of saving costs, the same communication material is sometimes given to students, teachers, parents, businessmen, farmers, etc., regardless of their different education background and interests (Philippine Bureau of National and Foreign Information, 1978).

2) Research has also shown that the effectiveness of communication is influenced by the amount of participation in the communication process allowed of audiences (Mercado, 1978).

3) Likewise, the effectiveness of communication is also influenced by the group to which the audience belongs or wants to belong. Peer group pressure has been identified as a powerful influence on behavioural change (Mercado, 1973; Alfonso, 1973).
Annex 4

What needs to be done?

Clearly, much needs to be done if we would make communication support to primary health care more effective. Since the workshop aims to address itself to this question, we can only start the ball rolling with a few suggestions.

1) **Innovative thinking and not innovations seems to be the key word.** We need innovative ideas on how to stretch a communicator's limited budget. As has been said before, "while a communicator's budget is limited, his imagination should never be". We also need innovative ways of maximizing the use of available though scarce materials and of stretching their lifetime as long as possible. We need innovative ways of using indigenous resources and talents.

2) One concrete step that we can take is to learn from lessons in other related fields of communication such as marketing and advertising. The *demand* orientation of marketing which stress needs of consumers is in sharp contrast to our *supply* orientation which stresses delivery of information regardless of need.

Social or development-oriented advertising has so much to contribute in our efforts to promote child/family welfare. Sitting down with professional communicators in the advertising and marketing fields may perhaps enrich our experience as well as extend our resources.

3) Along the areas for further research, perhaps we can put more attention in understanding the following:

   a) group and family communication dynamics and decision-making

   b) structural and institutional variables that influence primary health care, e.g. legal structures, policies, existing social structures of rewards and punishments, educational systems, etc.

   c) careful matching of receivers, messages and media.

4) On the action level, we can work for closer coordination between communication support and health services delivery, between media and field workers, between the various communication and service delivery programmes of different agencies concerned with primary health care. Perhaps, a worthwhile goal to aim for is the development of national information plans for primary health care (Lozare, 1980).
Conclusion

In summary, the answer to the question where are we now in understanding the roles of information, education and communication in promoting primary health care in the Western Pacific region is not easy to formulate since country health situations and programmes vary a great deal. However, it may be safe to say that most countries in the region are still in the policy formulation and clarification stage of promoting primary health care.

Indeed, we may say that we are just beginning to take the first major step towards meeting the gigantic task of achieving health for all by the year 2000. The greatest challenge to information education and communication is perhaps to give individuals and communities the capacity to improve their own health status and at the same time, the capability to improve their own environments as well.
Background Paper No. II

RENEWED EFFORTS FOR OLD PROBLEMS

by

Armando J. Malay*

On 6 through 12 March 1979, 25 participants from 16 countries of Western Pacific gathered in this same hall and participated in the first WHO-UNICEF Regional Workshop on the Promotion of Health Information.

Today, two years later, 21 participants (4 less than in 1979) from 16 countries (the same number as in 1979) are gathered again in Manila for a WHO/UNICEF Regional Workshop on Information, Education and Communication on Health. Comparing the agenda of both workshops, I can see very little difference in the objectives of both. If the objectives are practically the same, could the perceived problems and the suggested solutions be greatly different?

Why then this exercise?

First: The problems of effectively promoting health promotion described in 1979 are still the problems of this new decade, compounded by increased populations and shrinking budgets for health, information, education and communication.

Second: Although two years is really too short ("a wink in eternity") there is a nagging awareness that time is running out fast, especially since year 2000 is just 19 years away, and what can be achieved even in a short two-year period may well mean the survival into the 21 century of the 1 400 000 000 human beings living in this region.

This paper will attempt to answer the question: "Where do we, persons concerned with information, education and communication on primary health care, want to go?" The previous working paper answered the question, "Where are we now?" And the working paper that will follow this, seeks to answer the third question, "How do we get there?"

Where then do we want to go?

*Press Foundation of Asia, Manila, Philippines
On the overall, we want to reach the year 2000 with the objective "Health for All" a reality. More immediately, we want to arrive, in the next few years, at that stage where we shall have resolved or at least minimized the multifarious problems of promoting information, education and communication on health which continue to plague us. What I am trying to say is, we shall be able to know where we are headed if, and only when the problems that hamper our progress today, already identified in the 1979 workshop, shall have been met head on, resolved or at least, minimized. This does not mean that problems tackled now, will totally disappear. Or that new ones will not crop up. But if we can make some headway, then we can face the same or other problems with greater assurance. In this light, the 1981 workshop is not a mere replay of the 1979 workshop. At the very least, a repeat of the litany of problems perceived in 1979 should impress upon us that there is little time left to achieve what WHO has set as a utopian goal: Health for All by the Year 2000.

The problems of promoting health information identified in 1979 fall under two categories: those that will take some time - maybe the more truthful term is, a long, long time -- and those that can be tackled right away, given the right perceptions, the right motivation, and, what's vital, the resources available - not necessarily all provided by government. Only a select number of these problems need be taken up at length here.

Among the problems about which something can and should be done right away is the lack of trained, effective information workers in a number of countries which listed this, in the 1979 workshop, as a major constraint. Parenthetically, it may be stated that this problem is also listed as No. 1 in many other fields: government, journalism, education, business, yes, even churches. I know, because in my work as training consultant of Press Foundation of Asia, I am often asked how this problem could be solved.

Training of information personnel can be done at various levels, depending on the immediacy of the need and the resources available or can be made available. Schools of journalism or communication can start giving crash courses in science or health or development journalism. Press organizations, foundations, institutes or councils, even press clubs, can initiate training programmes: long-range for those who in turn will train the future information personnel, and short-range to answer immediate needs.

I suggest that those countries which unfortunately do not yet have training programmes do so right away. The question of funding this effort, of course, comes up. The expenses could come from one of three or all sources: from the organization's own funds, national budgets, and United Nations agencies like WHO and UNICEF. A group of countries close to each other, like those in the west or south Pacific, could organize seminar-workshops to which, if local trainers are not available, WHO could send teams of teachers. (Parenthetically, a criticism of seminars/workshops participated in by countries of varying socio-economic levels is that participants from those unfortunately still in the lower rungs of the development ladder have frustrations when they hear how other countries in the upper rungs go about acquiring the expertise of trained
personnel, not to mention the sophisticated tools like computers and cassettes at their disposal. Well may these "frustrated" nations ask: "will this advanced technology work? Is it really needed by my country?".

One word of caution, borne out of my involvement in many seminars/workshops like this. No sooner has, say, a reporter or radio man been trained to write competently on science or health or development, than the editor assigns him to other beats, or promotes him to sub-editor, or editorial writer. Thus, that paper or radio station is back, in such a short while, where it started: no competent health or science reporter.

Another word of caution: for countries in bad need of trained communicators right away, I'd not advise a training programme that would emphasize theories developed in other regions which will only leave the trainee confused - if not angry. I'd go to the basics and leave the sophisticated books spewing forth from communication schools alone (for the time being). The situation in some training programmes today in a number of countries is not unlike that in medical schools, where skills in general medical practice are by-passed for ultra-modern specializations like sophisticated surgery. In short, since the need for breaking ground is immediate, let's first train those who will use simple but effective tools like the spade or the hoe, and leave training for deepwell technology for the time being.

Three points must be said: training programmes need not be very expensive or elaborate if the suitable type of programme is developed and implemented; national or local resources can be tapped if the importance of health communication is stressed to those in government who hold the purse-strings; and world organizations like WHO and UNICEF would be only too willing to help in this effort if the request for funds or teachers is persuasively made.

The other problems identified in the 1979 workshop certainly will merit discussion in the plenary sessions or working group sessions. These are:

1) Problems of organization, such as limited availability of information given to media due to lack of accurate data or lack of clear-cut policy on what information is to be released; improper distribution of information workers, so that areas which need the services of information workers most are neglected, and too many information officers have desk jobs in the capital city instead of being farmed out in the rural or depressed areas; and too many duties assigned health workers so that their information work is neglected.

2) Lack of appropriate tools, facilities, and resources.

3) The positive and/or negative effect of value orientations and traditional beliefs on the social-economic development of a country, particularly in the promotion of health care.
4) Cooperation among agencies involved in health promotion.

5) Multiplicity of languages in some countries.

Regarding the fifth problem, quite a number of countries that participated in the workshop two years ago said that multiplicity of languages is an age-old problem in communication that must be overcome. Admittedly, the working out of a common language, or the reduction of the big number of languages to just two or three for common usage, will take a long time, what with so many constraints (which we need not take up here). But until a country, like my own, plagued by multiplicity of tongues, has evolved a common language, that country will have to make the best of the situation. Films, slides, posters, etc. can have messages in various languages since these messages are the only ones that have to be changed. The pictures remain the same. Newspapers present a different problem -- obviously it would not be feasible to put out several editions in different languages. But the comics book format easily lends itself to translations. Of course the less printed words, the better. An imaginative author can minimize the use of words and rely on the graphics to bring home the message, say in family planning or elimination of environmental pollution.

On the problem of development, production and distribution of informational and educational materials, again this involves funds and competent men. We have in Tagalog a saying, which, roughly translated, means: if your blanket is short, curl up in bed. It does not mean that because you have a short blanket you'll give up efforts to acquire a longer blanket, or give up sleeping altogether. It only means that one has to make do with what one has, until a better situation develops. If the Philippines cannot produce the sophisticated materials available to Japan, it means we will have to work with the materials we have, while aiming for something better and working towards that.

This brings me to my concluding remarks:

Workshops and seminars like this can spawn rising expectations among developing countries when the latter are appraised of what other countries have. But it is a fact of life that equality in all things - from wrist watches to freedom and human rights - is still a will-of-the-wisp, although the whole world, inspired by humanitarian organizations like the United Nations and its specialized agencies like WHO, UNICEF, and ILO, is striving for that ideal.

In the interval between the dream and the reality, we can exert new efforts, as we are doing now, so that we can reach our goals faster and in the least painful way. Come, let's work together.
Background Paper No. III

INFORMATION, EDUCATION, COMMUNICATION AND HEALTH FOR ALL BY THE YEAR 2000: THE NEED FOR ACTION

by

Mr Donald F. Treadwell*

Summary: This paper identifies possible areas of activity for information, education, communication programmes and critical points that may require changes or modifications. These points, if improved or modified, should result in more effective information, education programmes.

I. Introduction

On 7 April 1981, the World Health Organization through its member nations will make a world-wide call for "Health for All by the Year 2000". This is far from a catch cry; it is accepted as a policy at United Nations level having been adopted collectively by the 30th World Health Assembly. Several explanatory documents have been released by the World Health Organization explaining health for all by the year 2000 and the proposed major means of implementation - primary health care. Implicitly and explicitly there is a role for the mass media in promoting both primary health care and health for all by the year 2000. If some of us are unclear about these concepts we must consider how much more remote and obscure they may be for the public who have little involvement with health services and even less with United Nations agencies. The uncertainties that we may perhaps detect in the public mind indicate how successful we have been in promoting this concept to date, and provide a measure of the challenge for the future.

In this paper I have tried to identify key points to which those of us in the media and education could devote some attention in the future. I have no specific recipes for success. There are two reasons for this: if we knew exactly how to use educational and informational techniques to promote health we might not need this workshop to consider possible approaches; secondly, the great diversity of country health problems, information, education, health service and political systems represented here means that specific solutions may well vary widely from country to country. However, there seem to be some common elements to all countries.

*Chief Health Education and Information Officer, Department of Health, Wellington, New Zealand.
This paper tries to answer three questions:

1) What is the role(s) of the media and education in relation to primary health care and "health for all"?

2) Can the media in fact meet these roles?

3) What areas require improvement to make information, education and communication programmes more effective?

II. What is the role of the media and education in relation to primary health care and "health for all"?

What can we learn about this from WHO?

Let us consider first of all primary health care/health for all from a global perspective. Several WHO documents discuss concepts which appear to be important as far as health educators and information specialists are concerned.

Primary health care is essential health care made accessible to everyone ... it draws largely on community resources ... and has promotive, preventive, curative and rehabilitative elements as appropriate ... it is a part of a larger overall concept of social and economic development. It may include specific areas such as nutrition, water supply, sanitation, maternal and child health, treatment of common diseases and injuries, immunization, control and prevention of local endemic diseases, education about common health problems and what can be done to prevent and control them. It is concerned basically with building community self-reliance.

How is this to be achieved? The specific answer will vary from country to country, but of overall there is a concern to promote health by giving the individual family and community responsibility for primary health care with support from the health care system. While this is not a new concept -- far from it -- it is a radical "about face" for those individuals and communities who equate health with health services and a total reliance on health care system and who cannot see that health problems could be solved by decisions and actions they themselves could take. This is perhaps particularly obvious in the so-called developed countries where major determinants of health status may be the lifestyle of the individual himself or herself. I refer to, for instance, the use or misuse of alcohol, tobacco, diet, exercise, and so on.

It is further proposed by WHO that primary health care can best be implemented by using community resources, by the communities participating in defining their needs and finding ways to satisfy them; also that sectors other than health be mobilized -- for instance education, agriculture, housing, works, information, communication and industry.
In the need to stimulate community self-reliance and mobilize other sectors of a country, we begin to see some potential roles for education and information. The World Health Organization in fact is quite specific in this regard; it recognizes specifically the role of two sectors represented here today - education and the mass media.

"The educational sector ... has an important part to play in the development and operation of primary health care; community education helps people to understand their health problems, possible solutions to them and the cost of different alternatives; instructive literature can be developed and distributed through the educational system; associations for parents and teachers can assume certain responsibilities for primary health care activities within schools and the community such as sanitation programmes, food for health campaigns or courses on nutrition and first aid."

"The mass media can play a supportive educational role by providing valid information on health and ways of attaining it and by depicting the benefits to be derived from improved health practices within primary health care; for example they could support a sound pharmaceutical policy by helping to create public awareness that a number of drugs with generic names are just as good as advertised products with brand names; they could also help to popularize primary health care by disseminating authentic news about it in different communities."

As a national strategy, WHO suggests mobilizing public opinion -- "One of the fundamental principles of primary health care is participation of the community at all stages. For communities to be intelligently involved they need to have easy access to the right kind of information concerning their health situation and how they themselves can help to improve it; of particular importance is a clear explanation of the technologies available, their advantages, their successes and failures, their possible adverse effects and their costs: The information should be neither oversophisticated nor condescending but should be in a language people can understand. Newspapers, magazines, radio, television, films, plays, posters, community notice boards and any other means available can be used to secure peoples enthusiasm and their willingness to get primary health care going in the right direction."

Throughout the WHO literature there are a number of concepts we can think about -- "of overriding importance is the principle that public services should be accountable to the communities they serve ..."

"While the community must be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs."

"A continuing dialogue between (health workers) and the rest of the community is necessary to harmonize views and activities relating to primary health care" ... It is also a proper community concern to keep the implementation of primary health care under constant review and to make sure that it functions in accordance with its stated purpose."
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"Community participation also requires mutual support between government and community reinforced by mutual information feedback".

"Central planning has to provide (communities) with a clear idea of the part they play in the national primary health care strategy and in the overall development process at community level ... it has to provide any essential information that is not available in the community".

WHO also points out that special groups have their own particular role to play - young people, men, mothers and so on.

So much for the picture at global level. Let's move closer to home to considerations at this Western Pacific regional level.

I do not need to detail the proposed regional approach to primary health care. It is documented in the "Revised Report on Regional Policies and Strategies for Health for All by the Year 2000". This document describes the characteristics of the region and the variety of health problems within it as well as proposing regional strategies, a timetable and indicators of success. Again there is an identified need for education/mass media support. Under regional support measures we note that "Provision of information to the public will be a major component of support strategies; public opinion will be mobilized at both regional and national levels through the development of appropriate health education methods and approaches in community organization. The public will be kept informed through the mass media and through personal contacts with health sector personnel ... communication skills and community development approaches are an integral part of the regional strategy".

The global strategies are also reiterated - the need to develop individual and community self-reliance, the need for the governments to provide communities with information and other resources, and so on. Specific fields for educational endeavour are also proposed -- nutrition education, environmental education, lifestyle and behavioural change, and the development of educational services, for instance.

In summary, WHO has identified education and information services as being an integral part of primary health care. Running through the documentation there are I think three main themes: (1) the media to promote the concept of primary health care; (2) the media to provide the information and skills required for self-reliance in health and (3) the media to more effectively link health care providers and consumers.

It is quite clear that the place of education and information is accepted to support these three main themes.

WHO itself has also identified a variety of media, possible target audiences, and topics for public education, it has even suggested guidelines for media content. How then does this relate to our national education/information activities?
It seems that there are a number of specific tasks the information, education and communication specialists might tackle. There are:

1. Promoting the concept of self-reliance/primary health care/health for all by the year 2000.

2. Providing information on health and health services that will allow people to achieve health for all by the year 2000.

3. Planning long term information/education strategies and information policies that will promote health for all by the year 2000 and, by implication, information/education services.

4. Monitoring and reporting on progress toward implementation of health for all by the year 2000.

5. Providing motivation and leadership on specific issues that will promote community and individual health.

6. Assisting health professionals to become more effective communicators.

7. Developing two-way communication links so that health authorities are informed of community attitudes and activities.

8. Encouraging and assisting communities to develop their own information activities.

9. Research to determine the effectiveness of media education activities.

10. Reporting on and mobilizing other national/local sector of activities as they affect health.

Can the media meet these roles?

We must recognize that the media and indeed any educational strategy have their limitations. As far as the media is concerned this will be discussed more fully in Background Paper No. IV.

I hope I will not anticipate this paper if I just mention one or two examples. We know that the media are most effective when supported by other approaches; we know the difficulties in getting the coverage of health that we all might desire but somehow cannot achieve; we don't always know what exactly the impact of our communication activities are. We know that the media are ephemeral and that they can only go where there is - for instance - transportation, broadcast reception and to people who have some degree of literacy. On the other hand we know the media can be cost-effective, fast, attention-getting, stimulating and can reach a wide variety of people.
I don't want to pursue this topic any further but simply to point out that the media, while they have a real contribution to make, cannot be the remedy for all ills in the health care system that some people seem to think they are. An analytical approach to media usage as outlined in Background Paper No. II must be developed.

IV. What areas require improvement?

The following areas occur to me when I try to look at a health authority given the task of promoting primary health care.

A fundamental fact that faces us all is that resources are limited - you cannot do the whole job yourself. A major consideration must therefore be how one can become a "multiplier" and encourage others to promote primary health care through the media and education. The other major consideration is how to break out of the so-called "health education poverty cycle". There is a so-called poverty cycle in health education which goes roughly like this: because you do not have specific objectives you cannot demonstrate results; because you cannot demonstrate results you do not get resources; because you do not have the resources you cannot undertake programmes which will demonstrate results, and education/information activities remain perhaps at a level of tokenism.

(Consider for the moment the problem of those who have to make budget decisions - why should any activity that cannot demonstrate results be funded? Would funding be more forthcoming if those who make budget decisions had a greater awareness of the nature and uses of media and education? Clearly there are implications here for training and awareness within the health services.)

Here then are some suggested key points which might promote more effective information, education and communication programmes if further developed:

(1) The development of a national or agency media policy

This will inevitably vary from country to country. It may range from a type of public relations policy to setting standards for education/information staffing and resources or health reporting. Its basic objectives would be to ensure that (a) education/information is included in health programming, and that (b) certain basic skills and resources are available within the education/information system.

(2) Communications "pay-offs"

Where do we put the resources we have? We know that all elements involved - the mass media, health and education specialists have specific strengths. Is it possible to identify certain key areas where each can contribute and then try to achieve these successfully rather than attempting every unsuccessfully? Why for instance spend media resources promoting health services or practices for which there is already a ready acceptance or a more effective solution such as legislation?
(3) **Audience identification**

We cannot generally talk about "the general public". Communications must be planned for specific sub-audiences -- the aged, adolescents, specific ethnic groups, opinion leaders, and so on.

(4) **Specific goals**

Unless the health authority has specific goals it cannot expect its communication specialists to plan intelligently. As mentioned we cannot demonstrate success until we have specific targets.

(5) **Distribution systems**

Communication materials are useless unless they reach their target audience; planning channels of communication should be an integral part of planning. How often are official materials available only from official agencies? - why not availability through private enterprise agencies for instance?

(6) **Monitoring of standards**

Some health advice/reporting is simply wrong. Some advertising can promote hazardous health behaviour. What mechanisms can be developed to monitor and develop high standards of health reporting and to control negative media activities.

(7) **Coordination**

Essential if target audiences are not be confused by a great number and variety of possibly conflicting issues.

(8) **Training**

To increase standards of health education, reporting, planning, research, etc. of communication specialists.

Also to increase the "multiplier effect". Do communication specialists become the only link with the public or do they encourage other health personnel to become effective at this? The answer must lean toward the latter, I believe.

(9) **Research**

To find out more about target audiences, to measure communication effectiveness, to project possible payoff areas, to identify specific motivational factors, and to stimulate the interest of the research/academic community in health promotion.
Research in some form or another is essential to link with community groups and elicit their information/educational needs and goals.

(10) **Organizational changes**

Would some restructuring have useful effects? Do we centralize or decentralize information services, can we clarify various roles and their relationships? What about links with other agencies; could funding be spent better elsewhere?

Most of the concerns I have mentioned will I think be common to health authorities. I wonder how many of us could say that we are happy with all of the issues I have raised?

I want to make the point that these issues require effort – an additional effort. To step back and look at these issues requires time which we can all ill afford. Clearly though unless we take this time to plan, think, consult and perhaps brainstorm we will continue in our present habitual behaviour.

Taking time out for this sort of activity is the beginning of breaking the poverty cycle to which I earlier referred.
At this stage of the workshop, any attempt to define primary health care, its history, significance, and its community, national and global goals would be superfluous.

Most of us here, I presume, have read the proceedings of the First WHO/UNICEF Regional Workshop on the Promotion of Health Information held in Manila on 6-12 March 1979 and the recommendations made in the final report.

To make this paper brief, I will not review these recommendations, but before I go into the main topic of this essay, which is "What Mass Media Can and Cannot Do to Promote Primary Health Care", allow me first to clarify a few points.

The first point is that while I am supposed to speak in behalf of media in all its forms, the burden of my paper would fall on print media. I must admit that my experience with radio, television and other media forms is rather limited.

Another point is that this paper will not go into details of the avenues open to media to carry out popularization and acceptance of primary health care. I would leave this chore to the distinguished panel of resource persons who are here today to share their expertise and views with us.

Let me, therefore, start off by saying that what the mass media can and cannot do in the promotion of primary health care is a question that cannot be answered with a standard answer applicable to all countries in the Western Pacific Region.

I say this because the state of the art of information, education, and communication, or IEC in short, varies in each country. You may not believe it but experience gained by government health personnel from the pilot primary health care areas set up in Leyte and Cebu has shown that the method of entry or approach could vary from one town in one region to another town in another region.

*Health and Science Editor, Times Journal, Manila, Philippines.
Within the limits of its capability, therefore, the media in each state in the region will have to develop its own programme of primary health care promotion.

For instance, in the developed nations already mentioned, an all-out, year-round, high-pressure (or low key) information campaign could probably be conducted jointly by the government and the private sector.

This type of promotion has been tried successfully here in the popularization of the Green Revolution, family planning, nutrition, and the Masagana high-yielding rice variety.

Such a strategy, in fact, can be tied up with a nationwide educational programme that will include the primary health care concept in the health curricula, from grade school to collegiate levels.

Countries with a fairly adequate variety of media could launch a similar all-out information drive but this may have to face a number of constraints such as poor roads, power grid limits, lack of automotive fuel, inadequate or ineffective promotion materials, and language or dialect barriers.

But what about those countries where nothing more sophisticated than a lone radio, television, or printing press (newspaper) exist? Will the traditional forms of spreading information suffice?

For all we know, villages in some of these countries could already be self-reliant in health resources and need not be taught this virtue of primary health care. And perhaps, their way of life is such that they are kept healthy even without trying to do this consciously.

This is assuming too much, of course, but would it not be funny to preach primary health care to people who have been practicing it all along ... people whose only need for government assistance is already at a minimum, at best only for those things which they do not have in their culture?

Speaking for the people of these communities, we would say: harness whatever medium is available and use it. And if other countries in the region are willing to share their expertise and facilities, then by all means, spread the capability to speed up "evangelization" of the entire region on the new concept.

Selling the concept of primary health care is an exciting challenge, indeed, for both media and government. It will call for partnership to promote another type of partnership: one that will try to make every community health conscious and responsible for keeping its citizens healthy, with a minimum of help from the government.

At this point, allow me to call your attention once again to the regional workshop on health information promotion held in 1979 in Manila.
Participants in that workshop, some of whom are again here with us, stressed that "with respect to the objectives of primary health care, mass media in many countries will have to shift their emphasis from that of sophisticated medical technology and infrastructure to those dealing with the provision of basic necessities to the masses and the technology that would assure them of protection against diseases such as safe water, adequate sewage, immunization, nutrition, family planning, environmental sanitation, and others."

The report goes on to say that this new effort must be sustained on the part of media, and to keep the interest of editors and reporters from lagging, incentives by way of health reporting or feature writing contests sponsored by the health ministries, professional groups or even by WHO could be provided.

Multi-media agencies, we believe, can comply with the proposed shift in emphasis. But it will be a "tall order" which may require government and media policymakers to sit down for a long series of talks.

For unless the existing media in a country is government-owned and managed, any shift in the conventional treatment of health news may be interpreted as news management by the state.

Of course, it would be an entirely different thing if the proposed shift is left to the discretion of the media acting as an agent of change and development. If it is to be mandatory at all, the compulsion should be temporary in nature and part of the mutual agreement (a contract, perhaps) that will end as soon as perception and acceptance of the primary health care concept has been attained.

Regarding the second suggestion, keeping the interest of media in primary health care sustained through health reporting contests and other incentives will call for upgrading of health news coverage.

Media agencies may have to improve the reporting skills of their reporters on health subjects and this may mean training of specialists (some countries in the region already employ specialists in health and science reporting).

And now for the specifics on what media can do to spread the good word about community-based and community-supported health care. The following ideas could, perhaps, be considered:

1. An all-out, sustained information drive to reach every community. The package will include not only the basic primary health care concept but also how it can be introduced, the benefits it can bring as compared with the present system of health care delivery which caters only to the needs of the sick, practically ignoring those of the healthy who would like to remain hale and fit.
Annex 7

2. A year-round series of radio and TV programmes on various aspects of primary health care, with the materials prepared and packaged by the health ministries but modified to conform with the best of selling and advertising principles and ethics.

3. Periodical writeups, editorials, health columns, editorialized news, advertisements (testimonials, subliminals, etc.) and pictorial displays. These materials should be simple, readable, and brief and may be issued in the form of pooled or individual outputs in a newspaper, magazine, poster, billboard, etc.

4. Travelling shows which may be government or privately funded, including puppet shows, stage plays, and other traditional forms of drama with popular entertainers participating whenever possible.

5. Crusades to motivate the community, spur action on proposed primary health care projects, prod lawmakers to enact needed laws, and expose pressing community health problems that can be solved by the community itself.

6. A telephone-answering service similar to the "Instant Sagot" (Prompt Answer) project of the Institute of Maternal and Child Health, a family planning agency; and the Dial-A-Number projects in America for various services ranging from confidential information on sensitive subjects to prayer for a troubled soul or would-be suicide.

7. Sermons in church pulpits, group discussions, mass meetings, and planned home visits.

I am sure there are many other things media can do for the cause of primary health care and I hope the distinguished members of the panel can come up with a few suggestions this workshop can use.

In countries where government owns and controls media, formulation and implementation of information, education and communication campaigns would probably be easier and faster, although some of you here will probably contest this view.

In general, whether media is regimented or not, we can say that media will definitely play a central role in encouraging communities to go "primary health care" (I wish they'd think of a better, more suitable name for the concept).

Being basically agents of change, media will find primary health care a worthy cause. For this reason, it is almost certain that media will be an ally of government in the venture.

And now our comments on what media cannot do for the cause of primary health care. This is rather an awkward topic because the limits of what media can do are usually circumscribed by legal, ethical, and financial constraints.
Legal, if the changes proposed in the primary health care-promotion activities would run counter to duly constituted health programmes, projects, and health policies of government.

Ethical, if these activities would violate standing norms of conducting promotion programmes, ignore pre-screening requirements, ridicule traditional or ethnic standards and practices.

Financial, if funds and facilities, as well as expertise are inadequate or non-existent.

Media, of course, cannot and should not inject politics in pushing through primary health care promotion. Also, it cannot foist sophisticated health technologies on people who would find these new-fangled techniques and devices inappropriate.

Then, there's always the danger of oversell (some call it overskill) which could raise expectations, false hopes, or even panic in the extreme case.

Changing the attitudes and lifestyles of people is not an easy task for media. Media workers in government or out of it would do well to remember this.

Selling a relatively new and radical concept like primary health care, which will mean persuading people to assume responsibility for their own health and well-being may yet turn out to be one of the biggest and most difficult selling jobs for mediamen in this century.
The subject assigned to me is one that is, at times, taken for granted, perhaps little attended to, but the need for which cannot be overemphasized: coordination and training in information, education and communication programmes for health. However, since the preceding presentation is on what media can and cannot do, allow me to begin by stating what government can -- and should -- do in the area of information, education and communication support for health programmes.

First of all, government should plan out its information, education and communication campaigns thoroughly, defining the objectives and the audiences, at the same time taking stock of the resources available. Specially on the village level, the planning must involve the community: what are felt to be their problems should be tackled first. It will also be practical politics to involve the village head (in the Philippines, the barangay captain). In the actual implementation of the programmes, he will be very useful, specially in mobilizing the village resources and placing them at the disposal of the programme. Other sectors must be heard too: the priest, the teachers, the parents, even the known dissenters. It usually happens that someone who was so viciferously against some programme, can become its most active supporter if given a responsible assignment.

Private media can, and sometimes do, play a vital role in disseminating information necessary to push along government programmes - in crystallizing opinion about them, in galvanizing a community to action. But development information being of a non-exciting nature (although seasoned journalists can be dexterous enough with their typewriters to bat out an engrossing series on, for instance, schistosomiasis), government cannot always rely for full and consistent support from private media. After all, the private media have other kinds of information to give to their readers (details of the forthcoming wedding of Prince Charles, for instance), and unless an epidemic threatens to break out a type of IUD proves fatal to the women, health information will usually be relegated to

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*Officer-in-Charge, Inter-Agency Projects on Agricultural and Rural Development, National Media Production Centre, Quezon City, Philippines.*
the inside pages, if at all. In many developing countries, moreover, the newspapers circulated only in the cities and the larger towns. They play an indispensable role in keeping the opinion leaders informed, and it is expected that the information will seep further down, but for it to get to the grassroots may take too long a time. Budgets for information, education and communication programmes can allow for low-cost print materials such as leaflets; with newsprint as the stock, a simple two-fold 4" x 8" leaflet should only cost ten centavos or thereabouts. They can relieve the health worker of some of the burden of explaining health programmes to her clients. (Larger sized leaflets are not recommended. They will cost more and may only end up as wrapping paper).

Big, attractive posters can be displayed in stores, markets, or the village centre, to give important announcements or to play up a slogan, although smaller ones can at times be more convenient because they occupy less space. One does not have to print too many of them. Five posters displayed strategically per village, can suffice in doing its work of giving information within a reasonably short time. It may be a simple poster that announces a forthcoming event, such as when and where the next round of free immunizations will take place, or it may contain more information and serve like a wall newspaper (which we have found rather effective in our country). If it is to serve as a wall newspaper, the text should be large enough for a person to read from a distance of at least ten feet from the wall. If there is money to get posters printed, well and good. If there is none, the health worker can make out her own poster or inveigle a teacher to make her class work on posters.

During the recent visit of Pope Paul II to Manila, I noticed that the welcoming streamers and banners hang up all over the place had been made out of the material that is used for feed bags. The streamers and banners for the Pope were of new material and pristine white. In the rural areas, a health worker can easily ask a farmer for an empty feed bag, rip this off, bleach it clean and for the cost of a can of paint, fashion herself a streamer that says (instead of Totus Tuus) "Twos and threes is enough." (If, by the way, enough of you take up the foregoing suggestion and we see a plethora of streamers from recycled feed bags with health messages in our rural areas, I will be happy to write the Pope about this unexpected but welcome offshoot of his visit.)

Radio has a wider reach than newspapers (in the Philippines fully 80% of the households own a radio set) and can play an active role in disseminating health information to the rural areas. But then again, radio stations have to earn their bread, to put it bluntly, and depending on them to run your spot announcements, mini-dramas and jingles, when you want them and as often as you feel it will take to make the message permeate, is not something you can always rely on. A soap commercial that brings in revenue will always take precedence. You will have to cultivate friendships with the station manager, the disc jockeys, the newscasters, maybe invite them once in a while for a drink. You will have to keep sending them bulletins hoping that when they have nothing else to read, when they run out of the latest gossip on popular movie stars, they will pick up your bulletin on the latest in diarrhoea management and read it over the air.
In the Philippines, a recent presidential decree grants tax rebates to a radio station broadcasting development information for the people. The material should be approved by the Ministry of Information as one that qualifies and the broadcasting is monitored and logged, to discourage a station manager from applying for more tax rebates than he is entitled to. The rebates are applied on taxes for radio equipment acquired by the station.

Before I leave the subject of private media behind, may I cite one instance I know of when government and media together were able to rise to the occasion and help avert what could have been national disaster. Two years ago, there was a threatened infestation of tungro, a disease of the rice plant. At the time the incidence of tungro was discovered, the planting season was well on. There was need to warn the farmers immediately of the danger. The Ministry of Agriculture, already experienced in such matters with their Masagana 99 programme of increased rice production, rallied press, radio, government media facilities in spreading information on the tungro before it was too late. We at the NMPC produced for the Ministry hundreds of thousands of leaflets in 6 languages, with a picture of the grasshopper carrier of tungro, instructions on how to prevent the disease and how to combat it. Cablegrammes were sent to the farm technicians to warn them that the grasshoppers were coming. Press and radio pitched in. I guess the campaign succeeded because the crop for the year was not appreciably damaged. The country continues to export rice.

Films are expensive to produce and television, at the moment, has a limited reach, although it is hoped that by the year 2000, with the proliferation of earth stations, remote villages will already be served by video. So, what can the health worker do for something visual? The Chinese have a saying (and I daresay most everybody else has too, only worded differently): if I hear it, I forget; if I see it, I remember, if I do it, I know. (I hope I got that proverb right). At the NMPC, the nutrition communications office is making good use of the puppet theatre. Puppets do not cost so much to make; old clothes or leftover material can be put to use; the ubiquitous feed bag can make a passable stage curtain. Putting up a puppet show can be made a community enterprise, thus getting many people involved not only in the making of the puppets but in the weaving of messages into the scripts. So: they see and they do. One can be surprised at how a puppet show, no matter how amateurishly put together, can keep the interest of the audience, young and old. It is particularly suited for health messages -- nutrition, family planning, sanitation, immunization.

The idea of all of the foregoing is that health programmes can get the community support they need if efforts are taken to make the population aware of the programmes in the first place; having done this, of making them start thinking about the effects such programmes will have on them -- to enjoy life, to live longer, to earn more, since a healthy body can work better; and finally, to take action: the head of the family builds a toilet; the wife boils the water for drinking; the neighbours get together on a deep well for the community. From spreading awareness, through stimulating thought, to the final triggering off of action: this is what information, education and communication is all about.
And now (finally) I come to my assignment proper: coordination and training. In a recent address delivered by our Minister of Information on the role of the ministry in rural development, great stress was laid on the orchestration of information, education and communication efforts so that messages will not be cancelling each other out; so that unnecessary duplication will be avoided and therefore economy effected; so that the information may be given in the right doses, at the proper time and to the right audience. The admonition is valid both on the national and the local levels, on the macro and the micro scales. In some agencies, the task of coordination becomes a problem because the work is departmentalized, each department carrying on with its own programme and its own information, education and communication support with little coordination, or even consultation, going on among the various departments. In the Ministry of Health (Philippines), where separate bureaus and offices handle various health programmes, some coordination is effected through the Office of Health Education and Personnel Training. But this office does not get all of the budget for information, education and communication and one knows from experience that he who has the budget makes the decision. An information, education and communication committee is at present being organized by the Ministry, its members to be representatives of the various bureaus and offices under the Ministry with health programmes, as well as representatives of other Ministries that can have a role in planning and implementing information, education and communication programmes. When this committee becomes operational, the members may find out that they have common problems for which they can work out common solutions and strategies. Environmental sanitation, for instance, is a big factor in schistosomiasis control. But so is it in the control of diarrhoea, of worm infestation, of other gastrointestinal diseases. It is possible therefore to work out a joint information, education and communication campaign, pool resources -- and budgets -- use each other's materials -- on environmental sanitation.

May I cite one case where the need for coordination within an agency, can be very vital: the village nurse prepares for the great day when she will immunize all of the eligible infants in her community: she takes care of ordering the required amount of vaccines, gets the community involved in the preparations, launches her information, education and communication programme. The day arrives and all of the mothers come with their babies for their "shots". Somewhere along the line, however, there was a communication gap. The vaccines were not sent, and the poor nurse has to explain to the mothers that something went wrong somewhere, she'd let them know when to come again.

Even among different ministries the lack of coordination can often have unexpected and unhappy results. There is the case for instance of a government programme to construct more irrigation systems. The National Irrigation Administration getting foreign funding assistance buckled down to the task of building irrigation dams and the network of canals to bring the water out to the farms. While benefitting the farmers, however, these very irrigation canals are suspected of having caused the further spread of the tiny japonicum snail that serves as host for the schistosomiasis fluke.
But we learn from mistakes. Today, the infrastructure programme in areas where the disease is endemic, are integrated, multiagency programmes, with the health aspect a vital and adequately funded component of the entire programme. I understand they now build the sides of canals steeper so that the snails cannot latch on to them and proliferate. I have attended orientation seminars on schistosomiasis control where various agencies were represented: public works, education, social services, information, agriculture, and of course, health. I am also told that the irrigation works people just could not go on independently of the health people: some of the engineers got infected with schistosomiasis. I am not very sure this is true; however, it points up like nothing else can, the real need for coordination among agencies who share a common goal — rural development.

On the shoulders of the field workers — the nurses, midwives, paramedics, barangay nutrition scholars, barangay health workers — rests the burden of communicating with the community and getting its participation in the implementation of health programmes. Depending on the communication skills of the health worker, a community can accept or totally reject an entire programme. If she snubs the mothers, they will not bring their babies for immunization. If she does not relate with the community, they will consider her an intruder. And if she does not know what she is talking about in the first place, they will not look up to her for information. At one of the workshops being conducted for the local health personnel handling the Expanded Programme for Immunization, it came out incidentally that a few midwives would return leftover vaccine to the refrigerator to use again in the next round of inoculations. Instructions that leftover vaccine should be disposed of because it would have lost its potency, somehow did not get to some of the midwives. I imagine there are many more details in a programme that get to be threshed out and clarified in workshops that become occasions for the supervisors stationed in the central offices to meet with the workers stationed in the bundoks.

In the case of primary health care, while this is not altogether a new concept, the extension workers who will carry on the brunt to the work of introducing it to the villages, explaining what it is to a population that is often suspicious of government programmes, and setting up the mechanisms that will make it operational (such as community associations), will certainly need all the training they can get in communication skills, in organizational skills, in subject matter. In this area, we can perhaps look to the World Health Organization for support and assistance.

The following are some thoughts on strengthening government information, education and communication programmes on health:

1. The health programme should be taken in the light of the total development programme. Development here means the collective resolve of the mass population to achieve a desired quality of life. The people are not mere objects of development; they themselves are the means as well as the objective of development.
2. To involve the broad participation of the people in the total development process is to create the objectives close to the needs of the people. People participation is achieved through their organizations, cooperatives, professional associations, interest clubs, etc. The government's task is to strengthen these organizations to get more participation from the people.

3. Information is data used for decision-making, planning and problem solving. If people at the bottom are drawn to participate in the planning, information should flow to them and therefore, a feedforward and feedback mechanism between the people and the government must constantly go on. Keeping this mechanism flowing fast and smoothly is the responsibility of the information agencies.

4. As agents of change, the information/education channels should be able to stimulate new responses of the people, reshape their values, reflect their needs and aspirations, present new models to people, assist in social and cultural integration and disseminate technology through information and education.

5. If the people are to be the means as well as the objectives of development, government should take great efforts to motivate the masses. Motivation is the backbone of communication support for the attainment of the development goals.

6. Effort should also be exerted to avoid the rise of "a revolution of rising frustration". This comes about when the mass media manipulate or create awareness of public wants but do not create the means to fulfill them. Services and the fruits of technological progress should come hand in hand with information dissemination.

7. Government should give a clear communication policy linked to overall social, cultural, economic and political goals. Such policy should be based on inter-ministerial and inter-disciplinary consultations with broad public participation. The objective of the policy must be to utilize the unique capacities of each form of communication, from interpersonal and traditional to the most modern and sophisticated, to make people aware of their rights and foster their growth as individuals and communities.

8. In promoting communication policies, special attention should be given to the use of non-technical language and comprehensive symbols, images and goals. Similarly, development information supplied to the media should be adapted to prevailing news values and practices, which in turn should be encouraged to be more receptive to development needs and problems.
9. The other thrust that should strengthen the communicator, in the same context that a strong nation is made up of strong citizens. This means their skills as information givers and teachers, reshaping their values to deepen their commitments to the tasks at hand, developing their capabilities as individuals. In this way, he can perform his function well as the go-between of government and people.

10. Government should also work to resolve or minimize inequalities in communication facilities. Usually communication resources proliferate at the urban centres and the peripheral communities. Through some design or neglect, discrepancies in information flow are felt in the very rural areas. Importance should be given to eliminate imbalances and disparities in communication resources and in information flow.

National goals and health programmes

As expressed in the national goals, health is viewed as both a means and an end of development. As such, health programmes are conceived in relation to economic and other social factors involved. For example, the availability of almost every item such as food, housing, clothing, sanitation, roads and educational facilities is relevant to health conditions. These are intertwined with socioeconomic factors so that morbidity, mortality and fertility trends are largely affected and influenced by these factors.

In the national health plan, the Ministry of Health has outlined the following approaches for providing health for all Filipinos:

(a) improved managerial processes;
(b) health manpower development - to include the development of relevant basic and continuing educational programmes for all levels of health workers;
(c) health system development - to include the improvement in effectiveness of existing health services and the formation of needed support mechanisms; and
(d) development of appropriate health technology and research.

The Ministry's goal calls for a new approach which is the concept of partnership based on the recognition and respect for the communities in an intra- and intersectoral way. Health promotion and maintenance become a joint venture between health service (public or private) and the community. The former does not work for the people but works with them. While the traditional provider-recipient relationship reinforces the dependence of the community, thereby eroding the self-esteem of the people, partnership seeks to develop self-reliance and thus build the confidence of the people in their own ability to improve themselves.
Crucial to the relationship is the existence of mutual trust and an open communication line between the partners. The community reverses its role from that of passive recipient to that of active participant-decision maker. This means the community is able to assess its own situation and identify development activities, with government providing support when required.

The reality of course is that few communities possess skill and resources to organize and sustain health development activities. For this reason, health workers must be reoriented and trained to assume the role of facilitators in helping communities develop the necessary capacities, skills and tools for engaging in effective health development activities.

References:

Issues on the Social Responsibility of Mass Media, paper prepared by Mrs Rebecca P. Santos as a requirement for course on Public Information Management at the Pamantasan ng Lungsod ng Maynila.


With the expert assistance of Professor Armando J. Malay, the group formulated the following answers to the specific questions posed:

(1) Some countries have already fulfilled many of the recommendations made during the 1979 workshop. In fact, some had initiated a number of the initiatives even before 1979.

(2) All countries are supporting information, education and communication activity in relation to primary health care in various ways, including production of support materials such as posters, brochures, leaflets, etc. Expert people are being employed in each country to implement information, education and communication programmes - some are health educators, others are journalists or communications officers. Some countries are already equipped with facilities and hardware, others are acquiring it as resources permit. The report recognized the importance of linkages with other related sectors and institutions.

(3) The group identified the following constraints and problems but all those listed are not necessarily common to all countries:

(a) Inadequate funds to provide the desirable level of resources and personnel with which to implement information, education and communication activities.

(b) Reluctance of the mass media to impart information handed out by governments on health matters, except on more sensational occurrences. In some countries, this reluctance amounts to active cynicism about government-sponsored programmes.

(c) Difficulty in motivating some factors of the community to participate in primary health care (particularly in countries where the media display little interest).

(d) Constraints on health educators communicating directly with the media because of restrictive government policies on communications generally.

(e) Failure to centralize operations for the implementation of information, education and communication activities.

(f) Increasing cost of advertising, particularly on television and radio.
Annex 9

(g) Difficulties of communication in countries with scattered island populations.

(h) Lack of interest among politicians in supporting programmes which do not show immediate visible benefit or do not have some immediate political impact.

(i) Fragmentation in implementation of information, education and communication initiatives because of political systems which divide responsibility for health matters between central government and the governments of component states.

Group (A) participants consisted of:

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<thead>
<tr>
<th>Role</th>
<th>Name</th>
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<tr>
<td>Resource person</td>
<td>Armando J. Malay</td>
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<tr>
<td>Rapporteur</td>
<td>Valentin Loyola</td>
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<td></td>
<td>Tosiaki Takagi</td>
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<td>Christopher Wong Kwan-ming</td>
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<td>Lilia Juarez</td>
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<td>Chairman</td>
<td>Gordon Benjamin</td>
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WORKING GROUP REPORT - GROUP B
(18 March 1981)

Annex 9

Except for those countries that did not participate in the 1979 workshop, all reported that measures have been taken to support the recommendations.

Hong Kong, Philippines, China, Guam, Papua New Guinea, reported having policies on information, education and communication for primary health care but Papua New Guinea said the policies are awaiting organization of the Information/Communication Unit.

Japan and Marshall Islands have no policies to report (health education is new in Marshall Islands).

Programmes

Hong Kong, Philippines, China, Papua New Guinea (on the provincial level), Guam, Japan, have programmes on information, education and communication for primary health care. Japan has the Health Promotion Foundation which is non-government but fully supported by government. Hong Kong has a central health unit in the government health ministry to promote health activities. China's information, education and communication programmes are fully supported by government Marshall Islands has no overall programme but recently, government earmarked a sum for health activities. The 1979 workshop recommendations were not transmitted to the Marshall Islands.

Strategies

These range from interpersonal to use of mass media, community organizations and satellite facilities. Hong Kong reports a counselling service for organizations and schools, materials and equipment are supplied to these groups so that a multiplier effect is achieved. Doctors in Hong Kong are also being mobilized to conduct health education programmes. In Japan, there are no special health educators but primary health care is practiced by doctors and other medical practitioners.

Resources

(1) On the whole, a shortage of trained staff and trainable manpower was reported.

(2) Support materials: these range from simple leaflets to magazines that cost US$15.00, (in Japan, containing abstracts of health and medical news that have appeared in the press. There are also brochures, posters, calendars, table signs, comic books. The Philippines has printed a primer on primary health care for opinion leaders, health policy makers. Also reported were radio
programmes, TV programmes including lectures by doctors and other health experts (in China), tape presentations, films, video tapes, slides and a monthly satellite conference (on Marshall Islands, linking with health educators in six other islands).

(3) Information, education and communication facilities, hardware: radio and print were most used; television present in Japan, China, Hong Kong, Guam, Philippines, but not on Marshall Islands and Papua New Guinea. Papua New Guinea reported improved print facilities since 1979 workshop, from simple silk screening to offset printing. Philippines Health Ministry is purchasing audiovisual/vans.

**Linkages**

In Japan, bureaucracy is hampering linkages; in Hong Kong, linkage is achieved through the Health Education Coordinating Committee composed of many agencies; Papua New Guinea encourages linkages through the Health Board composed of different agencies. In China linkages need improvement. Overall, good relationships with the mass media were reported although some report lack of sustained support from this sector.

**Constraints/problems**

Except for Japan, all countries reported lack of funds as a problem; lack of staff training especially in communication skills was reported by all. China would like training in new approaches to make TV programmes more interesting. Japan deplored lack of popular forms of disseminating information on health such as jingles. Concept of primary health care as a strategy for achieving health for all does not seem crystallized yet in most of the countries.

**Group B participants consisted of:**

- **Resource person**: Natividad Nuguid
- **Rapporteur**: Esperanza Santos, Weng Min-Qin, Keiji Tanaka, Chan Wai-man, Geniembo Byron, Justina Langidrik, Rebecca Santos, Toribio Medina
- **Chairman**: Antonio Eustaquito
A. General steps taken

(1) All countries appeared to be showing progress in varying degrees in so far as their responses to the 1979 recommendations are concerned.

(2) Indications are that the pursuit of the recommendations are being further developed.

(3) Reports of the participants indicated that the promotion of health education and information has now become an integral component of their health establishments.

(4) This is not to say that all is well as delegates also spoke of problems, and frustrations which, while not too serious in nature, have nevertheless, left an impact on their respective national programmes.

After a quick run through, local responses to both the general and specific recommendations made in 1979, a summary of the group's observations are:

(1) Reorienting the set-up of health programmes to uplift general living conditions of the rural dwellers.

(2) All the health workers are very active in promoting primary health care.

(3) A definite shift of emphasis in reporting from sophisticated medical technology and infrastructure to those dealing with the provision of basic necessities to the masses.

(4) Most participants reported that they have established national health information and education councils/centres and to a degree their governments have provided funds for information, education and communication components in all health programmes.

(5) Efforts have been made to train educators and information officers on primary health care.

(6) The promotion of coordinated efforts amongst the various agencies has still been not realized although there is a general recognition that this is needed.

Primary health care has existed in various forms amongst countries represented in the group.
Participants were of the opinion that following recommendations and resolutions made during the 1979 workshop, very encouraging efforts have been made to further strengthen and supplement ongoing programmes.

For instance, many participants said their respective organizations had mounted further seminars, workshops and "communal" get-togethers in order to re-focus, analyze, coordinate and plan work programmes. Some, no doubt, reported that not much had been implemented or achieved during the intervening period although their existing programmes were still very much effective and served their local situations well.

**Constraints/problems**

(i) Funds - most of the delegates are of the opinion that the financial problem is a hamper towards the progress of information, education and communication programmes.

(ii) Cultural and traditions - quite a number of countries in the Pacific still have the superstitious beliefs that might hinder their activities in achieving the aims of providing good health for their people.

(iii) Lack of information, education and communication resources.

(iv) Religious beliefs

(v) Communication gaps

(vi) Illiteracy

(vii) Political will to recognize information, education and communication projects - i.e. given the low priority

(viii) Human problems

**Suggestions and recommendations**

Most of the participants are in favour, to the following suggestions and recommendations to meet the above problems:

(1) WHO should organize seminars for politicians

(2) WHO to organize Miss WHO contests to get funds

(3) United Nations should contribute funds for health projects

(4) A certain amount of tax on tourism should be given for health projects.
Group C participants consisted of:

- Resource person: Alberto Rous
- Rapporteur: Zulkarnain Hassan, Anna Hoff, Kairabu Kamoriki, Ezekiel Kikiolo, Susan Liava'a, Francisco Sungino, Anthony Santos
- Chairman: Eliki Bomani Momoivalu

Generally, the participants expressed views on setting up of public relations councils/committees which could greatly help in carrying out information, education and communication activities for the primary health care programme.

Status of Strengthening of Government Information, Education and Communication Programmes in Health: The Need for Coordination and Training - Mrs N.A. Nuguid: (Background Paper No. V)

The government should take interest in promotion of information, education and communication of health for the benefit of the communities when making its policies.

1. The Ministry of Health should be cordially working together with other health aiding agencies, e.g. Agriculture, Information and Broadcasting, Social, Education Services and Public Works, etc.

2. Health educational materials, posters, charts, flannel graphs, films, etc. are also very good contributions to create health awareness.

3. The other resources such as community leaders, priests, teachers and other people of high social standing should be trained or have some knowledge of health, to enable them to implement and disseminate health in their respective communities.

4. Radio, newspapers, etc. are other means of getting health messages to people in both urban and rural areas.

5. Formulation of communication policies, the language must not be too technical, confused symbols, etc. should be avoided.

6. Community participation is vital for the success of information, education and communication activities in the primary health care programme.

Rapporteurs:

- K. Mariappan
- Ezekiel Kikiolo
ON THE PROMOTION OF HEALTH INFORMATION

A. General

1. Restructuring and reorienting the health information/education set-up

(a) shift of emphasis in reporting from sophisticated medical technology and infrastructure to those dealing with the provision of basic necessities to the masses and the technology that would assure them on protection against diseases such as safe water, adequate sewage, immunization, nutrition, family planning, environmental sanitation and others;

(b) through a representative planning group, establish objectives, approaches and strategies that would lead to multi-media, multi-agency and multi-disciplinary efforts to promote health information, education and communication;

(c) identify health workers and officials known to be influential with mass media to help promote media relations and ensure publication of urgent, vital messages;

(d) use marketing strategies to increase effectiveness of health information systems;

(e) secure yearly allocations for health information, education and communication;

(f) make full use of radio for health information, education and communication.

Specific

(a) establish national health information and education councils/centres

(b) establish a representative planning group composed of personnel from health and health-related agencies to develop information, education and communication objectives, approaches and strategies;

(c) appoint full-time health information and education officers;

(d) provide funds for information, education and communication components in all health programmes.
2. Training of information, health and health-related personnel

(a) train health educators and information officers on primary health care;

(b) train mass media reporters on health reporting and identify local and foreign resources who can provide such training;

(c) provide trained health reporters with all necessary background materials, e.g. photos, glossaries, guidelines and research papers;

(d) WHO in cooperation with other international agencies to encourage and support the holding of national seminars/workshops among media personnel, health educators/communicators, marketing specialists, and other personnel of agencies involved in health-related activities:
   (1) To expound the concept of primary health care as defined in the Alma-Ata Declaration.
   (2) To train in the effective handling of health and health-related information.
   (3) To promote collaboration and coordination among agencies.
   (4) To familiarize participants with the problems faced by their own indigenous mass media.

(e) WHO to support training in terms of funding, teaching materials, expertise and resource persons;

(f) WHO to establish team fellowship for development communication with emphasis on health and primary health care; that these teams to be composed of at least one journalist in print and broadcast media, one health educator, one health communicator, one information officer, health administrator, specialist from each country; and for WHO to seek the expertise of international organizations and institutions such as University of the Philippines Institute of Mass Communication, Asian Institute for Broadcast Development, Press Foundation of Asia; and that these organizations will draw up courses for the handling of health and health-related information that may be used for seminars/workshops;

(g) WHO to develop an information brochure for media and information personnel on the concept of primary health care and on specific requirements of media.
3. Improving collaboration among organizations concerned with health information education.

(a) Dialogue and good relationship between health officers and the communications media

(1) Health personnel to make themselves more accessible to mass media;

(2) Health authorities should identify key personnel who are given specific functions with regard to media;

(3) There should be a continuing interaction between health educators, health information officers and health personnel themselves.

(b) Inter-organization collaboration

(1) There should be collaboration in the use of interpersonal, traditional, communication, extension services and multi-media approach;

(2) Radio should be supported by/supportive to other media;

(3) Ministries of health should explain and promote the concept of primary health care to agencies which need to be involved, i.e. agriculture, education, media, traditional medicine, social welfare, community development and others.

4. Needed areas of support from international agencies

(a) collaboration with member states in the formulation of comprehensive health education/communication policies and strategies with emphasis on multi-media approach as reinforcement to community organization and extension efforts in support of health programmes;

(b) support in terms of fellowships, training programmes, seminars and workshops at both national and intercountry level;

(c) support the development of infrastructure, hardware, software, for strengthening media resources for health education and communication.
With further expert assistance from Professor Armando J. Malay, the group identified the following goals and objectives for the next two years. Points 1 to 4 relate to target audiences.

**Target audiences**

1. **Politicians**

   WHO to impress on member governments the need to upgrade information, education and communication on primary health care to achieve health goals, to provide adequate resources for this purpose, and to pledge long-term, continuous commitment to information, education and communication initiatives.

2. **Health personnel**

   (a) Numbers of specialized staff to be increased to a level which meets the needs of the programme.

   (b) Existing health personnel to be trained in communication skills to enable them to become active participants in information, education and communication on primary health care.

   (c) Given the likelihood of continuing limited resources for information, education and communication activities, active consideration to be given to defining priority targets. The group identified the following as major targets in the region:

   (i) Control of population growth

   (ii) Control of infectious diseases, including venereal diseases

   (iii) Eliminating malnutrition

   (iv) Reduction of chronic and degenerative diseases

   (v) Reducing the incidence of smoking, drug abuse and excessive alcohol intake

   (vi) Control of environmental pollution

   (d) Attention to be given to upgrading, streamlining and reorienting as necessary information, education and communication resources to ensure their appropriateness for primary health care.
3. **Communities**

(a) Increased attention to be given to the health needs of cultural minorities.

(b) Attention to be given to ways of motivating individual commitment to health responsibility and self-reliance.

4. **Media**

(a) Greater cooperation to be sought from the media in promoting primary health care.

(b) Joint efforts to be made by health workers and the media to encourage improved reporting on health matters.

5. Continuous monitoring and evaluation of information, education and communication programmes in all member countries to be undertaken at all levels and in all sectors.

**Participants:**

- Resource person: Professor A. Malay
- Chairman: Ana Hoff
- Rapporteur: Elena Samonte
- Participants: Gordon Benjamin, Tosiaki Takagi, Weng Mingqing, Antonio Eustaquio, Eliki Bomani Momoivalu, Kairabu Kamoriki, Lilia Juarez
The task

To establish ways in measurable terms of promoting primary health care in the next two years.

Recommended objectives and goals

1. To influence key persons, i.e. government and political leaders, medical administrators, into forming a national policy on primary health care by the year 1982, if it has not been formed already.

2. To formulate and implement realistic training programmes for health workers at all levels, both nationally and internationally by the year 1983, i.e. medical and paramedical staff, health educators, school teachers, community workers, etc.
   
   (a) in skills and techniques of communication and education
   (b) in primary health care

3. To supplement the present resources which have been found to be inadequate by tapping from:
   
   (a) voluntary organizations
   (b) community leaders and influential groups
   (c) private sector

4. To stress the importance of improving literacy and education levels by the year 1982, by strengthening, in possible ways, the concerted efforts between health and education workers.

5. To continue efforts in correcting superstitious beliefs and misconceptions related to health.

6. To overcome barriers in the free flow of communication
   
   (a) between policy-makers and health educators
   (b) between health educators and the community
   (c) between communities in isolated locations
   (d) among community members

7. To motivate the editors, reporters and programmers in the mass media to help government in promoting primary health care, in the hope that a change of attitude may be established before 1983.
Annex 11

Participants:

<table>
<thead>
<tr>
<th>Role</th>
<th>Name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource person</td>
<td>Natividad Muguid</td>
</tr>
<tr>
<td>Chairman</td>
<td>Rene Silverwood</td>
</tr>
<tr>
<td>Rapporteur</td>
<td>Chan Wai-man</td>
</tr>
<tr>
<td>Participants</td>
<td>Christopher Wong Kwan-ming</td>
</tr>
<tr>
<td></td>
<td>Keiji Tanaka</td>
</tr>
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<td></td>
<td>Esperanza Santos</td>
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<td></td>
<td>Zulkarnain Hassan</td>
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<td></td>
<td>Ezekiel Kikiolo</td>
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<td></td>
<td>Rebecca Santos</td>
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<td></td>
<td>Toribio Medina</td>
</tr>
</tbody>
</table>
I. National and Regional Information, Education and Communication Goals and Objectives by 1983

1. Political will to support primary health care should be strengthened and linked with national development.

2. To explore possible ways and means to augment information, education and communication budgets.

3. To plan specific information, education and communication programmes under one agency (National Coordinating Council/Agency).

4. To hold national workshop in member countries with assistance of WHO.

5. To develop mechanism for inter-agencies linkages, including sharing information, education and communication materials and expertise.

6. To increase awareness and develop skills in copying out information, education and communication activities.

II.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Target audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. to establish policies or legislation to support primary health care.</td>
<td>Policy makers</td>
</tr>
<tr>
<td>to shift emphasis on budget allocation to disease prevention and health maintenance programmes.</td>
<td>Health Ministers</td>
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<tr>
<td>2. to organize fund raising campaigns with active participation of private sectors/civic groups, etc.</td>
<td>General public</td>
</tr>
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<tr>
<td>3. to set up a multi-sectional and multi-agency, national coordinating council/agency to plan, implement and evaluate information, education and communication programmes for primary health care.</td>
<td>Representative of government, media, etc.</td>
</tr>
</tbody>
</table>
Annex 11

Specific | Target audience
---|---
4. workshop on primary health care work assistance of WHO/UNICEF and other agencies | Administrators, Media, Health educators
5. WHO to set up a regional coordinating council/centre to monitor all information, education and communication activities on primary health care so as to promote inter-agency linkages. | WHO Regional Office
6. to conduct training workshop, seminars, courses to develop technique and skills in carrying out information, education and communication. | Government/nongovernment Health community Media

Conclusion statement

Suggestions and recommendations as outlined in this report is viable in furthering the advancement of information, education and communication programmes and objectives. It is therefore essential if not, practical that these suggestions and recommendations be considered and carried out to its fullest.

Group B participants consisted of:

Resource person : Alberto Rous
Rapporteur : Susan Liava'a and Justina Langidrik
K. Mariappan
Francisco Sungino
Valentin Loyola
Geniembo Byron
Anthony Santos
With professional help of Professor Armando J. Malay, the members of the Working Group A firstly identified six main problems listed below. These problems were then prioritised with goals, recommendations, activities and resources for each one of them as stated below:

1. Lack of orientation on the primary health care concept on the part of health programme directors, media, the community and other government and private agencies.

2. Lack of coordinating bodies to plan, implement, evaluate and monitor information, education and communication activities in primary health care at the national and regional levels.

3. Absence of definite planned information, education and communication programmes for primary health care in certain countries.

4. Inadequacy of funds and resources available for information, education and communication activities.

5. Lack of communication skills to carry out information, education and communication activities for primary health care
   - health personnel
   - media personnel
   - other related workers

6. Lack of commitment on the part of the media and the private sector towards primary health care and the existence of government policy restrictions on the media and the private sector on health-related information, education and communication activities.
<table>
<thead>
<tr>
<th>Problem</th>
<th>Goals</th>
<th>Recommendations/Actions</th>
<th>Activities (if any)</th>
<th>Resources</th>
</tr>
</thead>
</table>
| 1       | a. To make primary health care a priority in National Health Development policies | **At the regional level**  
(i) WHO to conduct orientation workshops/seminars/conferences for top-level policymakers of the member countries on primary health care.  
(ii) The 1979 and 1981 Regional Information, Education and Communication Workshop recommendations to be given due consideration. | | WHO Regional Office |
|         |       | **At the national level**  
(i) The ministries of health of the member countries to initiate and conduct seminars/workshops to orientate the programme staff, media, community and other related agencies/groups on primary health care at all levels. | | Ministries of Health of Member Countries |
| 2       | Coordinate all information, education and communication activities on primary health care at both regional and national levels. | **At the regional level**  
(i) To set up a regional coordinating council/centre to monitor all information, education and communication activities on primary health care so as to promote inter-agency linkages. | Develop mechanism for WHO intergovernmental linkages, including sharing of information, education and communication materials and expertise. | |
<table>
<thead>
<tr>
<th>Problem</th>
<th>Goals</th>
<th>Recommendations/Actions</th>
<th>Activities (if any)</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (cont'd)</td>
<td>To establish definite planned information, education and communication programmes for primary health care.</td>
<td>(ii) To carry out regular evaluation of information, education and communication activities in the regional level and institute appropriate measures, if necessary.</td>
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<td>At the national level</td>
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<tr>
<td></td>
<td></td>
<td>(i) To set up a multi-sectoral and multi-agency national coordinating council to plan, implement and evaluate information, education and communication programmes for primary health care.</td>
<td>Develop mechanism for inter-agency linkages, including developing and sharing of information, education and communication materials and expertise.</td>
<td>Ministries in charge of health, information, media, human settlements, community development organization, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(ii) To carry out regular evaluation of information, education and communication activities on primary health care at all levels within the country and institute appropriate measures, if necessary.</td>
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<tr>
<td>3</td>
<td>To establish definite planned information, education and communication programmes for primary health care.</td>
<td>(i) To establish national guidelines on information, education and communication programmes for the different target audience.</td>
<td>To carry out community and educational diagnosis of health problems in order to develop information, education and communication programmes.</td>
<td>National Information Education and Communication Coordinating Councils.</td>
</tr>
<tr>
<td>Problem</td>
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<td>Recommendations/Actions</td>
<td>Activities (if any)</td>
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<tr>
<td>3 (cont'd)</td>
<td>To explore all possible ways and means to augment information, education and communication budgets.</td>
<td>(iii) To develop information, education and communication programmes adopting the participatory planning process.</td>
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<td>4</td>
<td>At the regional level</td>
<td>(i) To solicit for sufficient funds for IEC activities from international agencies/foundations.</td>
<td>Carry out activities such as training, production of IEC materials and logistic support.</td>
<td>WHO</td>
</tr>
<tr>
<td></td>
<td>At the national level</td>
<td>(i) To solicit for sufficient funds for IEC activities from multinational and national organizations in the country.</td>
<td></td>
<td>Ministries responsible for health, information and Communication Development</td>
</tr>
<tr>
<td>5</td>
<td>At the regional level</td>
<td>(i) To provide funds and facilities for training. (ii) To provide resources for training key health, media and other related personnel in carrying out the management of IEC activities.</td>
<td>Workshops, seminars, fellowships, study tours consultation, observation attachment, training in media production, resource centres.</td>
<td>WHO</td>
</tr>
<tr>
<td>Problem</td>
<td>Goals</td>
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</table>
| 5 (cont'd) | To generate and maintain greater interest and continuous participation of the media and the private sector in IEC activities. | (i) To provide funds and facilities for training.  
(ii) To provide training for all health-related personnel to carry out IEC activities.  
(iii) To provide IEC material support to enable health-related personnel carry out IEC activities. | Pre-service and in-service for all health-related personnel | Ministries responsible for health and development |
| | | | Key personnel to attend courses in mass communication and journalism in suitable training institution. | |
| 6 | (i) The National Coordinating Council/Ministries responsible for health and development to initiate activities to gain cooperation of the media and private sector.  
(ii) To instil in the media and the private sector their moral obligations and roles to promote better standard of health.  
(iii) The National Coordinating Council/Ministries responsible for health and development to establish mechanisms for two-way communication among the various sectors involved. | Dialogue sessions workshops, seminars, brochures on PHC, observation tour, forums, briefings, information centres | The National Coordinating Council/Ministries responsible:  
- media  
- private sector  
- participants at the workshop | |

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Resources

Ministries responsible for health and development
- Training Institute
- Assistance from WHO

The National Coordinating Council/Ministries responsible:
- media
- private sector
- participants at the workshop
Annex 12

**Group A participants:**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource person</td>
<td>Professor Armando J. Malay</td>
</tr>
<tr>
<td>Chairman</td>
<td>K. Mariappan</td>
</tr>
<tr>
<td>Rapporteur</td>
<td>Cisco Sungino</td>
</tr>
<tr>
<td>Member</td>
<td>Yi Kie Mung, Valentin Loyola, G. Byron, J. Langidrik, S. Liava'a, Elena Samonte, L. Juarez</td>
</tr>
</tbody>
</table>
The group considered five broad areas which had been highlighted by all working groups.

Goal 1. Influencing policy-makers towards formulating a national policy on primary health care and/or to provide increased support for such a policy.

Recommendations:

(a) WHO to use its good offices to get policy-makers/politicians to support national programmes.

(b) That the recommendations of this workshop be included in the agenda of the next meeting of the WHO General Assembly in Geneva 1981.

(c) That WHO Western Pacific region organize a meeting of national health ministers or that regional representatives of WHO visit the countries to talk to health ministers and political leaders. (This should be given some urgency in view of our 1983 time schedule).

(d) Information, education and communication health workers to seek to influence community leaders to bring pressure to bear on policy-makers/politicians.

Goal 2. Expansion of resources: Manpower, finance, hardware and software.

Recommendations:

(a) That information, education and communication workers take stock of existing resources of information, education and communication programmes; to determine whether existing resources are being use efficiently or whether a re-ordering of priorities is necessary; and to assess future needs.

(b) To explore possible sources of additional finance from the government.

1. To work within existing frameworks to attempt to persuade governments to allocate a larger share of available resources for information, education and communication programmes; such persuasion to be based on presentation of realistic evidence of the value of specific information, education and communication projects and programmes.
Annex 12

2. Governments be asked to allocate to IEC activities specific percentages of revenue from health related sources of income, e.g. National Health Insurance schemes and taxes on alcohol and cigarettes sales and other sources of revenue such as lotteries.

3. Where appropriate, federal/central governments to seek financial support from local/state governments to help finance information, education and communication programmes.

(c) Community resources

1. To actively seek the support of service clubs or civic organizations e.g. rotary clubs, lions club, jockey clubs, church groups, etc. to sponsor and finance specific information, education and communication projects; similar support to be sought from professional and voluntary associations such as Medical Association, Anti-cancer association, Red Cross.

2. Similar action to be taken in respect of business firms and industrial organizations, such as life insurance and pharmaceutical companies.

(d) International resources

Where appropriate, financial assistance to be sought from United Nations organizations and other international agencies like Australian Development Assistance Bureau (ADAB), etc.

Goal 3. To introduce or improve training programmes for health related workers.

Recommendations:

(a) To set up national coordinating bodies to consider training needs and to formulate policies to meet those needs.

(b) Head of health ministries to seek the technical advice or direct assistance, whichever is applicable, from WHO to formulate and implement information, education and communication training programmes.

(c) WHO to centralize and coordinate relevant information, education and communication programmes for neighbouring countries or countries with similar training requirements.

(d) WHO to explore the possibility of assistance from international agencies, e.g. Colombo Plan Bureau, Frederick Ebert Foundation of West Germany, Asian Mass Communication Institute (AMIC), etc.
(e) Organizers of training programmes to recognize the need for information, education and communication training programmes for health workers at all levels, i.e. medical and paramedical workers, school teachers, community workers, etc.

(f) Training programmes to include skills and techniques of communication and education in primary health care.

Goal 4. To motivate the mass media to help government to promote primary health care.

Recommendations:

(a) WHO to sponsor and organize national seminars and workshops for media practitioners to promote greater awareness of primary health care.

(b) WHO to seek the cooperation of international media organizations (e.g. Asian Institute of Journalism, Asian Federation of Advertising Associations and Press Foundation of Asia, etc.) in urging their members to promote primary health care through the media.

(c) Each country to establish closer coordination with its media with the aim of seeking improved coverage of primary health care matters; to offer assistance in improving the knowledge and abilities of media employees in reporting health matters; to provide incentives to better reporting on health matters, e.g. through the giving of national awards.

(d) To seek the assistance of national organizations of media practitioners, e.g. journalists' unions, Broadcasters' Associations, Press Clubs, etc., in urging their members to promote primary health care; and to establish personal rapport with individual practitioners especially at the district level.

Goal 5. To recognize the importance of research in meeting information, education and communication goals.

Recommendations:

(a) Information, education and communication workers to use research to establish the needs of communities and individuals so that information, education and communication efforts can be appropriately directed and continuous monitoring and evaluation undertaken.

(b) Information, education and communication, workers to identify obstacles and resistance to information, education and communication programmes, e.g. superstitious beliefs and misconceptions; and to determine methods to correct them.
Annex 12

Group B participants consisted of:

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource person</td>
<td>Mrs N. Nuguid</td>
</tr>
<tr>
<td>Rapporteur</td>
<td>E.B. Momoivevalu</td>
</tr>
<tr>
<td>Chairman</td>
<td>Chan Wai-man</td>
</tr>
<tr>
<td>Member</td>
<td>Antonio Eustaquio&lt;br&gt;Keiji Tanaka&lt;br&gt;Gordon Benjamin&lt;br&gt;C. Wong Kwan-ming&lt;br&gt;Ana Hoff&lt;br&gt;Rebecca Santos&lt;br&gt;Toribio Medina</td>
</tr>
</tbody>
</table>
General priority statements

1. Creation of a National Coordinating Council
2. Influencing political leaders at all levels
3. Training of all nongovernment and government sectors
4. Resources: funds, manpower, equipment
5. Overcoming the barriers of communications
   a. Community leaders as opposed to health educators
   b. Health educators as opposed to mass media
   c. Mass media as opposed to dissemination of information to the community
6. International linkages for sharing of IEC materials and expertise

For numbers I-VI, the coordinators/implementors are as follows:

Health education specialists, the Health Education Unit or those primarily in-charge with IEC on primary health care.

I. To create a National Coordinating Centre/Council

A. Objectives and goals

1. To set a national policy along information, education and communication relative to primary health care.
2. To coordinate information, education and communication activities on primary health care.
3. To determine the national needs in terms of manpower, research and other resources.

B. Membership

1. Composition

   Government
   a. Health Minister (Health education experts)
   b. Budget officer
   c. Media Regulating Board if applicable
   d. Education Minister of Representative

   Private
   a. WHO representative
   b. President, National Medical Association
   c. Heads of different private media organizations (print and broadcasting)
   d. Civic association and religious group leaders
Annex 12

II. Influence of key leaders at all levels

A. **Key leaders definitions of:**

(1) Members of parliament or congress, health committees and other legislators.

(2) Executive Heads of State

(3) Heads of local governments

(4) Other political leaders and influential leaders in health

B. **Steps towards influencing leaders**

(1) Keep them informed of activities on information, education and communication on primary health care in the form of package information or situation.

(2) To promote frequent dialogues with lawmakers.

(3) To ensure good rapport between politicians and media in matters of health in facilitating exposure of the politician's health policies thru the media.

(4) To lobby for enactment of laws along primary health care.

III. Training of government and nongovernment sectors on primary health care and communications skills

A. **Personnel to train**

(1) Health educators

(2) All health personnel dealing in health matters

(3) Media people

B. **Types of training**

(1) Communication skills to be offered:

(a) Public speaking

(b) Interviewing techniques

(c) Use of audiovisual aids

(d) Health reporting - interpretation of government health reports

(e) Advertising

(f) Public relations

(g) Research and evaluation techniques

(2) A training on the concepts of primary health care.
IV. Resources

A. Funds

(1) To solicit from government and private sectors
   (a) business sector
   (b) service associations
   (c) civic organizations

(2) Launch fund-raising campaigns: e.g. lottery systems, etc.

B. Manpower

(1) Tap voluntary service organization for assistance
(2) Hiring of additional personnel
(3) Coordination with other organization, e.g. production of health film thru cooperation of media.

C. Equipment

(1) Explore all possible information, education and communication materials that can be obtained locally.

(2) Set-up a national and regional inter-loan system between countries or other agencies to obtain hardware.

(3) To institute maintenance programmes for all existing equipments.

(4) Share information, education and communication materials within the region.

V. To overcome barriers of communication

A. Physical barriers

(1) Motivate the provision of transportation
(2) Propose the provision of better access to roads and air strips
(3) Provide two-way radios

B. Psychological barriers

(1) Improve literacy

(2) Educate and integrate indigenous health workers in the information, education and communication programme.

(3) Seek out community leaders for their involvement
(4) Promote dialogues between government and private sectors of the media.

(5) Promote dialogues between health educators and the community

(6) Get acquainted with cultural groups and understand their cultural needs.

(a) prepare information, education and communication materials to suit cultural needs, including translations if necessary.

VI. Establish international linkages for sharing information, education and communication materials and expertise under the umbrella of the World Health Organization.

Group C participants consisted of:

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Resource person</td>
<td>Alberto Rous</td>
</tr>
<tr>
<td>Rapporteur</td>
<td>Anthony M. Santos</td>
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<td>Kairabu Kamoriki</td>
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