Dangers of reinventing the wheel

THE term ‘reinventing the wheel’ is widely used in health education. It means learning the hard way about discoveries which have already been made.

Over the years, a model approach has been developed which helps to avoid that danger. First, there is an idea based on identified needs. It might come from an official health organization, worried about a particular health problem such as AIDS, or it might come from a community worried about such things as inadequate sanitation. Whatever the source, whether it be health experts or the community, the priorities and resources must be identified.

Then comes the necessity to test the idea, to see whether or not it is a good one, to see whether or not the proposed health technology and educational messages are acceptable to the intended audience.

Are they socially and culturally acceptable? Do they confirm knowledge already held, or do they duplicate it? Will what is proposed encourage people to change and, if they do, will they have the means to maintain that change? How will the success of the scheme be measured?

These are questions which must be asked and answered before any activity takes place in the field.

Effective health education relies on skilled communication between people, supported by teaching materials. Training may well be necessary for the educators who are to use the materials—certainly they will need to be introduced to them, and to the intention behind them.

Experts are needed throughout, but at every stage materials must be tested with the people for whom they are intended, and the educators who are to use them. Only in continued on page 4
DESPITE an unstable political situation, an immunization project in a Mozambican province was so successful that its lessons are now being applied throughout the country.

The pilot scheme, in Inhambane province, set out to achieve its aims over an intensive four-month period. The intention was to meet a 70 per cent target for vaccinating children aged up to 11 months against the six communicable diseases, and a 70 per cent coverage of immunization against tetanus among pregnant women.

Before the project began, immunizations were offered in urban and rural health centres if there were trained staff and the security situation allowed. Teams from the centres visited outlying areas, paying a return visit if the response was slim.

The new scheme, based on house-to-house visits, was introduced through a series of provincial and district seminars, involving health workers, women's organizations, the Mozambican Red Cross and officials of the ruling party. Each district formed a working group, which called village meetings to train community leaders.

'House-to-house mobilization' involved a community representative, usually responsible for ten families, visiting each house to discover whether there was a child or pregnant woman within either of the target groups. Visits were paid two days before the arrival of an immunization team in rural areas, and printed cards were left to reinforce information about the visit, and about the importance and safety of vaccination.

On the day that the vaccination team arrived, cards were collected, and the number of people coming forward was checked against the number of cards distributed.

As the project developed, health education programmes were also launched in schools, and further educational materials were developed.

Out of the 70 per cent target figure, it is estimated that over the three years of the project, from 1985 to 1987, a 68 per cent success rate was achieved. Evaluation showed that house-to-house mobilization was successful in stimulating uptake of vaccination, and that the project reduced the previous drop-out rate between first and third vaccinations significantly.

Pointers for further health education included teaching about the quantity of
Happiness is the message of the campaign.

fluids a child needs when it has diarrhoea, the correct preparation of oral rehydration salts, and family planning. A particular problem with the latter area is that women are reluctant to discuss it with their husbands, who fear that adopting family planning techniques can encourage promiscuity among wives.

Among recommendations from the project evaluation are that there should be regular refresher courses for community leaders, and that health centres in urban areas should offer daily vaccination sessions.

One of the leaflets promoting immunization.
Family health guide is major part of Philippines strategy

A NATIONAL strategy for improving individual, family, and community health in the Philippines is being run by the country's Department of Health, based on home study groups in primary health care led by public health nurses and rural health midwives.

Since the scheme began in 1984, more than 58,000 groups have been organized throughout the 12 regions of the Philippines. Mothers are the main target audience, with a secondary target of fathers, adolescent children, and extended family members living in the same household.

To back the plan, the Department of Health has produced two editions of a Household Teaching Manual, now re-christened the Family Health Guide, which covers a wide range of topics in a colourful, easy-to-read style.

The Health Minister, Dr Alfredo R.A. Bengzon, says in a foreword: "The two most common books found in homes are a prayer book and a dictionary. Each family seems to need a reference when they are in prayer, or when they seek the meaning of words. This book seeks to be a basic family reference in the same category. It is a family reference on health promotion and protection."

Five chapters cover health and life, maternal and child care, the prevention and control of communicable diseases, first aid, and common medicinal plants. Within them, there is a large amount of practical advice, ranging from how to brush teeth properly to how to recognize and avoid malnutrition.

Two million copies of the guide are being produced.

The system works by a midwife mobilizing local health workers and influential local residents in organizing the groups. Help is also sought from teachers. The local health worker enlists between 20 and 25 household members in each zone for a course which involves between ten and 20 sessions over a month.

The aim is for all households to participate, and those who successfully complete the course take part in a public graduation ceremony. When the course is complete, each district is encouraged to prepare a health action plan, with action groups covering 20 households.

A detailed evaluation of the scheme, which will run until at least 1992, is planned with backing from WHO. The aim is to achieve increased health knowledge among 60 to 80 per cent of families, as well as more health-conscious behaviour, increased use of medical facilities, higher immunization rates among children, a higher rate of breast-feeding, and regular use of the Family Health Guide.

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this way can they be made as effective as possible, and even then there should be scope for revision, as evaluation of their use produces comments.

It is a process which is followed daily in many countries, but still the lessons have not been learned, and still some health educators believe that they can devise programmes and that communities will comply.

Partnership, an essential element in health promotion, holds the key to formulating plans which will work in the real world. Without it, there is every danger of reinventing the wheel.

Micheál Jacob
Promoting breast-feeding to Aboriginal mothers—a scheme that continues to expand

"Recognizing that the encouragement and protection of breast-feeding is an important part of the health, nutrition and other social measures required to promote healthy growth and development—of infants and young children; and that breast-feeding is an important aspect of primary health care."

WHO International Code of Marketing of Breast-milk Substitutes
A PROGRAMME to encourage breast-feeding by Aboriginal women in Australia is steadily increasing its scope, using mothers to advise other mothers about benefits and techniques.

The programme is run by the Nursing Mothers’ Association of Australia, a voluntary group which is receiving state funds for its Aboriginal outreach work.

A determination to promote breast-feeding to this particular target group began in 1979, when an Aboriginal activities network was established within the association. The following year saw a seminar for Aboriginal health workers who, while convinced of the need to promote breast-feeding, felt that they had neither the knowledge, the skills nor the time to do it.

Thus, the idea that mothers should become educators was put forward, and a pioneering scheme took place in New South Wales, with talks on breast-feeding taking place at an Aboriginal mission.

The first formal stage of the programme began in 1983, with the objectives of encouraging and supporting mothers who wished to breast-feed their babies, and to create an interest in breast-feeding as an aid to mothering. The Nursing Mothers’ Association undertook to train two women to carry out the work.

Its value was felt to be potentially great, since Aboriginal people suffer from reduced life expectancy due to poor health, and lack of breast-feeding in infancy has been found to contribute to high mortality and morbidity rates in children.

The first stage of the programme lasted for 26 weeks, and involved a training programme which covered not only knowledge and skills related to breast-feeding, but also counselling skills, general nutrition, and stress management techniques. Both the two trainees, and the volunteer trainers, found they were learning as they went along, and the original scheme was constantly revised.

The most significant departure was that the original plan had envisaged the Aboriginal workers educating other women in groups, but word of mouth was found to be more successful, since the Aboriginal community has its own way of spreading knowledge.

During the project a leaflet, poster, and video were produced.

The second stage began in 1984, with the objective of giving Aboriginal babies the right to be breast-fed, carrying long-term benefits to both physical and emotional health.

This phase employed four trainee outreach workers, and again, lessons were learned about the most effective means of communication. For example, sessions had been planned at a health centre, but Aboriginal women did not like the atmosphere, and more informal settings had to be found.

Among the practical results of the second phase, which ran for a year, was a resource...
Putting lessons into practice.

Cheryl and her baby Skye, who benefited from the programme.

In a report on the programme so far, the Nursing Mothers' Association says that its training of outreach workers has had a demonstrable effect both on Aboriginal communities in New South Wales, and on the confidence and abilities of the trainees themselves.

Community awareness of the importance of breast-feeding has grown, and wider programmes on health promotion have been stimulated.

The programme has also affected the work of educational institutions and government authorities, with new training courses being established for health workers.
Rural water schemes need women if they are to achieve success

As the International Drinking Water Supply and Sanitation Decade nears its end, enough evidence has accumulated to show that community involvement and responsibility are essential if rural supply and sanitation programmes are to be successfully introduced and sustained.

Reports over the decade have clearly established the need for safe water supplies and sanitation, with millions of preventable deaths each year. The vast majority of rural populations do not have access to such supplies, nor adequate facilities for disposing of excreta. And knowledge of basic hygiene practices is low.

Hygiene education programmes must become an integral part of all community partnership programmes and must be planned, designed and initiated before, during and from five to ten years after the construction of facilities. The primary purpose is to create a desire in the community to use facilities, and to keep them functioning.

Community preparation and hygiene education constitute a support programme which appears to be vital to the development of effective community management, and to the success of the community partnership approach advocated by WHO.

In order to create a strong enough demand, materials used to convey messages about the benefits of safe water, adequate sanitation and hygiene practices must be realistic, believable, and acceptable to the target population. This is why village groups should be organized, and particularly groups of women, since this tends to ensure that the information conveyed is sensitive to the sociocultural characteristics of the people.

Educational materials based entirely on the 'germ theory concept' are not always acceptable to rural people, nor are they always particularly effective, because it is hard to give a meaning to invisible organisms. To suggest that people are drinking water which contains the faeces of their friends and neighbours can be considerably more effective.

Religious beliefs, superstitions and taboos all contain some positive elements which can be used. In Papua New Guinea, for example, most people do not mind drinking from surface water sources (even though they may be contaminated), but are careful to avoid sources which enemies might use to poison them.

Many religious and supernatural beliefs are concerned with water quality, sanitation, and proper hygienic practices, and can be used as a means of communicating positive messages. When developing educational materials, this type of information should always be considered.

Whether people feel the need to maintain and repair the systems, and maintain acceptable levels of sanitation and hygiene because of fear of 'germs' or fear of 'enemy poisons' is irrelevant, as long as they use, manage, and maintain their programmes effectively.

A planned programme is the basis of the community partnership approach, with a national plan being established, and refined according to the circumstances of local communities.

National specialists, such as sociologists, anthropologists, health educators, and community development personnel should be seconded to work with women's groups, and
other organized groups in the project area. The aim should be to identify the most effective methods of implementing a programme through mass media techniques. Education and preparation should come before any facilities are constructed at community level.

After educational materials have been developed, and an educational programme has begun in a project area, the materials should be refined to fit community requirements. Women and community leaders should be recruited and trained to organize, promote, and implement the programme.

Community hygiene education sessions should take place at least once a quarter, and no less than once every six months.

Village caretakers should be trained in the operation, maintenance and repair of water supply and sanitation facilities, and latrine construction. They should work with women's groups and project personnel to advise on latrine construction in villages.

The health and hygiene curricula of rural primary and secondary schools should be reviewed by the expert group, who should develop teaching materials. They should also develop practical exercises to involve students in building latrine slabs, making shallow wells, and installing hand pumps. The curriculum should include practical training in the operation, maintenance and repair of community facilities.

This schools programme should be launched no later than a year after the introduction of a community hygiene programme.

But it is women who hold the key to success, since they are responsible for most water collection and use. They should be asked to advise on the acceptability of hygiene education materials, technologies, the location of facilities, and so on. Women should be trained by national project staff to promote programmes, construct systems, and operate them.

Only when a community has been prepared, and hygiene education programmes successfully run, should facilities be constructed.

The link between community water supply, sanitation, and health education is well established. With the promotion of the community partnership approach, even closer collaboration between these two fields will be necessary to design and implement successfully programmes which will enhance the quality of life, and the maintenance of life, in the rural populations of the world.
International action increases

Different methods used to bring home message about AIDS

EARLY in the morning Inonge woke up and went to see if her home brew was ready. It was. You could tell from the way it was making bubbles. Together with the other women she sieved the brew.

It was going to be a big party. Muhau had come home after many years in town. His friends were happy to see him.

While waiting for the customers to come, Inonge and Namatama were chatting.

"Muhau has changed. He looks good," Namatama said.

"Nice clothes, also," observed Inonge.

"The girls will like him, especially Poniso. She always goes for strangers..."

"One day she is going to regret. You never know with these travellers."

"What about this new disease they talk about?"

"AIDS. They say it's incurable."

"Unless they pray for you..."

"Nonsense. When you get it, you die."

After the men finished working, one by one they went to Kandiana, where Inonge was ready with the beer.

Muhau was early. The beer party was lively, everyone singing and dancing. When most people had left, Muhau was still hanging around, sweet-talking Inonge. She wasn't sure what to do...

This open-ended story is one of a number being used in Zambia on different topics, setting out to present people with a situation familiar to them, and encouraging discussion and the making of choices.

"An open-ended story is short, and stops at the point of decision," says Dr Joanne Harnmeijer. "It concerns emotions and values, and it is easy for people to identify with the characters, which present real-life situations in a balanced way.

"It is up to the discussion leader to allow the group to share experiences and ideas by posing questions like-can this happen to you or your community? Is it a problem? Can it be avoided? What are the choices open to the main characters?"

Other countries are also introducing AIDS education in schools. In Israel, the Flower Project is organized by medical students in association with the Ministry of Education.

Two AIDS programmes have been developed, one aimed at the 11 to 15 age group, the other at young people aged 16 and over.

The programme for the younger age group begins with a game about the human immune system and its destruction by the human immuno-deficiency virus. Cartoons give more information about bodily defence systems, and there is coverage of immunization against other diseases.

AIDS itself is dealt with towards the end of the programme, with information about how it is transmitted and how it can be avoided. Role play is used to help the children discuss and analyse their feelings.

The second programme pays more attention to risk groups, and the need to limit sexual partners, with emphasis on the use of condoms.

The aims of both programmes are to increase knowledge of the immune system, and to decrease fear of routine immunizations, as well as to increase knowledge...
Children become volunteers to change Asia's biggest slum

USING children as volunteer health educators is one of the methods being employed in an extensive programme taking place in Dharavi, an area of Bombay that is Asia's largest slum.

Four hundred thousand people live in one square mile, and 50,000 of them are the target of a primary health care project directed by Professor Gopa Kothari of the Lokmanya Tilak Municipal Medical College and General Hospital.

The aim is to improve the health and nutritional status of all the people, particularly children under five and women aged from 15 to 45.

The project began in 1981, with an extensive survey of behaviour and beliefs. The results were used to develop health education activities and a community-based health care programme with three main components—medical, welfare, and social activities.

Three doctors, three medical social workers, a nurse, and 14 community health workers form the staff, with the active participation of local residents.

Training programmes were designed for health workers, traditional birth attendants, child volunteers, and other groups. Immunization, oral rehydration therapy, good nutrition, and personal and community hygiene were major elements in the training, with the young volunteers, aged from eight to 14, carrying the messages home to mothers and grandmothers, as well as to other children.

Opening a dialogue with community leaders helped to bring informal health committees into being, and adult literacy schemes were launched, as well as ideas on how to generate income by selling vegetables or making articles for sale.

Competitions were also held for different groups.

Educational aids such as posters, flannelgraphs and slide shows were prepared locally, and used in group meetings and at exhibitions.

Experience has shown that the most successful health education activities have been the training programme, demonstrations of oral rehydration therapy, the production of flannelgraphs, and the establishment of a printing unit to produce posters.

Cookery demonstrations, and the provision of small feeding centres have also been successful.

Evaluation shows that, since the programme began, breast-feeding has increased from 60 per cent to 90 per cent, and immunization rates have increased to 100 per cent, continued over

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about AIDS. The programmes have now been adopted for use in all Israeli schools.

In Onsoy, Norway, a week of lessons was devoted to AIDS, with sessions for teachers, parents, and young people themselves. The talks were given by a public health nurse and a doctor.

Later, pupils were asked to develop a teaching programme for younger children, and this programme is continuing, with 16-year-olds teaching 15-year-olds.

“Students themselves are a great resource for preventive health information,” said the project organizer, Sten Johannessen. “Students guide each other, and influence one another’s attitudes, including ethical and moral attitudes, before they reach adult life.”
Today about 100 million people of the world’s population have no shelter at all.

**Evaluation shows success for project**

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except for measles which has risen to 60 per cent from a low base.

A 68 per cent improvement in personal hygiene has been noted.

“Well-planned communication makes an individual health-conscious, provides him with knowledge on health matters, and promotes the requisite desire and motivation to avail of health services and stay healthy,” says Dr Kothari. “It also encourages measures at both the individual and community level to prevent sickness.”

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**Education for Health**

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