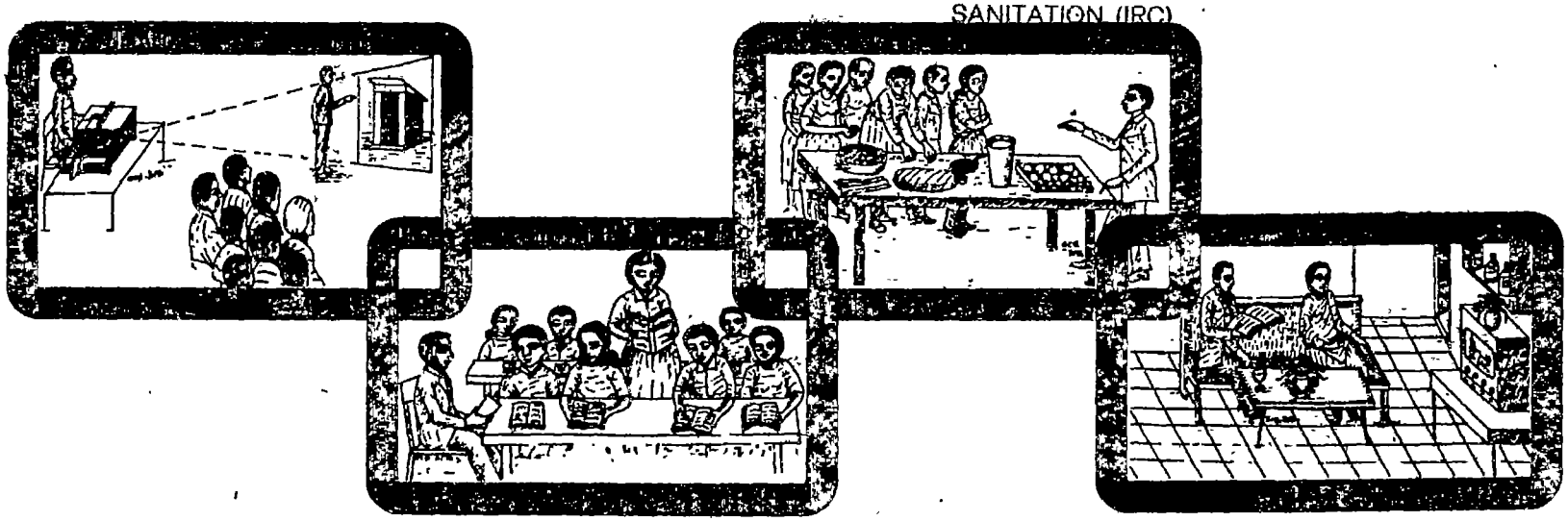
Education for Better Health

A Manual for Senior Health Educators



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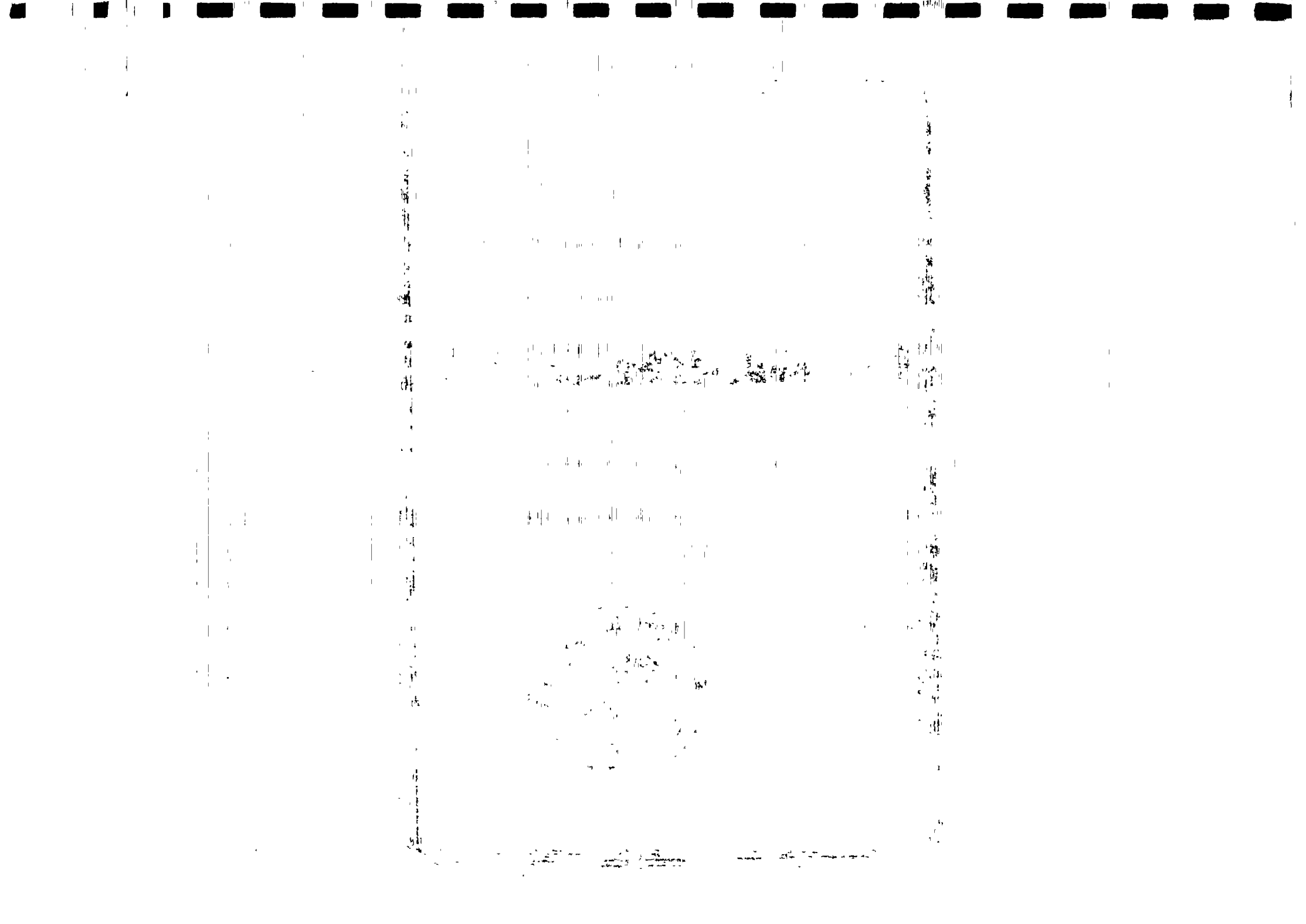

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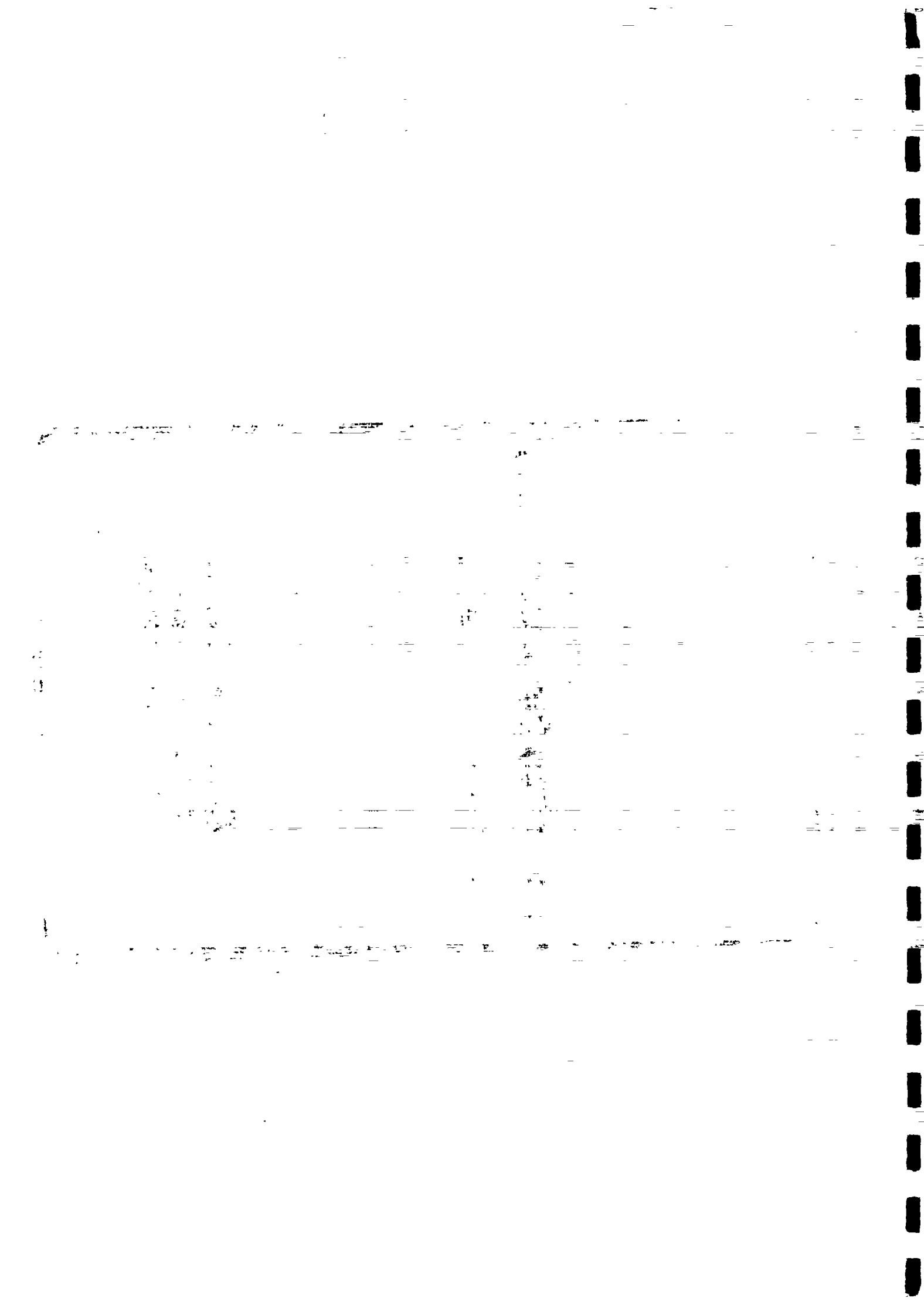

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A Manual for Senior Health Educators

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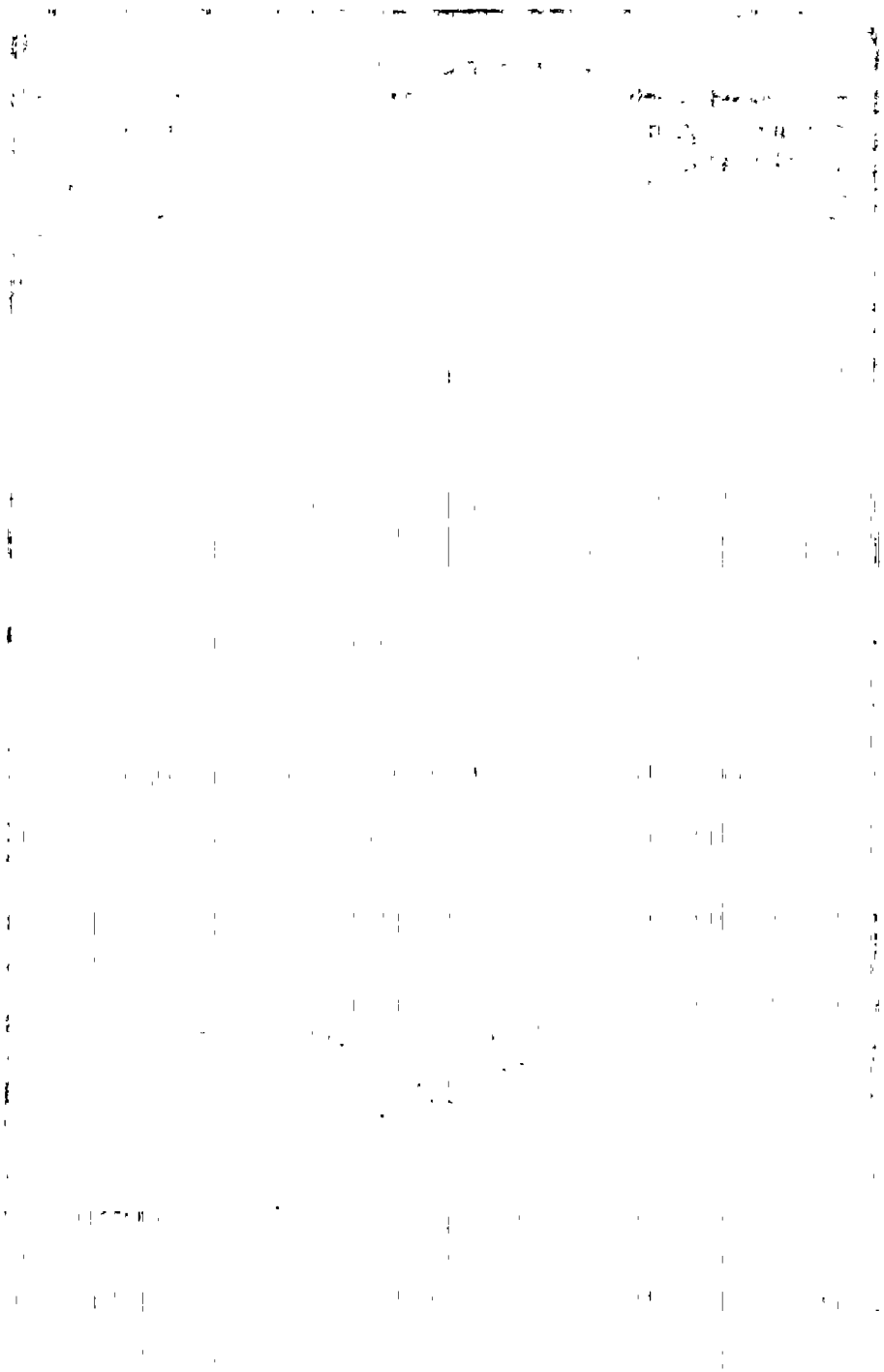

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We gratefully acknowledge permission from WHO and UNICEF to reproduce the Declaration of Alma-Ata on Primary Health Care in Appendix IV.

I dedicate this book to all those who care about the health and welfare of their fellow men.

To the Reader

The principles of primary health care as set out in the Declaration of Alma-Ata in 1978 noted eight components as a minimum requirement to achieve "complete physical, mental and social well being". These eight components are:

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

It is noteworthy that "health education" tops the list of these components. But it is not only the first; one could also say that health education is necessary for the realization of all the other seven components: education is necessary for proper nutrition, safe use of water, the proper use of sanitation facilities, good use of maternal and child care and family planning services, availing oneself of opportunities for immunization, prevention and control of endemic diseases, taking recourse to appropriate treatment facilities and proper use of medicines prescribed. One could also add that health education is needed to promote mental health.

There are many good arguments for advocating "care" rather than "cure" in matters of health where prevention is

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possible: prevention is normally cheaper than healing; the body works better if it is not sick in the first place; and unproductivity, suffering and unhappiness are reduced if illness is forestalled; self-reliance is promoted through giving (part of) the responsibility for health to each individual; *etc.*

Many countries are shifting the emphasis of their health services from hospital or clinic centred treatment to health education and prevention. This is not only wise - it is probably a necessity in order to reduce the heavy cost of comprehensive curative services.

Health education and prevention require a contribution from each individual of a community. Education and a willingness to make adjustments or changes in one's life style as well as modification of some of one's health related beliefs are essential to improve the health of people.

The purpose of this manual is to discuss principles involved in educating and gaining the co-operation of individuals, groups and communities so as to create healthy people in a healthy environment. It is written primarily with senior health educators in mind, and the emphasis lies on discussing ways of giving effective health education, not by prescribing but by helping health educators think creatively about available means and ways of giving education that will contribute to better health.

Only if readers *do* what is taught or discussed in this manual will they derive full benefit from it.

Introduction

Definitions and Scientific Bases of Health Education

Anyone will recognize a dog if he or she sees one, but to define "dog" precisely and adequately is not easy. In the same way, many who practise health education may know very well what they are doing without being able to state exactly what health education is.

A mother who gives a daily bath to a baby and child and supervises that it does so by itself as it grows, gives health education of the most valuable kind. So does a mother who insists that her children shall eat all parts of a well planned (balanced) meal which she has prepared, particularly if she also explains why it is important to eat various kinds of food.

Health education is any impulse or influence - verbal, visual or practical - upon a person which may lead to healthier living. I write "may lead," because much health education given does not lead to any (noticeable) results. Perhaps one day, though, a person will improve his or her health-behaviour, and for unexplained reasons: possibly some half-forgotten influences in the past combine with more recent ones to effect a change in behaviour.

However, some points should be made in more detail in an attempt to define health education.

What health education is, and what is does

What health education is based upon

Health education should increase health knowledge, and if it is effective it should also persuade and create a wish to live a healthier life, both for one's own satisfaction (greater well-being) and self-respect and for social reasons (one gains acceptance and respect for doing one's bit to create a healthy community); and health education should induce changes in health behaviour that are voluntary and routine. Health education aims at changes in personal, family and community behaviour, relating to individual lives as well as one's surroundings. In short, good health education gives knowledge, influences attitudes and changes practices in relation to health. Health education is based on scientific principles of communication, persuasion, motivation, clarification *etc.*, which can enhance our effectiveness and help us reach our aim: a healthier population.

Health education is, then, not a discipline that stands on its own feet: it needs the support of other sciences. As it borrows from many fields, it is valuable for a health educator to be (at least) a little acquainted with some (or all) of the sciences that can help us in our work.

To communicate or teach effectively, a health educator should know something about:

- how to teach (pedagogics, educational psychology);
- how people absorb and react to knowledge at different ages *etc.* (psychology);
- how to overcome obstacles in the communication process

The bases of health education

Health education as a science and as an art

etc. (communication theory);
- how culture influences health beliefs and practices *etc.* (social or cultural anthropology);
- how medical beliefs form systems and how they change *etc.* (medical anthropology);
- how our surroundings influence and limit our choices and opportunities *etc.* (sociology);
- how to build up knowledge systematically and how to proceed logically to further knowledge *etc.* (curriculum development);

and there are other fields it may be helpful to be acquainted with (*e.g.*, local languages, ecology, history).

We shall not discuss these topics or sciences here but only refer health educators to these sciences; they may find that it makes health education easier and more meaningful if they know something about them.

Health education is both an art and a science (or a combination of sciences). Even if we learn a lot of facts about health, preventive health care and health education theory, we may still reach a bit further and exercise a greater influence if we put our hearts into our task and develop our skills to the best of our ability with enthusiasm added to knowledge. We may end up thinking of health education primarily as a form of art. Then it also becomes more interesting than if it is a mere job or assignment we have to do. It may become an enjoyable challenge as well as a useful and necessary service.

Chapter 1

The Aims of Health Education

It might appear very easy to state the aims of health education: It is to teach people about health, how to avoid disease and how to get cured. But although this seems to be a simple and self-evident definition, it does not explain very much and it is far from satisfactory. It is the kind of definition that may have been the cause of much sloppy health education both in the past and at present. We must make our thoughts and aims more precise than the above definition of health education.

Many people have realized the unsatisfactory aim of just teaching people about health, and they have seen that it is the *results* of health education that count. Therefore they prefer to speak about education for health rather than of health education, which is far less exact and clear. Much "health education" has consisted in just formulating (scientifically) correct "messages" and leaving these messages to work on their own to bring about the desired (but not always stated) goals. We have come to understand today that little attention is paid to many of the health messages passed on, and many people who know the messages do not act on them. These messages have therefore little or no impact, and the efforts at health education have in these cases been largely wasted.

The aims of health education

Health knowledge and behaviour change

Can we arrive at a precise definition of the aims of health education that comprises the desirable results? To answer that question we should start by stating what we regard as desirable results. A good starting point may be the formulation in recommendation number 5 of the Alma-Ata document on primary health care of 1978. It stresses that "primary health care should focus on the main health problems in the community" and that health education should deal with "prevailing health problems and the methods of identifying, preventing, and controlling them". In the final declaration the word "identifying" is left out, perhaps because it would require a more thorough scientific education than most people are able to absorb. The key words are therefore "preventing" and "controlling" health problems as the aim of health education. This at once points us to realistic desirable results in terms of less disease and the possibility of cure when disease does occur. Health education is thus *not primarily* a question of *knowledge* but a process of education that leads to *better health*.

The *main aim* of health education is to make people healthier through:

1. reducing the incidence of disease, and
2. making recovery easier, safer, quicker and better than is the case for people without such education.

But to achieve this general aim, we must make clear what processes lead to such results. Here we need to go in more detail, step by step, and be precise in our thinking about

Knowledge needed for better health

A change of beliefs needed for better health

how to go about educating people (including ourselves) for better health.

What is primarily needed is a *change of behaviour* away from unhygienic, unsanitary habits to a more health-promoting way of life. To bring this about, several things are involved:

1. *Knowledge* necessary to avoid disease (where avoidable) and to obtain cure (where best obtainable). This is a basic requirement, but also *only a first step* towards the provision or attainment of better health. Several points must be considered in passing on valid and useful knowledge: We must have the best, most reliable and up-to-date information related to good health; we must have understood and absorbed this information so well that we can explain it in terms the non-professional can grasp; we must develop a "medical" layman's language that makes it possible to pass on our knowledge in the language of the people we want to educate; we must use teaching aids by means of which we can communicate meaningfully and effectively with people we want to reach - and as we must aim at reaching everyone in a community, we must develop various methods of teaching the different "layers" or groups in society, from the illiterate to the best educated and the young as well as adults.

2. *Beliefs* concerning the causes of diseases and their cure may have to change before people will pay attention to health education. This is a much more difficult and crucial part of health education than the mere passing on of knowledge. We must obtain people's trust. For this purpose we may have to try to first convince people in the community whom the others trust, and then to get these "change agents" or opinion formers to take part in the process of educating the rest of the community about better health. But the trusted people may be those who know and respect the traditions of the people and may thus be the hardest to convince. We may have to take some time and make an effort to understand the beliefs and traditions of a community before we can communicate meaningfully with people, and we may have to show a sympathetic understanding even for beliefs we know to be wrong - most unscientific beliefs have arisen with the best intention of explaining vital problems of people, and we may need much patience to get people to adopt more correct and useful beliefs. We may need to argue convincingly as well as to demonstrate the effects of more scientific beliefs where this is possible, and we have to practise what we teach so as to set an example to others and thus make our words more credible - at least they will understand that we ourselves believe in what we say (and do not only try to hoodwink them or get customers to come to us rather than go to their "traditional" healers). If people's beliefs change, their attitudes and hopefully also their practices will change.

3. *Examples* may have to be given of the effectiveness and benefits of good health education if people are to practise what they are taught. This may not always be easy, for two reasons:

- first of all, the results of healthy habits (good hygiene *etc.*)

are mostly not immediate but long-term, *i.e.* cleanliness will over time reduce the incidence of health problems;
- secondly, it is not easy to convince people by the absence of disease about the causes for it.

It may be easier to believe in strong "counter-magic" than in the effects of the use of soap, giving babies boiled water, eating a balanced diet, *etc.* Good health is from one point of view the absence of health problems, and people tend to forget about health problems when they are well and only think about them (perhaps with excessive worry sometimes) when they are sick. One aim of health education is to make people think about health also when there is no health problem. If people do this, they may also notice the beneficial effects of proper hygiene, *etc.* If a whole community starts to become healthier, perhaps they become just as eager for health education as for better health (*i.e.* curative) services. Health education needs to be followed by actions, by behaviour change. Health education is not only words - it tells us about things *to do* to live healthier lives. An example is education about the benefits of immunization. This education is effective only if it leads to people being immunized. If a community suddenly experiences a much lower incidence of diseases against which their members have been immunized, they may become convinced about the arguments and explanations used in health education. But people may not connect the absence of disease with immunization unless we point this out to them by helping them to recall what has happened. Parents of immunized children who have never suffered from any diseases against which they have been immunized may thus become "witnesses" in support of health education. When people have become convinced about the truth of our words in one area (such as immunization) they may also trust what else we say in relation to health.

Examples needed to convince people

Organization of health education

4. *Organization* of health education so as to relate it to life is a crucial point if it is to lead to changes in behaviour that promote good health. We must organize our health education so that it makes certain people responsible for certain aspects of it, and so that all (or as nearly all as possible) in a community are reached with our messages and get involved in health related activities. Education must be organized so that we get the attention of people and so that it can lead straight to action. We need to involve all existing organizations or institutions in a community so as to get to everyone and so as to use communication channels that they are familiar with and trust, *e.g.*, community meetings (of the whole community), peasants associations, youth and women's association meetings, Red Cross clubs, literacy classes, formal schools, *etc.* In addition, the mass media can be used for further support of activities in and with the community. The organization of health education may be related to all phases of such education. Community members may be involved in defining their health-related problems and needs, in selecting members for a health committee and members to be trained as community health workers or given first aid training (*e.g.*, a member of a work group may be trained to deal with injuries that are related to certain kinds of work); they should be involved in discussing professional and economic questions re-

Community participation

The focal point of health education

lated to types of health-promoting facilities a community should choose (such as a suitable water source, or which model(s) of latrines to build), *etc.*

5. *Community participation* is implied in what has been said already, but it is worth stating this separately. No health professional(s) can alone create a healthy community. The participation of everyone in leading clean and healthy lives and keeping their surroundings clean and healthy is necessary to get a healthy community. It should be noted that in many communities people like to discuss matters among themselves and make decisions that involve their neighbours as well as themselves, rather than making individual decisions that make a person stand out a someone who wants to be different from (and better than) the others. Rather than being an example to imitate, such a person may become a stumbling-block to further progress (as people may not want to give him the position of "path-finder" and thus accept him as a kind of example and leader for the others). This is of course different if a person is chosen by the community to try out an innovation on behalf of the other community members. One should always be aware of the views and the sensitivities of each community. If one starts out wrongly, it may later become very difficult to overcome resistance that has built up in the community.

6. *Identifying the pivotal point* around which health education can best be directed or guided in a systematic way. Although the community should be involved as much as possible, there must be a centre for wider co-ordination and planning for an area. At the highest level this will of course be the responsibility of the Ministry of Health. But the conversion of central plans and directives into on-the-spot programmes, projects and activities must be the responsibility of someone closer to the local communities. Hospitals must have their own health education programme, but they are usually so absorbed in curative work that it may be difficult to make them responsible for co-ordinating the health education activities in a wider area. Such tasks may be best assigned to health centres which should have a programme both for its own health education and for surrounding clinics and also help all communal activities in relation to health education wherever their help is needed. Sometimes they will be called upon for help; sometimes they need only to provide special support (information, teaching aids, *etc.*) when asked for it; sometimes they will "interfere" when they see problems that communities are not able or willing to deal with on their own. They can participate, advise or supervise as the situation demands. The health centre can thus effectively serve as the focal point for health education in its "catchment area". The kinds of activities and personnel they will need in order to fulfil such a task may vary from place to place and from time to time, but the overall responsibility should remain constant. There are, however, other possible focal or pivotal points which health education can be organized around. And where health committees exist, health education for the community should be organized by (and with) this committee in such a way that the greatest possible number of community members are

reached.

To sum up: The aim of health education is not the impartation of knowledge - although knowledge relevant to good health is essential - but the aim is better health. Only when education is so thoroughly absorbed by people that it leads to changes in their life and behaviour which in turn lead to better health can we say that our health education has been successful. To achieve the desired results, we have to consider *how* we give our health education (methods and techniques), *who* our audience is, *whom* we involve as our collaborators, and *what* we teach to different groups or individuals (this must be relevant to their situation). All these aspects of health education must be carefully analysed before we embark on a project or "campaign" of educating people about how to stay healthy, be strong, and achieve physical, mental and social well-being.

For added impact, define: methods, audience, coordination, contents

Use this page for your notes

Chapter 2

The Health Educator and his Tools

The way health education should be given will depend on many things: the age, sex, education, culture and interests of the audience, *etc.* We must know:

- Our subject (what to teach),
- The audience (physical, social and cultural facts),
- How to teach (teaching methods and techniques, as well as some educational psychology).

We shall first look at some of the ways of giving health education that have been used and found to work in different contexts. Later we shall evaluate these methods and techniques in the light of what kind of people we want to educate (the target audience). We shall also consider how to teach or educate in an organizational context or framework, so that health education may have a good chance to lead to behaviour change. First, then, we shall talk of methods and techniques of giving health education in a descriptive way, leaving the comparison and evaluation of them till later.

We shall discuss ways of giving health education in the following order:

A survey of teaching methods in health education

- talks;
- talks with demonstration (doing what is being taught, by the "teacher" and by members of the audience);
- talks with discussion (questions by audience and replies by "teacher"; questions from "teacher" and audience which are discussed freely by everyone present; group discussion of theme followed by group decision and "follow-up" actions);
- talks with teaching aids (flipcharts, pictures - photos or drawings, flannelgraph, blackboard or chalk board, scale models, leaflets or folders, slides, overhead projectors);
- use of the mass media (radio; newspapers and periodicals; television and videos);
- health education in schools (curricula, examinations, school health day and sanitation week, readers in literacy classes);
- "reminders" (posters, slogans, "handouts," circulars, various forms, proverbs, cassettes, spot announcements, displays or exhibits, "town criers");
- "entertainment" (films, plays, role play, puppet shows, folk tales and fables, songs, dance).

It will be noted that some of these overlap. Thus, plays, songs and dances can be seen on television, talks can be given on the radio, folk tales printed in newspapers, *etc.* But

Health education talks

when the same technique is used with different media, we shall see that it is the same with a difference. A talk may be given in one way when you can see and hear your audience, and in a very different way when you only see a microphone and a couple of producers in a radio studio and for the rest have to imagine your audience and their reaction. A method will be discussed, not in isolation, but in relation to the audience one is addressing (or at least is expecting). A presentation often improves when one can address specific needs of specific people.

Talks

We start with the cheapest, easiest, best, most efficient method of health education of all: that of talking to people without teaching aids or other supports. In an age with an exaggerated faith in "media" it is worth stressing that the human being with its natural "equipment" is a marvellous instrument for communication. The voice, gestures, the way one uses one's eyes, *etc.*, will all influence the effectiveness of our presentation, and some can use their natural gifts better than others. Although many "means" and "media" can be used to support a verbal presentation, it is probably correct to say that nothing equals the person to person "confrontation" when one person speaks to another or to others in a (big or small) group. In addition to the message, people tend to pay better attention to it if personal contact is established between the person who gives the message and the one(s) who receive(s) it. There is no excuse for neglecting opportunities of giving health education because one

lacks teaching aids, equipment and "interesting" supports (such as films, pictures, charts, *etc.*).

But person to person communication through talking to people can be made more effective if we pay attention to some basic rules or principles of presentation that have been discovered by professional speakers.

Perhaps we should start with defining the topic. If we do not know exactly what the audience would like to hear a talk about, or if we do not know their precise needs, we all from time to time fall back on a more or less relevant topic we pick up from a book on health or health education. This may do for a start when we are new to a place, before we know an area and people there properly. But our aim should be to first make ourselves familiar with the health situation in a district; then to know the various interests and preoccupations of different groups in the community. Then we shall be in a position to talk to the point about what people need to know and like to know about in that particular area. Thus, it is not very interesting for people to listen to a talk about goitre in a place where goitre is no health problem; nor should we give unrealistic advice to people, such as eating meat every day to avoid protein-calorie malnutrition if people are so poor that it is impossible for them to follow such advice.

Our first concern should, therefore, be to learn about people - their health problems, their social and cultural life, their work and economic life: everything that may influence their health - and then we can "teach" them in a way that makes sense to them.

If follows that we have to put some hard work into the

Health education talks

presentation of a talk (or any other means of giving health education). We must do our "homework" by collecting data - in the community as well as from reading - and by giving thought to the best way of explaining our ideas: by using examples (taken as much as possible from, or at least relevant to, the local scene); by using language that is easy to understand (this may require a knowledge of the local language - the use of interpreters is a poor substitute; it definitely requires that one can speak without using medical words or jargon except where absolutely necessary, and then such words should be well explained, and one should find out if there are local names used for the same concepts, *e.g.*, if there are local terms for diseases that you may know by a more scientific name *etc.*); by addressing real problems in that particular community; by adapting our talk to the age, the educational level, the sex and marital status, the religious beliefs, the political awareness, and the work situation of our audience. There is no purpose in talking about family planning to very young or very old people, nor about what food crops to plant to obtain a balanced diet for people in town (and when we advise townspeople about diet we must keep their purchasing power in mind). Food preparation is a suitable topic for housewives; a talk on immunization is most appreciated by parents with young children; *etc.* When you talk about food, be precise in your presentation. This will depend on who you are talking to: The nutritional needs of babies and small children are best looked after by the mothers; the nutritional needs of pregnant and lactating mothers may have to be met by some expense that depends on the

Health education talks

willingness of the fathers to pay, so the advice on what mothers should eat should be given to both the mothers and the fathers; nutritional needs of sick people may have to be given to both the sick and those they depend on. In each case, one should choose one's topic according to the need and the situation of the ones talked to.

Talks need not be "formal" in the sense that one puts it all down on paper. One should be prepared to give specific and clear advice to individuals, dealing with their special situation. One should talk differently to a class in formal schools and a literacy class, to a youth group and a women's group, to a political gathering and a gathering of the whole community. In all cases one should be well prepared, know the topic well so as to sound convincing and be able to answer questions, and so as to be able to talk freely, without relying on looking at and reading from a manuscript all the time.

A person who has to talk regularly to people in this way should also train his or her voice to obtain the best possible effect. It may be necessary to pay attention to the level of one's speech: it must be loud enough for everyone to hear, but not too loud either (no individual likes to be addressed as if he or she were "a public meeting"). If people do not easily grasp what is said, it may also be because we speak too rapidly: We may have to speak more slowly when addressing a group of people than we do when conversing normally. We should also avoid using difficult words or long sentences: speak simply and use short sentences. If we are advising individuals, our talk should be very short and to the point (as well as polite and considerate: we should try not to embarrass or hurt people, as that may annoy them so much that they will not do as we tell them). If we address a gathering of people, we should also try to be brief - perhaps 10 to 15 minutes - and leave time for questions if we want to go on for a longer time. In groups with very specific and strong interests in a topic, we can go on for longer - half an hour or even more may be possible without boring our audience: This applies to professional groups or school classes where a topic has to be thoroughly absorbed. The main objection to long talks or speeches is that they are ineffective: the "attention span" (the time most people are able to concentrate on one topic) is limited, and to lengthen this span, it is good to vary the presentation. Thus, after giving an explanation of a point, one should illustrate it with relevant examples, and if serious points could be illuminated by some light-hearted or humorous anecdote or story, people's attention can be kept longer. It is also important to be able to repeat essential points, preferably without appearing to repeat. This can be done by stating a point, then giving an example of one who did the opposite - with dire consequences, or (perhaps in addition) of one who did "the right thing" (perhaps after several mistaken attempts - using wrong drugs or visiting unqualified healers, *etc.*), and then the main point can be stated again. Sometimes it is good to state the main points as easy, well-phrased slogans or rules, or even to refer to appropriate local sayings or proverbs (if they exist and are correct).

When giving a talk, the speaker should be calm, not move his arms or body too much, not walk up and down all

the time, but not be too "stiff" either, speaking with a monotonous ("boring") voice, or standing without any movements of all; and he should let his look move calmly and slowly over the audience, without fixing his stare at one spot all the time (neither in the audience, on the manuscript or - worst of all - some other point such as on the wall, the ceiling or out through the window). It may also be important to dress "ordinarily" so as not to distract the audience by peculiar, "funny" or even too nice dress.

The human body is a fine instrument for communication and we should do our best to make that communication as effective as we possibly can. We can assist this "instrument" by adding different supplementary techniques, but we should not underestimate the possibilities of the human body alone for giving effective health education, and we should least of all neglect the potentials of our bodies by doing less than we could in personal communication: our cry for more "media" or "aids" may sometimes conceal our laziness to make the most of what we do have (*i.e.* ourselves). Even the effectiveness of "aids" and "media" depends to a large extent on the way we have developed our personal effectiveness as communicators.

Talks with Demonstration

Talks with demonstration

We shall talk about the use of teaching aids later. What we are concerned with here is

the demonstration of what is being said through accompanying actions so as to make the words or "lesson" visible to the audience.

It is important to pay attention to the talk accompanying the demonstration. This must be clear and spaced out so as to assist the demonstration point for point. One should not talk all the time but let the actions speak for themselves at suitable points, so as to "underline" the words, as it were. But not all actions or objects seen during a demonstration are clear enough by themselves, so it is important to explain well what is being shown. A demonstration should be given in a

Talks with demonstration

logical sequence, so that one step follows naturally upon another. One should not be afraid to make pauses and to repeat what may not be clear at once.

Let us take some examples of such teaching sessions. If we want to teach people to change to a more balanced diet, or to start eating foods that they are not used to, we should have all the recommended items present, arranged in a good order, and not only show them to people but also let them handle them so as to become familiar with them. But more than that, one should arrange sessions with the housewives where the food is being prepared and tasted or eaten after it is prepared. During such a session, one should not only show how it is done while the women look at, but some (in a big group) or all (in a small group) should be given tasks so as to participate in the demonstration. They learn better in that way, and they will probably have a better attitude to new and unknown foods they have helped to make than what is handed to them as something "strange". They must also be told the benefits of the new foods. But the introduction of new foods may also involve new crops, and then the farmers should be invited to a meeting as well. If for example maize is being introduced, the plant, the cob, the individual seeds should be shown, and explanations should be given of how to plant and look often the crops, average expected yields, the market situation for maize, how to handle the cobs till they end up as flour, what work is involved and what labour-saving machinery may be available at different stages; and all that is being said should be shown, if possible, or at least as much as can be found, and illustrations may have to do for the rest.

Other examples: If breast-feeding is being recommended for new mothers, it may be good to have that demonstrated by an experienced mother - if she knows how to do it well, as it is more complicated to breast-feed well than many people imagine (the flow of milk has to be easy and the baby held to the breast so as not to give pain or sore nipples to the mother, *etc.*). If family planning devices are demonstrated, the real devices should be shown, and although the demonstration of their actual application may be difficult, one should try to come as close to the real situation as possible. If Oral Rehydration Therapy (ORT) is being recommended and taught, the mixing of Oral Rehydration Salts (ORS) should be shown as it is really done, and the participants in the meeting (especially mothers) should be given a chance to do it. They can also be asked to taste the ORS solution. It is better if they taste it (and may be disgusted by it) in a meeting than at home - and then may think that a sick child will not take it. If the benefits of ORS are explained to them and if they are also told that a dehydrated child will drink almost anything to replace lost fluid, they are more likely to go ahead with it at home. If they have made ORS in a meeting, they may feel confident to do it at home, but if they have only heard about it they may still hesitate to do it.

There are other kinds of demonstration that are not as easy as the examples above. To show harmful germs in unclean water may require the use of a microscope, but poorly educated and uneducated people may not believe that what they see in the microscope is actually what exists in reality - they may rather suspect a "trick" of some kind. It may therefore be necessary to explain the principles of

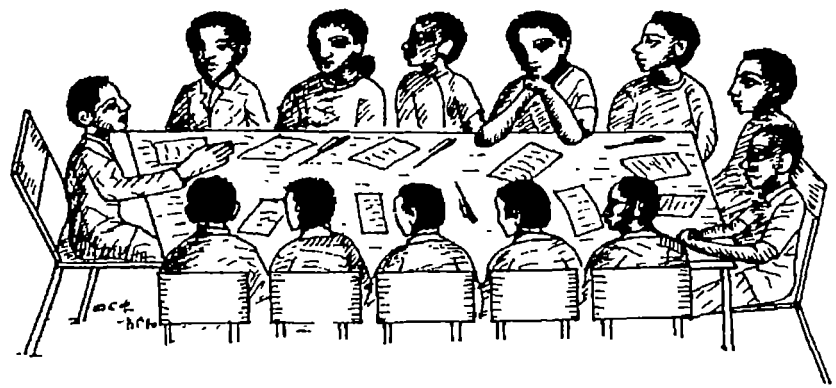
magnification and take them stage by stage, enlarging only on recognizable scales, going further and further, till one can show things that are not visible to the naked eye. Some may be convinced, and the doubters may be convinced later. But it may be worth trying in any case. One could also "visualize dirt" that is not immediately visible by taking three glasses with pure water, then spit into one glass and dip one's fingers in the second, and leave the third glass as it is; then one can rapidly move the glasses around so that no one knows which is which, and then ask them if they are willing to drink from one of the glasses without knowing which contains pure water. This can open the eyes of some to the fact that there can be dirt in food and drink even if it is not visible to the naked eye.

A talk with demonstration gives variety, may keep the interest and attention of people longer than mere words, and such a session is better remembered than a mere lecture. You may have heard the saying of the Chinese that "what I hear I forget, what I see I remember, and what I do I know". That may be true here.

Talks with Discussion

Talks with discussion

It may be true what we said above, that "what I do I know"; but even if I know how



to do a thing, it does not mean that I am convinced that this is the best (or even a necessary) thing to do. I may learn how to prepare a delicious pork chop, but I may not therefore be persuaded to eat it. There is another teaching method that may have greater impact and influence as a means of persuasion, and that is the free, open and candid discussion of questions of common concern or relevance.

One can talk to and discuss with individuals and groups, and the "techniques" involved may not differ much from one situation to another, but the impact of group discussions may be greater than individual discussions and persuasion; this is particularly so in societies with strong communal identity and

Talks with discussion

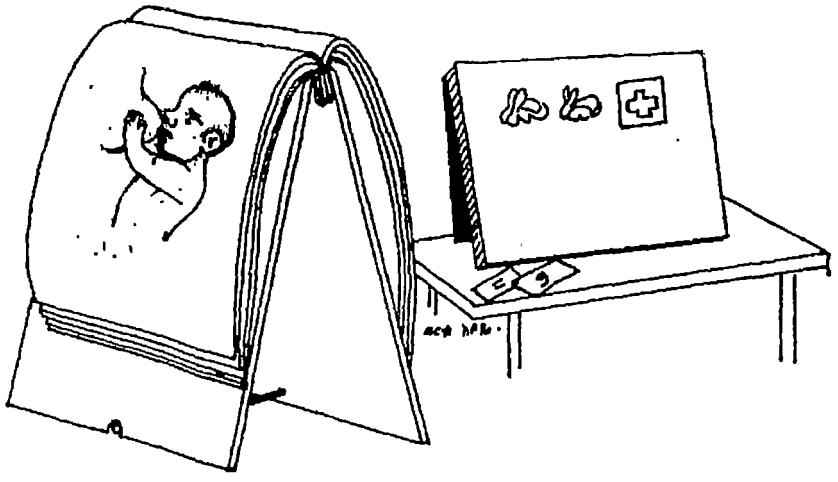
solidarity and where people have a strong feeling of being part of a group. In large groups, such as meetings of whole communities, it is not possible for everyone to take part in the discussion, but a reasonable number of people should be allowed to participate. In small groups, each one should be given a chance to participate, and the leader or chairman of the meeting should see to it that everyone gets a fair chance to have his or her say. If there are some who are shy or feel that they have nothing to say, the chairman can call upon these silent ones (if necessary by name) to give their views or to ask questions if there are things they do not understand or do not agree with. It may be necessary for the chairman to let several people speak about the same topic before he allows new topics to be raised. This will depend on the importance of the topic: some topics can be passed over quickly whereas others are more essential to the theme of the meeting and will need more thorough discussion.

The main speaker at such a discussion forum must be well prepared so that he can answer all (or at least most) questions pertinent to his topic. Sometimes a "panel" or group of specialists or professionals may be asked to be present at a meeting and give their views and answer questions. It is possible to let each of them give a short introductory talk and then let them discuss the topic briefly among themselves, and then the chairman can declare the floor open for discussion, when anyone present can participate. It is possible to let people ask questions to the main speaker or the panel, and have questions answered. On the other hand the speaker(s) can put questions to the audience, so that a wide spectrum of views and observations are aired. But a more lively and effective means of informing and persuading is it to let the discussion be free, as among equals, with due respect given to professional information and opinion, without deferring to it completely. If the audience cannot be persuaded to follow a certain course of action which professional people may be convinced is to the benefit of the community, it may be necessary to hold several such meetings, perhaps alternating with information and education activities in other fora.

When a group is persuaded or convinced of the desirability of a certain course of action, it is important to let them get a chance to make a common, group decision and resolution about it. Names should then as far as possible be noted down and means of follow-up should be devised. If there is a secret vote about a matter, it would still be good to ask for volunteers to try out a new thing and report on their experiences to a future meeting. Such practical experiences may have great persuasive power.

Any resolution must be followed up. A group or a person must be made responsible to see to it that the resolution is followed through, and that reports on any follow-up action is given, as far as possible to the same people as those who were present at the original meeting, and if possible with new participants as well. Unless people know that they will have to, or are expected to, account for a resolution made in a meeting or a promise given (especially to other community members), they may easily "forget" about the matter and no useful result comes out of the original meeting.

Talks with Teaching Aids



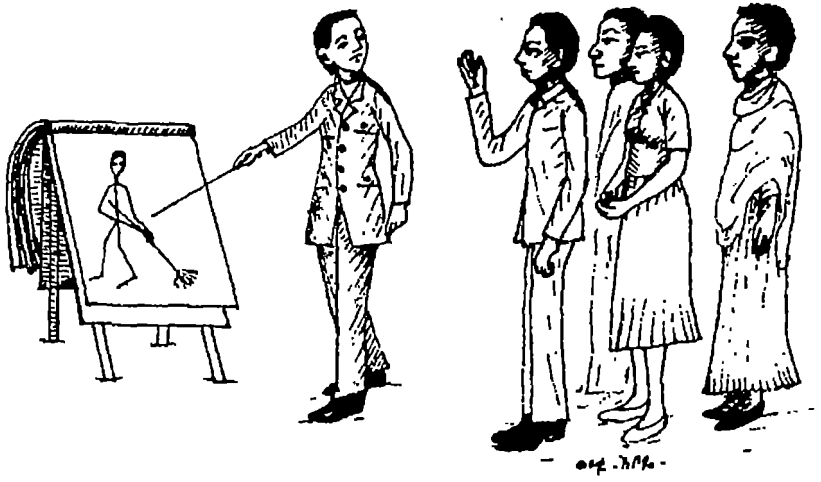
The use of teaching aids when giving health education is very popular. Teaching aids help to emphasize the main points of our message, and by seeing or hearing things in addition to what we say with our voice, people's attention will be more easily kept and they will remember more of what we say. Some teaching aids have become so sophisticated that long training may be needed to use them all effectively. We shall here concentrate on the more straightforward teaching aids, both because it is good to use aids that people can use everywhere, in the poor and remote areas as well as in more affluent centres, and that can be handled by all kinds of health educators. We shall also see in a later chapter that the simple teaching aids may be the more effective ones.

Flipcharts

Talks with teaching aids

Flipcharts

We shall start with a teaching aid that can be said to be a further development of the poster. The flipchart may be



like a poster, with or without words, but the essential things about flipcharts are that:

- they are a series of pictures making up a connected sequence of illustrations or explanations; and
- they are used to support the oral explanations given by the instructor.

Flipcharts are held together at the top, so that they can be turned over and seen clearly one after the other. They should form a logical sequence of explanations. If there are

Flipcharts

no words, the meaning of the pictures must be given clearly by the "teacher". If there are words on the charts, they are also reminders for the instructor about what to teach. There are some flipcharts with headings and slogans in big letters for all to see, and with the main points of the "lesson" in small letters, and these latter serve to help the health educator to recall the main points. These points in small letters are not meant to be read by the audience.

It is good to activate the audience by asking them what the picture means and to let them come with different opinions before the instructor gives the meaning of the chart as it is intended to be. If there are words written in big letters for the audience, one can ask someone near-by who can see the words clearly to read the words or text. If the charts contain names of diseases or medicines that may have local names that differ from the more scientific words used in the charts, it is important to get the local names, either from the audience or to tell them the local names if the instructor knows these. The whole "lesson" should as far as possible be given in the local language used by the people irrespective of the language used in the charts.

When using the charts, it is necessary to hang them up so that it is easy to turn the "pages" or charts. If there is no place to hang them, it may be best to ask two persons from the audience to hold them, and show them how to turn the charts smoothly.

The instructor should be well prepared so that he can explain each chart clearly and fluently, without hesitating. Even when he can read the explanations on the charts themselves, he should have studied and memorized these explanations so well beforehand that during the teaching session he can speak fluently without having to read from the charts all the time.

When he has finished explaining one chart, he can say to the helper or helpers who turn(s) the charts, "Next picture please," so that the session runs smoothly. (Even when there is a table or "pulpit" or rack to hang the charts from, it may be good to ask someone from the audience to turn the charts.)

It is possible to stand behind the charts when explaining them. This allows everyone to see without anyone coming in the way of the pictures. In this case, the written explanation of the charts may be written on the back of the previous charts, so that the instructor can read these or look at them to help his memory in explaining the charts. This may sometimes be the best way, if the charts are complicated and there are many things to remember and explain.

But in most cases the charts are simple enough, and it is usually best to use charts that do not require too much explanation, as people will forget what is said if it is too detailed or complicated. In most simple charts, it is good to have at least something written on each chart, such as a heading and/or a short explanation. When explaining such a chart. the instructor should stand in front of the chart, but to the side so that all can see it. He could well have a stick or pointer to point at different details in the pictures as well as to the written words. He can also ask people to say what they

see and to read the clear words in the flipcharts. For this, he needs to see the charts and be able to point to them from time to time.

It is essential to use flipcharts so that they become an integral part of the teaching session, reinforcing what is being said. Thus, spoken words, read words and pictures should make up one whole, each aspect of the teaching process reinforcing the other. Teaching aids do not work by themselves; that is why they are called "aids"; they *help* us when we teach people.

Flipcharts can be made simply by the instructor or by people in the community; or ready-made, printed ones can be obtained from government ministries or elsewhere. If the ready-made ones are suitable and can be obtained easily, it may be best to use them. These may have been pretested and found suitable for a wide audience before they were printed. But sometimes there are no suitable printed charts available, or they may be found to be "unacceptable" to certain audiences; *e.g.*, there may be pictures that some groups or societies find offensive, or they show pictures of things that are not supposed to be shown in a community. Then it may be best to make flipcharts locally. This is also the case if printed versions use a language that is not (well) understood in the local community.

If you make your own flipcharts, or if you get someone in your community to make them, you should find cardboard or drawing paper that is big enough to make illustrations that are clear enough for everyone to see in the audience with whom you expect to use them. Often it is good to teach small groups at a time; but you may find that you have to teach a meeting of the whole community also. In this latter case, you will need to have charts that are big enough to be seen also from some distance. Some make charts out of calico or linen cloth, which is more durable than paper (and the cost of locally made calico is often reasonable). The cheapest charts may be in black and white, but audiences may prefer colourful illustrations, and if it can be afforded, it may be good to use different colours.

Flipcharts

The pictures should reflect local scenes and the people should look and dress like people in the local community as much as possible. When making a chart, it is important to leave out unimportant details and concentrate only on the main points, so that people easily get the essential message you want to pass on and not be distracted by other things in the picture that are not relevant to what you want to teach. If there are things that people find offensive in the picture, they are likely to note such things first of all and may even not notice what you want to tell them.

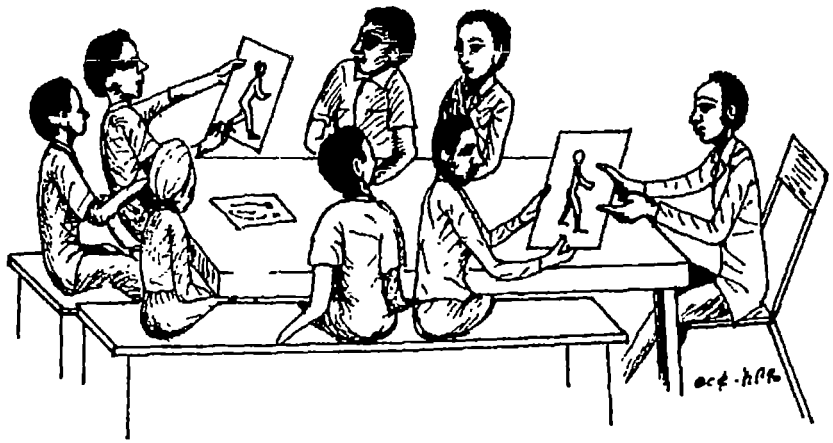
When teaching with the help of flipcharts, stress essential points. Tell first what the "lesson" is about; then go through each chart, teaching only essential points; then, at the end, repeat the main points. This last you can do with the help of the audience, asking them if they remember the main points, going through them together - instructor and audience, with the instructor correcting any errors, of course. The whole "teaching session" by the instructor should not be too long, not more than 30 minutes, but 15 to 20 minutes may be

Flipcharts

a better time. After the teaching session, it is good to let the audience get a chance to ask questions and come with their own suggestions and comments. Even this "open" session should not last two long. The total session, with the teaching part and the open question and answer or discussion part, could last for half an hour or up to one hour, but not more. The short sessions with clear explanations and concentration on main points only are often the most effective. If people have too many questions, it may be best to arrange another (continuation) session, or tell people where they can meet the instructor for private advice and discussion. The instructor may find it worthwhile to visit the homes of members of the audience to continue the education process privately. It may be the people who ask no questions in public meetings who need most private help. They may be silent in big gatherings because they are too shy to ask questions, or because they do not understand and are afraid to ask questions they think others may regard as "stupid". In private it may be easier to reach these with the relevant health message.

Flipcharts may be made cheaply and still be among the best teaching aids available if they are used properly and effectively. Each chart should make one main point, and together a series of flipcharts should tell one connected "story," *i.e.*, they should give the necessary instruction around one main theme, *e.g.*, immunization, a balanced diet, the main "entry points" of communicable diseases, how to keep latrines clean, how to treat unclean water, how to make and give oral rehydration salts, *etc.* "Not too much, not too long" - these are essential points to remember when using flipcharts.

Pictures



We are here talking about photos and drawings one can prepare beforehand and even make during a teaching session (on paper or on the blackboard). We do not refer here to large posters or flipcharts - these are discussed elsewhere.

Small-scale pictures are most suitable in small gatherings where the pictures can be passed from person to person and each can take the time he needs to absorb what is in the picture. The group leader or instructor can explain each picture as it is sent around, either for the whole group or for each person as he sees the picture. Although the latter approach - individual explanation - may be time-consuming, it may also be the most effective method: it ensures a personal touch in the explanation (and this people tend to remember), and it may ensure repetition for those who listen in. Another way is to explain a picture to the person nearest the instructor and ask him to explain it to the one next to him again, and so on, till everyone has heard the explanation and had a chance to explain the picture to his neighbour. (The sequence in which the pictures are seen may be slightly altered - but not too much, as that would cause confusion - so as to avoid that the last person gets no chance to explain them to anyone. But if the last to see them explains each picture to the teacher, it is a check that no distortions have been passed on.) What people explain they remember better than what they only hear, so this is a device to help retention or the memory.

Whereas charts usually only have the outline or mere essentials of a "scene" - what is necessary to pass on a message, pictures may have all the details of the real situation: this is the case with photographs. But uneducated people or people who live in areas where photos are rare often have difficulties in interpreting photos or seeing what is actually shown in the picture. This is a difficulty people who are used to photos, films, magazines and books with pictures do not always realize. Photos should therefore only be used with audiences with some education, unless they are "simple". Photos can be from the instructor's own collection or they can be borrowed from others. Pictures can also be cut out of magazines or newspapers if they are suitable for what we want them for. As teaching aids they may not always be quite to the point (although some are), but if they are used in a small group in a friendly atmosphere they may have a strong impact because "friends" may be open to advice and suggestions from each other, and the scepticism or hostility to

Pictures

Flannelgraph

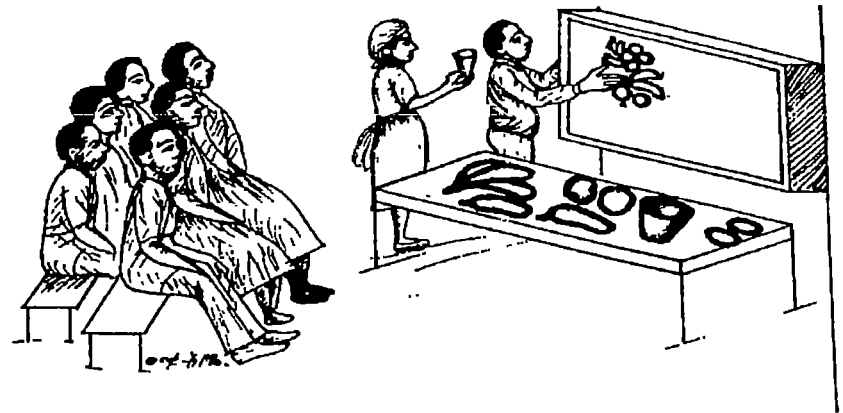
new ideas may be overcome in "home-like" surroundings more easily than in a more formal "teaching session".

For people who are not used to photographs, it may be better to use small drawings on paper/cardboard or the blackboard. Then inessentials may be left out and it becomes easier for some people to get the point. This is most often the case among uneducated people living in remote areas. But the friendly "family" atmosphere can be maintained and drawings and more personal conversation and discussion can be used in the same way as with photographs. An "intimate" approach can be persuasive to some who would be "left cold" by instruction given in larger meetings. Photos and small drawings can also be used to emphasize messages given during home visits.

You should use pictures that resemble life in the community if this is possible. This is easier to understand for most people than pictures from foreign cultures. (More educated people may enjoy seeing pictures from foreign parts, but we are not so much concerned with this kind of audience here.)

Instead of keeping or storing pictures individually it may be a good idea to keep them in a simple album.

Flannelgraph



A flannelgraph can be made fairly easily if you can afford to buy some coarse cloth, called flannel, enough to cover a board of the size you want (about as big as a small blackboard) and also to cover the backside of pictures (which are glued to the cloth). Usually coloured cloth is used (*e.g.*, dark green). The pictures stick to the flannel-covered board when you put them up. It is also possible to buy ready made flannelgraphs. These teaching aids are not so much used, perhaps because of the cost involved to make or acquire one, and the work involved in storing and keeping the pictures in a proper way, and the work involved in making new pictures needed each time you want to change the content of your "lesson".

Some people use the idea of the flannelgraph and cut out cardboard figures and colour them and fix them with glue to a board of plain cardboard. The fixtures (or pictures) have to be torn off after each use, which may spoil the set a bit. But

if it is rarely used, it may be possible to replace spoiled parts each time this teaching aid is used.

The advantage of a flannelgraph is that one can illustrate what is being said step by step, so as to build up a total picture of the contents of a talk gradually, in step with the understanding of the audience. If we want to teach about protein-rich foods, we can put up one picture of one protein-rich food at a time, and add to it until all the main sources of protein are displayed. If a total picture of all these foods is shown at once, this may easily confuse people because the brain may not be able to absorb so many details in one go.

But with the use of a flannelgraph, one detail is taken at a time and new details are added in step with the speed with which the audience can grasp or assimilate them. The total picture should not be built up too fast. If people are asked to help with selecting and putting up the pictures on the board and perhaps discuss or comment on various points during the building-up of the total picture on the flannelgraph, they will be able to digest the lesson as it goes along.

It is important to prepare a session with a flannelgraph well. All the pieces or pictures must be ready at hand, and they must be arranged in an orderly manner so that each piece can be found easily. It is possible to number each piece; and in any case they should be placed on a table or an easily accessible place near (in front of) the flannelgraph, so that one picture can be picked up after the other without having to shuffle through the lot to find the illustration or picture one wants

If the flannelgraph cannot be attached to the wall, it can be placed on a table and be leaning towards the wall with the pieces/pictures/illustrations (which can be pictures of scenes, a piece of cardboard cut out like a fruit *etc.*, or letters and words) placed on the table in front of the flannelgraph board.

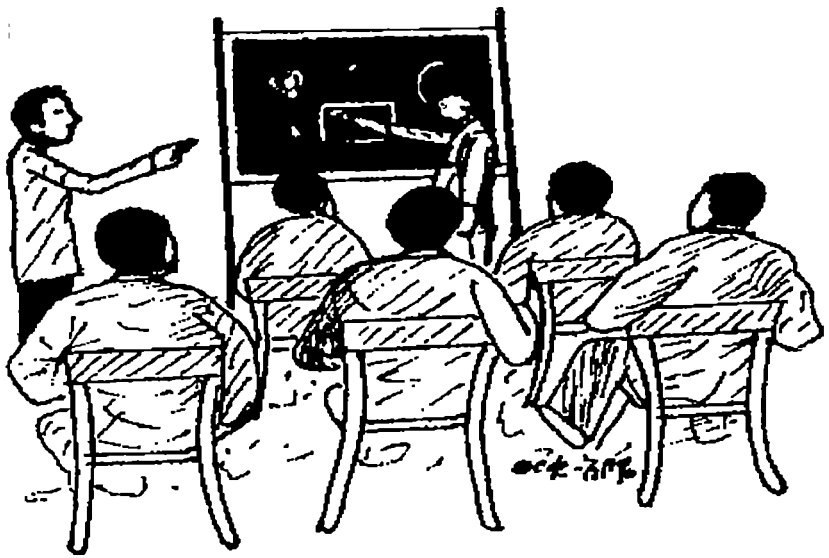
Flannelgraph

The flannelgraph can be used best with small groups, as the board and pictures are usually not big enough to be seen easily or clearly by everyone in a big audience or group.

Blackboard or chalk board

Blackboard or chalk board

Teaching aids are aids to help or assist the talk we give on health. Teaching aids are

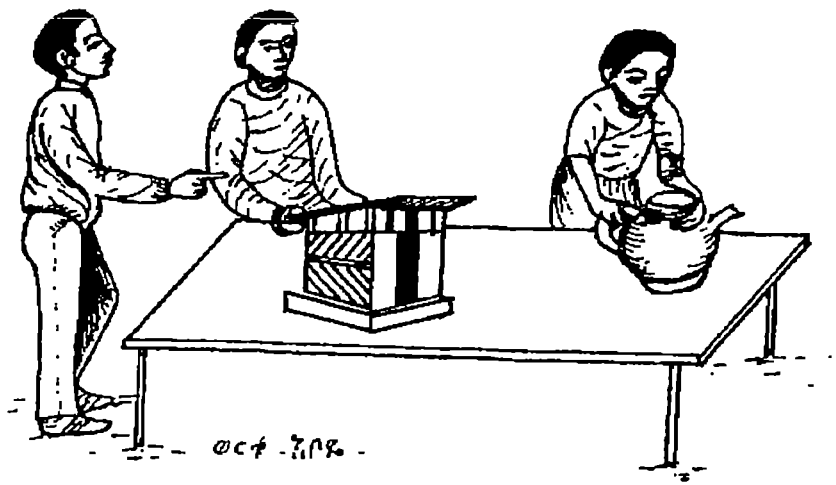


thus not the main things when we teach about health. Very sophisticated aids can become so absorbing and "interesting" in themselves that people may even overlook what the message is supposed to be. One simple teaching aid that can be used to good purpose and with a strong impact is the blackboard. This is present not only in classrooms but also in many halls where instruction is given, and in addition there are portable blackboards that can be taken almost anywhere. On a blackboard, we can easily note down main points, make illustrations if we have the talent for it (or we can ask someone else who can do such things well to draw illustrations for us), and erase and re-do what has been badly done, and we can ask people to participate in writing on the blackboard. After the instructor has gone through the main points and written them on the board, he can erase what he has written and ask one from the audience to write them again, perhaps with help and corrections from the rest of the audience.

As many people will be used to the blackboard - from literacy classes, school or meetings - it is an accepted tool people feel at ease with, and this teaching aid should be exploited to the full, especially where other aids are not easily available. But in many cases the blackboard should be the teaching aid of choice, even where other teaching aids are available. This is particularly the case when teaching at a (slightly) higher level, where many things may have to be written or illustrated. If typewriters and duplicating machines are not available, the blackboard may also be used for "lecture notes"; but any message, point or straightforward illustration may be put on the blackboard.

What is seen is remembered better than what is only heard, so one should put down what is said in writing as well, if possible (but only the main points during a talk). If people from the audience are involved, it is easier to maintain their attention and interest during the whole teaching session, whereas their minds may wander if they only sit and listen passively.

Scale models



Instead of using pictures or drawings of what we talk about, we can use models of the objects. If large things are the topic of our talk, we need scale models that show a smaller "version" of the things than are found in real life. If we talk about latrines, we may use a small model to illustrate our points. Sometimes we use enlarged models, *e.g.*, of harmful insects. In other cases we can use full scale models, such as of a banana or a loaf of bread. Although we sometimes can use the real thing (as when we demonstrate things from real life), a model has the advantage that it does not rot or decay, and it can be used again and again. People can handle it gently - even models can break, and it can pass from hand to hand if it is a small thing, or people can gather around a model so as to study all the details.

Expertly made models can sometimes be costly, so it is almost always preferable to make one's models locally with cheap, locally available materials, using local skills (people who can make models in the local community). Models should have the right proportional measurements (scales) so as to come as close as possible to a real situation, and the difference in scale between the model and the real thing should be explained to the audience. If a model of a fly is shown in a "lesson" about communicable diseases, people may be relieved to think that there are no flies as big as the model in their community and therefore the danger of transmitting disease by such flies is not very great - unless they are told that your enlarged model is meant only to make clear what is not in every detail easy to see *e.g.*, a tiny fly (or mosquito, *etc.*). Such explanations may be even more necessary when talking about germs that in a normal state are not visible to the naked eye. When you have a small model of a thing that is large in reality (such as a latrine), it may be easier for people to relate the model to real life; but especially for uneducated people one should not take such things for granted, but explain how a model differs from the real thing.

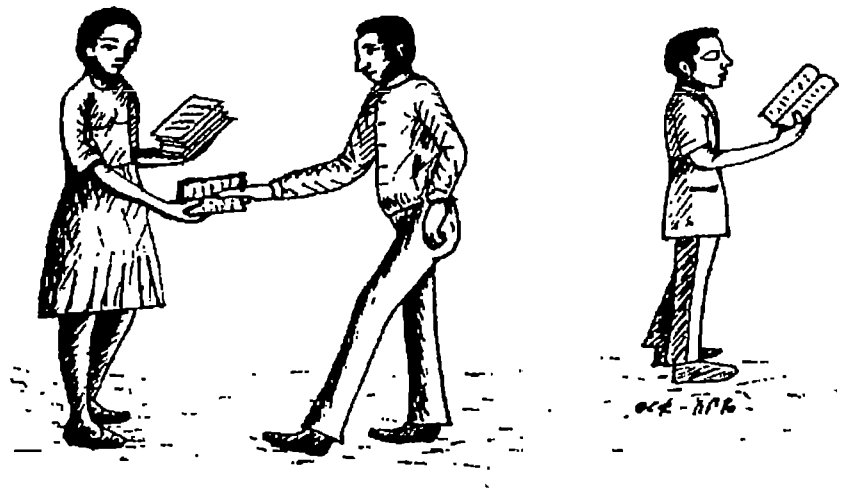
Models may be made of clay, pulp (basically paper), cloth, wood and other materials. One should look for people in the community with various talents in this field if one wants to use models as teaching aids, and especially useful people in this respect may be elected as members of health committees so that they become co-operative in the field of health education and at the same time are shown appreciation for their contribution.

Scale models

Leaflets or folders

Some models can be made parts of displays of a more permanent kind, and some may be used in puppet shows. Instead of always making new things for different uses, one should look for different ways of using the same things. This will reduce the cost of and work involved in acquiring such teaching aids, but a suitable storing place will then be needed.

Leaflets or folders



A leaflet can in a way be said to adapt the idea of the flipchart, but the arrangement and use are different. A leaflet is a series of pictures on a piece of paper, with short, simple explanations, arranged in sequence and folded, and both sides of the paper are used. They are also called folders. The size is small so that a person can carry a great number in his hand at a time. They are mostly used with individual instruction, so that each picture or "page" can be seen by the person being instructed. The size of a "page" in a leaflet or folder is about the same as in a "pocket book," but it is one connected strip of paper with perhaps four pictures or "pages" on each side. Thus, a leaflet/folder may have a "front page" and seven "pages" with pictures or illustrations and short explanations. But some folders/leaflets are shorter and some quite a bit bigger. (If they become much bigger - more than ten pages - it may be better to arrange them as in a book with

staples in the middle. This may become a small book.)

Leaflets are ideal for health workers who visit homes. What they have to say may be emphasized and reinforced by such a simple teaching aid. After the home visit, the leaflet should be left behind in the home visited, and thus it can be read or looked at again (and serve as a reminder),and the person who has received the instruction may explain (the contents of) the leaflet to other members of the family (or to visitors) at other times.

The illustrations in leaflets must be clear and simple, concentrating on main points and leaving out unimportant data. For mass consumption, the language must also be simple, and as far as possible the local language should be used. Leaflets can easily be produced locally, using stencils and duplicating machines. Others are made and distributed by the government and by many organizations. It is important to use leaflets that are relevant to the situation in the community where they are used and that are also culturally acceptable (so that people do not find them offensive).

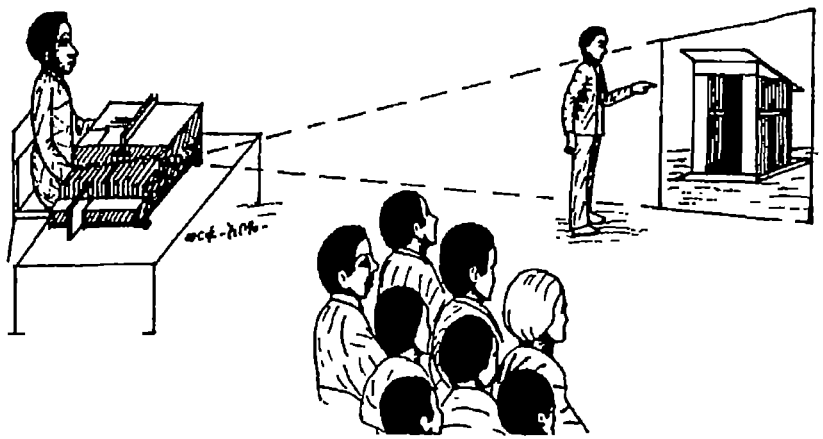
Leaflets should not be just handed out or left anywhere people may come and pick them up. Leaflets are meant to be used in person-to-person encounters, with further explanations and encouragement to practise what is being taught. The advantage of the personal approach is that the "teacher" can check if the "lesson" is properly understood, answer questions and arrange for a further (follow-up) visit to see if the instruction (or theory) has been put into practice. At the end of a home visit, the health educator should tell when the next visit is likely to be, and the people in the home can be told that the same topic will be discussed again and that people are expected to do something about their health behaviour in the meantime. Then they are more likely to do something about what they have been taught - and not just forget it, as many people tend to do.

Leaflets or folders

Slides

Slides

Slides are transparent colour pictures projected on to a white screen in a dark room. The advantage of a dark



room when the pictures are being shown is that the audience cannot see other things very well and will therefore usually concentrate on the pictures. With a big screen, slides can be shown to a fairly big audience. With a small screen, the audience ought to be smaller. Because the pictures dominate the teaching session when slides are used, people may pay less attention to what is being said in the dark. As the impression is mostly on the eyes, with very clear pictures, the explanations should not be continuous, but brief comments to the point should accompany each picture, and then the audience should be left for some seconds to absorb the meaning of the picture after the explanation has been given.

Sometimes a more artistic presentation of a slide show is attempted. One can thus record the comments on tape, with a good, experienced commentator reading the text accompanying the slides, and background music to fill the time between the spoken words. There is then also usually a special sign (a tone recorded on the tape) to indicate to the person in charge of the show when he should change the picture. Although this may be good entertainment, there is a danger with too artistically prepared and presented slide shows that the impact with respect to "lessons learnt" may actually be reduced in this way. The advantage of a personal presence should not be underestimated. A person in charge may notice if the audience gets restless and then speed up the presentation, or he can ask some questions of the audience to "wake them up" by activating them to some extent. People will also normally react more attentively to a person who is present while explaining the pictures than if the voice is recorded and the speaker is not there.

A slide show should not be so long that people get tired and bored. Half an hour may be found to be the maximum time for profitable instruction, and that a show of 15 or 20 minutes is to be preferred. But a show should not be looked upon as complete in itself. A careful, but short, introduction about the reason for showing the slides (the theme or topic of the session) should be given before the slides are presented. The presentation must also be carefully prepared, so that the slide projector and screen are placed so that all can see clearly, so that the cable reaches the wall plug, so that the pictures fill the screen (neither more nor less), so that the person presenting the show does not block the vision of part of the audience (it is better to place the chairs correctly before the show starts than to have a lot of reshuffling of chairs

when the first pictures are being shown), *etc.*

After the show, it is good to use some time (but not too long) to revise the main points of the show and to challenge people to take action on the basis of the slide show, or in other words, to change their behaviour accordingly. It may be good to note down the names of those present (or at least some, if the audience is large) and follow the show up with home visits, when reference can be made to the slide show and its message. This will reinforce or strengthen the impact of the show.

But because of the strong impression usually made by slides by themselves, some find that people feel bored by too much talk after a show of slides, and that it is therefore not useful to use many words after the show is over. It may be better to let people air their views, or to have an informal session when people stay together and talk - perhaps while drinking tea - when they may express their feelings about the show to each other. Although the instructor may not get a full picture of what people say and think in this latter case, it may still have an impact. People may wish to know what others think before they put the "lesson" into practice, and informal discussions may therefore prepare future action, or only prepare the "mood" for the next meeting on the same topic.

Although people like slides (and other projected or picture shows), it may be that their importance as teaching aids are sometimes exaggerated. People may enjoy and even remember pictures better than spoken words, but this may not lead to a change of behaviour more than a talk session - actually talk and discussion and/or demonstration may be better suited to influence people to change their health-related behaviour. In addition, slide shows are dependent on the availability of slide projectors and electricity, which may not be the case in rural areas that need the "lessons" we want to teach most. But as a supplementary teaching tool, slides should not be overlooked. It may be that they are best suited to teach health educators, who will then bring the message to others, using simpler teaching aids.

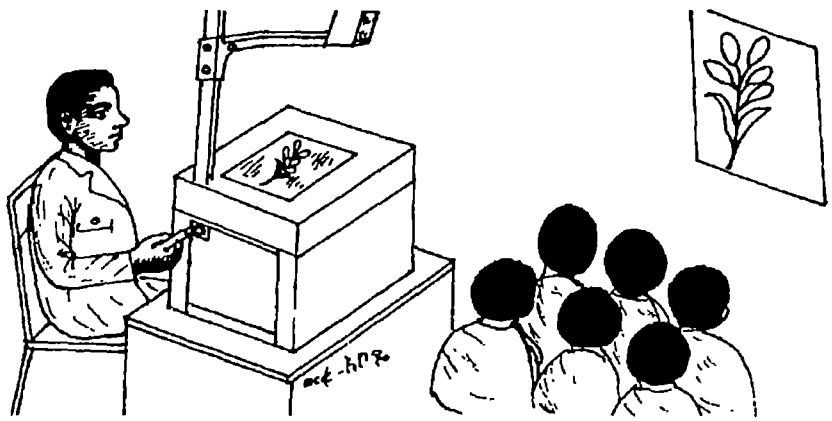
Slides

Overhead projectors

Opaque projectors

Overhead projectors

Overhead projectors can display on screens or a suitable wall what has been prepared on transparent plastic sheets; or we can write, with suitable pens, on these sheets while we give our "lecture". It is possible to write words or draw illustrations on these transparencies while the lecture is going on. It is also possible to photocopy materials on to transparencies. The overhead projector can be used in ordinary day-light - it is not made for use in darkened rooms. These projectors can only be used when electricity is available. It is quite convenient to use an overhead projector while seated, and many therefore find this teaching aid a simple and helpful device. It is easy to rub out what has been written on the transparencies after use, to make changes or corrections or to wipe it all out and re-use



the same transparencies many times. In a way it functions like a blackboard, but as it is easy to use it while facing the audience all the time and as it can use sheets prepared before-hand, it has also many advantages over the blackboard. Its main drawbacks are that electricity is needed (which makes it unsuited for many areas) and that it needs an initial input (the cost of the machine is beyond what many organizations can afford).

If a good series of sheets are ready for use when the talk begins, it can be used somewhat like a series of flipcharts also. The audience should ideally not be too large. Overhead projectors are ideal tools for training of health educators, when giving lectures, and teaching at somewhat advanced levels, although they can in fact be used with all kinds of audiences.

A more adaptable tool, but also a more difficult machine to move from place to place (due to its size and weight) is the *opaque projector*, with which you can show pictures and texts directly from any printed materials. Only larger centres (towns) are likely to have this tool, and the owners may be afraid to lend it to anyone to operate, except their own technicians. It may therefore not be so easy to make regular use of opaque projectors. Still, they should be kept in mind where accessible. Again, like the overhead projector, the opaque projector may be most suitable when teaching audiences at a somewhat higher level, that is, educators who are being trained to train the broad masses. Electricity is needed to operate an opaque projector.

With both kinds of projectors mentioned above, it is important to keep in mind that they are teaching aids only,

and that the most important part of the teaching session is how you use them to *support* what you have to say: aids should not take over from the speaker and make him superfluous or secondary. The meeting of people is more important and has greater impact than the meeting of people with machines only. The speaker uses - and should not be used by - teaching aids, and he or she is more than a mere operator of machines.

Overhead projectors

Opaque projectors

Use this page for your notes

Chapter 3

Use of the Mass Media

When we talk of the mass media, we use the word "mass" differently from its use in the phrase mass meeting. At a mass meeting, the "mass" of people is present at the same time and a speaker addresses a large group of people who are together at the same time and who by their reactions and moods can influence each other (and perhaps the speaker and organizers of the meeting). In the use of the mass media, we talk to or write for many people (and in the case of radio and television, many people who listen or watch at the same time), but these people are not together, - they do not form a mass audience (although groups of people come together occasionally to listen to the radio or watch television). The typical radio and television audience is the family, the individual, or a small group of close friends; and newspapers and periodicals/magazines/journals are usually read by individuals (although sometimes one who can read is asked to read for small local groups). The important thing about the mass media is that a great number of individuals and small groups are reached, and if we are successful in our use of the mass media, we can achieve valuable results; if, on the other hand, our use of the media is poor, we spoil and miss a great opportunity of influencing people, and we fail them if they give us of their time and attention, only to find that they benefited nothing from listening to us or reading our article in the newspaper. The wide dissemination of radios and newspapers in particular makes it a heavy responsibility for anyone who has access to the use of these media (as contributors, not only as "consumers") to use them well.

Use of the mass media

One other misunderstanding of the mass media should be cleared up before we proceed to discuss each of them: that we can have a vast influence on a whole population through the mass media. A more realistic attitude to the media shows that the impact they make is gradual, accumulative, and almost imperceptible; that is, each programme or article may achieve very little, but totally, over a long period, the mass media can form the habits of thought and the general views ("the climate of opinion") of a large number of people. The mass media may not even work well (have a great impact) on their own but may function best when they prepare the ground, or are used as supporting media, together with other means of educating the masses, such as school or literacy education, personal visits to homes, mass meetings, group meetings (of women, new mothers, youth, professional groups, *etc.*). Instead of being discouraged by the "weak" impact the mass media may have, we should rather be encouraged to make the very best use of the media so as to increase their impact, and also to organize our health education so that our success or failure does not depend on one kind of communication only, but that the use of the mass media is integrated with the use of several other media and approaches. The mass media do not work miracles but they are important tools for health education.

Radio

Radio

Radio programmes are produced centrally for the whole nation and locally for audiences that are more limited. Main programmes may

use one major (national) language, whereas regionally/locally produced programmes may employ languages that are spoken and understood in smaller areas. People who work in more responsible jobs in the field of health education may be asked to participate in radio broadcasts. This participation may be as planners (suggesting suitable topics for radio programmes, either during critical times of epidemics, or pointing out endemic, constant health problems in an area or making long term plans for health programmes touching on topics of major concern both nationally and locally), as participants (being interviewed, taking part in a discussion, or organizing the staff under one's leadership for participation in radio programmes), or as promoters of health education by radio. The latter requires that the health educator or health education officer responsible for health education in an area does not wait to be asked to participate in a radio programme; on the contrary, he should look upon radio as a national resource meant to serve the people, and a resource over which he should have some influence in the form of making suggestions as to its proper use. In case he thinks that health education is not getting its proper share of the programmes, he should make suggestions about how it could be better used for health education. Health education is not given for the sake of the health educator but to serve and benefit the people of a community and country. National media (whether general or educational radio services or other media) should therefore be used for the benefit of the nation. It is the responsibility of each professional to be alert to all channels and opportunities to help the people of the country and to make media people aware of unused opportunities. Radio professionals have the appropriate skills to make good radio programmes, but it may be beyond their ability to know all the needs of a country and how to serve the people in all fields. Co-operation between radio professionals and other (such as medical or educational) professionals is therefore needed. A health educator should thus not wait to be asked to participate in radio programmes but he himself should ask radio workers to make more and/or better health education programmes if he thinks there is a need for them. He must then also be willing to participate if asked to do so.

To make and participate in radio programmes needs preparation. Much help with this will be given by radio professionals, so it shall not be discussed in detail here. But some general points should be known to participants in radio

programmes, and we shall look at these here.

When talking on radio, we should regard ourselves as guests coming as visitors into a home. If people like us, they will listen to what we have to say. If they do not like us, they will switch off their sets or start talking about or doing something else. It is not good radio to thank people for having listened to a programme: nobody listens to radio to please those who make or participate in the programme - on the contrary, they listen to please or benefit themselves (and if they listen, they would be grateful to the people on the radio for a good programme, rather than the other way round).

It is a mistake to overrate radio, thinking that one can quickly and easily educate the whole population by means of radio. It is true that radio probably reaches more people than any other means. It is fairly cheap and popular, and very many homes have a radio set, in all communities. It reaches people who can read and write, as well as illiterate people. Radio is not dependent on electricity (except the small amount obtained from batteries). The only reservation to regarding the whole nation as a possible audience is the limitation set by the language barrier: not everyone understands the languages used on radio. Still, the potential audience for radio programmes is very vast. Even so, we do not, will not and cannot achieve everything we want by means of radio. Still, it is a powerful means for communicating knowledge, views and ideas and for educating and entertaining people.

The entertainment aspect of radio should be stressed. People do not regard it or treat it like a school or a teacher. At best it is a good friend and guest in the home. People look upon it as a source of pleasure as much as a source of news and education. But it is a mistake to regard entertainment, news and education as separate or opposites. And here is where the question of presentation, or techniques or "formats" is important. It may be that *the way we say things* is more important than *what we say* on radio. Even the most useful and important piece of information on radio may be ignored if it is not presented in a good, effective, interesting and professional way. We must pay the most careful attention to *how* we say or present things on radio.

Radio

But before we talk about ways of presentation, we shall say something about the radio audience. Our immediate hope for a radio programme is probably that it shall reach (be listened to by) "everyone," or everyone who has access to a radio set and is free from other duties at the time of the programme. Then we may start to make a survey of everyone who has a radio - his or her education, age, sex, religion, interests, profession, *etc.*, in order to obtain a picture of the "average" listener. Then we may go on to find out what people are doing at different times of the day to be able to make programmes for people with access to radios at different hours: housewives can listen when working at home while those who work outside the home are away from radio sets; the whole family may be present around mealtimes and at night; school broadcasts must be aired during school hours. We even talk about "peak hours," when we have the largest potential audience, or the hours research has shown that the greatest number of people are listening. But we can

Radio

also create our audience by making programmes that "fit" a particular "target audience" only. These can be the most effective programmes of all. We can even do more than finding out who listens when, or specifying our own target audience: we can go around and ask people what kinds of radio programmes they like, or just after a programme has been on the air (one or two days later) we can ask people how they liked it (what they liked and disliked and why) and also what they learned or remember from it (retention or memory of radio programmes may be weak and fade very fast). We may even go so far as to ask what change in people's behaviour has resulted from a radio programme or series of programmes (but here we must be prepared to be disappointed: few or no changes may result from radio programmes; the most we can normally hope for is that people have got a favourable or positive attitude to what we have talked about on the radio, and that people will change when other means - personal visits or community or group meetings, *etc.* - are used in support of or in addition to radio programmes). We may also discover that a single radio programme has little impact, and unless a message is presented repeatedly in various ways and different contexts (not only re-runs of the same programme), we will achieve little or nothing.

We should also keep in mind that people remember, on an average, only 20% of what they hear, and perhaps they remember less of what they hear on the (impersonal) radio than what they hear directly from a person who talks to them (personally or in a meeting they attend of their own choice).

It has also been found that people's ability to listen continuously to a topic without some change (their "attention span") is very limited. It has been calculated that most people can listen to a straightforward speech for only three minutes before their attention lapses (they start thinking about something else or are distracted by sounds or movements in their surroundings). To overcome this, we need to change our way of presentation very often. Only small changes may be needed. If one person is speaking all the time, he can alternate between straight explanation, telling a story, asking questions (and leaving a few seconds for people to think about an answer), or the talk can be interrupted by a short "interlude" with music. But it may be better to ask other people to participate in a programme, so that the written part is read by two voices, preferably one male and one female, or if they are of the same sex, voices that are not too similar (one deep and one high), but the difference between voices should not be so great that it is disturbing or distracting to the listener.

On the other hand, one should not read from a prepared script more than necessary. One can prepare points and questions relevant to the topic of the programme and make an interview with a knowledgeable person or persons, hold a group (panel) discussion, or go "out of the studio" and make a reportage from places where people gather for work, queue up for medical treatment, *etc.* But neither is it good always to use only one "format" during a programme. Small bits from an interview can be used to illustrate points made in a talk. Even "scripted" programmes (written beforehand) can be made more lively and interesting by writing them as short plays. Instead of writing one long speech, one can also

script a dialogue between two or three people. (One should not use too many people or voices in the same radio programme because the listeners will confuse them as they have only the voices to go by and cannot see the participants.)

One should also not present ideas and pure information on radio "at the expense of" action. That is, one should let ideas and information come through by an "action approach," let people do things, let people tell about their experiences (or how they came to realize a "truth" rather than only present it in abstract terms). A story is easier to follow and remember than the pure idea, and the message may be both better understood, remembered longer and sound more credible if it is related to life experiences.

To create a kind of "tension" in a programme,it may be worth trying to "oppose" people with different views in a programme (but they must not be so opposed and strong-minded that the discussion ends in a quarrel). This can highlight the pros and cons, the arguments for and against a case. But so as not to lose sight of our aim, we must have an authoritative person to let sound health education come as a result of the programme. (There may, however, be cases where the medical profession has not come to a unified view, and then it may be justified to present the various viewpoints without giving a premature conclusion. But the normal health programmes will aim at giving sure, useful health information to people.)

Radio is very popular as a source of news. This should be exploited also for health education. If new discoveries are made, and they are important for the common man, they should be presented as news. These news items can then be elaborated through the presentation of a more "in-depth" programme by professionals who are knowledgeable about the topic.

Radio

It may be that a health educator is asked to contribute a script to be read in a radio programme. It is then important to start with an important and interesting point (to catch the listeners' attention), to stick to essentials but try to make them easy to follow (*e.g.*, in the form of a story), and to use simple language that can be understood by everyone.

Topics suitable for health education on radio are basically of three kinds:

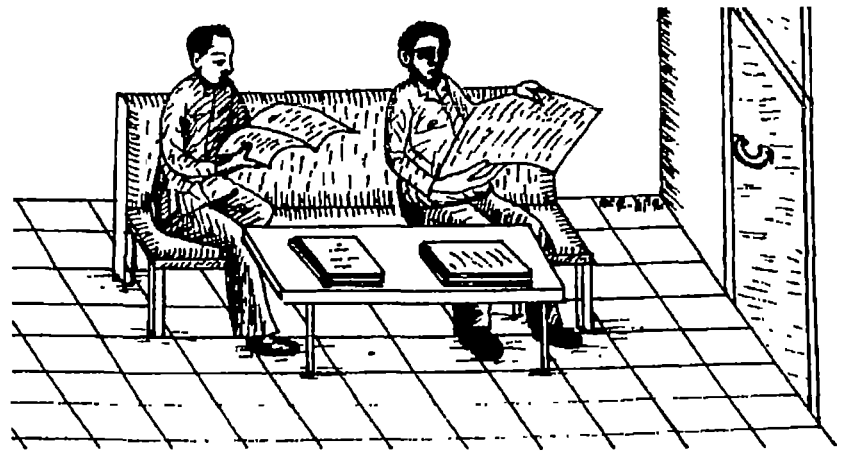
- Health problems that we know from statistical sources to be of importance for the country and/or a specific areas;
- Health problems that become acute at a certain time, either nation-wide or for a more restricted area (*e.g.*, an epidemic);
- Health-related questions that may preoccupy people's minds, especially when new or hitherto minor health problems occur. (This may be the case with AIDS, or the sudden spread of TB, VD, goitre, or whatever.) Even when some such problems are minor statistically, it is important that people get enough information to know how to tackle new and unknown situations.

Radio

Newspapers and periodicals

The latter point is best dealt with by asking people to write to the producer responsible for health programmes. Listeners' questions can give us a good idea about what people are interested in and want to hear about. Although there may be more important things than what people ask about, it is good to make a mixture of programmes so as to meet both their wishes and their real needs (and often these are of course the same).

Newspapers and periodicals



Like all printed materials, newspapers and periodicals are meant for a literate and thus more or less educated audience (although newspapers are sometimes read by a literate person to a group of illiterate people). Periodicals come out "periodically" (but not daily): weekly, bi-weekly, monthly, quarterly or even less frequently. Some are journals of a rather scholarly nature, whereas many magazines are for wider consumption. It is mostly such popular magazines we have in mind here. They are often for a more educated audience than newspaper readers need to be, but only slightly so. Magazines carry popular, entertaining materials, in addition to more informative feature articles. It is possible to write somewhat extensively about important health topics in such magazines, but one should go straight to the point and not make any article longer than necessary to state one's point or points. It is important to keep the language simple and not use rare, scientific terms more than necessary, and

if such terms are used, they should be explained in layman's language. (This applies to the use of mass media in general.)

Our main concern here is with newspapers, which are intended for and reach a very large readership. Often a newspaper is read by more than one person, and the total readership is thus larger than the total number of newspapers printed. Still, not everyone (probably no one) reads everything in a newspapers. As their name indicates, newspapers are primarily sources of news. That may also tell us that it is good to present as much health information as possible in newspapers as news. It is important to give much thought to the "headline," as that is the first point in any article that either attracts or repels a (potential) reader (or it leaves him indifferent). Then the first paragraph must be well written and make a (or the) major point, to tell the reader if it is worth his while to go on reading or not. But that is of course only the beginning: the whole news story or article is important. If a reader finds one article about health interesting, he may look forward to articles on this topic in future issues as well and make sure that he reads them. Unlike radio (and television), newspapers require a literate audience, but they have the advantage over radio that what is not immediately understood can be re-read and the newspaper can be picked up again by the reader who wants to make sure of a point he may have forgotten or remembers only vaguely. This may partly make up for the fact that most people remember only 10% of what they read and 20% of what they hear.

The average reader likes "a good story" better than just "dry facts," and probably he remembers stories better that facts, too. The same "dry facts" can in most cases easily be turned into stories. Instead of telling the medical facts about

Newspapers and periodicals

diarrhoea, it is possible to tell about a child who has suffered from repeated cases of diarrhoea, how his mother took care of him, what treatment he received (from a traditional healer perhaps), and how he was (scientifically) treated in a modern hospital, health centre or clinic. Then it is possible to tell what damage can be done if a child suffers too much and frequently from diarrhoea, and it is possible to describe how a child may die (or has died) from diarrhoea or dehydration.

Similar stories can be found in health institutions about most (or all) common diseases, and these personal histories may be used to give "life" to an article about health.

It is also a good device to interview both patients and healers (doctors, nurses and others, even traditional healers in some cases) about diseases they suffer or have suffered from and how they have healed or been healed. This helps to sustain interest for the reader. But stories of this kind are not told for the sake of the story but for the sake of the health education it communicates: it is therefore important to include all the relevant medical facts in the course of the article, either as part of the story or at the head or the end of it. If it is told first, it should not be so long and "heavy" that readers are put off before they even have read the whole introduction.

On the other hand, there are topics that should be treated so seriously as to get readers away from unreasonable fear or an undue emotional attitude to a medical or health problem. Such questions are best presented in rather

Newspapers and periodicals

"heavy," informative and soundly documented articles (but "documented" does not mean references to books with titles, authors, years of publication and pages; rather it means mentioning the views of specified authorities - persons or organizations, such as the WHO or a country's Ministry of Health).

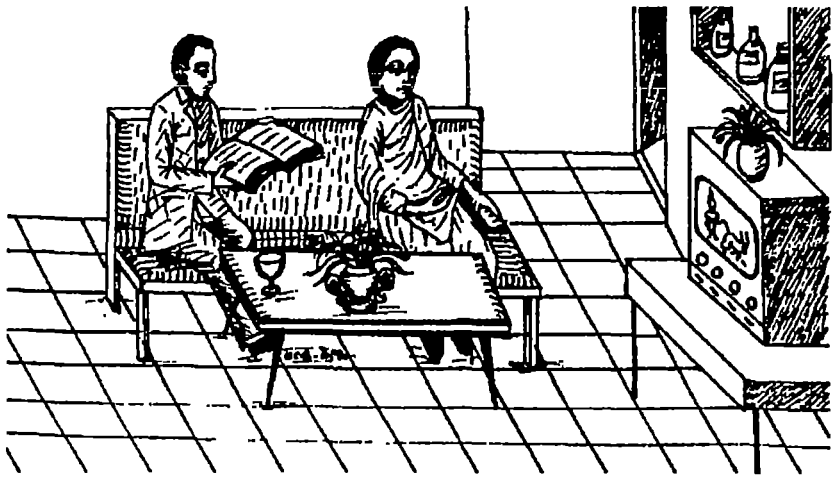
Pictures and illustrations should be included in the newspaper or magazine where this can enliven the article or clarify a point. But neither superfluous words nor pictures should be used: long-winded articles have no appeal.

Another feature of modern print media is the use of cartoons. It is possible to use persons who draw well and (perhaps together with others) can devise a striking caption or words spoken by the figures in the cartoon - although it is perhaps best to work the other way round: first devise a message and then make a suitable cartoon to fit the words or message. These cartoons are very popular and are seen and read by many and can be used for health education.

One need not be a journalist to write in a newspaper. If there are important events or things to write about, one can contact journalists to write about it. Or one can write to a paper about a matter and ask if they could assign a journalist to write about a suggested event or topic. If one can establish a more or less regular relationship with a paper, one can get health written about quite often (perhaps there can be weekly health features). This may be easier with small local newsletters than the big national newspapers. If one has good ideas and can write well, newspapers may print a non-journalist's article as written. This is a resource and opportunity for health education one should not neglect. If one can contribute regularly with health articles, one should also ask readers to write to the person in charge of these articles about matters of concern to them and to ask questions. This will give ideas for future articles as well as telling a writer about what people are interested in, and it will show the depth of their understanding (or misunderstanding) in matters of health and disease.

Even a person who does not write articles in a paper can occasionally contribute "Letters to the editor," giving pieces of information, raising issues, and expressing opinions and views. When using the mass media, do not try to impress (with your knowledge and command of difficult words) but to communicate meaningfully, clearly and simply on matters of importance to people and for their benefit. To be able to use the mass media is not only a great opportunity but also a great responsibility, and we should use it to serve people to the best of our ability.

Television and Videos



Both television and video sets are so expensive that only the better-off can afford them, and the owners have usually access to other media where health education for the masses is or can be given. But television sets (where video films also can be shown if the necessary equipment is there) are now installed in many schools and community halls, in bars and restaurants, so that a lot of people are able to view television programmes. Such programmes can be seen only when transmitted by the television station, whereas video films can be shown at any time.

The great advantage of television and video programmes is that they make a strong impression on the viewer. It has been estimated that most people are able to retain or remember 30% of what they see, and that by both seeing and hearing, 50% of the information given may be remembered (at least for some time). This gives television and videos a great advantage over the printed media (10% retained) and radio (20% retained). But it should also be said that this refers only to memory: it does not mean that television and video programmes lead to much change in people's health-related behaviour. For this, other media with a stronger *personal* presence, challenging people to decision-making and action may be better suited. (If people are in situations where they are able to *do* something in connection with the instruction given, they remember even more - 90% - and are also more likely to continue to practise what they have done once during a teaching session.)

Television and videos

The technicalities connected with television are of such a nature that they can be learned only in a television studio, but it happens that people are interviewed and take part in panel discussions, *etc.*, even when they have no experience of television work. The points to remember is that one should be calm and clear, keeping the simple "average" viewer in mind. Many people who appear rarely on television may feel too conscious about themselves - their looks, clothes, the way they hold or move their hands, their voice, *etc.* The best thing to do when the camera runs is to forget about these things and concentrate on what is being said, or shown if things are being demonstrated.

If little attention is paid to health issues on television, it is the right of anyone interested (and the responsibility of professional health educators) to make suggestions to the

Television and videos

authorities in charge of television programmes. The same is true if one feels that the coverage of issues is one-sided or irrelevant.

Where video sets are available in a community, health educators should make an effort to find out what videos on health are available (and where) and try to borrow these for viewing where and when the community comes together, *e.g.*, in a social hall, but they can be shown anywhere: in schools, restaurants, bars, clubs or associations, hospital waiting rooms, or in private homes.

When health programmes are transmitted, the health educator could make an effort to make people aware of these so that they can benefit from the programmes. If the programme topic is known beforehand, it may be useful to call a group of people together so that they can be exposed to the programme together and then let it be followed by discussion, so that points can be further clarified and decisions can be made on how to put the instruction into practice. People need a further "push" in addition to mere instruction before they will practise or do what they have been told is the better, healthier, safer way of living and behaving. That is part of the health educator's task.

Chapter 4

Health Education in Schools

Two approaches are common to health education in schools. One is to teach about health as a separate subject through all the years in school. The other is to spread the subject over several other subjects. In this latter case, the sports teacher may teach about the normal and healthy body and how to build up a strong and healthy body; the biology teacher and chemistry teacher may teach about the structure and function of the well adjusted body and biochemical processes involved in digestion, *etc.* The national and foreign language teachers may give some instruction connected with the terms used in relation to health, the body and food, *etc.* The geography teacher may teach about environmental health and food production (agriculture). The history teacher may teach about the development of science, also in relation to medicine and health; and so on.

The other approach is to teach about health mostly in a subject called hygiene, health science, or something else. The great advantage of this approach is that a qualified teacher in health science is needed and is available in the school, exams will be given in the subject, the students will have to take the subject seriously; and to prepare teachers the subject will have to be taught in Teacher Training Institutes (and at university level to prepare teachers for TTIs). The latter approach will strengthen the subject much more than if it is taught only as a minor supplement to other subjects.

Health education in schools

The best approach is probably to combine the two approaches set out above: to let health science be a major subject in its own right, but to raise several topics in other subjects as well. Such co-operation between teachers and interlinking of subject matter can benefit any subject, not only health science.

Although the latter approach is advocated here, the subject matter taught may be much the same in any case. A health educator who is not a professional school teacher may be more needed and more frequently called upon for assistance in schools without a full time teacher in health science than a school with such a teacher. In any case it is good for a health educator or health education officer for an area to keep in touch with schools and what and how they teach and to give support where needed. In co-operation with the sanitarian or health inspector for an area, it is also possible to keep an eye on how hygiene is practised on the school premises. This will show if health education is more than school-book stuff: only if it is practised (in the area of sanitation, cleanliness of the school kitchen if there is one, and of the school itself) is health really promoted and taught in an effective way.

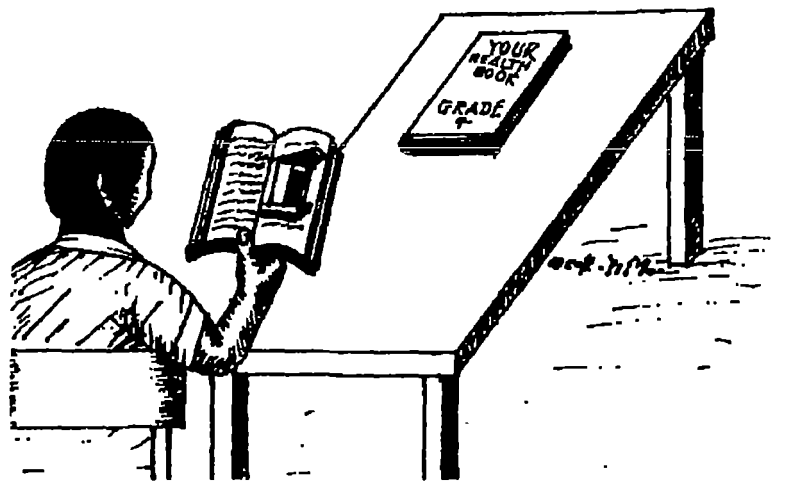
School health is more than what is taught in formal classes. There are also days for immunization and perhaps other health activities. The health educator should also use

School curricula

these opportunities to give or strengthen the health education that should go together with such activities: people ought to understand what happens to them when they are being vaccinated, *etc.*

It may be that a school has no fixed plan for its health education. In case a health educator is asked for advice, or if he feels he should advise school authorities on how to improve health education in the schools, we shall give some suggestions on what to pay attention to in devising a curriculum and other aspects of health education in schools.

Curricula



We shall not set up a detailed curriculum of health education for schools here but merely discuss some general viewpoints or principles one should keep in mind when devising curricula. The age and maturity of school children as well as the logical sequence of educational topics must be kept in mind, and the total understanding of health and (the prevention of) disease should be built up over the years, so that people can leave school well equipped for adult social life. But many people leave school after only elementary school, and all knowledge necessary to lead a healthy life should therefore be taught in elementary school. In higher grades, students should be helped to acquire a more scientific understanding of the principles of health, the functioning of the healthy body, *etc.* (But science must of course also form the basis of what is taught in elementary school, although the principles or "laws" of science may have to be

presented in simplified form.)

One should start with obviously useful knowledge in the first grades. Thus, there is a need to stress the importance of personal cleanliness (hygiene), cleanliness of the home and the homestead (environmental health), the importance of clean water, the regular use of latrines or other safe disposal of excreta, proper disposal of waste, a varied (balanced) diet, as well as simple scientific terms and concepts, such as cells, germs, names of common (especially childhood) diseases, and the channels (vectors) through which disease enters the human body (*i.e.* air, water, food, contact with sick people, and insects); simple physiology should also be taught, especially what can easily be visualized, such as the parts of the body, the skeleton, *etc.*

Gradually this knowledge should be extended to cover all main areas of health science (without overcrowding the syllabus). Scientific methods that have helped us to obtain more knowledge about health and disease should also be taught (perhaps in the form of short biographies of great scientists in the field, stressing their scientific working methods that led to valuable results). The concept of "germs" should be extended to all the (main) causative agents of disease (bacteria, viruses, protozoa, fungi and worms), and all studied in some detail. The carriers (vectors) of disease should also be studied more carefully in higher grades (especially very harmful ones, such as mosquitoes carrying malaria and other diseases, *etc.*); principles of prevention should be given full scientific explanation; food and nutrition should be taught in a thorough way, together with explanations of how food is absorbed (biochemistry), and, from the physiological side, a rather detailed description of all normal, healthy body functions; major threats to health should be described so as to make the scientific study of disease clear (several diseases that are common threats to health in a locality should be studied so as to illustrate scientific principles); and some wider perspectives on food production, trade in food, international aspects of health and disease prevention should also be treated.

School curricula

To work out a detailed curriculum for schools requires careful attention to the step-by-step approach so as to gradually build up a total picture of health and how health can be preserved, but taking the child's (the student's) ability to understand, absorb and make use of the knowledge obtained at each stage into consideration. It may not be possible for a child to practise good hygiene at home unless parents are also taught about hygiene, and it is therefore important not to isolate school knowledge from what the rest of the community is taught - at least the basic facts and principles concerning good health and disease prevention should be taught everyone in a community.

It is important to have good curricula in health science; but it is equally important to have good teachers, and to get good teachers, health science must be taught in Teacher Training Institutes (TTIs), and to get qualified teachers in TTIs, health science must also be taught at university level. Furthermore, health science can be well taught only if there is scientific equipment in the schools and if it is well used. Rote learning of facts may be helpful to some extent, but

School curricula

proper understanding through observation and experimentation leads to conviction of the value of scientific approaches to problems of health and disease.

To make the outlining of curricula for schools a bit more concrete, we shall go into more detail about one possible way of setting up a curriculum in nutrition education from kindergarten till the end of secondary school. We shall first outline the targets or goals for teaching each age group, and then suggest what should be taught to achieve those goals.

The food or eating habits we acquire early in life are difficult to change later. It is therefore important to teach nutrition well during early childhood, especially throughout nursery/kindergarten and elementary school. In later years, early teaching should be reinforced by adding to the student's knowledge and understanding of scientific principles of good nutrition. To be able to practise good nutrition, parents (in meetings between teachers and parents or in community meetings) should also be told what the children are taught, and then co-operation in practising good nutrition should be invited and stressed.

It is good to incorporate nutrition education as part of the total curriculum of health education, rather than teaching it as a separate subject (although some aspects of nutrition education can be incorporated into other subjects, such as geography - on food production, chemistry, biology and general science).

One can divide the curriculum into phases of a few years each, the first including kindergarten and the first three years in school; the second part can include the rest of elementary school (such as till the end of grade 6); the third phase can cover junior secondary school (grades 6 to 8 or 9); the fourth and last phase goes till the end of senior secondary school (till the end of grade 12 in most cases).

Phase One (kindergarten and grades 1-3)

Aims: To help children appreciate many kinds of food; to recognize many common items of food; and to associate food and eating with strength, growth, health and (the need for) cleanliness.

Food and nutrition knowledge desirable during this phase: Discussion of food eaten at home; foods grown in parents' farm or garden; foods seen and bought at markets. Names and description of common food items; what goes into dishes commonly eaten in the community (not too many details). Discussion of "good" food - what is good to taste and what is good for health (children will understand and need some warning against foods that can be harmful if consumed to excess, such as too many sweets), stressing the importance of milk and other foods important in childhood (protein-rich and energy-rich foods and vegetables). Stress the connection between growth and eating well.

Activities: Work in school garden; making house and serving food; making "mock" or real meals (simple); a visit to a market and/or a near-by farm (prepare them about what to

look for), and discuss what has been seen when back in class; show food items in their natural state as well as ready for cooking (*e.g.*, various grains, peas in their pods and when shelled, *etc.*); at food breaks, stress the need to wash hands; play shop where food is sold (perhaps discussing quality and even prices of a few common items in the last of these years).

Phase Two (till the end of elementary school)

Aims: To widen knowledge of food; to increase understanding of how different foods are combined in meals (composition of meals); to learn about good eating habits (sit well, regular meal times, cleanliness); to learn about different customs concerning food (not all people have the same food habits, but one can be as good as another, if all nutrients are consumed); to understand how food affects the body (health, growth, looks); to know how different foods do different kinds of "work"; to learn about the biological aspects of food assimilation by the body.

Food and nutrition knowledge desirable during this phase: Food production in the community and the nation; trade in food; food customs in various "ethnic" groups; evaluation of the "sufficiency" of various "staples" and the need for a balanced diet ("food groups" and what "work" they perform in the body: milk and milk products; meat, fish, eggs and protein-rich legumes; vegetables and fruit; cereals/bread); the need for hygiene (cleanliness, sanitation); biological knowledge about the digestion, absorption and elimination of food; understanding of the relation between a proper diet in adequate quantity and body size, body function (ability to work, study, be good at sports) and health (also harmonious body proportions, looks, "zest" or vitality).

School curricula

Activities: Preparing of dishes of various kinds and their composition into a balanced diet; making an "overall plan" of food preparation for a balanced diet over a week, a month and - especially where there are seasonal variations and long fasting and non-fasting seasons - a yearly cycle; laboratory work on food; creation of a pleasant atmosphere for meals; experiments with spices (and explanation of the value of attractive food for appetite and good food absorption); study and report writing on people's food and eating habits; visit to food processing plant; visit to food trade area; storing and preservation of food; weighing and other measuring of food, *etc.*

Phase Three (junior secondary school)

Aims: As school children at this age grow fast and become lanky, ungainly and awkward, a main object must be to stress the need for a good diet for healthy growth and good performance at school and sports, for strength and a well-shaped body. Vast appetites are often not satisfied wisely at this age, and the need to balance the diet and not only to absorb huge quantities of food must be stressed. At this stage, the more theoretical aspects of nutrition (and health) science should be introduced. The wider aspects of food and nutrition should be taught (international trade, the food industry, *etc.*); the importance of costs in nutrition should be tied up with affordability and the possibility of obtaining adequate nutrients from simple, cheap ingredients; one

School curricula

should also teach the influence of food preparation on the quality of the food we eat (*e.g.*, over-cooking destroys vitamins, *etc.*).

Food and nutrition knowledge desirable during this phase: The different food groups should be well known as well as what they do to the body and how they influence growth and health; the functioning of the body in assimilating food should be put on a more scientific basis (in the way it is taught and how experiments are conducted); personal hygiene should be tied up with a good understanding of sanitation; energy and ecological questions should be raised in relation to food; the relationship between work, health, growth, looks and food should be explained in detail; the need for protein (and amino acids), carbohydrates, fats, minerals, vitamins and water (fluids) should be explained with some explanations of their absorption and work in the body; how food influences the teeth and bone structure should be taught. National and international food production and policies should be discussed.

Activities: Conduct many experiments of increasing complexity; study food consumption in the community and nation and write about it; study marketing practices (how people are influenced to eat and drink various foods through consumer information and advertisements) and evaluate them on the basis of sound food knowledge; study pricing policies and their relation to proper eating habits and their influence on the balancing of diets; connect the health aspects with sport activities in the school and study how nutrition influences both; make experiments to form the basis of reports on comparison of quantity and quality in food consumption (perhaps with reference to early studies on vitamins, by Hopkins and Funk); visits to food plants of various kinds are useful (with study reports assigned beforehand).

Phase Four (senior secondary school)

Aims: To deepen the understanding of the relationship between food and growth, also intellectual and emotional growth, and of the importance of consuming a balanced diet (students in this age group eat well but tend to neglect fruits and vegetables and get too little vitamin C, especially boys, but girls may eat too little because they fear getting fat); to explain thoroughly scientific principles involved in nutrition; to help students know well the nutrients in various kinds of food and be able to explain the body's need for various nutrients; to prepare students to decide on food consumption (what to buy and how to preserve, prepare and serve food in their own home; how to make balanced diets); to help understanding of physical, including sexual, growth and how food and health influence the health of one's children.

Food and nutrition knowledge desirable during this phase: This is a time for completing (but also revising) what is taught about food and nutrition in formal schools, and a full review course on the components of all common sources of food, their work in the body, the physiological aspects of food assimilation and the relationship between one's (and one's children's) body and food should be thoroughly taught. The wider aspects of the influences of climate, soil, food policies,

School curricula

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pricing, appetite, knowledge and external influences (marketing and advertising) on nutrition should be stressed. Appropriate foods for different ages and needs should be explained.

Activities: Experimental (laboratory) work should be depend and scientific methods demonstrated as fully as time permits; menus at restaurants can be studied and analysed from a nutritional point of view, with recommendations of appropriate changes; studies of national food policies (including a comparison of budgetary allocation to agriculture and other government activities, food imports and exports); evaluation of productivity in agriculture in the local community (including a study of tools and fertilizers used, and a discussion of the use or desirability of the use of animal and human manure in agriculture); discussion of the importance of good consumer knowledge to have a healthy population (with discussion of whose responsibility it is to give such knowledge: the school, the clinic, the agricultural co-operative, the mass media, *etc.*); discussion of health activities and the duties of public health officers in the field of food (quality) inspection, inspection of places where food is prepared and served to the public (restaurants, factory and school canteens, *etc.*); evaluation of international efforts at food improvement and security (by governments, the Food and Agriculture Organization, the World Health Organization, the United Nations' Children's Fund, *etc.*).

* * *

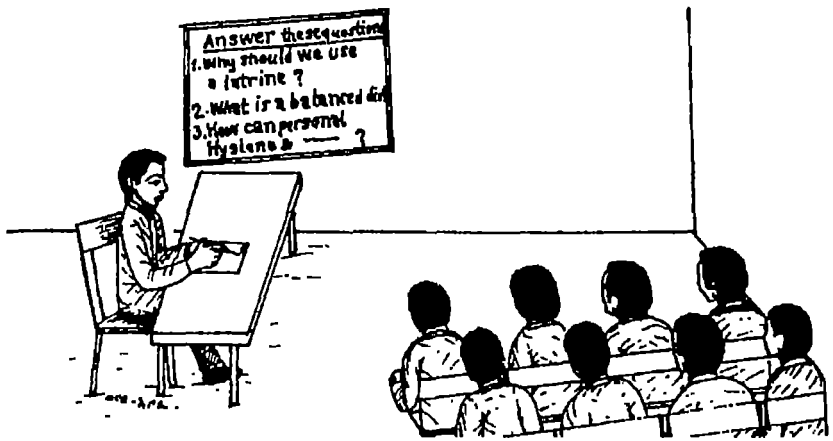
The above discussion of school curricula gives only a rough general guideline on how to approach the problem of curriculum development. It is important that there is a logical development of topics from the simple to the more advanced or complicated, and so that cumulatively the knowledge gained through a full course of school education forms a basis both for healthy living and for further, more advanced scientific work (or for practical work with problems relating to health and/or nutrition). But logic is not the only guide when developing curricula. The physical, intellectual and emotional development of students must all the time be taken into account. This makes it necessary to combine knowledge of health science with knowledge of educational (and general) psychology when outlining curricula for schools.

School curricula

School examinations

Examinations

Examinations are set by the teachers in a school and to ensure secrecy about exam questions, outsiders may not



be involved in formulating such questions. But in some cases, as when health science is not a separate subject in a school but taught piecemeal in many subjects, the topic of health education may be neglected by some teachers. The health education officer in an area may try to strengthen health education and the attention students will pay to the subject by suggesting (and if possible, insisting) that questions relating to health and nutrition be set even if health education is given only as part of other subjects (biology, general science, geography, *etc.*). This will make the students study this part of the wider curriculum and not only skip quickly over it, "knowing" that no questions will be asked about health. It may not always improve people's health thus to "force" them to study the subject more deeply than they otherwise would, as it is change in behaviour that leads to change in health; but without proper and exact knowledge it is not possible to make the correct changes in health-related behaviour, and therefore it is important to work for better knowledge alongside with making efforts to improve people's health behaviour.

Examinations in health science should be insisted on however the curriculum is devised. The health education officer or the health committee in an area could co-operate with the school authorities in strengthening health education where needed, also in keeping an eye on the way examinations are set in a school and by giving advice and suggestions where there is a demand for it.

School health day and Sanitation week

However well health education is given in a school, a School Health Day gives the school a chance to emphasize the importance of good health and good health behaviour both for the students, the staff, the parents and the community at large. People can be invited from outside the school to attend or even to participate in certain activities on this day. This will strengthen the co-operation between the school, the homes and the community, and in order to ensure good health such co-operation is essential.

Much preparation goes into a school health day, and the more preparation is done, the more successful and effective it will be. The impact on the school may be stronger due to the days or weeks going into this preparation.

School health day and Sanitation week

Several things can be done on (and before) the school health day. Here are some suggestions and examples:

A creative teacher or student (or even an outsider), or a group, can write a play or a sketch/skit or a song/songs to be performed; posters and slogans and pictures can be prepared and posted up all over the school (and in the community); demonstration sites (with latrines, appropriate technology, foods with explanations and demonstrations) can be made; short talks can be given; films and slides can be shown; leaflets can be distributed; puppets shows can be performed; and exhibits can be arranged in several parts of the school.

Some of the things particularly well done can be repeated in community meetings or given as permanent posters or displays to the community for later use or to become a lasting part of the health education programme of a community. Besides, students can take home individual contributions for which there may not be a permanent need, and the instruction on the school health day may thus continue to have an impact in the homes of the students.

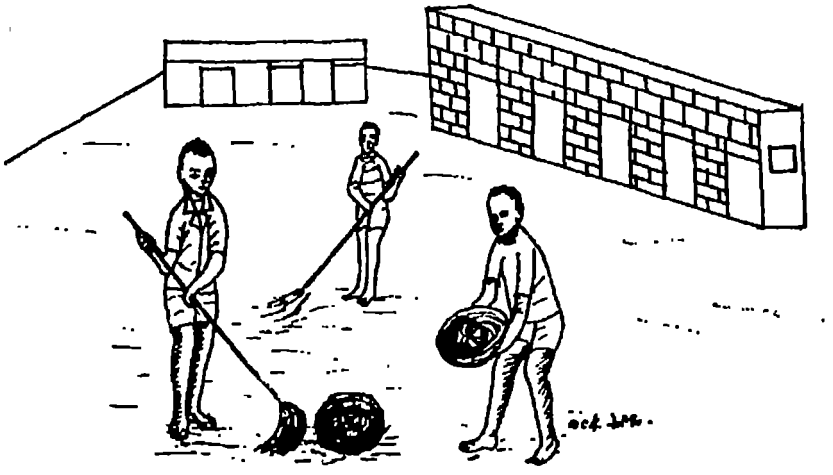
A Sanitation Week is a more internal affair of the school, although the last day may be made into an "open day" when the community around the school can attend. There may not be so much preparation needed for a sanitation week as for a school health day, and most of the preparation may have

School health day

and

Sanitation week

to be done by the teachers in devising assignments for the students during this week.



- The practical aspects of such a week may be arranged by the physical education teacher, and "things to do" may include work on hygienic improvements of the school surroundings, and if not all can be rectified, it is at least possible to make a list of what should or needs to be done.

- The arts teacher can assign the students to design posters, devise slogans and do other art work to be put up in the school. (This he can also do in preparation of a school health day.)

- The teacher of the national (or a foreign) language can give essay topics on how sanitation was practised in the past (this must be home work so that the students can consult old people in their family or the community), and also how it is practised at present (and to give an evaluation of various practices).

- The science teacher(s) could teach and conduct various experiments related to health and sanitation.

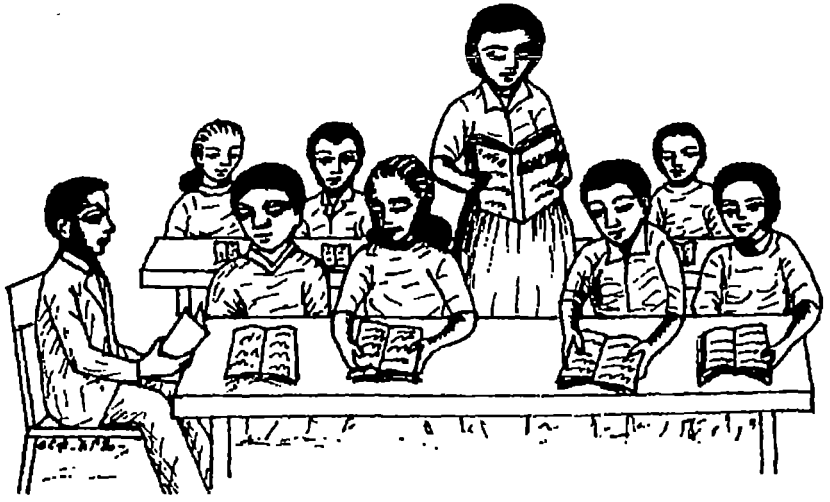
- The geography teacher can devise and supervise a study by the class of agricultural practices in the community and have the students write reports on their findings.

- The home economics teacher can concentrate during this week on the importance of hygienic handling of food when prepared and consumed, with appropriate experiments.

After the sanitation week is over, the art work can be given to the community or taken home by the students for further use in educating parents and other community members.

Wherever possible, health education officers should participate on such school occasions, and also help to bring the essential messages to the wider community.

Readers in literacy classes



Literacy classes are not part of the normal formal school structure, but they have a great mission in educating parents, and unless parents co-operate with their children in school, these children will not be able to convert what they have learned in school into practical action that will influence the state of their health.

The main tools of teaching adults is the use of simple books or booklets or "readers" that convey useful information at the same time as they teach reading skills (this is called "functional literacy"). It may be good to co-ordinate what is taught in community meetings with what is taught in adult literacy classes, so that people will recognize the topics and the main messages but also feel that class teaching adds something to the more slogan-phrased, short messages they may get in mass meetings.

Readers in literacy classes

Readers should be clearly illustrated and contain simple, clear and essential information which it is fairly easy to put into practice.

When readers related to health are used in adult literacy classes, a health education officer may be called in to assist the teacher, and such opportunities should be well used.

Use this page for your notes

Chapter 5

"Reminders"

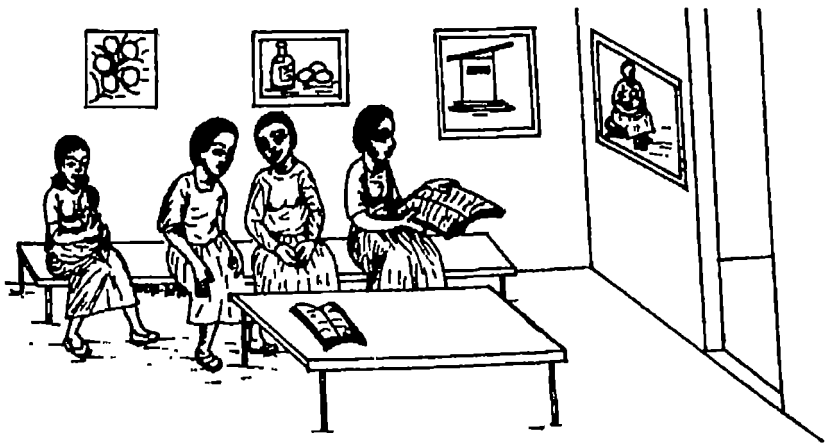
The teaching aids discussed in this section are popular and widely used. The common heading "reminders" is used for them here to stress their supportive role in health education and also that they may be less effective on their own than is sometimes thought. A poster or a slogan or a proverb becomes meaningful if it is seen against the total social or cultural background in which it has been conceived, coined or created. People may react less positively to these techniques of education than many hope and expect, unless they serve to reinforce already well known and previously explained facts, ideas or messages. But they cannot "reinforce" what has not been well taught already. This is why they are called "reminders" here: They help to bring back to mind what is already fairly well known. Although it is not justified to have too great expectations of the impact of these means of educating people, they have a supportive role to play, and in this respect they should not be neglected. It is often the combined impact of many media of communication (a "media mix") that finally leads to the desired result: a change in people's health-related behaviour so as to bring about a healthier population. To emphasize the many-faceted approach needed to achieve this, we nowadays talk about the need for all of the components of "IEC" in health education, *i.e.*, information, education and communication. All of these terms can in some contexts mean the same, *e.g.*, an informative educational radio programme is all of what IEC wants to convey; but we should try to keep in mind that we need a combination of approaches in health education and not choose only one method as our "pet" to overcome all obstacles and solve all problems. On the other hand, it may not be right to blame our methods for our failures, thinking that we have still not found the final great method or technique that will "do the trick": there is no such method. Conscientious and persistent efforts will bring some results, whatever methods or techniques are used.

Reminders in health education

Posters

Posters

Posters have been very popular teaching aids in health education. These may consist of fairly big pictures put up



in places where lots of people often congregate. They may have a very short text or a longer message, but rarely is very much written on posters - and it would be a mistake to overcrowd a poster with words, or to make the picture too detailed: posters are best suited to transmit or communicate one simple message per poster.

A poster must be easy to understand, the picture must depict a familiar situation in easily recognizable ways (clothes and features of people must be somewhat like what is common in the community, and things portrayed must be what people use), and the picture must be acceptable in that culture (it must not show things found offensive in such a way that people will tend to reject the message or do the opposite of what it teaches), and the language must be easily understandable in that community. Many communities have also favourite colours and dislike some colours; it is therefore worth finding out about people's colour preferences or tastes in colours, and use them in the best way to achieve one's objective (*i.e.* to use colours people like so as to gain a positive response, and to use colours they dislike if we want them to react negatively to something in the poster, such as defecating in the open; the use of an X to denote what should not be done may not be easily understood in all communities or among all groups of people).

There are some "weaknesses" with posters. If they are displayed for a long time in the same place, people tend to ignore them. They do not become more and more familiar with them so that the message "sticks" just because it has been seen very frequently - on the contrary, it seems as if less and less notice is taken of a message that one tries to "ram home" by tedious repetition. Posters should be changed rather frequently, and if the supply of posters is small, it is possible to put up "old" posters again after some time, perhaps at different places. If the same poster is used again it would be good to use a new copy of the old poster, as colours may fade and old posters will thus become dull, and often they are also torn. Attractive posters have greater impact on people than dull, plain ones even if they contain the whole message we want to convey; but if they are not attractive to look at, people may easily ignore them, and may even feel repelled by them, so that they do not accept the message - they may even reject it and become negative in their attitude, so that it may be more difficult to "win them over" later even if other, more attractive means of communicating

the message are employed.

Because there is no "personal contact" between a poster and the onlooker, the impact is rarely strong, and one should not take the easy way in health education by putting up a lot of posters and think that one has "done one's duty" by that alone. Posters are supportive means - reminders - in health education, and they are rather "weak" communicators; but we still need them.

Posters should be pretested before the final version is made. Pretesting consists of getting impressions of and reactions to posters from people among whom they will be used, so as to make sure that people perceive what we want to communicate. Both pictures and words should be pretested, and we should not be satisfied with a poster till we get a majority of responses that show that the "receiver" of the message perceives what the "sender" wants him to see or understand.

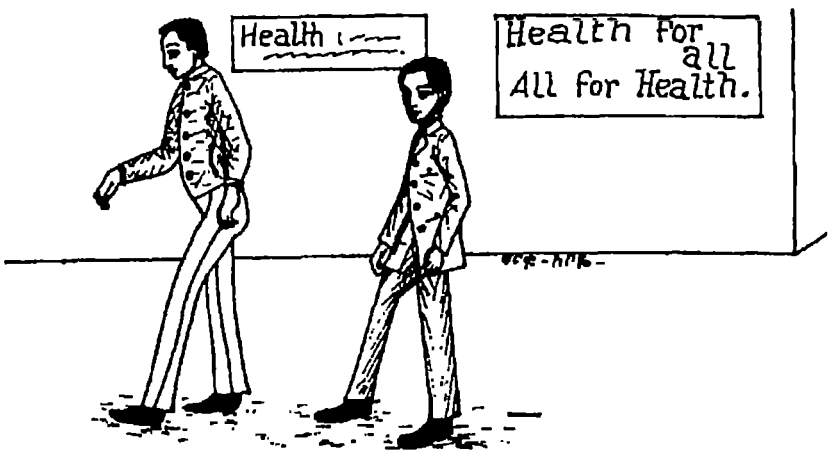
Tests have shown that people recognize most readily pictures that do not contain all the details of a scene or situation (such as a photo would reproduce them), but still are more than the mere outlines (or contours) of persons and things represented in the picture. Essential details should be included, but not too many of them (the picture should not be overcrowded), so as to make recognition easy and the impression strong.

Slogans

Posters

Slogans

Slogans may be full sentences or short, elliptical expressions summarizing or expressing an essential message in clear, comprehensible



ways. They are most meaningful and effective if they sum up ideas or information from more detailed explanations given in other contexts. Some health slogans have become so familiar that they are almost considered as proverbs. In English we say, "An apple a day keeps the doctor away". This stresses the importance of eating fruit to keep healthy and fit. Where it is necessary to stress the importance of personal cleanliness, we could turn the above adage into: "A bath a day keeps the doctor away". The importance of sleep is emphasized in the saying: "Early to bed and early to rise makes a man Healthy, wealthy and wise".

Slogans

Handouts

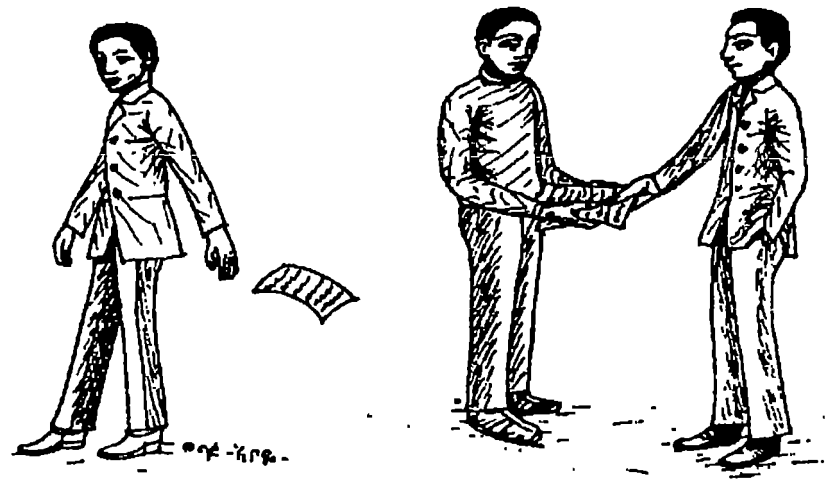
A number of short phrases can be formulated with an essential health message, such as: "Wash your hands every time you come from the toilet/latrine"; "Wash your hands before every meal"; "Eat vegetables every day"; "Exercise your body and keep fit"; "Protect yourself against mosquito bites"; "Keep flies away from food"; *etc.*

Slogans should be written in familiar, clear and easy language, and they should not be too long.

As with posters, the impact of slogans may weaken if they stay in one place for a long time. It may therefore be best to vary slogans after some time, and to change the places where they are put up. New things in new places will catch people's attention more easily than old, familiar messages always displayed at the same place(s).

It may be good to consult several people (conduct a short pretest) before a slogan is put up, to avoid that people do not understand it, misunderstand it, or that people should get a wrong (perhaps comic) impression.

"Handouts"



In this context, the word "handout" is used to designate a sheet of paper of one page almost like a poster in miniature, or both sides are covered, or it is folded, so that it has a total of four pages. Short messages can be communicated in this way; but sometimes rather more text may be included than in posters. The best approach will depend on what kind of audience it is intended for: The more educated people are, the more they may be prepared to read, depending on the importance they attach to the topic.

Handouts are probably most suitable and effective if given out after a meeting where a topic has been treated and handouts are written to sum up or support what has been said in the meeting. They thus serve as reminders to people when they come home and can study the topic at their leisure and

perhaps discuss it with their family and friends. If a handout is kept in a home, visitors may also see and read it.

If they are regarded and used as reminders, to support and reinforce or expand on a familiar message (*e.g.*, one given in a meeting where the handouts were also distributed), they can have a useful function. They may also be given to people together with some words of explanation, if, *e.g.*, people are given the handouts at a market, in the waiting room of a clinic, *etc.*, where people also have some time to talk and read. All "reminders" may work best if there are people who can also talk to those who receive them.

Circulars

Handouts

Circulars

Circulars are short information sheets informing people (all or a select group) about important events. They

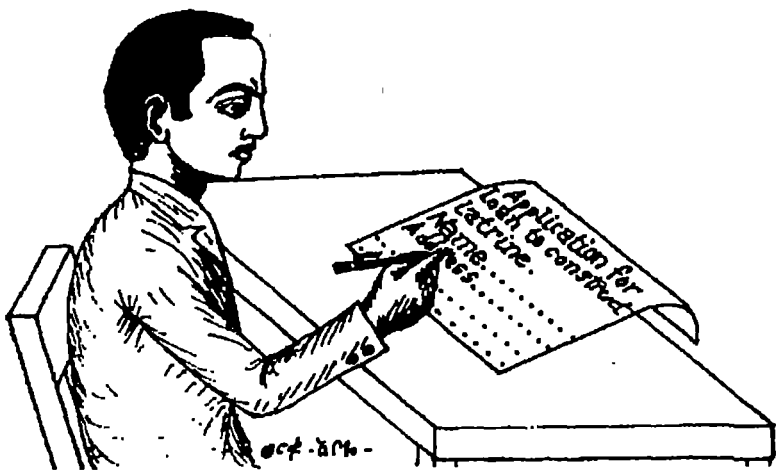
can tell people about available services at a clinic, the arrival of medicines to prevent malaria, a meeting to be held where important health matters will be discussed (*e.g.*, the building of latrines in the community, the selection and support of a community health worker, the immunization of all children in the community, *etc.*). These may be more effective than notices put up here and there in the community, and should be used if we think it is very important that (almost) the whole community should be present or assist a programme or project. Such a circular may be more personal (like a personal invitation) than a public notice and may draw more people to a meeting, or secure greater support or participation.

Various forms

Proverbs

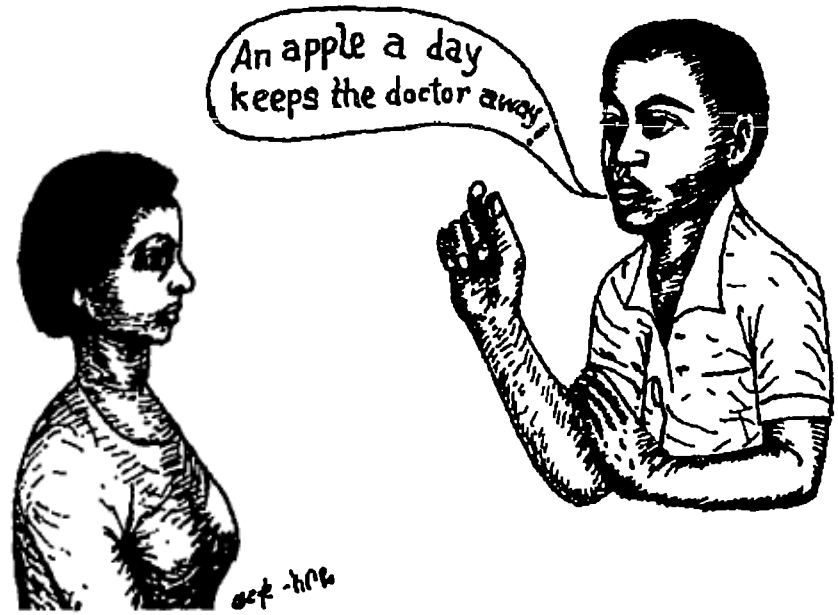
Various forms

There are certain services available to people in a community that people may not even know about or know



only vaguely, so that they do not know how to make use of these services. It can, for example, be a credit facility to construct a latrine, but they do not know how to go about obtaining a loan. If forms are available, giving necessary information, and which can be filled in and handed in to the proper person or institution, it helps both people and the development of health facilities, *etc.*, in the community. Such forms are tools to promote health and should therefore be considered and used as teaching aids in our work for the health of people and communities.

Proverbs



Some cultures have a rich heritage of proverbs, and several of these refer to health. These can be collected by a health educator and used when giving health education. They could also perhaps be put up a few places as slogans. Especially people who feel strongly bound to their traditions will find a strongly convincing power in proverbs. (Some well-educated people do not always react so favourably to proverbs, saying they are unnecessarily conservative and sometimes wrong and should therefore be examined as to their validity in the light of modern knowledge.)

Proverbs alone may not be explicit enough to convey our message unless we put them in the context in which we want

them to be understood.

Proverbs vary from place to place or culture to culture, and one should not use a proverb just because it is a proverb unless it is well known where we use it. (Unknown proverbs may in fact be found to be difficult and may complicate our message rather than help it.)

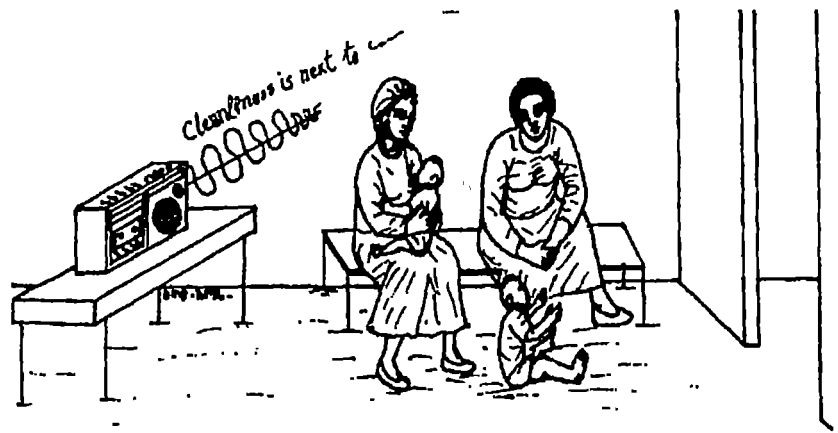
When we use proverbs we must of course make sure that we have understood and use them properly. Many proverbs are old and may contain some rare or old-fashioned words, and they may refer to earlier customs. They may also be more subtle (have double meanings) than at first appears. We should make sure that we do not use these proverbs so as to sound ignorant or ridiculous, which would have the opposite effect of what we intend. But good proverbs well used can elicit positive responses.

Cassettes

Proverbs

Cassettes

Few are so eager to acquire health knowledge that they will buy cassettes with health messages for private



use. Cassettes with health messages are for public, institutional use. Although it is possible to use them wherever people gather, their principal use is in health institutions. When people sit in the waiting room or area waiting their turn, they have time "on their hands" with nothing in particular to do. As they have come to the health institution for a purpose or with a problem related to health, they may be receptive to health education. Simple messages straightforwardly explained and in a clear, local idiom can be prepared for tape and read into the tape by someone with a distinct and pleasant voice, easy to hear and understand. Such messages can be general, on health problems that may affect anyone in the community, or - and this may be more effective

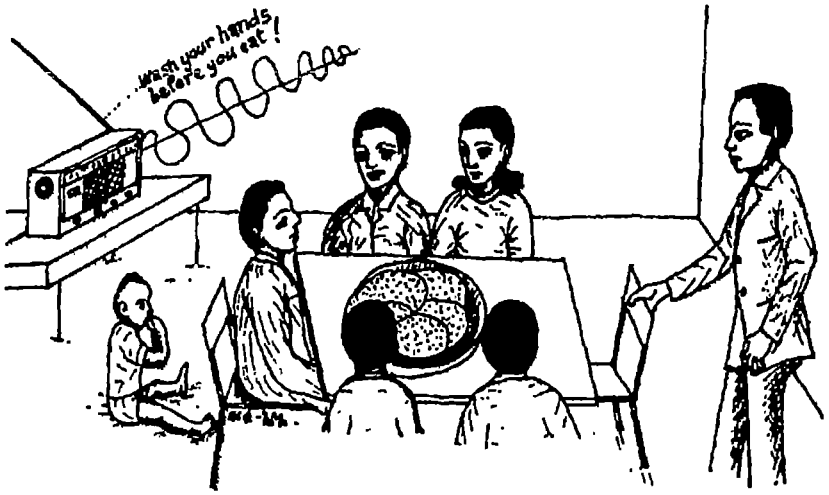
Cassettes

- they may be specific and related to problems of the audience at a specific time. Thus, on days set aside for immunization, or maternal and child care, or for TB patients, or for antenatal or postnatal care, *etc.*, messages made specially to help and interest people who come to a health institution with problems in these areas will probably meet with receptive ears. These messages on cassette tapes should be repeated at regular intervals. If cassette players are used for these purposes, it is good to have a large number of tapes with various messages, so as not to repeat the same few tapes very often, which would make people "go to sleep" mentally and not pay any attention to the message. It is also good to make a long-term health education programme or schedule, outlining what health messages one wants to "play" over a long period (*e.g.*, a monthly programme).

The drawback with such cassette programmes is that people who come to a health institution with a health problem come also with a preoccupied, worried mind and may not be disposed to listen to any message except one relating to their specific, personal problem. To overcome this obstacle, cassette programmes ought to be well made, perhaps even with calming music and a calming voice (or voices) so as to help people think about something else apart from their own situation. In this way one can get a message through and at the same time help people a bit in their worries or sufferings. It may be good to use stories (life stories or other stories) or interviews or reportage about people "in action" to make the programme a bit easier to follow than a straight talk programme (refer to what was said about the use of radio).

Such cassettes can be made for lending to other institutions or organizations as well (mass organizations, schools, *etc.*), and a "lending library" of tapes could be kept in a health centre or other health institution. A list of available tapes should be circulated to health (and perhaps other) institutions in the area "under" a health centre, *etc.*

Spot announcements



Spot announcements are used on radio (and could also be recorded on tape and played at intervals in health institutions and elsewhere). They are messages that are very brief, containing one point only, broadcast at irregular intervals or at carefully chosen times of the day, and they occur unexpectedly and without any preliminary announcement (such as: "Here is a health message for you"). On the contrary - their effect may to a large extent depend on their unexpectedness, coming "out of the blue," to remind people about essential points relating to their health. Usually these occur between programmes, but some programme producers may (agree to) incorporate them in their programmes.

Such messages may be scheduled for specific hours. Thus, a message "out of the blue" near meal-time may say: "Don't just eat: wash your hands first"; or: "Vegetables with your dinner help you fight disease". Messages at any time may be, *e.g.*: "Breast milk is the best food for newborn babies"; or "A child with diarrhoea must be given much fluid to drink". There are also times of local or nationwide health hazards or epidemics when spot announcements may be used to tell people continuously or repeatedly what precautions to take, where to go for help, *etc.* But in general, if such spot announcements fill the air too often, people may get tired of them. They should therefore be used carefully, with a good plan and not so often as to lower their effectiveness or impact.

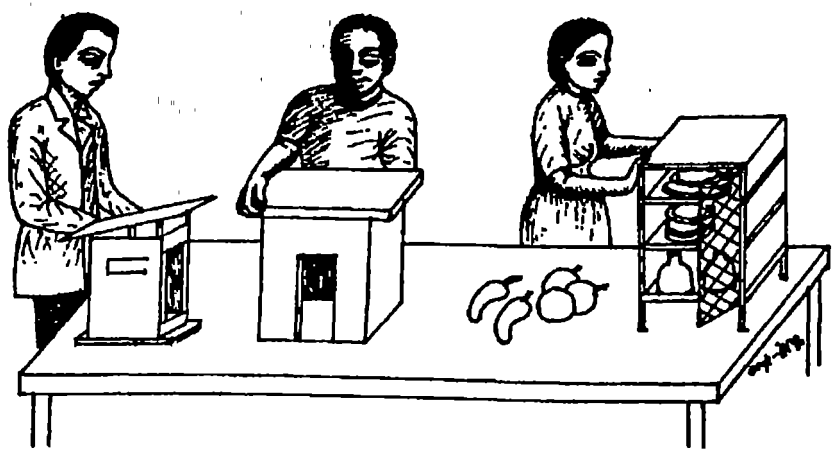
Spot announcements

They should be announced as friendly advice and not as tiresome nagging as from a "teacher" telling "naughty children" what to do.

Displays or exhibits

Displays or exhibits

Displays and exhibits are charts, models and the real things, tools or devices put in



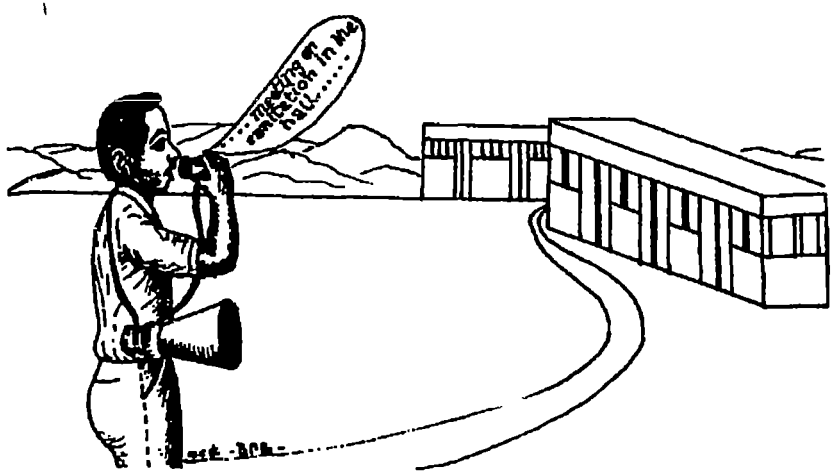
a special place for people to see (and study) either by themselves or with the help of a "guide" who explains what is displayed. Such places can be open at regular hours for anyone to visit, but they tend to be less and less used/visited if this is the case. The best use is probably made of them if they are used as teaching tools to make things that have been taught in school or at meetings more visual. Thus, such exhibits may be opened "on appointment" only, when a school teacher or a group leader takes his class or group to the exhibition area.

It may be good to renew such exhibits from time to time so that people need not think that since they have "been there" they already know it. Each time there may be at least something new.

Local artists should be involved in making pieces for the exhibition (and some artists may be selected as members of health committees to make them more interested in and involved with such work).

With each piece in the exhibition, a short "title" or explanation may be attached for people to read. One person (at a time) should be put in charge of the exhibition, with a duty to keep it in good order, clean and up to date.

"Town criers"



Some cultures use "town criers" to pass important messages to the community. This old use may be expanded in modern times to employing people to pass on messages about community meetings, important events, and also messages related to health. Perhaps they can be most effectively used to announce such events as immunization days, what to do during an epidemic, the arrival of medicines the community has been waiting for, *etc.*

A modern "town crier" may be equipped with a microphone, and he may have to be taught how to use it. If the microphone is too close to or too far from the mouth, people will not hear what he says, and if he shouts at the top of his voice, that is also not the way to use a microphone to best effect.

Health educators should be aware of the presence of such announcers, where they can be found, and make use of them at suitable times. Over-use of "town criers" may reduce their effectiveness. Therefore they should be given messages to carry to the community only when something of rather greater importance than usual is up. If people know that something important is happening every time the "town crier" is heard, they are likely to pay careful attention.

Town criers

Use this page for your notes

Chapter 6

"Entertainment"

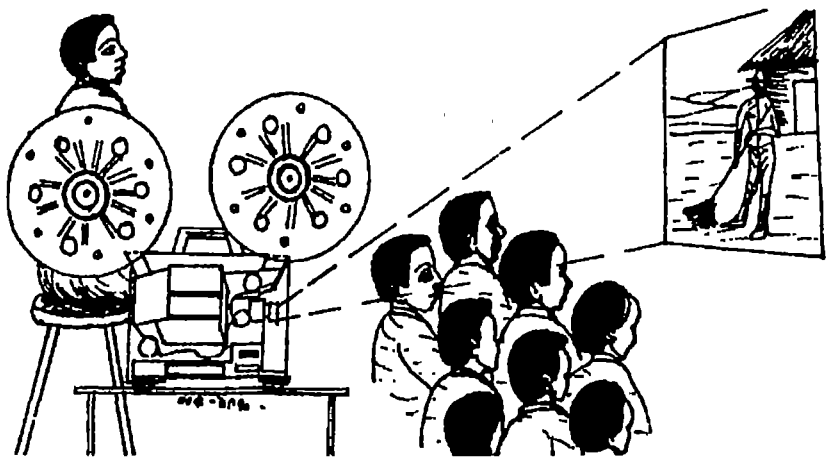
Some teaching aids are rather more popular than others, and some tend to exaggerate their impact and importance, confusing popularity with effectiveness in communicating a message and leading to behaviour change. The word "entertainment" is therefore used, not to "deflate" their importance but to discuss them under a more realistic viewpoint than is sometimes done. Some of these "entertainments" are expensive to make or require rather much organization to stage, but not always. Some may also depend on expensive equipment or the availability of electricity and other facilities. Therefore, they are here treated last rather than first. Some difficulties connected with these "entertainments" can be overcome by calling in "mobile teams" from more central health institutions, such as the Ministry of Health or one of its main "branch offices".

Films

Entertainment in health education

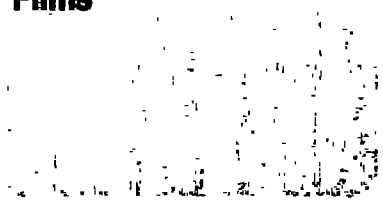
Films

Films are very popular, and they are popular as films. That means that many people (perhaps especially children



and young people) will come to a film show irrespective of the content of the film. It has been said that "the media is the message," and that may to some extent apply to media like film (although the phrase expresses an over-generalization). People will come to watch a film, not the message it conveys. This has both advantages and disadvantages. It is possible to reach vast numbers of people by using films (if the show is properly advertised). But as the crowd may not be motivated by a desire to learn about health, their receptivity may be low. They watch to be entertained, not to learn. If one has something important to say in connection with the film it is best to say it before the show, not after. After the film ends, people want to leave rather than sit around listening to a

Films



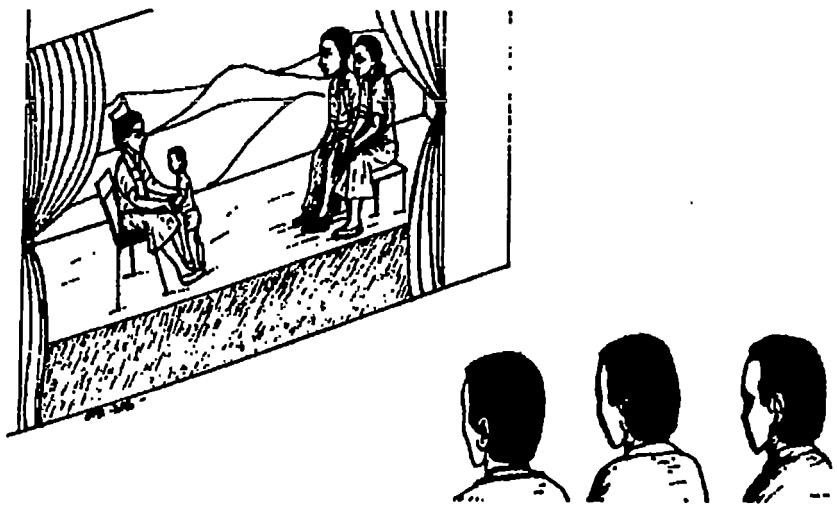
"boring" lecture (it is boring for those who have come primarily to be entertained). The audience will be restless and inattentive after the show, and it is difficult to get any message across. Although films may be watched attentively and be remembered well, they seldom lead to any changes in the behaviour of people who regard the film show as pure entertainment. As many young people come, they may also not be mature enough to appreciate the message of health films. But because of their popularity, films are useful means to introduce people to the subject of health. This is especially true when film shows are open to all.

The most effective way of using films is to show them to select, limited audiences that come by invitation to see a film on a specific subject they are interested in and want to learn more about. Films can be accompanied by short talks and discussion in such groups, and the message of the film can be strongly reinforced by combining it with such other approaches, where the "personal touch" is much more strongly felt.

It is necessary to have expensive equipment and trained operators in order to show films. It is also necessary to have electricity. Mobile teams are, however, often available, and the best way may be to ask such a team to come to an area and show a film. Such teams may also have their own generator, so they can come and show films also where there is no electricity locally. But when asking a mobile team to come to a place, one should tell what facilities are available, including the availability or non-availability of electricity, so that the team can make the necessary preparations and arrangements.

Because of their popularity, it is easy to exaggerate the importance and impact of films; but used properly, they are a valuable tool in health education. Health educators should try to obtain lists of films available for borrowing or showing by mobile teams in their areas.

Plays



Plays are of various length, the shorter ones often being called playlets, skits or sketches. We shall discuss them together here, without making much of various categories of plays. A common feature of plays about health is that they should (generally) be realistic, true to life, to be effective.

A "full-fledged" play may require a big team of people, to write and edit the script, to get it typed in many copies (one for each player, plus one for the producer and a few others), to direct the play, and to do the acting. A suitable place (stage), with decorations and perhaps special clothes for the actors will also be needed. All this is time-consuming and may even cost some money (entrance fees may cover such costs). To perform such a play successfully requires dedication and hard work and can only be done properly by people who really believe it is worth doing (and who also enjoy doing it). A good play is enjoyed by big audiences, and perhaps most of all by those who participate in it (and they are likely to be the people who learn most from the play).

Script writers for plays may be found in schools or other institutions, or there may be "private" individuals who enjoy and are capable of writing such scripts. To find someone who can direct (or instruct or supervise) the people participating may be as hard as to find a script writer. Actors may be more easily found (in schools or elsewhere in the community: play production gives good opportunities for community participation). To arrange space, announce the event properly and get the co-operation of a lot of people who need to be involved is a major organizational task, and all this should be thought through before one decides to stage a play. But staging plays is an enjoyable and entertaining way of communicating health messages, and the visual effect can be strong in helping people to "recognize" situations, and they may remember the message better than if it is merely spoken by one speaker.

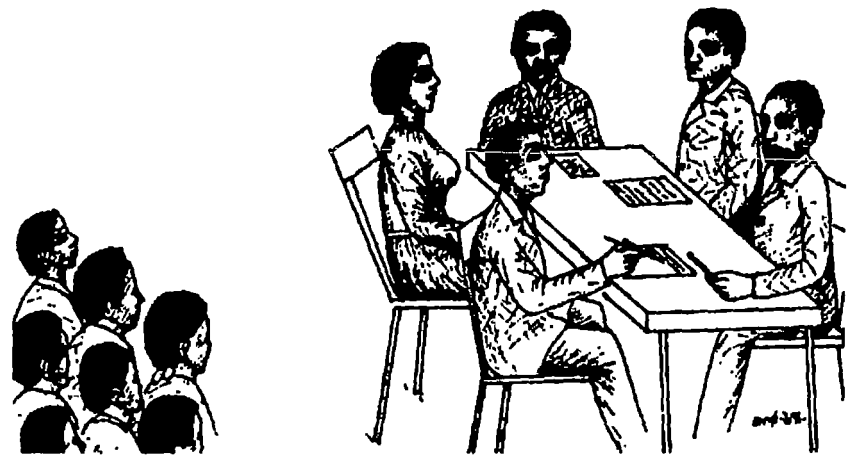
It is both easier and cheaper to prepare and stage playlets or brief skits. Here it is necessary to concentrate on one point or message, and this makes it possible to combine a play with discussion, group involvement, and perhaps the skit can be changed and re-acted after suggestions from the audience. The actors may be "ordinary people" from the community and the "script" may be worked out by the actors and a "director" and perhaps a few people asked to be present to evaluate the playlet while it is being created

Plays

Role play

(written) and rehearsed. The playlet should be modified to reflect "true" situations and problems. That is why it is not enough to accept such a playlet as it is, from the hand of an artist (the writer), as is usually the case with plays performed in theatres. A situation play(let) created to help people understand and improve their life situation(s) is not evaluated only on artistic merits but also because of the usefulness to people who act in it or who watch. It is a teaching tool and should therefore provoke discussion and lead to practical action if it is effective.

Role play



Role plays may appear as plays or skits, but they are also different. In a role play, there is usually no script: people (perhaps chosen at random from an audience) are asked to act a role (*e.g.*, as health educator, or as a mother who is being taught about child care, or as a peasant who is told to build a latrine, *etc.*) and, without a script and without preparation, they are asked to come up with all the arguments a person in a real situation is likely to come up with. It is natural that some will defend a point of view, whereas others will oppose it, and some may be specifically appointed as advocates and as opponents, to get the pros and cons of a matter clearly out. It is, because of this, a good tool for managers, to have a problem highlighted so as to see whether a suggestion is "good" or "bad". It can help decision makers to understand a problem better after hearing many arguments from all sides before a decision is taken. But as a large group or the community as a whole may be involved in decision-

making, this is a tool that may be useful in many contexts. If the audience feels that all arguments or viewpoints have not been brought out in a role play, it may be repeated with other participants.

If a number of people are involved in various role plays, one can get wide community involvement and participation in a problem. All aspects of a problem can be highlighted in role plays: needs of the community, feasibility of proposals, costs and skilled manpower involved, problems of use and maintenance, benefits to health, *etc.* It is also an enjoyable and at the same time often entertaining teaching tool as well as a tool to help in decision making, and because it is possible to involve several "ordinary people" (not professional actors or managers or administrators), it can help to increase the awareness of the community.

What needs preparation for a role play are:

- a clearly defined problem or topic, and
- specified roles to play or act by participants.

Participants can be chosen without any preparation during a meeting (although it may be good sometimes to let people know their "role" beforehand so that they can think about the topic and come up with as many arguments as possible). Spontaneity is one of the aspects of role plays, and it is probably best to regard the role play as a discussion forum where a situation is debated either at "the scene" (*e.g.*, of a spring that is being polluted and the discussion is about what to do to keep it clean, such as to protect it), or it can be a simulated meeting of people with different interests and viewpoints. There should always be a leader or chairman who can also bring the discussion to an end when it seems that all (essential) arguments have been brought up, or the play has lasted "long enough".

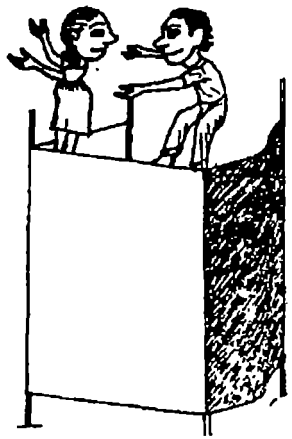
Role play

A role play is part of a larger meeting, used to illustrate or clarify a situation or problem. After that is done, the meeting "proper" may proceed to discuss the matter further (even adding arguments), and then come to a decision about what to do in a certain situation.

Puppet shows

Puppet shows

A puppet show is a play where puppets are "actors" instead of people. The puppets are held by the hands of



a person behind a screen (usually the puppets have long clothes covering the hands of that person so that they cannot be seen) or they are attached to strings manipulated by people. Their "voices" are (usually) distorted voices of people. As well as being used for instruction, such shows are also (ideally) always funny and entertaining. (Often this last point is the essential things: to entertain; but we are here concerned with the use of puppet shows in health *education*.)

Puppets can either be obtained from "production centres" (in the capital or elsewhere) or they can be produced locally by talented people. It will be necessary to find and train some people who can use the puppets properly (regulate their movements) and talk "on behalf of" the puppets (in different voices) at the same time. It will usually be people with a comic talent and who can also distort their natural voice in an amusing and captivating way who should be picked for this task. However serious the topic of a puppet show may be, it is always most effective if it can also get the audience to laugh. Not only children and young people but also adults enjoy puppet shows a lot.

Puppet shows require puppets as well as a miniature "house" or other scene where the puppets "perform" and where also the people "behind" the puppets can be concealed. Only if people with the required talents are found to participate will a puppet show be successful. A good puppet show may attract many people, and perhaps especially the very young can be instructed in this way.

Folk tales and fables

Folk tales are part of the living tradition in many countries, so that new tales are being created all the time, and old ones are being modified. Fables are tales using animals to represent people (and they are a special category of folk tales). It is also possible to "invent" folk tales, using the style of real folk tales when creating new tales for educational purposes, but these may be less effective than the telling of known tales (perhaps with modifications). To use folk tales well may require special talents. If the "moral" or the point one wants to make is made too explicitly, the story character of the tale is easily lost. A good story teller will know how stories can work on and affect the subconscious mind of the listeners, so that the effect can perhaps not even be known to the listener (at least not at once). But in health education, folk tales and fables are not told only for the sake of the story or the enjoyment people get out of them but for what they teach. They should therefore be carefully chosen. Although adults also enjoy tales, they may be most suitable for instructing children.

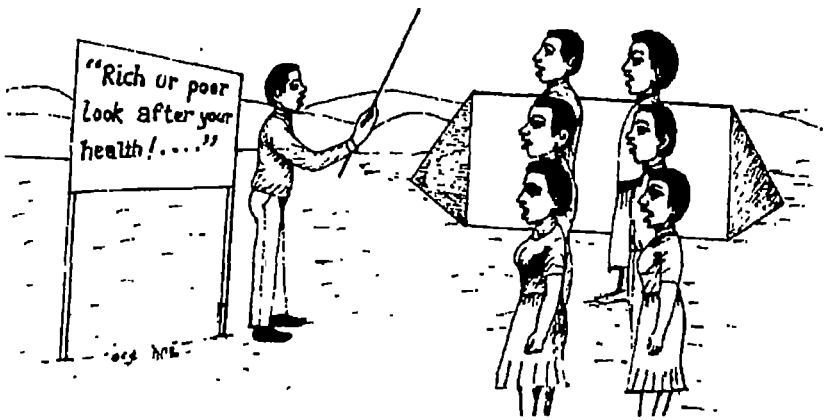
Folk tales and fables

Songs

Dance

Songs

It is within the tradition of many countries to make up songs on current events and problems, and also to use



songs for education. Where this is the case, there is good reason to employ singers to communicate health messages to people through this means. Popular singers may be employed (or asked) to sing such songs at meetings where health issues are discussed, or where there is a slide or film show on health, *etc.* Once such songs have been composed, they may also be introduced to schools and elsewhere.

Songs on health may not be major contributions to health education, but they may be learnt by children and the message frequently repeated by them in song. Songs about health can also be used in plays and they can also be recorded on cassettes and played at health institutions, *etc.*

Dance

In some societies people may have the custom of passing on messages through dance. When this is the case, one should also make use of this means for health education. Only expert dancers are capable of communicating in this way, and the health education officer's task in this connection may merely be to be aware of this art form and to involve such dance groups where they can be found. Although he may not be able to instruct them in how to dance, he can discuss with the dancers what messages should be passed on. An artistically sensitive audience may respond well to such an art form and its message, but for the general populace it may be more effective to use this form of communication only in support of other ways of teaching about health.

Teaching about health: a summing up

In the preceding chapters we have discussed important ways and means of giving health education. But there are other ways and means/methods/techniques as well. It should be up to the individual health educator to find and use the ways and means of giving health education that he or she finds most suitable to the topic and to the audience.

It should be stressed that teaching aids are helpful accessories in health education but that it is possible to teach about health well and effectively without sophisticated, costly or even any means except the human voice. If people react to health messages more slowly than we want, we should not be like the workman who blames his tools for work poorly done. But we should also be aware that people do not change beliefs, customs and habits related to health and nutrition easily. They need time to change, and health educators need patience and dedication. If we show that we really care about people's welfare, they will listen sooner or later, and we should not be easily discouraged. People do care about their health, and if they refuse to take our advice, they do so because they think their way is better. When they come to a deeper understanding, they will change. To achieve this, time and hard work are needed.

When we use teaching aids, we should also note that sometimes the simpler tools that we can make ourselves (or others in the community can help us with) are the most effective and helpful. If we need more time than we expected to give people good health knowledge and get them to change their health-related behaviour, it is usually of no value to cry for more and more teaching aids, although they do help, and they may make our work easier and more interesting. We should use teaching aids sensibly but also remember that in health education much depends on the care, knowledge, interest and dedication of a whole team of people involved in health education. Although there are health educators who are so full-time, there are many who are involved in this work as part of their work or duties, such as community health workers, health inspectors or sanitarians, nurses and health assistants and doctors, school teachers and members of health committees. In some respects the most important health educators are the parents. It is perhaps due to the influence people have received in the home during their childhood that they are so slow to change. If parents change, the children will also change.

Ways of giving health education: summary

It is important to co-ordinate the efforts of all who are involved in teaching about health so that there is co-operation and no conflict of interests or messages. No one is capable of doing everything alone. Co-ordinated efforts by everyone concerned are bound to bear fruit sooner or later, and the better the co-operation is the sooner our goals will be reached.

Use this page for your notes

Chapter 7

Evaluation and Comparison of the Effectiveness of Various Methods of Giving Health Education

There are basically two things to evaluate in relation to the effectiveness in our health education methods:

1. The effectiveness in passing on useful health knowledge, and
2. The effectiveness in bringing about behaviour change that affects people's health status.

For the first point, we need help from studies done by communication experts, educational psychologists, educators and psychologists generally.

For the second point, we need help from studies done on people's culture and culture change made by social anthropologists, sociologists and development researchers.

But we shall discuss the two topics both separately and together, so that they will not appear as two separate questions in the following discussion. When action is involved in the learning process, memory is better, so one affects the other; memory and willingness or ability to change often go hand in hand.

Evaluation of health education techniques

We have noted earlier that we remember roughly 10% of what we only read, 20% of what we only hear, and 30% of what we see (acted out). 50% is retained of what we both hear and see, and if it is possible to "act out" the lesson or information or instruction (such as making a dish while learning how it should be made) and discuss the information at the same time, up to 90% may be retained or remembered. (These statements are supported by research done on how people learn and retain information.)

But this is a general rule, and some who are used to reading and studying a lot may remember more and better than the average reader, especially if he has "learned" to study, by making an outline of the main points and reviewing them after a chapter has been read, and especially if a student takes time to think about what he has read and discuss it with someone else (preferably a fellow student or someone with similar interests).

Even if there may be various influences on the degree of retention of information given, we can still give a rough guide to the effectiveness of different teaching techniques when what is measured is what is retained and not (necessarily) what leads to behaviour change. (Even if health-related behaviour change is our real goal, no change will take place unless informatioh is given and understood and retained; but

Methods for effective retention of information

something else may be needed in addition to knowledge: we shall discuss that later.)

We shall try to group the various media according to their effectiveness, but we should remember that such a classification is only indicative and not absolute - and some ways of teaching about health may be evaluated in different ways, as we shall also have occasion to point out.

1. We mentioned that we remember best information we receive while we do something to accompany the verbal instruction; furthermore, we are not likely to do at home what we are told we should or ought to do (even if we fully agree with the instructor and realize the importance of what we are told) unless we also do what we are told to do at the same time as the instruction is given.

   This kind of instruction with "something to do" is most suitable when verbal instruction is given together with demonstration to illustrate or explain or accompany the verbal instruction or explanation - but only if the participants in the meeting (those being taught or instructed) take part in the demonstration and *do* what is being *explained* to them. If there is any degree of difficulty or complication in doing what one wants people to do, it may be best to first give an oral explanation (using pictures or the blackboard if this is found suitable); then to show (demonstrate) what has been taught or explained; and finally (the most important and influential and decisive step) to invite listeners or participants in the meeting to come and perform the "experiment" for themselves - under the guidance and supervision of the teacher or instructor.

   Examples of lessons that can be taught in this way are: the preparation of a meal; the washing and dressing of babies; the cleaning and dressing of small wounds that can be looked after at home (or any part of what is called First Aid); washing of clothes or utensils; breastfeeding (for lactating mothers), *etc.*

2. Second in importance when it comes to helping people remember what they are being taught are techniques combining both spoken words and pictures - to let people both hear and see what we want to teach them. Demonstration with explanation but without participation from the audience is an example of such a technique. But there are many more: teaching by means of pictures, or the use of textbooks in addition to a teacher's oral explanations, the use of leaflets together with spoken instructions, the use of flipcharts illustrating a talk, television programmes, plays, role plays, films, slides with commentary, *etc.*

   It is important to *use* the illustrations, not only to leave them visible in the background (or foreground) but without referring to them or using them to make points clear. They should be used so as to emphasize points, give people time to absorb and digest explanations given and thus double (or treble or more) the effect of the spoken word alone. The best combination may sometimes be to let people hear about a topic, then read short texts further explaining the topic, and also use pictures or other illustrations to clarify the lesson further. But sometimes this may

be confusing (people may start reading while the spoken instruction or information is given and thus miss part of the lesson), and it may be more effective to give oral explanations that can be absorbed while people study the illustration at the same time.

3. Next in effectiveness for retention come instructional materials that can be seen only. Here we have teaching aids such as illustrated books or booklets, posters, illustrated magazines or leaflets, pictures, strip-cartoons, scale models, calendars, *etc.*

   Since these media are left to work by themselves, without the benefit of a teacher or instructor who can explain them, great care has to be taken that they communicate exactly what we want to teach by means of them. It is advisable to pretest such materials (at least some of them), to make sure that the person taught or instructed gets the message in the way we want him or her to understand it.

4. Still weaker as means of given information that is retained are the means that use the spoken word only: What the audience only hears. As examples we can mention speeches or talks, radio programmes, spot announcements, messages given by "town criers," *etc.*

   Here as elsewhere, the way the messages are presented can make a great difference in relation to what is remembered. Professionalism is important in getting the message across.

5. Least effective for retention is what is read only. This includes "plain" books, booklets, newspaper or magazine articles, written slogans (without accompanying pictures), *etc.*

Methods for effective retention of information
Motivating listeners
Pretesting

After having made such a "catalogue" of teaching aids, classifying them according to their comparative effectiveness when it comes to retention of information given, we must add that there are influences on retention other than pure "ease" of remembering information. At a time when a person feels that he "needs" certain information (*e.g.*, when lack of such knowledge affects his life negatively, whether through ill-health or the prospect of failing an examination), he will remember better than a person who is more indifferent to the information given. To enhance attention to health knowledge, the teacher or communicator should therefore pay as much attention to raising the audience's awareness of the *usefulness* of such knowledge as he does to the *contents* of this information itself, *i.e.*, he must *motivate* his audience to become receptive to what he teaches. It is always useful to know some (educational) psychology and something about good communication techniques for a health educator.

We have also learned some useful general principles about communication from pretesting educational materials. We should avoid what is ambiguous, unclear, misleading and offensive, and we should try to be clear, create a desire to follow our instruction, please and attract our audience as much as possible. We shall take one example of what we have learned from pretesting (*i.e.* trying out teaching materials for correction and adjustments among a sample audi-

Illustrations
Specify aims and target audience
Opinion formers and change agents

ence before we give final shape to them). If we use illustrations, we may use pictures that represent or show reality with all details, both what is important for what we want to teach and what is irrelevant, or we may cut out all irrelevant details and show only the bare essentials in a kind of outline drawing. It has been found that for the average person in a developing situation it is confusing to use pictures with a lot of details, and it is too abstract to use drawings showing the outlines only. The best results have been obtained with illustrations that have several details, without being either too bare or overcrowded with details. But in each case, one should make independent tests, as the situation differs from place to place, from audience to audience, and from person to person.

One of the most important points when we make or choose educational materials is to specify

1. our goals or objectives, and

2. the target audience, *i.e.*, the group we want to reach with a specific message.

We should use a different approach if we want to talk about child care for maturing school children (to prepare them for adult life) and if we talk to new parents or if we talk to older parents whose traditional customs of child care we want to change. Sometimes we can choose our audience; at other times we have to confront an audience that others have chosen or invited for us. Very often we get a mixed audience, *e.g.*, when we talk to a community meeting or on radio or television. Even in such cases, our health education is likely to be most effective if we make up our minds what we want to achieve (our goal or goals) and whom we want primarily to reach in the mixed audience (*e.g.*, community leaders, the young adults such as first time parents, the school population, *etc.*). It is a "temptation" for many to try to reach *all* at the same time; but such sessions or programmes are usually the weakest and least effective. If we have specific objectives and a specific section of people in mind for a health education session or activity, we have a good chance to influence at least some. If we try to talk to and reach all at the same time there is great likelihood that no one will benefit from our health education.

Some health educators have tried to aim for the "opinion formers" and the "change agents" in a community. If this is overemphasized, there is a danger that we "create" so-called change agents that are not accepted by the community. People may even react negatively, saying that they will not follow the example of someone they do not recognize as their leader, for to do so would mean to give him a position and importance they are not prepared to accord him. Such wrongly selected opinion formers and change agents may actually become a hindrance (rather than a help) in bringing about change and development. It may very well be that it is the "outcasts," or those with a very weak link with other people in the community and with their customs and traditions who are most willing to change - perhaps they have least to lose by adopting new behaviour. To outsiders working for development, such people may seem progressive, and it is easy to "use" them wrongly. The main thing is to get

whole communities, or the majority of their members, to change and progress.

We should perhaps not attach too much importance to individual "change agents". There is another way to go, and that is to deal with groups, with communities (not individuals), and they can choose their own representatives to try out new ideas, to experiment, to bring about change, - but these "agents" should do it on behalf of the whole group.

Here is an important principle: The group or community approach. Instead of starting with individuals it is better to start with groups - the bigger the better (ideally the whole community) - and then carry the idea (the message) to smaller groups, ending with home visits and individual approaches. Decision-making is usually a community matter, and decisions in relation to health care should be made in and by groups after the groups have been able to discuss the matter thoroughly. Group decision after group discussion is much more likely to bear fruit than the person-to-person approach alone. But after decisions have been made by the group, it is essential to follow up these decisions to see if they are implemented. This can be done by appointing a person (*e.g.*, the chairman of the meeting) to arrange for such follow-up. The chairman can appoint someone, *e.g.*, the community health worker, to keep track of what is done with respect to implementation. If the project decided upon by the community is to immunize all children under five years of age, a list can be kept in the clinic, and the names of those who have taken their children for immunization can be read out in future meetings, and the names of those who have still not done so should also be read out with a reminder that they ought to do like the others. If some are very recalcitrant, home visits may be helpful to "remind" them.

The group approach in health education

After large groups have been mobilized, it is essential to approach smaller groups concerning the same question. If health education has been given to the community in communal meetings, it may be best to next approach special groups, such as women's (or mothers') groups, youth groups, Red Cross groups, school children's parents, school classes, literacy classes, neighbourhood groups, or to just call people living close together to a (perhaps open air) meeting and discuss with them their special needs and problems. Then finally families and individuals can be approached. In families, it does not harm if visitors come - perhaps they should even be encouraged to call neighbours to come to the house where the health educator visits. People are often hesitant to make decisions alone, especially if they are important and radical, involving major innovations for them or the community. It is therefore easier for many to make decisions after hearing the views of others. People may not want to "go it alone". The support (or discouragement) of others may therefore be decisive in getting people to change their health behaviour.

But after people have committed themselves to a step, individual approaches and encouragement may be helpful. Perhaps there are special problems people like to discuss or ask advice about individually before they take action. And there are also some problems of a very personal nature where the individual approach is necessary. Family planning is such an area, where individuals or couples may be the

Group involvement

Group decisions

most ideal audience, as some may fear to ask questions or even to show any interest in public, for fear of disapproval from others.

To illustrate the effectiveness of the group approach and group involvement, it may be worth quoting an experiment that clearly demonstrates the principles discussed above. The example is quoted from the popular Penguin book, *Fundamentals of Psychology*, by C. J. Adcock (emphases have been added):

> "During the Second World War food supplies became a pressing problem and in many countries food had to be rationed. In the United States of America... some interesting research was triggered off...(on) how to change people's eating habits...
>
> The first step was to determine who were the key persons in controlling eating habits. Housewives, it was decided, play a vital role here. They are in an excellent position to initiate the trial of new foods and generally influence consumption habits. An experiment was therefore set up to discover the most effective way of modifying their behaviour. Red Cross groups, formed for the study of nursing and first aid, provided convenient samples of housewives for the experiment. These women were all seriously concerned with the war effort and likely to be sympathetic to the aims of the experiment.
>
> Six groups were chosen. Three of these received carefully prepared lectures designed to interest them in the merits of less favoured forms of meat such as hearts and kidneys. These lectures were delivered by women who were able to speak not only about the nutritional qualities of the meats concerned but also of their own success in preparing attractive dishes from them for their own families. The other three groups were given similar information but in the form of *discussions which were concluded by asking how many housewives would be prepared to try out these foods during the coming week.*
>
> The response to this appeal was excellent but it was in the actual behaviour of the women afterwards that the most striking effect was observed. Of the women in the first three groups who had heard the lectures only, the number who actually tried the proposed dishes was *three per cent*; but *thirty-two per cent* of the members of the other three groups, *those who had actively participated in discussion and made a group decision, responded in a practical way.* The second approach was thus *more than ten times as effective.* Further experiments gave similar results and indicated that a sound technique had been discovered." (1964 edition, pages 19-20)

The technique discovered in the experiment described above may be decisive when it comes to bringing about behaviour change. The situation described involves, not reluctant persons who have to be convinced and persuaded first, but concerned, educated and highly motivated housewives in a crisis situation, instructed by competent and trusted women on an important subject. It is even more important to use the group approach with persons who may be initially doubtful of our message and perhaps suspicious of the motives of the (often unknown) health educator. People like to make up their own minds, but their minds are influenced by their friends, by their neighbours and other village or community members. Individual innovations may cause envy, and delighted derision if the individual innovator fails. People may hesitate to try to be different, and the support of the community is usually essential, either in the form of a knowledge that others also are trying out the new thing, or that one has been asked to experiment on behalf of the community, so that a failure is not an individual failure but failure of an experiment that the community wanted tried out. Thus no one loses face. Community or group participation and group decision are essential for lasting behaviour change.

When we consider the techniques discussed above, it is worth noting that it is not always the most sophisticated and costly techniques that are the most effective. On the contrary, by involving people in decisions concerning their own and their children's life and future, simple and inexpensive teaching aids and techniques may be the most effective to achieve our goals: behaviour change that contributes or leads to better health for individuals and for the community.

Group involvement and behaviour change
Media mix
Comprehensive approach

But this observation should not lead to a lazy attitude to health education. The best techniques and presentations should be used, and often a combination of several teaching methods (a "media-mix") may give the best results. But it is equally (perhaps more) important to know the mentality, the psychology, the way of thinking, feeling, making decisions and acting of people in an area.

Our aim is not only to impart knowledge but to produce behaviour change that improves people's health.

We may find that we are convincing a certain group of people to change their behaviour in relation to health. School children may thus be seen to practise good hygiene in school. But the same children may discover that their parents (or grandparents) are reluctant to be "taught" by their own children. It may therefore be essential for lasting and universal change in a community to teach all age groups the same things about health. If older people are taught in community meetings and literacy classes what children are taught in school, there is a better chance that personal and environmental hygiene will be practised by all than if only one section of the population is given health education.

We must consider age, educational level, social awareness and people's mentality and willingness to change and progress when we want to give effective health education that will be put into practice by our target audiences. And we need patience: Change is not brought about in a hurry. But

Comprehensive approach	we should use all possible or reasonable means to speed up the process of change.

Chapter 8

The Organization of Health Education

Good and effective health education is not only a question of teaching but of *organization*. Health education must be well organized to reach every member of a community, and organization is a prime requirement in order to bring about social change, including change in health-related behaviour.

A health educator who tries to do everything related to health education himself cannot be as effective as one who obtains the services or assistance of all who in some way do work that may have a health education component. The kind of organization needed to help all such workers to make the most of their efforts is *co-ordination*.

A full-time health educator is normally an employee of the Ministry of Health. Although he will have to look around to find collaborators in other ministries or organizations, he may do well to start looking at the organization of health education in his own ministry and immediate surroundings. Planning of health education activities will be a question for the Ministry of Health, but the implementation of health education policies may start in a health department at local level. Plans must be studied for detailed execution there. This will involve the deployment of personnel and the procurement of teaching aids and the setting up of health education programmes. But the actual work of giving health education will normally start elsewhere. Hospitals should have a daily programme of health education, but as their main responsibility is to give curative services, they cannot be expected to take the main responsibility for health education elsewhere as well. The local activities in health education for an area are probably best organized around a health centre. Although health education should be given, among others, by those responsible for maternal and child health services, immunization programmes and others, the principal officer in charge of health education should be a full-time health education officer, or someone who works closely with teaching activities, such as a Primary Health Care Officer/ Public Health Officer or a Sanitarian/Health Inspector. This officer should both do health education himself and also set up weekly programmes of health education and supervise that they are followed. He should also supervise programmes and teaching activities in all clinics sorting under the health centre. He should organize the distribution of health education materials in his area, and if possible get help to do local production of such materials. He should, as part of his work of supervision, keep records of what is done in the area of health education. The methods of health education he can use are discussed in an earlier chapter.

Organization of health education
Hospitals and health education
Role of health centres

People come to health institutions when they are ill, or, if they have caught on to the idea, they may come for check-ups even when they are well. In any case, they come for health services with their minds set on questions related to health, and they are therefore receptive to health education.

Health institutions
Mass education
Health committees
Community health workers

(The only "obstacle" may be such intense preoccupation with their personal health problem that they are not prepared to listen to more general health topics.)

But the fact that people come to health institutions when they are ill also sets the limit to the audience or outreach. Even if most people are ill from time to time, they rarely come on a regular basis. This makes it difficult to give comprehensive health education at health institutions: Even if our health education *programme* is comprehensive, people attend so irregularly that they benefit from only part of the programme. It is therefore good to look for ways to supplement the health education given at health institutions.

To reach the masses, the whole communities, it is good to get the co-operation of organizations of large groups of people - peasants, women, youth, and of sports clubs, scout groups, Red Cross societies, *etc.* If possible, health committees should be established, and these should do most of the regular planning and supervision of health education activities in their community, and perhaps some or much of the actual giving of health education as well. Although such health committees may be quite independent, they will usually welcome professional advice, and it would be good if professional health educators could either be members on local health committees or be so close to their leaders that they can be invited from time to time - and they should use the opportunity of such invitations to guide and help less experienced health committees to make their work more effective and to the point.

Where health committees are operational, they may be in charge of guiding extension workers who do health education (or other health educators). In case no such committee exists (or where it does not function properly), it may fall to the health education officer of the area to guide and supervise health educators at lower levels. If there is a community health worker, he/she may be the best contact person with the local community, both for instructing mass meetings and for home visits. But there may be nutrition extension workers, agricultural extension workers and others who should be helped to set up programmes so as to address the real health problems of an area and do it in an effective manner, and also to co-ordinate their teaching and other health-related activities with other workers in the area.

It is best to start health education with large groups (the masses, preferably the whole community) and then proceed to both repeat the "lessons" (for reinforcement) and then to expand them into greater detail and take up problems of more individual concern or relevance in smaller groups (of women, youth, new parents, teen-agers, sports clubs, *etc.*). It is part of the idea of primary health care to "demystify" medicine, and also in health education it is therefore good to let the masses know what we have to teach and let them discuss it openly, before our teaching is taken to more closed groups.

Everything feasible should be done to encourage the work and strengthen the position of the community health worker. His work should be appreciated and support should be given at all levels. If his work is appreciated by the

community, he will get much more done than if he works in isolation, more or less alone.

Health education of a more intensive kind can be given in classes. These may be of two kinds: literacy classes for adults and formal classes for children in regular schools.

If there are readers or textbooks on health prepared for literacy classes, a health educator may ask (or be asked) to be present during some classes when health topics are taught. If the adults being taught have questions, discussions of health in such contexts may be very effective - perhaps even more effective than the written text, both because people remember more of a topic if they both read and hear about it and because they will understand better what is explained to them personally. Probably the most important consideration of all is the much greater likelihood that people will change their behaviour and practice in line with what they are taught if they are able to discuss their health problems and receive guidance from a qualified and concerned person. (It is also much easier to follow up and continue the topic in private talks in the home if the health educator has met and taught a person previously in a literacy class.)

One important aspect of adult education is that parents are given the same knowledge as their children in formal schools. There is in such cases much greater likelihood that the health knowledge will be turned into practical action in daily life in the home.

In formal schools, it is important to have as strong a syllabus in health (or health science) as possible. Even where the subject is well covered in textbooks (see chapter 4, Health Education in Schools), there is still much support that a health educator can and should give. This may range from inspection of health facilities (together with a public health inspector/officer or sanitarian) combined with relevant and appropriate advice to the school authorities, to taking part in the teaching of health (occasionally,- especially where there is a shortage of qualified teachers in the subject) and giving encouragement and guidance in relation to arranging a school health day or a sanitation week in the school (see chapter 4).

Health education in schools and literacy classes

Community participation

To ensure as much and as positive co-operation from the community as possible, it is advisable to involve a wide range of community members in the process of health education and in activities aimed at improving the health of the community. This need not and should not be limited to discussions in health committees or other decision making fora. It is good to bring matters concerning health before the whole community as early and as often as possible. Health committees or their spokesmen or a health educator can present several questions to community meetings, *e.g.*,

- What are the greatest health problems in the community?
- What can be done to improve the health of the community?
- Does the community need a clinic?
- Who is to run it?

Community participation in health education

- How can the clinic be built and equipped?
- Do they need a community health worker?
- How is he or she to be supported?
- Should every house-owner build a latrine?
- Who in the community has the necessary skills to do the more difficult parts of latrine construction?
- How can people obtain the necessary information and training for various health-related tasks?
- How will people be able to pay for the cost of latrine construction? Are there credit facilities?
- Do they need sanitary guards, and how will they be paid?

It is not enough to involve the community in discussions of health-related problems; they must be involved in the decision-making process as well, at all stages of the project, from planning through implementation to follow-up. They should also be asked to appoint trusted people to carry out experimental projects and people to supervise and follow up on the work at each stage. And at the end they should be involved in the assessment of the project: was it successful or not? Did it bring the expected benefits? What mistakes were made or what could be done better? (This kind of questions are useful for the planning and implementation of future projects.)

Community participation or community involvement is an important question that is considered more fully in Appendix I.

In health education it is important not to try to do everything oneself. People's support must be enlisted at all levels. In the last analysis it is each individual's contribution that counts when it comes to improved health. Only the individual can look after his own health as it relates to personal hygiene, the hygiene of his/her home or surrounding, as well as the necessary care of one's children, the sick in the family, or - for husbands - to pay the best attention to pregnant and lactating women. Good nutrition cannot be imposed, it must be done voluntarily by people who understand and appreciate the benefits of it. Individual as well as collective contributions to health are the result of good teaching and good organization.

Conclusions

Better than cure is not to be sick in the first place. A country needs not only good hospitals and other health institutions that care for the sick - it needs a population with sufficient health knowledge to look after its own health, and even its own sick in some minor but very important and often harmful or debilitating cases (such as diarrhoea in children and minor wounds). Health education has the very practical purposes of helping people to be ill less frequently and to know what to do when people become ill.

Health education is not meant for an elite or for a few - it is knowledge that should and must reach the masses. Good health increases well-being and happiness, makes possible better use of money, increased production and better services or work by all who perform any kind of work. Healthy parents are much more likely than sickly parents to get healthy children. Healthy children do better in school (and later at work) than children who are frequently sick. Expenses that are used for cure could be used for other useful purposes - including a better diet - if people are ill less frequently.

The importance given to health education and preventive medicine or preventive health services (or "care") depends on the priorities of a country's government. The benefits derived from a healthy population are so great that it is wise investment to spend a good proportion of the health budget on prevention and not invest only in curative services. But the two (cure and care) should be seen as part of one aim: to get a healthy population. Although special employees may be assigned to the task of spreading health education, the prestige and authority of people working in curative services are so great that it is valuable to get doctors and other "curers" or "healers" to pay attention to and participate in preventive services and health education as well. In addition to teaching health education to medical professionals, the subject should be taught in all formal schools and literacy classes, and adequate knowledge for the preservation of good health should be given to every member of a community and every citizen in a country. All means at one's disposal should be employed to spread such knowledge - mass media as well as more personal approaches. In the end, we do not get a healthy nation without the active co-operation of all its members, and such co-operation is given by people who understand its advantages. This understanding comes from effective health education.

Why prevention is better than cure
Cooperation and coordination in health education

Use this page for your notes

Appendix I

Community Participation or Involvement in Health Care

What is community participation?

The whole population of a country ought to participate in the building and development of the nation or country. Unless the broad masses are drawn into the development process, a valuable resource goes unused. For effective participation of the masses in development, they need to know what development means and what development aims they are asked to help accomplish. This requires education, motivation and a raised consciousness. The way this can be done is to educate the masses in basic skills (primarily literacy) so as to enable them to take part in the national discussion of development and what development objectives to pursue. This may involve a process of "politicization" before people become clear about what kind of development they want. Only then, as a second major step, can participation in concrete development projects on a comprehensive scale become meaningful.

Community participation
Extent of community involvement in health care

In many developing countries, literacy campaigns and political education have taken place for a number of years. In addition, the population may have been organized in mass organizations that make both mass education and organized mass participation in development projects possible. Participation in development can take place at many different levels. To co-ordinate objectives, plans and activities, a national consensus is necessary. To implement national plans, regional and community participation to achieve overall objectives is needed. At the community level, sometimes the support of the whole community will be required (*e.g.*, in the support of a Community Health Worker); in other cases, women's interests are best taken care of by women's groups, and the interests of youth by youth groups; and in many cases individual participation to achieve agreed objectives

How to obtain the participation of the community

may be required (this is particularly important in activities invisible to outsiders, such as personal hygiene and cleanliness in the home, in food preparation and consumption, *etc.*; but it is also important in the construction and proper use of latrines and general cleanliness of one's homestead, *etc.*).

But community participation is more than the exploitation of the labour resource of the masses. Participation in development may be active or passive, contributing much to development at high speed or reluctant participation in projects that one participates in without understanding or enthusiasm, only because one is forced to participate. Different attitudes to participation are created by the way one goes about mobilizing the masses. If orders are issued without efforts being made to raise the consciousness and to educate and motivate the participants, alienation is created, with the result that people feel they are participating in projects belonging to others. This may still have some advantages over the procedure of doing everything for a community without their participation, as this would create an attitude of dependency, so that they will do nothing themselves but wait for someone from outside to initiate and execute all development activities in their community.

The best way to achieve active community participation is to educate, motivate, persuade, and raise the consciousness of the community before they are drawn fully into the development process. One way of doing this is to let the new ideas take root during a process of education and "politicization" and wait for people in the community to ask to be actively involved in the development process. This would be community participation initiated from below. Another way to get community participation in such projects is to mobilize communities to participate in development projects so as to achieve national development objectives within the time limits set by national development plans. Central planning and community participation can best be harmonized if extensive information, education and persuasion are applied. This will avoid the feeling of "forced labour" and conflict of interests at the national and the community levels. The latter approach is especially important in the area of health. One can force participation in the construction of a road or assembly hall or the payment for communal projects, but one cannot force people to be clean and hygienic in their personal habits. In order to practise cleanliness and take the necessary measures to lead healthy lives and to eat food that promotes health and gives strength to work well, people must have the *personal conviction* that to act and live in that way is worth their while, some extra effort and perhaps some extra expense. Such conviction comes through information, education, child rearing practices (upbringing), persuasion, and demonstration of the beneficial effects of a certain practice. Personal experience of any benefits will strengthen people's conviction and help them continue a valuable practice.

The best way to convince people is to let them participate in the decision making process, through group discussions and resolutions as a group, to try out what they are advised to do (or better still: what they think themselves that they ought to do). If they know that it is their own decision to try out a certain course of action, they are more likely to follow

it up in their private lives than if they only have been told what to do by others, without having a say in the matter themselves. If they get a chance to follow up by reporting to a community meeting on the benefits of a certain practice after it has been tested out (*i.e.* if they also participate in the evaluation of development projects), they are likely to persist with a good habit and make it a permanent part of their daily lives. When the community health worker visits homes, it is easier to talk about matters the community has discussed and decided upon than to talk about matters that are new to the community and about which there may be hostile feelings if no community decision has been made about it.

Why community participation?

Community participation is so obviously necessary and essential for creating a healthy community that the matter is almost not worth discussing: nobody can keep a person clean and make him lead a healthy life except that person himself. No amount of outside pressure can make a person wash his hands after defecation or before every meal, or before food is prepared, unless the person is convinced that he ought to do so for his own good, to protect his own health.

But community participation has many advantages that are still worth pointing out. If all members of a community are convinced of the benefits to them of cleanliness, they will help each other to find pure water sources and to keep such sources clean. They will build and use latrines everywhere in the community and keep them clean. Thus, much can be achieved also when the government cannot (afford to) carry out all development activities in a community. If community members do (part of) their own development work, they learn and become more conscious of their needs and potentials for solving their own problems, they make use of local skills, they learn to be responsible for projects and their maintenance, and they gain the necessary self-confidence to tackle further and perhaps more complicated development projects. Community participation may not be cheap or always efficient, but the burden of costs is borne by the community rather than the government. In order not to create dissatisfaction in this way, the benefits of projects must also be clearly seen to be to the community's advantage. It is not only labour that is needed in community participation in development - also participation in need assessment, organization, management, accounting, and evaluation is required in order to draw a community fully into the development process. This will then be a question of power sharing at the community level, but it also leads to greater democratization and self-reliance. If it also generates greater unity and a spirit of co-operation and self-confidence in a community, a basis has been laid for further development of the community.

Reasons for community participation

There are traditions of co-operation in small-scale, local development projects in many countries. It would benefit the development of a country if such traditions were strengthened and used to achieve national development objectives. Primary health care will never become a reality without community participation. One needs to make all the mass

How community participation is made possible
Limits to community participation

organizations in a country participate in primary health care through informing, educating and motivating people for such participation. A long term aim of a special nature may be to train or educate every woman in a country to be able to handle simple health problems of the family (for which a manual on *Health Care in the Home* may be needed).

Premises and limitations of community participation

When a community is invited to participate in the development of their own community and the nation, the response can be negative if people do not clearly perceive and understand the purpose of such participation. They may think it benefits others but not themselves. To become enthusiastic about community participation in development projects, people must first of all understand that such projects are to their own advantage. Projects initiated with community participation must therefore clearly be of such a nature that people can easily see their benefits. Particularly the first time such communal projects with popular participation are suggested, the benefits must be obvious and easy to see. Later, projects that require more education and perhaps abstract reasoning and understanding may be initiated. Health-related projects may be among them. All will see the need for water, but only those with some health education may see the need for *clean* water from a *pure* water source.

It is of course possible to impose decisions on a community (tell them what to do), but participation is likely to be much more effective if people understand the reason why a project should be executed. This needs education and persuasion at two levels. It is not enough to let a community waste its efforts and resources on any haphazard projects that come to mind. Local projects and efforts should be co-ordinated with overall (central) national planning. This needs explanation and education in the community. But beyond this, specific education is needed in relation to concrete projects. Thus it has proved wasteful to ask people to participate in health and sanitation projects when they lack understanding of the causes of diseases and their transmission and how they can be prevented or restricted. Health education is a necessary prerequisite for meaningful community participation in health and sanitation projects. Through such education, it is possible to raise a people's consciousness of the need for change, to increase their understanding, to change their attitudes and values. It is also important to understand the feelings of group solidarity prevailing especially in rural communities. Therefore, such education and persuasion must take place in groups where there is possibility for group discussion, group decision, and group participation. Only when a community is ready to make a decision to participate in a project as a (fairly) united entity is participation likely to be effective and lead to the desired results. Motivation is thus an important part of the education and persuasion given. The chief motive for a community to participate is likely to be that they see that a project is useful and beneficial to them, that it will lead to improvements for them personally and for the community (and eventually, if all communities participate, it will be seen to increase the welfare of the nation).

The next step - after a community is persuaded that their participation in development projects is desirable and necessary - is to impart the necessary skills to a community. Persons chosen or approved by them and with the necessary aptitude need to be trained in organizational and managerial matters (election procedures, how to make and formulate project plans, how to supervise, how to account for financial inputs, how to write reports, *etc.*) as well as in particular skills (construction and maintenance of latrines, protection of water sources, basic medical knowledge for community health workers, *etc.*).

It is possible (perhaps even desirable) to use some coercive persuasion to get a reluctant community to build and use latrines, to immunize their children or to vaccinate cattle, if this is necessary to preserve or protect the health of people. But the best way is normally to increase their knowledge and understanding of why this is for their good. And in the area of personal hygiene this is the only method that works.

It should therefore be clear that community participation in development is not always quick, easy, and cheap. Motivation and education require time and manpower. It is mostly quicker to use professionals with mechanized back-up (machines). It may even be cheaper in many cases. But community participation leads to the creation of a more qualified work force on the local level and - combined - nationwide, and it leads to local and national self-reliance and, eventually, self-sufficiency. It is part of an educational and mobilization process that has as its main advantage that it makes use of the total work force of a country.

Problems with community participation
Meaningful participation
Old and new forms

To get the best out of community participation, it is necessary to have confidence in the ability and (potential) skills of a community and to be willing to share power with them - power to make meaningful and "correct" decisions, to mobilize their own members and to see the "why" of development projects. One also needs to let them keep (or get) enough resources in the community to carry out development projects, as some cost is almost always involved. If all decisions are made for the community, without their participation in the decision-making process, they may fear that projects benefit someone other than themselves, fear *e.g.*, that community participation is only an excuse for getting cheap or free labour for the creation of new classes of people who use them to build up their power to oppress and exploit them. Trust and a willingness to share (power, responsibility, resources, knowledge) are the best foundation for effective community participation in development projects. At the same time, community efforts must be part of national development plans to be truly meaningful in a national context.

Mechanisms of community participation

There are old traditions of community co-operation in many places - to build a house, to harvest, *etc.* Such co-operation was often a response to an acute short-term need and did not involve permanent organizational forms. Today,

Ways of organizing community participation

most countries have advanced beyond such casual forms of mutual help. Even when more lasting associations existed, it was intended to help in "life crises" - at weddings and burials mostly. Even if the structures of these associations were and are inadequate for development projects of a sustained nature (building and maintenance of roads, water supply systems, clinics, *etc.*), one can still build on the spirit of co-operation that has thus long existed in a country.

Among common forms or mechanisms of community co-operation and participation in development well known from different countries are political movements, elected local governments, trade unions, co-operatives, community councils and committees, youth clubs, women's associations, *etc.* One should not form new associations for community participation in development where suitable organizations already exist. New tasks can be incorporated in or added to the objectives for which already existing mechanisms have been established. In cases where no mechanism for co-operation in development work exists, it would be useful to organize the community in such a way that it will be able to solve communal problems where there is a need for community co-operation to accomplish such tasks.

The obvious way to go in most cases is to make use of existing mass organizations. A health committee should ideally exist in every local community, and where it does not exist a primary task in involving the community in primary (community) health care would be to establish one. The more authority one can get behind the health committee, the stronger and more influential it will be. To get an active health committee, it is necessary to have at least some people educated in primary health care on this committee (and where such knowledge is lacking it is important to inform and teach them, as without some basic knowledge and understanding of the causes of disease and health the members will not be enthusiastic in performing the tasks of this committee), and the health committee must know fairly precisely what tasks need to be done in the community, either through observation or study of their own community (specific local health problems), or through knowledge of health problems that are universal and can be remedied through following national guidelines (*e.g.*, the proper use of latrines can help to remove many ailments that are the same, or nearly so, in all communities that do not use latrines).

One of the most important tasks of a health committee is to help select and get training for a community health worker and later give him/her the support needed to be effective. But one should not depend solely on this person for health work in the community. If there are several health workers, the health committee could help to make them co-operate rather than compete (and perhaps work against each other). Similarly, other health workers could supplement rather than duplicate the community health worker. In some cases it is useful also to widen the field of co-operation to workers in other ministries; thus it is natural to get help with some health education tasks from home agents, and perhaps others who visit homes regularly. It may also be helpful to co-operate with voluntary agencies who do health work in the area.

To increase understanding and appreciation of health activities going on in a country, one should use all educational and information media available. Besides regular school books, readers for use in literacy classes and for community reading rooms as well as opportunities for teaching the communities in community meetings should all be used. Person-to-person encounters are probably the most effective means for teaching hygiene and other health related matters. It is also important to let people discuss the issues and participate in the decision-making process in matters relating to community health. A more impersonal kind of education takes place through the mass media (especially the radio and the press) and through the use of posters. These can support health education given in more personal approaches.

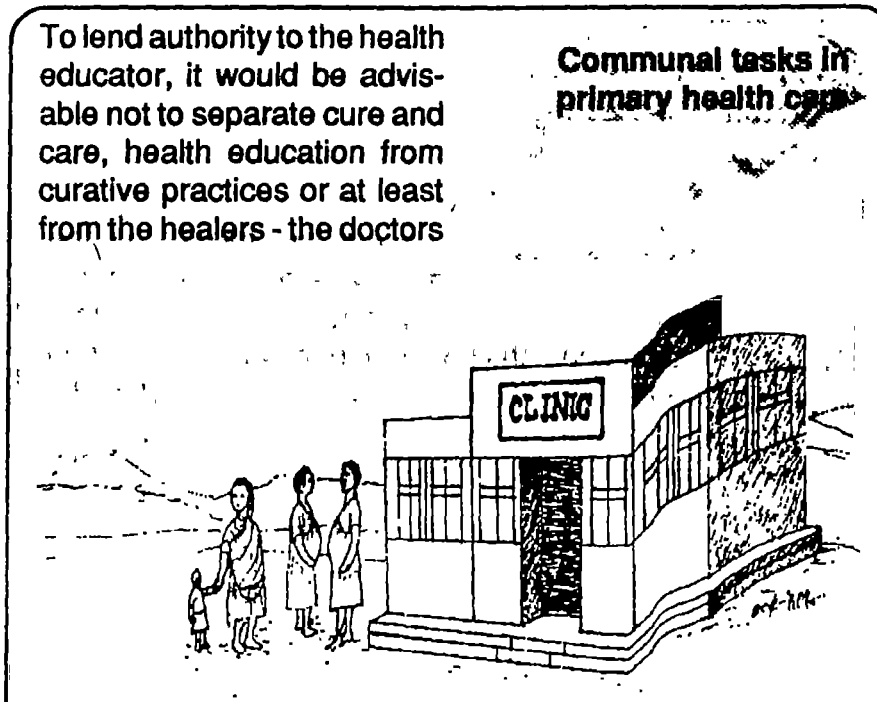
One special group to teach may be the mothers, who often function as (unofficial) health care workers in the family. The more they know the better they can perform this task.

The mechanisms for community participation in health care are often there. The challenge is to make the best possible use of them.

Tasks for health workers and the community in primary health care

Community participation often fails because community members fail to see what they should co-operate about. The first thing needed in our context is therefore health education.

To lend authority to the health educator, it would be advisable not to separate cure and care, health education from curative practices or at least from the healers - the doctors



and others who often have great authority in communities after they have been established long enough to prove their ability to cure. A doctor using scientific medical methods may be trusted and respected in the community - but for reasons that might horrify him if he knew about them (perhaps people respect him because they believe he knows powerful magic). If he lends his authority to the health educator, who is supposed to explain the principles behind the activities of the doctor (in simplified form, admittedly) - and also thereby to explain how the services of the doctor may be needed less frequently, people are much more likely to lend the health educator their ears and take the advice given than if the health educator and the doctor seem to work with no (or only a very tenuous) link between them. If the doctor has little time,

Tasks for the community in health care

he can at least introduce the health educator to people who are to be taught and thus demonstrate that they work together as a team and that care and cure are two aspects of the same work and that both aim at getting a healthy community. (What is said about the doctor above applies to all who do curative work.) It could be an opportunity for good health education to let (some) relatives be present during the therapeutic interview, as decisions about health may be family matters.

Some medical professionals should also be trained to use the mass media and learn to speak and write in such a way as to make sense easily for the broad masses. At the same time, it would be valuable to have some professionals who are working in the mass media to acquire enough special knowledge of medical questions and enough interest in this field to make good programmes or to write interesting articles.

For effective health education, it is useful to know and understand the totality of beliefs and customs a people have in relation to health and disease.

After some education has been given (and health education ought to be an ongoing thing in which the community itself should be involved), the community needs specific, concrete tasks to co-operate about in order to accomplish (although many tasks in the area of health and hygiene will be invisible co-operation as most such activities take place in the privacy of the home). To derive the greatest possible benefits quickly from community participation in health projects, it is often good to present possible projects to a community where community participation is needed for their completion, and then leave it to the community to come to a decision about them, based on felt needs. But so as not to leave it to chance and the whims of the moment or the place (or some strong individual) which projects should be taken up, some persuasion and explanation may be needed, especially in order to get local community activities in line with overall national development plans.

Among projects communities could be asked to participate in, several are mentioned below - their priority ranking will in practice often be decided by their relation to centrally decided development plans for nationwide co-ordination. After the presentation and adoption of concrete development projects, community leaders, women's groups, youth groups and community members generally should be trained in what is involved in the execution of community projects - to plan, initiate, finance, do accounting and reporting, implement, execute and evaluate projects. This will give a community the feeling and understanding that a project is their responsibility and to their advantage.

Some concrete tasks for the community in relation to health are:

- production of food that will ensure a balanced diet;
- building and maintenance of community clinics;
- building, maintenance and proper use of latrines;
- protection of water sources to ensure clean water;
- storage facilities that will protect and keep their food safe;

- organizing the people for immunization of all children;
- ensuring ongoing health education in the community;
- obtaining necessary health education materials;
- giving proper information about the benefits of immunization;
- motivating people to turn from magical to scientific medicine;
- selecting and supporting community health workers;
- identifying and getting training for traditional birth attendants;
- keeping the community clean (using sanitary guards?);
- encouraging personal hygiene;
- encouraging care with drinking water (boiling or filtering it where necessary);
- encouraging the growing and use of more fruits and vegetables;
- establishing health committees;
- establishing water committees to ensure proper use and maintenance of water sources;
- encouraging introduction of appropriate technology where it relates to health;
- building cattle dips to ensure healthy cattle, *etc.*

The community and the community health worker

The community health worker is a key person when it comes to increasing the understanding of health and the causes and prevention of disease in a community, and thus the activities and effectiveness of the community health worker will be crucial in raising the standard of health in a community. It is important to ensure fair and proper selection procedures of the community health worker to get full community support for his or her activities.

Support for the community health worker

To feel appreciated and to get encouragement to go on with the work, the community health worker needs certain incentives from the community. To find one's work rewarding, it is necessary to reward a person. But this can be done in several ways, and one has to consider several possibilities when the community is responsible for the keep of such a worker. It is not only money that can be reward for services. Where a community can afford it, cash payment to the community health worker may be the easiest and most satisfactory solution. But some communities may have so little cash that other forms of compensation for services rendered should be considered. Some communities have a surplus of goods produced in their workshops, and these could be used as payment (*e.g.*, cloth, furniture, agricultural tools, pots and pans, fuel efficient stoves, jars for water storage, *etc.*). If this is not possible or acceptable, one could agree to do communal work on the farm of a community health worker for as many man-hours as he/she does service in the community (but the hours of work must be distributed in such a way that people are at home when the community health worker visits in homes and also so that the community health worker can be present and see that work done on the farm is done properly). The fourth form of reward is symbolic - the giving of badges or caps or other symbols that make community health workers known for their function in the community. When health is discussed in community meet-

The community and the community health worker
How to involve communities in health care

ings, the community health worker should be seated close to leaders of the community, including the chairman of the health committee, and the work of the community health worker should be supported by these leaders (as well as by other officials) in speeches and introductions as well as in other acts of public appreciation and encouragement. It may be good to use this last kind of (symbolic) support in addition to one of the three first forms of reward mentioned (and combinations of the three forms of reward can also be used).

Other support of community health workers is to let them always have supplies of equipment and drugs supposed to be in their kit; to let them attend periodic refresher courses; to have them properly supervised (which should combine encouragement with necessary correction); to equip them with necessary teaching materials for their own reference as well as educational materials for use in community meetings, literacy classes, and home visits: books, flipcharts, readers, folders, posters, *etc.*; to train them in the best and most interesting ways possible; perhaps to consider ways of advancement (with two categories or grades, depending on years of service and excellence in work done). In remote and difficult areas it might be worth considering adding to their normal responsibilities by allowing them to do immunization and also by giving them some supervisory work which would normally be done by sanitarians and others (inspect or supervise water supplies, market cleanliness, public latrines, school health, *etc.*), but this can be done only in cases of shortage of personnel, so that their duties do not conflict with the duties of others. They should also be used as resource persons when health is being taught or discussed in literacy classes, women's groups, and even perhaps schools. The supervision of community health workers should not be left entirely to health assistants or regional health education co-ordinators or other outsiders but much of it should be done by the community through its health committee. But so as not to be negative, such supervision should be combined with active support, such as the building of a clinic with an office, *etc.*

Although the community health worker is the lowest on the scale of health promoters in a country, their work is crucial in the effort to raise the health standards of the people. It is therefore very important to give them all possible support and encouragement. This is one essential task where community participation is needed.

A strategy for community participation in health care

The main points to take into consideration in working out a strategy for community participation in health care are set out in the preceding discussion. Here follows a summary of these points with the enumeration of steps needed to be taken to involve the community directly in looking after, or caring for, its own health.

a. The community will need help to come to a proper understanding of how they can best look after their own health. This involves some initial teaching and awareness-raising activities. In addition they will need help to get organized,

e.g., to establish health committees, to select and get training for community health workers, and with the logistics of maintaining basic health services.

b. After such initial guidance, the community should be encouraged to start looking after communal health matters as much as possible: to reward a community health worker; to assess their own problems and needs in relation to health; to establish links with other health institutions in the area, and especially to establish regular links with all governmental health services where they can receive help; to find out about possible financial aid, assistance with training, extension or mobile services that deal with health problems, *etc.*

c. The community, preferably through a health committee, should organize itself to solve their health problems; *e.g.*, get guidance and support to provide adequate sanitary services and mobilize community members to solve sanitation problems through self-help; obtain basic medical facilities through their own initiative and efforts (build a clinic, get essential drugs, supervise the community health worker, work out schedules for health services and establish links with other service institutions for referral in emergences; organize for the immunization of all children, *etc.*).

d. The health activities in a community should be known to and be (made) the concern of the whole community and be assessed by them in periodic community meetings.

The community and health care

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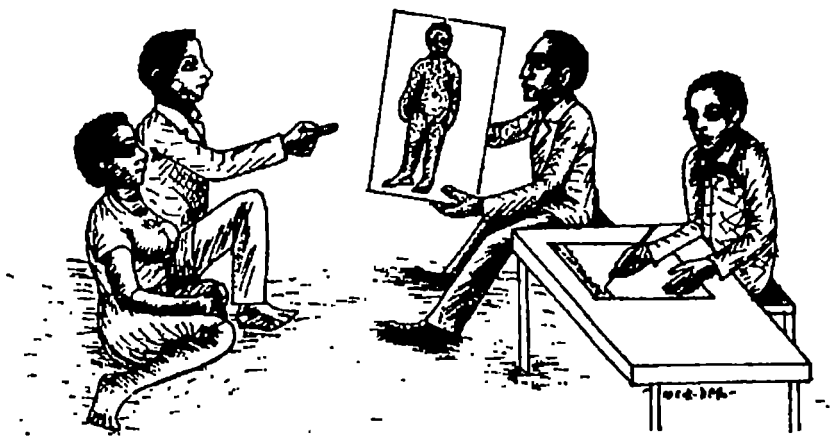
Appendix II

Pretesting of Teaching Aids in Health Education



If teaching aids are locally made, it may be good to pretest them before they are made in great numbers - it would be costly to have to discard them if serious mistakes are discovered only after they are ready for use. Even if teaching aids are made and distributed centrally from a ministry, it may be good to know something of the principles of pretesting, as teaching aids that have been pretested and found acceptable to the majority may for some reason be rejected by small groups, for example if people there find a picture offensive, or they may think that some pictures themselves can bring disease - our audience may be at any educational or cultural

level. It is good to respect such "prejudices" and teach people in ways and by methods that are acceptable to them.

Pretesting teaching aids

Pretesting of educational materials is done

- to find out if our materials communicate what we want to communicate, and
- to eliminate as many errors or offensive or misleading points as possible.

To test such materials, we must first define whom we want to teach by means of the prepared (or drafted) materials (our target audience). Then we try to find a few small groups (a sample) that may be as close as we can conveniently find to the larger groups among whom we intend to use the finished products. The sample group should have approximately the same culture, health practices and beliefs, educational level, age and ecological situation as the target audience. If there are differences, these should be of such a nature that they would influence the effect of our health education as little as possible.

If the sample is representative (*i.e.* nearly like the target audience), we can obtain much useful information about the appropriateness of our health education materials (maybe it does not meet any real or seriously felt needs), and about their attractiveness, acceptability and intelligibility. We should pretest

- the colours (are they liked or disliked?),

Stages in pretesting
Procedures in pretesting
Evaluation of pretest results

- the drawings, (do people understand them or see what we want them to see), and
- the words/the texts.

Sometimes it is good to pretest the pictures alone, and then again when the text is added. If the illustrations are acceptable and understood, the words may be too difficult, too technical, or just not used in an area. The local language should be used when possible, and if another language is used (*e.g.*, the official national language), it is particularly important to use simple language.

If models or puppets or some other means or teaching aids are used, the pretesting procedure is similar. Slides, films, even demonstrations may also have to be pretested in similar ways. It may be good to do some simple pretesting among colleagues or friends before a sample is selected for more systematic testing. Some weaknesses can be eliminated even before going to the people, and if it is tested among colleagues, some professional advice may also help to improve our teaching materials.

So as to make the testing as uniform or consistent as possible, it is good to make a questionnaire - write down the questions beforehand - so that each person is asked the same questions in the same way. This makes it easier to write down the answers and later to interpret (or analyse or code) them. A separate questionnaire (which should also be pretested) should be used for each person with whom the materials are pretested.

Before people are allowed to pretest materials, they should be properly trained: The process must be explained to them, and then they must be allowed to do some mock tests before the real testing starts. People who conduct pretests must understand the materials and how they are to be used, so that they can evaluate questions and answers intelligently. Mostly pretests are held in the form of interviews, and people should be interviewed in such a way as to be put at their ease - they should be given a feeling of being right (if they misunderstand a picture or a written or spoken message, the fault is with the teaching aid - not with the person who expresses an opinion), that they are helping to improve teaching aids and methods, and that their help is wanted - not to ridicule them or show up their ignorance. Interviews must therefore be relaxed, friendly, and easy for all to understand. Interviews should be short so as not to tire people, and only a few teaching aids should be tested at a time (*e.g.*, a few pictures such as a series of flipcharts).

When 20 to 50 interviews have been conducted concerning the same materials (20 is enough if most people give similar replies, but up to 50 may be needed if their replies vary considerably), the answers given must be analysed. If the replies are similar (uniform or consistent), the analysis (coding, interpretation) is easy, but if the replies vary a lot (are not consistent), the analysis may be more complicated - even sometimes so difficult that a new series of pretests may be advisable. If we have clear indications that our teaching aids are good or bad, we must make the necessary changes before we finalize our materials. If the changes are many and great, it may be necessary to pretest the changed materials to find out if the changes are real improvements. We should

not prepare materials for the printers before the materials are pretested, for at that stage, the people involved in preparing them (artists and writers) may be reluctant to make changes. The people who have made the teaching aids should not pretest their own products, as it is often found that they are defensive about their work and are reluctant to accept suggestions for improvements.

Particularly if materials used (even successfully) in one country are adopted (or copied) for use in another country (or culture), it is particularly important to carry out pretests. What is suitable in one country (*e.g.*, in its country of origin) may not be so good elsewhere. It is preferable to make teaching aids in the country or culture where they are to be used.

Use of original materials

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Appendix III

A Theoretical Framework for a Health Education Strategy

In order to work out a health education strategy, one should start by defining one's objectives.

The objectives of health education are:

1. To help healthy people to stay healthy;
2. To help people who are frequently ill to be ill less frequently (ideally never);
3. To help people who suffer disabilities (without being actually sick, *e.g.*, the undernourished) to live healthier lives;
4. To help people to learn enough about disease to detect impairments to health early, so that treatment can start early;
5. To help people to know enough about existing health services to seek the best means of cure;
6. To promote effective rehabilitation;
7. To decrease infant and child mortality and increase life expectancy.

Health education is part of a process to preserve or improve health. The state of health depends on the health related behaviour of people, and health education encourages health-promoting behaviour.

How to plan health education interventions

Problem identification

One does not start a health education programme by consulting text-books only, teaching anything that one finds there in relation to health. After acquiring adequate health knowledge, the next stage is to make health education relevant to the situation of the people one wants to teach good health behaviour.

Effective health education proceeds along these lines:

1. First one must *identify the health problems* of the people one wants to educate.

   This requires that one collects sufficient relevant health data about a community/area from available sources, or if such sources are not available, one finds out through independent research in the area.

   Existing information can be found in local health institutions, ministries of health, central statistical bureaux, in libraries if the area has been researched, *etc.*

   If it is necessary to conduct independent research, one has to learn something about research methods. To find out about the health situation of the people, it may be best to formulate a questionnaire based on known facts from other areas. Thus one could ask questions about the incidence of diarrhoeal diseases, eye diseases, helminthiasis, skin infections, acute upper respiratory diseases, venereal diseases, malaria, tuberculosis, *etc.* When in-

Stages in a health education strategy
Analysis of health problems and remedies

vestigating the health situation of young children, one should find out about the occurrence of measles, poliomyelitis, tetanus, pertussis, in addition to diseases mentioned above. One should add questions relating to diseases in neighbouring areas, or if these are unknown, one could ask questions about health problems known to exist in ecologically similar environments. When investigating nutritional problems (malnutrition and undernourishment), one should learn techniques of precise measurements and collect data by observation rather than by interviews alone; but observation should be supplemented by questions about what people eat, the frequency of meals, as well as the incidence of diarrhoeas and helminthic infestations.

Environmental health and epidemiology departments can often give helpful suggestions about the probable health situation of an area on the basis of comparative data even when no precise statistics exist - in addition to more exact data they may have collected. These sources of information and professional advice should be exploited.

2. One should follow up the information obtained with *investigation of sources of the health problems.* These sources can (broadly speaking) be of two kinds: ecological or behavioural (or both). The ecology or environment can tell about scarce food resources, difficult access to information or health services, endemic diseases due to unclean water sources or the prevalence of malaria-carrying mosquitoes, *etc.* Health related behaviour will tell if people are using their potentials to the full, whether personal or ecological: harmful health beliefs or practices as well as under-use of the natural environment both affect health. Economic status is influenced by both the environment and one's use of it (*e.g.*, poor agricultural techniques), and in turn, economic status is related to health. Ignorance is not the only behavioural obstacle to good health - even people who get good health education may be slow to change their health behaviour. The health educator should find out about both social and cultural constraints to good health behaviour, and to this end he should study people's health beliefs and traditions relating to health. Then he should devise his health education methods accordingly.

3. The next step is to *decide on appropriate remedies of the existing health problems.* The health educator should not think in terms of information only but should first of all study how he can start and follow through an educational process leading to changes in health related behaviour. Motivation and the giving of adequate and correct information are necessary parts of this, not only initially but all through the process of change; that means that health education must be a continuous process, accompanying a continuing process of behaviour change. To obtain the desirable link between knowledge and behaviour change, health education should as often as possible be given in connection with concrete, practical measures that could, should or must be taken to improve health. This can involve, *e.g.*, preparing, accompanying and following-up an immunization programme with adequate health education in relation to immunization; the motivation of people to build, use and maintain latrines (and keep them clean) can

be combined with practical instruction on how to make latrines, how to get professional help and perhaps credit to construct them; this should go together with education about diseases due to poor sanitation; help to upgrade the environment should go hand-in-hand with warnings against using unclean water sources or allowing mosquitoes to breed in the surroundings of the home; *etc.*

But however effective health education is, people still fall ill from time to time. Health education should help people both to identify their health problems early on (if not precisely or fully, at least well enough to seek professional help), and to make the best possible use of health (curative) facilities. This may even include information on some basic drugs - people may be unwilling to go far and spend (much) money each time they (or children in the family) have diarrhoea or a bout of malaria, and in such cases self-care or home-care may be appropriate. Teaching about the prevention of accidents or (simple) First Aid, or the preparation of nourishing meals should be more than words - people should be helped to do what they are taught.

The methods one can use most effectively for health education leading to change in health behaviour which is conducive to better health is discussed in the main text of this manual.

4. Finally one should *evaluate the impact of the health education given and take whatever corrective measures that are necessary* to improve the situation further. Health education does not always have - perhaps rarely has - the impact hoped for. We have still not reached a stage when we can say we are very successful health educators. This should not discourage us but rather inspire us to look for ever new ways to give health education. When we see a clear trend towards improved health in a community which we have taught, it may indicate successful health education - but it can also be a result of expanded immunization, curative health services, better water supply *etc.* - or these in combination with health education. We need to be imaginative in health education, and use many approaches and methods - concern should guide us as much as theoretical knowledge. As we want our audience to change, so we ourselves may need to change. Only when people are living healthy lives have we as health educators achieved our goal.

Teaching people to solve health problems

Evaluating impact of health education

Two further points should be kept in mind:

1. The community should be involved as much as possible in the processes described above.

2. In practice, all the processes described above go on (or should go on) parallel all the time, involving different health problems and interventions.

Use this page for your notes

Appendix IV

The Declaration of Alma-Ata on Primary Health Care

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

The Declaration of Alma-Ata on primary health care
Health for all a human right

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

The Declaration of Alma-Ata on primary health care

Definition of primary health care

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

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

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and tech-

nically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * *

The Declaration of Alma-Ata

Policies, plans and cooperation to attain health for all

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

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