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DEVELOPMENT OF HEALTH EDUCATION IN SOUTH-EAST ASIA

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PREFACE

The magnificent Opera House of San Francisco, USA, presented in 1945 what must be considered the most significant event of its history when it served as the venue for the signing of the United Nations' Charter.

To those who witnessed this "new beginning" in the endless struggle for peace and well-being, it was an experience of intense drama and high hope.

In no action of the new undertaking did the reality of its purpose stand out more clearly and concrete steps to achieve it appear more meaningful than in the establishment of the World Health Organization (WHO) as a specialized agency of the United Nations in 1948.

In its Charter and in the commitment of its leadership, WHO provided to nations old and new, to people young and old, a glowing example of the ideal of peaceful international collaboration directed to the betterment of the human condition everywhere.

True to this commitment and to the action required to meet it, the WHO secretariat in Geneva established, as an integral part of its first team, a section on Health Education of the Public. Under the able leadership of Ms Helen Martikainen, this section was to become the conscience and vanguard of the need for public health to focus on people in communities, on total quality of life, on efforts to help people learn that which would improve and enhance their own action for health. It saw this not as a matter of strategy but as an expression of value.

Nowhere was this philosophy and all its implications for action better or more wisely stated than in the report of the First Expert Committee on Health Education which met in Geneva in 1953.

As harbinger of that which would take two decades to permeate the whole of world public health, it said:

"The aim of health education is to help people to achieve health by their own actions and efforts. Health education begins therefore with the interest of people in improving their conditions of living, and aims at developing a sense of responsibility for their own health betterment as individuals, and as members of families, communities or governments.

Health is but one of the elements in the general welfare of the people, and health education is only one of the factors in improving health and social conditions. It is, however, an indispensable factor and should therefore be integrated with other social, economic, health, and educational efforts."

But to convert such rhetoric to action required more than could possibly be managed from a central headquarters situated in a highly developed and tranquil city. The real work of the Organization was not to be achieved in Geneva, but through regional offices that could function within the possibilities and realities of the conditions of which they were part.

And thus the capital of a new nation became the central focus for action in a region of new nations when the South-East Asia Regional Office (SEARO) was established in New Delhi.

From this office, housed at first, ironically enough, in the Delhi estate of a Maharaja, were to emanate some of the most exciting initiatives for international collaboration ever attempted and, at the same time, the earnest commitment to serve to facilitate and not control or direct the development of national health services. From those first days to now, these policies have remained firmly in hand.

It is against such a background that the main theme of this paper is set in place. The story of health education in South-East Asia, even in the profile which can only be outlined here, is perhaps most of all the story of the development of new awareness of human potential and renewed emphasis on freedom from arbitrary control and dependence.

The major tellers of this story should by right be the actors who wrote, directed and continue to play out the drama. These include at a first level the sequence of distinguished health educators, who, through their commitment and vision, their perseverance and empathy, successfully inspired an entire region to take up the challenge of health education: Vivian Drenckhahn, Annie Ray Moore, Venkatram Ramakrishna, C.H. Piyaratna and S.H. Hassan. Each has in turn had a place at the helm, each playing some small part in the effort to move millions of people closer to what is now called "Health for All".

However important the regional role, the major figures in the drama are those stalwarts at the national level who translated intention to action, words to deeds. These pioneers include, but cannot in any way be limited to: Mr Siri Dengalle of Sri Lanka, Dr Wirjawan Djojogugito of Indonesia, Mr Mohammed Moizuddin of Bangladesh, Dr V. Ramakrishna of India, Mr U Min Swe of Burma, Dr Yupa Udomsakdi of Thailand. Among those to whom the torch subsequently passed are Mr Nazrul Islam of Bangladesh, Dr Ida Dabagus Mantra of Indonesia, Dr Tilak Munasinghe of Sri Lanka, Dr Bhem Sehgal of India, Dr Somjit Supannatas of Thailand... and many others.

All these leaders, those named and unnamed, known and unknown, those recognized and those as yet undiscovered, moved a region from a standing stop to rapid locomotion in an achievement of considerable scope. South-East Asia has led the way to Alma-Ata and to the year 2000. This is a synopsis of that story: a loving reminder of all who were a part of it and the countless workers and citizens in whose heart and hands rests the hope of public health so beautifully expressed by the American public health leader and educator Milton Rosenau.

"Public health dreams of a time when there shall be enough for all and every man shall bear this

share of labour in accordance with his ability, and every man shall possess sufficient to the needs of his body and the demands of health. These things we shall have as a matter of justice, and not as charity. It dreams of a time when there shall be no unnecessary suffering and no premature death, when the welfare of the people shall be our highest concern, when humanity and mercy shall replace greed and selfishness, and it dreams that all these things shall be accomplished through the wisdom of man. It dreams of these things, not with the hope that we individually may participate in them, but with the joy that we may aid in their coming to those who shall live after us. When young men have vision, the dreams of old men come true."

INTRODUCTION: PROFILE OF THE PROFILE

Health education development in South-East Asia cannot be characterized as a "straight line" process. Indeed, if pictured graphically, the state of the art could well be represented by peaks and valleys - ups and downs - periods of rapid growth and periods of deceleration.

From the mid-1950s to the mid-1960s, much of what is now foundation was put in place amid high excitement and great expectation. But with the lack of quick results, and with health and social problems clearly more intractable than the early optimism had suggested, some degree of retrenchment in areas such as health education, which were based on the premise of a substantial development period, was inevitable. There is less administrative and political support, unhappily, for processes which are slow, cannot promise miracles, shun fanfare and do not utilize high technology. Although the overall enhancement of health education continued, it sometimes was pushed to do so in the context of campaigns and as part of highly centralized single-purpose programme in which one-way communication was heavily emphasized. During the same period, the entire health field was subjected to lower priorities by developmental policies which laid less emphasis on human resource enhancement.

But the logic and wisdom of integrated, community-based, people-oriented public health - the basic context of health education - gradually reasserted itself.

The two significant milestones which mark this resurgence were: (1) The 1974 resolution of the World Health

Assembly which requested the Director-General "to develop ways and means of providing additional support, including manpower and funds, for the Organization's programme of work in health education in accordance with available budgetary resources, taking into account its essential role in programmes for socio-economic development", and (2) the historic Declaration of Alma-Ata in 1978.

Events of the decade which followed Alma-Ata leading to WHO's fortieth year have brought increased attention to what has always been the domain of health education - community participation, self-reliance, people-centred action, the values of human development and social justice.

In the following pages, an attempt is made to highlight health education development to the year 1988 using selected key content categories as the framework for presentation¹.

For some aspects of the profile, much detail is possible with fine shadings and good contrast available - almost a portrait.

In other aspects, the profile may be less detailed with the general outlines clear and the subject recognizable to those with some familiarity.

For some items, a few strokes are all that is available. A stick figure is perhaps close to what emerges.

It should be understood that this review focuses on the organized health education system and the work of health education specialists, managers and teachers. Health education as a process occurs in an infinite variety of

¹The profile is based on the programmes which have developed in the national efforts of Bangladesh, Burma, India, Indonesia, Nepal, Sri Lanka and Thailand. Efforts which will surely result in a viable health education system have been more recently under way in the remaining countries of the South-East Asia Region, viz., Bhutan, Democratic People's Republic of Korea, Maldives and Mongolia. Except as specifically mentioned, however, they are not included in this profile.

situations and is a primary responsibility of all health development workers, and community and family leaders. The main aim of the health education system is, in fact, to create, nourish, support and extend health education purposes at all levels and in all reasonable circumstances. The relationship between the two deserves, and hopefully will be separately discussed in a future paper.

Forty years of international life are hardly more than a preparatory moment. As health education charts its course for the decades ahead it can do so with what can fairly be called its "adolescence" behind it and its full maturity ahead. It moves ahead with its value-base intact, its conceptual framework becoming ever more relevant to the cultures in which it relates and functions with practitioners who take pride in their increasing competence in the application of what we know to what we do.

The most important element of the health education profile of the South-East Asia Region is its reaffirmation, in the words of the Regional Charter for Health Development of:

"... our faith in the dignity and worth of the human person, and in the fundamental right of every human being to the highest attainable standard of health. Furthermore, we have implicit faith in the indomitable spirit of man, in the inexhaustible creativeness of the people and in their infinite capacity to work individually and collectively to usher in a better quality of life for all."

ESTABLISHING THE FOUNDATION

2.1 POLICY AND FOCAL POINTS

The foundation for any serious developmental effort is acceptance of the goal as social policy, the political will to achieve it and the material and human resources to pursue it.

The countries of the South-East Asia Region have, without exception, supported health education as an imperative need in social and health developmental processes. Although there are - in health education as well as other areas - large gaps between the stated purpose and implementation, one important indication of policy-in-reality is the presence at the national level of a focal point for such effort and the leadership to manage it.

In the countries of the Region, such focal points have been put in place within the health service organization.

The Central Bureau of Health Education in India, under the leadership of V. Ramakrishna, was an early prototype which established a form and spirit for the Region as a whole. Burma, Bangladesh, Indonesia, Nepal, Sri Lanka and Thailand all acted positively in creditable efforts to meet the challenge.

In Indonesia, health education was for some time a component of a comprehensive Centre for Health Education and Training. The unit has since been converted into an independent Centre for Health Education. Policy support for health education in Indonesia has been strong and consistent.

The health education manpower development effort of the 1970s remains a high point of concerted national action.

With the exception of Thailand, and more recently India, the central units of the South-East Asia Region are directed by individuals who meet the international standard for health education specialists. In the cases of Indonesia and Sri Lanka, the directors are also physicians.

Staff of the units are consistently well qualified with formal health education preparation or appropriate qualifications in the speciality areas for which they are responsible. The Master's degree, with speciality in public health, remains the basic qualification and is supplemented by science, communication and education, to name a few.

The central units function, in all cases, in support of national programme, in providing training and in information dissemination services. They, perhaps most importantly, are committed to the development of an organized national system in which competent units function in state, provincial or divisional levels as well as the "districts" into which the larger units are divided.

All central health education units, as all central health services, have a number of categorical, subject matter or high profile problem areas to which, by policy, they relate by providing health education consultation, training or service. Malaria, tuberculosis, family planning, environmental sanitation are examples of familiar national programmes to which health education has made significant contribution.

If a programme is large-scale, it will have its own health education unit, the most prominent example being family planning.

In order to avoid territorial conflict with established health education programmes or to be independent of technical oversight, many of these free standing units utilize titles such as "communication", "information", "publicity", to name a few. In most cases, however, the function is education in the broad and clear sense in which that function has been spelt out in public health. Although the work carried on may be of good quality, the fractionation of health education

action and resources tend to hamper needed efforts to develop comprehensive and interrelated systems for educational components of public health management.

2.2 COUNTRY-WIDE HEALTH EDUCATION SYSTEMS

There is much attention in development concepts to the need to create "infrastructures" - to establish the basic conditions that will allow the initiation and sustainment of action.

Yet infrastructures are meaningless if they do not lead to goal-directed activity. The failure to utilize an infrastructure which has been elaborately developed is not uncommon - buildings which remain empty; projectors without film; workers without resources; clinics without medications.

The most important and continuing need in health education development is, in this sense, the proper maintenance and utilization of the central infrastructure which has been put in place. It is only in this way that health education can maintain a primary health education focus on authentic efforts which support community-level programme.

It is disquieting to note that many programmes at the central level become internally focused, functioning largely in staff roles within the central organization and frequently becoming confined to desk and office.

Such outcomes are far from the scope to which health education as a field addresses itself. Every country health education system development plan has, on paper, committed itself to a hierarchical development with health education foci at each of the administrative and management levels in which the country is organized.

The overall India plan provided for Health Education Bureaus at the state level which would, in turn, establish units at lower levels.

Indonesia undertook an ambitious health education manpower development plan in the early 1970s, a major thrust of which was to staff the regency and local units.

Although there has been a strengthening of the network in recent years, it is a process which continues to require priority attention as part of comprehensive efforts to reorganize health service systems. Recent WHO proposals to strengthen "district" organization and management is further indication of the need.

Highly centralized management of health services, which generally function best as categorical or vertical programmes, has created "top heavy" mechanisms in which peripheral units are seen as implementors of central policy and procedure. Under such conditions the system develops one way contact and communication. Although concepts of primary health care took form in efforts to reverse this flow and make higher level groups supportive of initiating efforts from "below", such a change faces restraints which are rooted in convention and struggles for control.

Indeed, because primary health care development can be characterized with values, concepts and methods akin to those of health education, it faces in its growth and development the very same problems which the field of health education has faced. This is so because it runs contrary to the conventional authority structure of public health, because it emphasizes social rather than biologically focused science, because the methodology it proposes reverses the flow of communication and decision-making and because it places health in a broader intersectoral context. As much of our history tells us, the internal organizational implementation change process is sometimes surprisingly slower than the policy change process.

All of the central units are aware of, and, in one way or another, strive to develop some kind of countrywide network. In India and Indonesia, from the centre to states to sub-areas; in Bangladesh, from the centre to divisions to newly formed upazilas; in Sri Lanka and Burma, from the centre to districts; in Thailand, from the centre to regions to provinces and smaller sub-divisions.

Although there are some very bright examples of community-based functioning, Korat in Thailand, Banjaranegara in Indonesia, Gandhigram in India, this issue will remain as a high priority concern for the fifth decade.

2.3 MANPOWER DEVELOPMENT

Health education manpower development has been a truly impressive regional "success" story.

Early leadership was provided through a select group who received specialized training abroad, mostly in the USA. Although participants continue to be sent abroad, indigenous health education training programmes were initiated to establish the critical mass of professionals needed.

A pioneering certificate course, developed by the All-India Institute of Hygiene and Public Health, became the prototype for first-level preparation in India, Sri Lanka, Burma, Bangladesh and Nepal. Recruits for these courses were first drawn from existing health cadres (medical, nursing, sanitation). In a later development, recruitment has expanded to provide for a wholly new group to enter the field - individuals with preparation in social sciences.

With the experience of short courses to build upon, the Region was witness to a veritable explosion of postgraduate health education specialization beginning in the mid-1960s. First, the Diploma courses in India at the All-India Institute of Hygiene and Public Health in Calcutta, Central Health Education Bureau in Delhi and Gandhigram in Madras. This was followed by Master's level courses in Jakarta, Bangkok, Sri Lanka and Bangladesh. The Region now has a capacity to prepare over 100 postgraduate specialists annually.

In the Intercountry Meeting for Professional Preparation in Health Education, held in New Delhi in 1980, it was concluded that the countries of the Region have "demonstrated that there is now a critical mass of experience, wisdom and resource to make possible postgraduate programmes of increasing complexity, quality and relevance".

In the almost full decade which followed, the context provided by primary health care pointed to important new directions. The effort to take such a new direction and move more forcefully to meet the hope of HFA cannot yet be said to have been spectacular, but it is substantial.

In a follow-up regional meeting on postgraduate preparation held in Jakarta in November 1985, the regional training programmes had another opportunity to share interests and progress in moving to more relevant instruction for health education specialists and others. These efforts, if they can be developed in a spirit of collegial collaboration as a form of technical cooperation among developing countries (TCDC), deserve a high priority. The development of an Asia-Pacific Academic Consortium for Public Health provides an illustration of a framework for joint action.

BUILDING THE PROGRAMME

3.1 INFORMATION DISSEMINATION

Responsibility for the dissemination of accurate, timely and, when appropriate, persuasive health information is the oldest and most recognized component of health education.

A majority of the central health education focal points throughout the Region developed from publicity sections of one kind or another and the function continues to be a significant aspect of their work.

The integration of "publicity" into a broader framework of health education has not always been smooth.

Health education specialists tend to view the achievement of goals in terms of social and behavioural objectives and believe that desired outcomes are a result of many interacting factors of which information dissemination is an important but not exclusive element. Administrators and programme offices often, however, appear to have greater confidence in the impact of media acting alone than do many professional health education managers and communication specialists.

The glamour and visibility of the mass media provide a formidable incentive for their utilization. The large investments in equipment and the ever-present role of media in commerce and political affairs often lead to inferences

about impact on health-related behaviour which have never been confirmed. The obvious social and interpersonal magnetism of newer communication media, particularly television, adds to their attractiveness to human service workers.

The debate, which sometimes becomes strident, is not really "either" this "or" that, but the choice of communication processes in relation to specific purposes, audiences and nature of the change problem. Policy decisions relating to resources and personnel frequently are characterized by decisions relating to methodology without appropriate attention to purpose or possibility.

As a professional field, health education is clearly defined by the fashion in which has been integrated a range of concepts drawn from a variety of human experience and academic sources into something approaching a meaningful whole. A major element of this concept is to focus on the person with a problem rather than, as discussed above, rationalizing the approach to suit the methods available.

The skills which have become part of this "whole" are soon discovered by harrassed administrator-managers to be of use in a variety of situations. "To communicate", "to inform", "to facilitate", "to develop teamwork", "to involve citizen participation" are each, after all, essential to organizational life. Although an individual enters an organization with skills bound together in a value framework of health education, it may not be long before he is required to separate his skills from the health education context and harness them to some other ends. Whether such other purposes are important or unimportant is a moot point. The fact is that communication skills which are utilized without a value and conceptual framework grounded in public health are not part of a health education thrust although they may be represented as such.

The pull and tear of various approaches to "information", "education" and "communication" will continue to present both a problem of conflicting roles and goals and an opportunity for integrating available resources in a unified goal-directed effort. Administrative solutions which create marriages of convenience to meet short-term organizational needs are not likely to serve long-term social purposes.

Beyond the issues of the role and function of mass communication, all health education programmes are heavily involved in the production and distribution of printed material and support, where feasible, of efforts to utilize radio and television. Contacts with the press are often a responsibility of health education although the scope of such duties varies from country to country.

The use of indigenous information dissemination methods - plays, puppets, dramas - has been successfully undertaken in all the countries of the Region.

The health education units have played a creative role in pioneering pre-testing as a means to relevant material production and in efforts to involve people themselves in the production and utilization of material.

The implications of large, illiterate populations in the countries of the Region has been a constant concern of the health education group and has reinforced efforts to try to understand the information-giving process in terms equal to the challenge of primary health care.

An important focus for the extension of information dissemination resources has been the efforts to involve journalists and professional information specialists in health promotion efforts. In the same vein, information specialists in agriculture, education and related government agencies have, in the spirit of primary health care, been increasingly stimulated to make health messages an integrated part of communication with their constituencies.

Many of the issues summarized above were aired at a 1983 intercountry workshop. Among the many recommendations, the following deserves special underlining at this point:

"Integration should be seen as merging related aspects of information and education for the achievement of common goals, without sacrificing agency or professional identity. This means that information and education will have a common content of messages, while the personnel concerned with information or health education will work independently."

3.2 SCHOOL HEALTH

The school health focus of health education in the Region has been a salient characteristic from the very beginning of the period under review.

Although school health education is normally not a direct function of the health organization, support for activity in this area quickly became and remains a priority.

The basic plan of the Central Health Education Bureau in India included a "Students' Health" section as did the prototype put forth for each state.

Thailand has several baccalaureate programmes in the school health education area and within the past few years established a master's degree at Chulalongkorn University. The Mahidol University M.Sc. course has enrolled a large proportion of its students from teacher training institutions.

Every country has focused on the health components of teacher training and the role of the teacher as "health educator" through workshops, curriculum development, faculty development, participation in teaching and development of texts and teaching-learning aides and demonstration programmes.

Health education curriculum development has been actively stimulated through national conferences, regional meetings and assignment of short- and long-term consultations.

In recent years, the important potential role of the school in primary health care has been recognized and has resulted in renewed attention to the teacher and the school. Special attention is particularly noticeable in pilot programmes in countries, such as Thailand, where the teacher's role in community-based efforts is actively promoted.

The "school health" area has also been a subject close to the mission of UNICEF and UNESCO, and regional and country efforts of WHO have been coordinated where relevant with these sister agencies.

3.3 COMMUNITY DEVELOPMENT

No phase of health education exemplifies more the unique tradition which the field has developed over the preceding half century than its commitment to community development as an educational and health development process. There is hardly a serious report or contribution to the field in which this aspect is not implicitly or explicitly understood as a foundation of the entire health education enterprise.

The obvious paradox is the fact that the specialist does not often function at the community level. What every organized unit has attempted to do, therefore, is to stimulate community organization and participation through the training of all health workers and the utilization of special categories of personnel specifically put in place for this purpose.

In Sri Lanka, midwives and sanitarians are community organizers of some skill under the guidance of the Health Education Bureau. Also, the concept of citizen community organization volunteers to assure participation has developed on a large scale. Thailand has experimented with various approaches to community involvement through the use of health communicators and health volunteers. In Burma and India, health education has utilized community policy-making groups as a channel for participation. In Indonesia, nongovernmental organizations have played a key role in participation initiatives.

The heavy emphasis on relationships within the community by the health education profession has led to a strong emphasis on field experience as part of professional and specialist training programmes. Field training centres are part of the health education programmes in all the training programmes of the Region.

With increased attention to community participation as a cornerstone of HFA, there is what may be an unfortunate tendency to separate this process from the broader concern of health education. Indonesia is an example of this approach. Such separation has, in the past sacrificed long-term continuity for short-term gains. The 1983 Expert Committee Report on Health Education in primary health care

states the position which all the health education units in the Region attempt to support:

"Many health professionals tend to encourage people to want what they themselves think people should want, rather than attempting to understand the need of the individuals and communities and helping them to reach goals of their own choosing. This attitude, where it exists, perpetuates the elitist position of health care providers who make plans, define objectives and develop messages that aim at persuading people, thus creating a certain distance between health professionals and the 'receivers'. Yet, the objective should be to promote a dynamic interaction between health professionals and the general population, keeping in mind that the individuals and communities are not necessarily what the health professionals would like them to be."

"A people-oriented health technology will require a fundamental change in the relationship between the community and the health care providers. In essence, this implies that people will no longer be fitted into a predetermined framework of health care. Instead, the approach adopted will enable community members to play an active role in the planning and setting up of a health care programme."

3.4 HEALTH EDUCATION IN SPECIAL SETTINGS - HOSPITALS

Efforts to integrate curative and preventive medicine within the health services of the countries of the Region have been a persistent theme in health service administration over the past two decades. It is a goal which has been even more greatly accentuated with the emergence of the primary health care movement.

One of the most viable of the efforts to bridge the prevention-therapy "gap" has been the initiative to assure patient education an accepted and supported role in all medical care. In this concept, the education of the patient

is an integral part of the medical care itself and focuses attention on the need to involve the patient in his own care and to prepare patients and families to continue this responsibility in the post hospitalization period.

Outstanding examples of hospital health education are particularly apparent in Sri Lanka and Indonesia where this area has long been a concern of the central health education unit. In Thailand, the Faculty of Public Health has provided leadership and offers graduate instruction for those who wish to specialize in hospital-based health education. Some activity, however limited or sporadic, has been noted in all the countries of the Region. There is indication that the concept will be expanded in the future to view hospital and medical care educational activity in a primary preventive perspective with the target group being all members of the community rather than only patients. Although such concepts are only now in a developmental stage in the Region, they are likely to take on much greater significance, as they already have in Europe and the USA, as hospitals move from a purely internal to a broad community-wide frame of reference. The hospital as health education centre is an idea whose time may not be far away.

3.5 HEALTH EDUCATION IN SPECIAL SETTINGS - WORK PLACE

Rural public health work has always been concerned with the "work place" and its impact on the health of the worker and the family. In rural areas, however, work place is usually the agricultural field. Home and work are so inter-related as to defy artificial separation. With growing urbanization and industrialization, however, greater concern is shifting to the factory and industrial work place as the source of problems and a major entry point for prevention and health promotion. Although such efforts are sporadic, it is clear that there is growing interest among health educators and occupational health workers to have this setting more fully exploited for educational work. Thailand and Indonesia have already begun to lay the general ground work for a more comprehensive occupational health effort in both government and academic areas. This area will rapidly become a concern throughout the Region in which the competence of the health education specialist will be surely called upon.

3.6 RESEARCH AND EVALUATION

Evaluation and research activities are usually coupled together conceptually in that both processes utilize some of the same methodology. However, they represent essentially different endeavours and focus on different needs. All units in the Region include concern with both research and evaluation. In the case of India, there is a long-established section in the Central Health Education Bureau which has a fine record of positive service. In cases such as Bangladesh and Sri Lanka, research officers are posted within operational sections. In the following discussion, the two topics are treated separately.

Research

The research profile is clear in general outline but lacking in detail. All countries share the need and the desire for some research capability as part of most health education services.

Research, as most of the phenomena with which we deal, covers a wide and varied range of possibility, and the nature and direction of "research" reported, desired, or in process is not clear.

Health service agencies must focus on inquiry, which has more immediate application and utility with great importance attached to responding to questions of application and implementation. The universities are freer, and indeed obliged, to conduct inquiry of a broader scale in which conceptual advances, theory building and testing need be more the norm.

To a broad extent, these emphases hold true although there is much less reported conceptual development and theory building from universities than survey and observation.

The problems and opportunities have been thoroughly and intelligently aired at several intercountry meetings and technical consultations in the past decade. The status of research shows some steady improvement in the same period.

The higher education institutions have a fundamental commitment to research, and in India, Thailand and Indonesia, inquiry is continually under way. University health education programmes in Thailand and Indonesia provide emerging leadership in research action and preparation of researchers. The Department of Health Education, Mahidol University, Thailand, initiated, in 1986, a doctoral programme which will enhance the research capability of many organizations.

A difficulty in the area is that research, in whatever form, tends to be ad hoc to a particular grant or need and is generally not a part of a continuing developing pattern within a predefined framework. The studies tend not to be widely reported and are generally unrelated to each other. This observation applies to both within-country as well as intercountry contexts.

The separation between the broader research of the university and the more action-oriented needs of the services requires an interface which is not always present. Although the need for such strengthening of joint effort is understood and intellectually supported, much remains to be done to bring it about.

The report presented to the South-East Asia Advisory Committee on Health Research in August 1987 provides a detailed summary of the present status and an admirable approach to next steps.

Evaluation

Evaluation activities in health education mirror the same progress and problems, the same strengths and weaknesses of the field as a whole.

As a beginning frame of reference for this discussion, evaluation here will refer to efforts to develop and utilize mechanisms to assess progress in achieving goals and objectives in any phase of programme development - from planning to establishing the conditions, to implementation, to output, to impact.

The major progress in the evaluation area over the past two decades has been in the development and better

understanding of the evaluation concept and the development of materials, methods and personnel competent to design and carry out appropriate activities. How to do it, in general, is now more widely understood and the need more widely accepted than has ever been the case. How to put this knowledge and understanding to appropriate use within the demands and constraints of ongoing and usually undermanned programmes remains the key deficit.

Serious efforts are being made in all the countries to build evaluation into programme design. As with all action programmes, however, the evaluative aspect is usually insufficiently provided for in staff or fiscal resources. Most evaluation efforts are small scale and specific to single or limited undertakings.

Although specialists in evaluation have been helpful in recent years in designing evaluative procedures that can be undertaken by practitioners, the fact that evaluation is a process fraught with bureaucratic danger looms large in every agency. Although it may be intellectually accepted as important to know how well one is doing in achieving outcomes, it is also true that individuals and programmes feel at great risk when dealing with the possible consequence of data which may show that all is not going well. Evaluation more frequently than not serves a defensive purpose in resource allocation. Although such characteristics are not universal, they are common enough to be taken into account when considering the status of this aspect of development.

Among other implications which this human side of the evaluation process suggests is the fact that evaluative efforts are required to meet a variety of needs each of which may require different assumptions and data.

In a typical case, for example, we find that a health education unit may be concerned with meeting assessment needs which are related to at least five different constituencies.

- (1) The internal management perspective of the Bureau or Office of Health Education itself.
- (2) The departmental or broad agency perspective including both the intra-departmental and extra-departmental supervisors which we serve.

- (3) The policy-maker and "resource allocator" - internal or external.
- (4) The community perspective - the perspective of citizens.
- (5) The professional-ethical perspective, both as learners and educators.

Health education units which recognize the different perspectives and can keep data needs relevant to each in mind appear to do a better job in the area than those who have not learnt to differentiate.

Another significant observation is that evaluation frequently flounders because the assumptions on which the effort is based are not clearly articulated or tested. There are, for example, three types of situations each of which reflects a different set of needs.

Situation 1

The assumptions on which the intervention or action is based are clear and persuasive. They are part of a tested strategy and involve indications which have a demonstratable relationship to outcome or progress.

Situation 2

The assumptions are promising but do not hold up consistently. A broader variety of indications are needed and continued testing of the assumption is called for.

Situation 3

Assumptions are fragile. They are not well tested and probability has not yet been established.

When health education programmes recognize the situation correctly and act accordingly, they have more valid evaluative procedures. It is not uncommon to find situation 2 or 3 being treated as if it were a situation 1.

Every legitimate health education cadre should be prepared to carry out situation 1 type evaluation. Evaluative efforts of situation 2 frequently require consultation assistance and continuing development. Situation 3 is one which may be productively undertaken by a university or technical support group interested in evaluative research. Regional support in validating indicators is an important need.

IMPACT AND ISSUES

4.1 HEALTH EDUCATION FOR WHAT: THE QUESTION OF IMPACT

The impact of public health on the lives of people can be counted in many ways.

There are the big numbers which form so important a part of the way we talk to ourselves - rates, trends, cases, norms, indicators, beds, patients, manpower, and so on.

Although health education leaders are usually more cautious than others in claiming a share of credit when the numbers are good, it is a matter of simple logic to make such a connection.

Although the final glorious days of smallpox eradication are perhaps rightly credited to a relatively small and energetic group, it must be true that the foundation for this event of such historic proportion was painstakingly laid by a silent army of health educators which preceded and made possible the final events.

But even to a greater degree, the impact of public health and health education - aside from the visible successes - can be understood and appreciated only as people tell what has happened in their lives - and hopes. It is a story that will never suit the computer, the camera or the public relations brochure for it does not fit their language or purpose or format.

It is those who sit for a time with villagers anywhere in Asia - with children in any school, with mothers in any city, those who sit and talk, who take time to listen - who have the best chance of understanding where health education and public health have had an impact, and where it has yet to be given a chance. If we wish to judge impact, we must learn to do so in the lives of people.

Health education is a supportive, facilitating, enabling process. Education without action is not relevant to public health; action independent of learning is irrelevant to education.

Educational evaluative considerations focused on impact - on actual significance in problem-solving - cannot yet be easily directly measured except in the most simplistic and obvious cases. One approach to the question is to look first at the broader outcomes to which health education is a contributing partner. When such outcomes can be described, the subsequent analysis of assessing the extent to which the presence or absence of an effective health education component was significant can be undertaken.

For example, the mid-point assessment of Health for All, presented to the Regional Committee for South-East Asia in September 1985, reviews socio-economic and development trends, government implementation and health status. Health education is an integrated part of each of these areas of analysis.

Changes measured in terms of key indicators in these categories, such as infant mortality and life expectancy, do show positive trends but not yet precise achievement. The identification of outcomes and the analysis of the relationship of intervening factors is a historically complex problem the solution of which is not easily anticipated. Health education certainly does not stand alone in its desire for definitive impact data or the realization of the gap which is present between the hope and the reality of measurement.

It is also true that, inasmuch as health education is rarely an exclusive determinant of outcome, the health education objective can be achieved but the overall objective remains unreached. People can, for example, know how and what to act in desirable ways, but remain without the resources or services necessary to do so.

The following statements from a 1986 World Health Assembly report provide a clear focus for the task ahead.

"The ultimate impact of the health-for-all strategy must be measured in terms of improvement in the health status of the population. For most countries, it is too early to measure this impact in terms of overall reductions in mortality or to attribute any improvement directly to national efforts. Nevertheless, changes measured in terms of the key indicators like infant mortality and life expectancy show trends towards better health in a majority of countries."

"A notable feature of the recent past is the re-emergence of politics and measures to reduce poverty and inequity through the expansion of "basic needs" services. The effects of such policies enunciated in many countries will generally not be felt in the short term. But equity and basic human needs must remain the primary concern of social development strategy."

"Much of the evaluation is focused on processes which have been developing or were set into motion since the adoption of the health-for-all strategy. Information related to such processes is generally not quantifiable; their real effectiveness in the absence of specific methods or procedures is difficult to ascertain. Yet the evaluation has yielded useful information which forms the basis to assess achievement in terms of effectiveness and impact over the past few years and led to a clear recognition of what was not being achieved and the formidable task which still lies ahead."

4.2 FOCUS ON ISSUES

A number of inter-related issues form the central core of problems which thread through the profile of the health education status in the Region. Many of the questions this analysis raises relate to public health development as a whole.

The issues summarized here are not likely to be open to simple solutions or quick resolution. They certainly, except for discussion, cannot be separated from the same issues which exist in the larger context of public health and developmental planning and action or from each other.

The dilemmas posed by these issues represent major constraining factors in the planning and management of educational services in public health. Although the conflicts are most visible when they take the form of disagreements between disciplines, they are also often seen within the health education group itself.

The extent to which these differences can be wisely resolved may well determine the extent to which the promise of health education can continue to make the contribution required of it for the 21st century.

These common issues are presented in six groups: (1) Differing perceptions of scope and purpose; (2) Varying etiological perspectives for the understanding and diagnosis of problems; (3) Conflicting strategies for planning; (4) Methodological disagreements; (5) The ambiguity of educational role definition in public health, and (6) Inconclusiveness in the search for a common understanding of "health".

(1) Differing Perceptions of Scope and Purpose

It is inevitable that a process so complex and mysterious as that of human learning and change should have many interpretations and be the subject of many different value judgements.

And so it is that each of us, whether we view the process from the perspective of value, concept or method, bring different meanings and purpose. These differences tend to be accentuated in systems, such as acute medical care, where the action of the patient is seen as less important than the acts of the practitioner. Thus an educational concept which seeks to empower the person with the problem, and which seeks to sharpen his own decision-making to enable him or her to take charge of his own affairs, runs contrary to the goals and purpose of systems geared to do things for

people. Although "cooperation" is a frequently-stated goal, such cooperation in public health practice commonly turns out to mean that a patient or client or member of a community complies cooperatively with the practitioner.

The pressure to accomplish certain specific objectives leads to pressure on people to do the kinds of things which will make such system-generated goal possible of achievement. When the needs of people and the needs of the service system coincide, education is a valued process. When there is divergence in goal, however, the meaning of education tends to be distorted to meet the system's goal. Educators may then be asked, or judged by, the extent to which they can bring about compliance. It is in these cases - unhappily more numerous than the former - in which frustration, conflict and tension grows between the education-oriented and non-education aspects of the public health family.

(2) Varying Etiological Perspective for the Understanding and Diagnosis of Problems

Simple "cause and effect" relationships are wonderful to work with. So wonderful that it is the dream of all of us to have at our disposal a single magic bullet which can be easily used to quickly demolish an obvious problem. Public health has had such success, although the long gaps between the availability of a "bullet" and the demise of a problem are frequently forgotten. (How long ago did Dr Jenner give us his bullet?). But not many human problems provide such easy access to simple cause-and-effect analysis. It is, in fact, no longer conceptually possible to ignore the fact that problems of human health and well-being, to be understood and coped with, cannot be unidimensionally explained. Factors within the individual, factors in his/her social or cultural relationship, factors of economics and politics all present themselves for analysis and understanding. We have, indeed, even begun to look within the behaviour of the health practitioner and health organization itself in diagnosing sources of problems which require attention. This etiological complexity, particularly when it takes us beyond the boundaries of a single individual, runs contrary to the conventional diagnostic priorities of the public health field.

Although it is now much more than a quarter century since studies of the importance of understanding health behaviour in the context of social, cultural and political factors have regularly appeared, public health management, worldwide, appears still to focus on the narrow identification of single factors. In many cases, such single factors are quickly assessed as being the problem of the individual with the problem and efforts to directly influence his or her behaviour through information, fear arousal or extrinsic rewards becoming preferred actions.

Inasmuch as the way the problem is perceived (and the process through which that perception occurs) provides the framework for the development of action steps, the difference in diagnostic perspective inevitably leads to differences in actions deemed necessary and appropriate. Very often the methodological argument is carried on without an awareness that different assumptions about the nature of the problem are the real issues under debate.

(3) Conflicting Strategies for Planning

Contemporary social planning, of which public health is a part, is often characterized as "social engineering", a process which Donald Michael describes in his book Planning to Learn and Learning to Plan as "elitist top-down planning which assumes the planners hold a monopoly on expertise." David Korten discusses the "textbook version of how development planning is supposed to work" as the "blueprint approach." "Researchers are supposed to provide the data... which will allow planners to choose the most cost-effective project design... and to reduce it to a blueprint for implementation."

Such planning models more often than not run contrary to the values and demands of a sustained learning process. How can we predetermine specific goals for people and, at the same time, suggest that we are providing individuals and groups with the decision-making skills from which their own objectives will emerge? We, in fact, cannot. When a choice must be made between a learning outcome and an outcome predetermined through a planning process from which the people to be affected are far removed, we feel caught in a wicked problem which the conventional health system abhors.

Although health education is an exponent of systematic and orderly planning, it does raise questions about the data used in planning (as discussed in section 1 above), the scope of participation in the planning process, the flexibility required to modify problem definition and intended outcomes as ongoing analysis in specific situations suggests. Perhaps a most important difference is in an emphasis on long-term efforts to influence human development in contrast to specific short-term objectives relating to a single outcome.

Most planning utilizes a "need" concept as a starting point. Individuals trained in the natural and physical sciences make a strong case for, and have developed a technology consistent with, a concept of "objectivity" in need analysis. Such "needs" are based on the extent to which certain measurable conditions depart from a technically determined standard of what the case should be. A minimum nutrition intake level, for example, has been set as 2 380 calories per head per day by FAO. Conditions of less than such a standard clearly need to be improved. In extension of the need concept, however, is an aspect of need identification of importance to the educational and development process in which needs perceived by people provide legitimate data. Such needs, frequently labelled "subjective" - whether postulated as strategy or value - the principle of initiating action planning with "felt needs" of people has been for some time a central thrust of effective community education and development.

(4) Methodological Disagreements

Responses to questions about how people learn and change - factors which influence human behaviour - are the core concern of education. Such concern is not easily resolved since it is everywhere apparent that the demands and expectations of culture and society create the conditions within the context of which one learns to learn. In addition, it is apparent that different learning tasks are restrained or facilitated by different factors. Not all "learning" results in behavioural change (we may know, but not do), not all behavioural change is the result of learning (we may do for a variety of reasons unrelated to our knowledge, need, desire, value or understanding).

Given these and many other issues which complicate our understanding of learning and change, health education has attempted to develop a range of educational interventions designed to provide appropriate help to the learner in different situations.

A more general approach to the change process is, as previously discussed in an earlier section, widely evident in the health field. This approach - primarily based on the interest in certain communication technologies - lays emphasis on information dissemination in varied forms. Perhaps influenced by the celebrity status accorded to the mass media performers and aware of the tremendous impact media can have in society, great emphasis is laid on such a methodology. The tremendous popularity of mass media and the obvious influence it may have among social groups to which it caters, the health establishment ignores the obvious realities which prevent it from any but the most superficial utilization of media. Educational and communication methodology in public health further exhibit a characteristic which in the practice of medicine be labelled "quackery". That is to say, choices about interventions are frequently made on the basis of availability of a technique rather than on diagnosis of the problem. Thus a whole range of material is utilized for purposes which meet the needs of the "sender" rather than the "receiver".

(5) The Ambiguity of Educational Role Definition in Public Health

The complexity of the educational process and related social change processes require that practitioners be prepared to play a variety of roles consistent with the demands of particular situations or with the needs of particular phases of the change process.

Conventional public health services, however, frequently stereotype and thus limit role definition and performance expectations. Doctors doctor, nurses nurse and statisticians calculate. When the role rules are imposed on health education, they lead to similar stereotyping of the actions expected. As health education specialists seek to enlarge their roles (and sometimes create new ones), they function in ways which are perceived as inconsistent, ambiguous and out of step with the expectations of the organization.

The multiple-role demands of effective health education create further confusion when few of the roles are directed at a specific service delivery outcome which is as tangible as the construction of a latrine or an immunization provided. Indeed, in order for health education to conform to the service delivery norm, it must frequently be reported as something which has been "given".

The therapist-patient model remains the preferred role expectation. (The "community as patient" is, for example, a familiar expression of the medically-oriented approach to community work.)

(6) Inconclusiveness in the Search for a Common Understanding of "Health"

As serviceable for its purpose as the famous definition of health provided by WHO, it is not difficult to establish the fact that an enormous range of meaning is attached by individuals - lay and professional - to the concept of health.

It is often stated, in fact, that for many in the field, it is not health, but disease which has the central focus. In the USA today, for example, the health promotion movement, as it is officially sanctioned, is based on a disease prevention rationale.

But aside from the individual, biologically-oriented enhancement which we may do to our notion of health, a larger, more contentious question is the extent to which we desire that human state we wish to bring about to include increased self-esteem, freedom from poverty, the satisfaction of basic needs.

Education moves towards such broader goals seeking not only health as it is conventionally understood, but asking as well "health for what?"

The Health for All initiative is often coupled with the phrase "A Contribution to Human Development and Social Justice". Whether such visions are judged as wise or foolish - as fine but not real, as fuzzy and not meaningful - will be a measure as well of the difficulty which educational processes encounter in the promotion of health and well-being.

*Chapter 5***EPILOGUE: NOTES FOR THE AGENDA AHEAD**

Health education has experienced remarkable growth and substantial development in the South-East Asia Region, both as an organized system and as a process recognized as essential to the mature development of public health in the four decades since WHO was founded.

It is a field of action and concern now characterized by a firm value orientation, an expanding conceptual framework, and a methodology increasingly relevant to the cultures in which it functions.

It has inspired a whole generation of public health leaders whose interest and commitment are central to the philosophy and implementation of Health for All. The skills and understanding which have been developed are now being passed on to a new generation in organized programmes of in-service and pre-service preparation at university and ministry training programmes.

With the considerable progress as prologue, a number of significant initiatives to strengthen existing practices and set new directions present themselves. Illustrations of options which appear worthy of consideration form the final section of this report.

5.1 CONTINUED REINFORCEMENT OF POLICY AND RESOURCE SUPPORT INITIATIVES

Health education in recent years has benefited from policy-level leadership in recognition of its central role. To translate such abstractions from "resolutions" to an appropriate resource allocation in an organized and competently managed system remains a persistent need. Although focal points for the broad health education effort have been put in place in most countries, the follow-up steps of support for implementation of stated commitment have not yet been fully or consistently realized.

As important as such action is, the realization and support of focal point is not meaningful when it becomes an end in itself. Central units are but a foundation for a national network which will find its expression at the community level fostering the true partnership envisioned by primary health care. The ultimate criteria by which national health education development can be judged is in the extent to which it provides leadership in a system in which all public health is focused on the genuine implementation of Health for All.

5.2 STRENGTHENED COMMITMENT TO A CONSISTENT APPROACH TO HEALTH EDUCATION EQUAL TO THE CHALLENGE OF PHC AND NATIONAL DEVELOPMENT

Clear and firm emphasis on health education concepts and practices so well put forth in the 1986 Expert Committee report on new approaches to health education in PHC need continue to be the hallmark of regional development.

The value base of health education to which the Region has been committed with pride and enthusiasm must be broad enough to deal realistically with changing problems and opportunities, yet strong enough to stand firm when confronted with approaches which would violate the core of purpose on which public health is based.

The dimensions of health education as a part of public health must include as basic minimums:

- Focus on partnership with communities in development appropriate to the needs, aspirations and rights of its people. Specific health programme development will be an important part of such community organization, but not allowed to overwhelm or distort it. This process will assume the value of decentralized decision-making in contrast to the conventional "top-down" management.
- Decentralized decision-making as a rule rather than exception in organized systems in which central groups provide resource support, technical assistance and interdependent action with local groups.
- Acceptance in action of the intersectoral emphasis in which the advocates for various sectors (health, education, agriculture, etc.) function as interdependent agents for the satisfaction of basic minimum needs and continued enhancement of quality of personal, social, economic and political life.
- Acceptance of the point of view that purpose precedes method. Health education prospers only when methodological ideology is replaced by emphasis on the primary need to clearly define purpose and to adequately diagnose the scope and nature of the problem as a prelude to selecting this or that intervention. The problem of integration of various approaches which are sometimes labelled as contradictions can be most satisfactorily resolved in such an emphasis.

5.3 REVITALIZATION OF THE POSTGRADUATE PREPARATION PROGRAMMES

The development of postgraduate preparation in the Region has, as discussed previously, been one of the major

accomplishments of the past two decades. The programmes clearly require continuing self-analysis and interchange to prevent a levelling off or falling back. Problems and opportunities are changing at a rate which may well outstrip the existing programmes if attention is not paid to their continuing development. Some of the efforts already under way to develop standards, encourage advance preparation, stimulate interchange and experiment with new and improved teaching and learning deserve enhancement and continuity.

5.4 RESEARCH EMPHASIS ON APPLICATION OF THEORY TO PRACTICE

Research needs and possibilities are frequently reviewed and such reports provide a meaningful agenda for the future. A persistent problem, however, is that researchers usually speak in their own terms rather than in those of the field or of the problems of the practitioner. The need then is to explicitly move the research focus of the Region to a problem-centred orientation.

Rosenfeld's discussion of the Special Programme for Social Science Research in Tropical Disease provides a splendid prototype for health education research for the Region:

"It is not ivory tower research, but rather takes place under thatched roofs, in rice and cotton field, schools, health centres and hospitals. It is research fundamental oriented towards the solution of 'real world' problems. A sound scientific approach and practical orientation are essential, but not sufficient... the recommendations resulting from research must be used... As part of the research activity, attention should be given to the identification of factors influencing the use of research results..."

Emphasis on research, which is problem-focused and concerned with utilization, may require an adjustment by the Region in the range and scope of research specialists with whom it works and continued training of individuals and groups who can work in these directions.

5.5 ACCELERATE THE NETWORKING PROCESS

Health education development throughout the Region can be more fully and quickly realized as the countries of the Region, in association with partners from other regions, function as an interdependent network of colleagues and partners. This is the concept of TCDC and its realization can be substantially fostered by helping establish the relationships which make it possible. Ad hoc conferences and related meetings are certainly important, but long-term help in the form of sustained networks may provide a more beneficial use of time and resources. Associations of national directors, professors, field centre managers or other categories of compatible groups could, for example, be assisted in establishing frameworks of continuing relationship in sharing problems, ideas and outcomes. As mentioned, networks such as the Asia-Pacific Academic Consortium, are beginning to provide examples of such a process. Technical consultation assignments themselves may be another means of not only meeting substantive needs, but purposefully planned and carried out in a way which supports intercountry long-term relationships. In the same way, problem-solving teams from several countries working together on a single issue may nurture the kind of intra-regional collegiality referred to here. Such ventures may serve more the twin purposes of personal growth and health education development than many of the present study tours.

5.6 STAFF DEVELOPMENT

At the heart of WHO support is the staff or consultant. It is important to emphasize the need for continuing to sustain and re-energize this group both in content and consultative process areas. It is a small note, but one of enormous potential significance.

5.7 NEEDS ASSESSMENT

All planning, we constantly remind ourselves, is somehow need-based. To be aware of needs, at whatever the level of expression, is to be on the first rung of an effective

helping process. A system for the more efficient tracking of need by the Member Countries as a frame of reference for assistance and a yardstick for assessment is itself a need requiring further refinement and implementation. It is a process in which the client, country office and SEARO personnel must somehow function more connectedly than may now be the case.

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