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New approaches to health education in primary health care

Report of a
WHO Expert Committee

World Health Organization
Technical Report Series
690



World Health Organization, Geneva 1983

ISBN 92 4 120690 X

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PRINTED IN SWITZERLAND

83/5722 - Schüler S.A. - 10 000

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WHO EXPERT COMMITTEE ON NEW APPROACHES
TO HEALTH EDUCATION IN PRIMARY HEALTH CARE

Geneva, 12–18 October 1982

*Members**

- Dr D. Banerji, Professor and Chairman, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, India
Dr T.F. Corcega, Associate Professor, Health Sciences Center, University of the Philippines System, Diliman, Philippines (*Vice-Chairman*)
Dr W.A. Hassouna, Professor of Health Planning and Director of Social and Cultural Planning, Institute of National Planning, Nasser City, Cairo, Egypt
Dr J.A. Laoye, Assistant Director (Health Education), Federal Health Education Division, Federal Ministry of Health, Lagos, Nigeria (*Rapporteur*)
Dr L.S. Levin, Professor Public Health, Yale University, New Haven, CT, USA
Professor D.N. Loransky, Director, Central Institute for Scientific Research in Health Education, Ministry of Health of the USSR, Moscow, USSR
Dr A. Nondasuta, Director-General of Health Services, Ministry of Public Health, Bangkok, Thailand
Professor R. Senault, Director-General, Centre for Preventive Medicine, Regional Organization for Health Examinations, Vandœuvre-les-Nancy, France
Sir Kenneth Standard, Professor and Head of Department of Social and Preventive Medicine, University of the West Indies, Kingston, Jamaica (*Chairman*)
Dr Zhang Bei-zhu, Director, International Peace Maternity and Child Health Hospital of China Welfare Institute, Shanghai, China

Representatives of other organizations

United Nations Children's Fund

Mr R.R. Tuluhungwa, Chief, Project Support Communications Service, UNICEF, New York, USA

United Nations Fund for Population Activities

Mr G. Perez-Arguello, Associate Liaison Officer, UNFPA, New York, USA

International Labour Organisation

Dr M. Stilon de Piro, Occupational Safety and Health Branch, ILO, Geneva, Switzerland

United Nations Educational, Scientific and Cultural Organization

Mr J. Kim, Programme Specialist, Literacy Adult Education and Rural Development, UNESCO, Paris, France

International Union for Health Education

Dr D. Berthet, Secretary General, IUHE, Paris, France

Mrs R. Erben, Director of the European Bureau, IUHE, Cologne, Federal Republic of Germany

* Unable to attend: Dr Carmen D. de Thays, Adviser in Education and Communication, Ministry of Health, Lima, Peru; Professor A.M. Wright, Faculty of Engineering, University of Science and Technology, Kumasi, Ghana.

International Council of Nurses

Miss C. Holleran, Executive Director, ICN, Geneva, Switzerland

League of Red Cross Societies

Miss M. McTamney, Technical Adviser, LRCS, Geneva, Switzerland

Secretariat

Mr A.K. Agarwal, Director, Centre for Science and Environment, New Delhi, India (*Temporary Adviser*)

Dr G.M. Foster, Professor Emeritus, Department of Anthropology, University of California, CA, Berkeley, USA (*Temporary Adviser*)

Mrs A. Kaplun, Division of Public Information and Education for Health, WHO, Geneva, Switzerland, (*Consultant*)

Mr J. Ling, Director, Division of Public Information and Education for Health, WHO, Geneva, Switzerland

Dr A. Moarefi, Associate Director, Division of Public Information and Education for Health, WHO, Geneva, Switzerland (*Secretary*)

Professor J.M. Navia, Director, The John J. Sparkman Center for International Public Health Education, University of Alabama in Birmingham, Birmingham, AL, USA (*Temporary Adviser*)

Mr J. Wiio, Senior Programmer, Finnish TV, Channel II, Tohloppe, Tampere, Finland (*Temporary Adviser*)

NEW APPROACHES TO HEALTH EDUCATION IN PRIMARY HEALTH CARE

Report of a WHO Expert Committee

A WHO Expert Committee on New Approaches to Health Education in Primary Health Care met in Geneva from 12 to 18 October 1982. Mr J. Ling, Director, Division of Public Information and Education for Health, opened the meeting on behalf of the Director-General, and read the opening address prepared by Dr J. Hamon, Assistant Director-General, which emphasized the need for a fresh look at health education approaches and practices in view of the WHO goal of health for all by the year 2000. Health education had progressed considerably since the first meeting of the Expert Committee on Health Education of the Public in 1954 (1). Furthermore, the experience gained in recent years in health education and the many developments that had taken place in the fields of social sciences and mass media technology had broadened the scope of the discipline of health education. This was, therefore, a particularly opportune moment to review the current approaches in health education in order to bring these into full harmony with the principles of primary health care and to increase activities in that field. The WHO Seventh General Programme of Work, covering the period 1984–1989 (7), indicated that the role of information and education for health would be more prominent than ever before.

1. INTRODUCTION

In 1977, the World Health Assembly unanimously adopted a resolution (WHA30.43) which stipulates that “the main social targets of Governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life” (2). With regard to the achievement of this goal, the *Sixth Report on the World Health Situation* (3) states that health

has to be attained and cannot be imposed; thus the first requirement for the attainment of health is a commitment by both the people and the government. Adequate education in general is essential for the development of this commitment.

The International Conference on Primary Health Care organized jointly by UNICEF and WHO in Alma-Ata, USSR, in 1978, declared that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care", and that "education concerning prevailing health problems and the methods of preventing and controlling them" was the first of eight essential activities in primary health care (4). It is within this context that a new look at health education is essential.

In calling for new approaches to health education in primary health care, the Expert Committee recognizes that no aspect of health care is static. In the case of health education, in order to make it more effective, it is essential to attune it to the prevailing lay and professional perceptions of health problems.

Originally, health education developed along the lines of the biomedical views of health and disease current at that time, according to which social, cultural, and psychological factors were thought to be of little or no importance. The assumption underlying health education activities was that people would enjoy better health if they would act in the manner recommended by health workers. Hence, the emphasis was on the transmission of correct health information to the general public.

The term "health education" itself suggested to some the outward and downward communication of "health knowledge" to individuals supposedly with limited ideas on how to avoid illness or on how to cope with disease. In the early years of health education, relatively few efforts were made to understand people's traditional health beliefs and practices, and to consider these beliefs and practices in developing health education strategies. While some attempts were made to learn about what the communities themselves regarded as their health needs and priorities, these were not systematic. It was assumed, rather, that only health professionals were in a position to assess these needs and priorities. Furthermore, health education was committed to values derived from allopathic medicine, including its normative goals, its diagnostic and therapeutic techniques, and its criteria regarding the success of interventions.

Although the role of culture, religion, and society in shaping people's behaviour was emphasized by the Expert Committee on

Health Education of the Public in 1954 (*I*), these factors have seldom received the careful attention they require for effective planning of health education activities. This remark also applies to the concept of participation.

Today, because of changing disease patterns, rising social expectations, and a new relationship between community members and health care providers,¹ health education is facing a challenge unparalleled in its history. With the recognition of the fact that there is conventional wisdom in every community, and that people are able to think and act constructively in identifying and solving their own problems, the emphasis in health education is shifting from “intervention” to community involvement.

As a result of this, the health educator² becomes a learner as well as a “facilitator” and a teacher, just as the community members become teachers as well as learners. The community members need to introduce health educators to their “health culture” by explaining to them the rationale behind their health beliefs and practices, their therapy-seeking behaviour, and their perception of their own health problems. Health educators, for their part, must engage in a constructive dialogue with community members to find culturally appropriate responses to health problems—identified jointly by the community members and health workers—within the context of the primary health care philosophy.

In the reorientation that health education is currently undergoing, new roles are emerging for health care providers. In order to perform these roles effectively, new forms of training will be required in line with the new strategies of working with communities and with new concepts in education. This new approach should create in the health care providers a better appreciation of how research and evaluation can contribute to improving the effectiveness of health care activities. These issues are discussed in detail below.

¹ Health care providers include: physicians, nurses, midwives, pharmacists, traditional health practitioners, birth attendants, health auxiliaries, child care workers, physiotherapists, and appropriate lay persons.

² Throughout this report the term “health educator” is not limited to the “health education specialist”, whose functions are outlined in section 5.1.7, but refers to health care providers and professionals from various sectors who use the educational approach and can influence levels of health through their action.

2. THE ISSUES

It is realized today that science and technology can contribute to the improvement of health standards *only* if the people themselves become full partners of the health care providers in safeguarding and promoting health. Furthermore, in a number of fields it is more urgent to make good use of existing knowledge than to generate additional knowledge and new tools. This is particularly important in the light of the large increases in medical expenditure in recent years (especially in the industrialized countries), and because of the logistic limitations to the provision of adequate health care to the majority of the world's population.

It is not accidental, therefore, that education was given special attention in the Alma-Ata Declaration (4). Also, it is not by chance that the WHO *Global Strategy for Health for All by the Year 2000* (5) constantly refers to educational activities as the very best way of encouraging people from all walks of life to participate in health care and of making them the true artisans of health and development.

In fact, the WHO Seventh General Programme of Work stipulates that activities in the field of information and education for health should aim to increase "individual and community capabilities for involvement and self-reliance in health and to promote healthy behaviour, particularly regarding family health and nutrition, environmental health, healthy life-styles and disease prevention and control" (7).

These decisions constitute a major challenge for all those involved in the broad field of communication for health. But is health education in a position to meet this challenge?

The situation in the world today is paradoxical. On the one hand, we are witnessing more and more elaborate technical advances and a trend towards continuous material progress, but, on the other hand, we see a majority of the world's population still grappling with malnutrition, poverty and illiteracy. The contrast is striking, but the two extremes are equally dangerous. Both poverty and affluence may generate somatic disorders and psychosocial problems. The world today is changing at an unprecedented pace, and a number of developing countries have made technological progress in some fields within one or two generations that took several generations to accomplish in the industrialized countries.

In the field of health, there is general agreement that the mere absence of disease is not sufficient. Good health should enable

individuals to develop to the maximum both their physical and mental potential, and to live socially and economically productive lives in harmony with their environment. Despite this broad objective, the health education approach often remains paternalistic and commandment-like. Many administrators still believe that watching a film, seeing a poster, or listening to a talk will lead the individual along the right path. Remembering the success of campaigns concerned with disease control, they insist on using the same methods as before, and when these do not work, they consider health education at fault. But the problems of today are much more complex. The coercive approach often used in dealing with epidemic or parasitic diseases is not applicable to such issues as personal hygiene, breast-feeding, smoking, alcoholism, overeating, or excessive use of medicaments.

Many health professionals tend to encourage people to want what they themselves think people should want, rather than attempting to understand the needs 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.

Even when health professionals and social scientists attempt to understand the concerns of the community they serve, seldom do they consider the appropriateness of the technology they are offering to the people, and rarely do they pay adequate attention to the relationship between the community and the health services. They consider contemporary health technology *prima facie* as something good and desirable, and assume that people should be made to accept it. If people fail to respond positively, they are branded as victims of their cultural and traditional beliefs, and health professionals are often employed to educate such (presumably "mis-guided") people so that they learn correct health behaviour.

In the developing countries, health professionals have too often focused on "selling" modern health practices to the people without giving sufficient thought to whether the modern practices are relevant to the community concerned in terms of its social and

cultural background. A key issue, then, is whether a health system based on modern technology should be imposed on a community or whether each community should be allowed to select the type of health technology it prefers.

Another problem is related to the fact that health care has become a monopoly of the health professionals, and, moreover, every aspect of life is being drawn into the realm of medical science. Often, health care is regarded as synonymous with professional care, with a clear distinction between the providers and consumers of health services. In effect, health care has developed along the lines of an industrial model, becoming increasingly labour and capital intensive. Health education is also using that model, adhering largely to "clinical" strategies, which imply that those who "know" should diagnose individual or community needs and should decide on the educational "treatment" required.

Furthermore, health education has been operating almost entirely within the value system of professional allopathic medical services. Its goals are set within that framework and its achievements are measured in terms of outcomes, such as the patients' compliance with the treatment, the reduction of hazardous health habits or reduction of the period between the beginning of an illness and the time when the patient seeks treatment. In the past, health care providers have focused mainly on the modification of individual behaviour, implying that the individual is solely responsible for his plight. This approach blames the sick, the poor, and the miserable for their illness, their poverty, and their misery. It ignores the fact that in a number of situations it is not the individual who needs to be changed but the social environment in which he or she lives. In other words, the political, economic, and environmental factors that have a negative or neutralizing effect on healthy behaviour need to be modified.

In assessing the impact of society on health, it must be kept in mind that no society is homogeneous. In fact, there may be many societies within a given region or nation. This is particularly true for populations in some developing countries where, in addition to many ethnic and linguistically distinct groups, there may be a pronounced polarization between the privileged and the underprivileged. In such cases, the privileged often have considerable influence over the underprivileged by the very fact that they establish certain standards and the norms of behaviour. They also have an easier access to health care than the underprivileged.

Historically, health education has been committed to prevention and, more recently, to the concept of health promotion as well. The objectives of health care in the past have been limited to helping people gain access to professional services and to maintaining appropriate medical regimes. Today, however, it is necessary to find new ways of meeting the expectations of the people with regard to the cost of health care, access to professional services, and the quality of these services.

It is realized also that some of the models and structures of health education developed over the years are no longer relevant. Hence, there is a pressing need for a critical assessment of the current approaches in health education in order to select those which promise a sound basis for greater efficacy in implementing the objectives of primary health care. Those engaged in health education must decide what changes are needed and how they can be achieved.

3. THE CONCEPTS

The revolutionary Declaration adopted in 1978 at Alma-Ata (4) will remain a landmark in the history of health care and health education. It gives a place of prime importance to health education in promoting individual and community self-reliance and in developing people's ability to become full partners in health promotion and care.

Indeed, one major statement in the Declaration is the affirmation that people not only have the *right* to participate individually and collectively in the planning and implementation of health care programmes, but also a *duty* to do so. In addition, it is the duty of all those concerned with health education to help the people measure up to this task. No longer should the health services filter down through a number of layers to *reach* the underserved. A movement, starting from the people, has now been initiated, which reflects the will of individuals and communities to take a full part in the affairs of their country and to share with the government the responsibility for health care and health promotion.

Though community participation was already singled out as an essential component of health progress several decades ago (1), never before has it assumed such importance. In the past, participation was too often equated with the provision of local labour to construct a well, a school, or a health centre, while public funds were being

used to build sophisticated hospitals in larger cities. Participation—or more correctly *involvement*—is a process in which individuals and communities identify with a movement and take responsibility, jointly with health professionals and others concerned, for making decisions and planning and carrying out activities. This is clearly a process that health education can promote.

Primary health care has been defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and country can afford (4). The objectives of primary health care can be achieved only if health education plays a part. In fact, if primary health care is to be made accessible to all, the inhabitants of every community must strive to rely as far as possible on their own resources. To achieve such self-reliance, the people should be involved in the planning, implementation, and evaluation of health systems based on primary health care. This aim may be most effectively achieved through suitable educational activity aimed at enabling people to cope with pressing health problems.

The WHO *Global Strategy for Health for All by the Year 2000* (5) provides further guidance on this point. In the primary health care approach, the focus placed on community involvement means that decision-makers, in developing new policies for health education, must understand and accept the need to make provision for communities to define and pursue their own goals, mobilize their own resources, and control and evaluate their own efforts.

It also means that mechanisms must be developed (or strengthened) to ensure that individuals and communities can express their views on their country's health policy and take an active part in the planning and delivery of health programmes, including health education. Ways must be found of building up this process of community involvement so that communities can regularly communicate their opinion on health matters and on their needs to the national policy-makers. Eventually, the synthesis of local priorities should dictate national priorities.¹

This is a substantial departure from the traditional approach in which the health education component of policies was defined in connection with highly targeted programmes concerned with disease control or family planning and which were carried out according to

¹ Unpublished WHO document TD/HED/82.1.

professional values and expectations. Targeted disease control programmes are still necessary, but they should fall increasingly within the community's own framework of a comprehensive health and development programme.

What is then the role of health education? The Director-General of WHO has clearly outlined (6) the areas where new thinking is required:

- (1) health education needs to develop new policies in harmony with the principles of primary health care and the strategy of health for all by the year 2000;
- (2) health education needs to facilitate the development of human resources with the skills to translate social goals into educational objectives for health for all by the year 2000;
- (3) health education needs to reflect on the educational technology most appropriate to promote individual and community involvement and self-reliance;
- (4) health education needs to strengthen its multisectoral approach and to increase coordination of health education efforts through appropriate technology;
- (5) health education must pay greater attention to monitoring and evaluation.

The views of the Committee on these issues are summarized in sections 4 and 5 of this report.

4. CHARACTERISTICS OF THE NEW APPROACHES TO HEALTH EDUCATION IN PRIMARY HEALTH CARE

Primary health care, with its commitment to provide health for all by fostering self-reliance and social action of an intersectoral nature, has to cater specifically for the needs of the underserved and/or the underprivileged in order to help bring about equity in the field of health. In this perspective, priority is to be given to the development of a people-oriented health technology¹ to meet the felt needs of people while giving appropriate consideration to the needs that are recognized, epidemiologically, as requiring urgent attention.

¹ The word "technology" is used here in the same sense as that in the Report of the International Conference on Primary Health Care, Alma-Ata (4). It means: "an association of methods, techniques and equipment which, together with the people using them, can contribute significantly to solving a health problem".

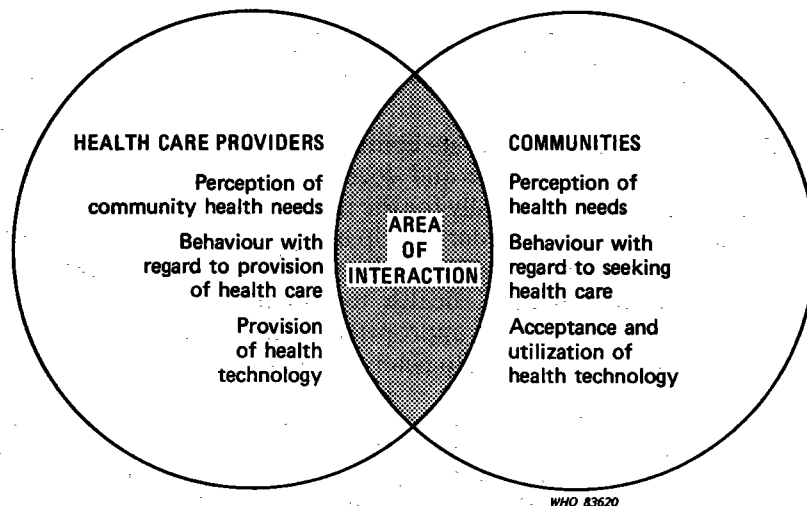
4.1 A people-oriented health technology

In order to contribute to the promotion of primary health care, some aspects of health education need reorientation and a number of principles already acknowledged require forceful reaffirmation.

For one thing, it is necessary for the health care providers to develop a better understanding of what can be called the "health culture" of a community and of how this culture is influenced by social forces such as the dynamics of social and cultural change and the political and economic organization of the community. The cultural perception and the meaning of various health problems, the response of the community to these problems, and the various customs of the community constitute the three major interacting elements that give to the health culture of a community its particular characteristics.

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

Fig. 1. Interaction between health care providers and communities



role in the planning and setting up of a health care programme. This calls for a thorough understanding by the health care providers of the people's perception of their health needs and their acceptance and utilization of different health care technologies—influenced as these are by sociocultural and economic factors.

Fig. 1 shows that there is an area where health care providers and the community share the same views on health problems, health needs, and the appropriate solutions. As the exchange of ideas, information, and technology between the health care providers and the community increases, so does this area of "interface". Health education plays a key role in increasing such common thinking.

While health care workers should not compel communities to accept the health technologies they propose, they should also not allow themselves to be forced into a situation where they have to abdicate their views on technical matters. The common ground between the two groups should serve as a basis for a fruitful dialogue, which may lead to change, provided health workers keep in mind that sociocultural factors and beliefs are not necessarily obstacles to development; in fact they can be points of departure for development.

4.2 Lay resources in health care

The Report of the Director-General on the work of WHO in 1976¹ states: "...The primary health care approach represents a reformulation of some of the basic tenets of public health, i.e., it 'aims at promoting individual and community self-reliance. It implies that people should act to improve their own health rather than rely on others doing so for them.'" Therefore, in developing people-oriented health technologies, priority should be given to available lay resources and to indigenously developed health practices.

Recently there has been renewed awareness of the contribution that lay people can make to health care. Lay self-care is a long-established fact. Today, it is realized that lay self-care has an essential role to play in improving the health status of people and decreasing health costs. Health for all by the year 2000 is not likely to be achieved by using the available professional services alone. Lay resources will need to be involved and will need to receive the type

¹ *Report of the Director-General on the work of WHO in 1976*. Unpublished WHO document, A30/2, 1977.

of support that will enable them to make a useful and effective contribution to the promotion of health. People will benefit most from available professional services when they themselves have some knowledge of health issues.

Health education has a powerful new role to play in promoting the involvement of lay persons in health care. This role will require: (a) a reorientation of techniques of social analysis; (b) new educational methods which aim to enable people to identify and assess health problems and to give them confidence in solving those problems; and (c) new ways of creating links between key groups in the community and of negotiating solutions to health problems. Health professionals will have to assume an advocacy role for the cause of health *vis-à-vis* both the people and the decision-makers, giving due consideration to political, economic, and environmental issues. Similarly, community health education, school health education, patient education, and health education in the workplace will require revision of strategies, objectives, methods, and of evaluation criteria.

One problem that must not be underestimated concerns people's attitudes to the concept of community involvement. Experience has shown that individuals and communities may not always feel comfortable in accepting responsibility for their own health. Even when they have been involved in defining their health problems they may respond negatively, at least initially, to the idea of being partners in planning solutions. The attitude that health care is someone else's responsibility is linked to the fact that in the past health professionals have taken away from the people their decision-making power with regard to health. Therefore, an effort must now be made to give them back their confidence and to help them develop their skills in making the right choices.

The promotion of people's self-reliance should in no way be an excuse for health workers to avoid their responsibilities. On the contrary, it will demand additional patience and effort on their part to enable people to develop effective action for health; and it will also require a fundamental shift from the elitist attitude to one of respect for lay values, practices, and preferences in health. The involvement of the people should not absolve health care providers from their duties, and health education should not be used as a substitute for services that must be provided.

4.3 New approaches concerned with human ecology

During the past few decades, a number of health education models¹ have been developed, most of which could be described as “cognitive”. These models were based on the view that health education is basically concerned with “telling people” what is good for them, what they should or should not do, how they can achieve a desired result, and what consequences they should expect from certain actions. The underlying concept in this approach was that only a few people knew certain facts and that the majority of the population knew little or held the wrong views.

Once the shortcomings of the simple cognitive models were realized, health education focused on “motivation” as an answer to the reluctance or inability of people to translate the information received into the desired action. Soon, however, it was realized that motivation alone was not sufficient and that there was a need for a much wider approach. As a consequence, a social element was introduced in an attempt to explain the failures of the decision-making process and to translate knowledge and attitudes into behaviour.

In recent years, however, a better understanding has developed of the processes that have a positive or negative influence on the harmonious functioning of a person, both as an individual and as a social being. This has prompted study of the role society plays in influencing the individual’s health behaviour. It is now recognized that a community’s values and norms play a vital part in defining the general approach of people to illness and health as well as to treatment and prevention, and that the process of socialization is one of the most important mechanisms in transmitting certain values and norms from one generation to the next. This has resulted in the development of social intervention models of health education, in which the emphasis is placed on influencing social, instead of individual, factors associated with health and illness.

Once it was recognized that the health of individuals and the community is influenced by the social environment, it became clear that individual life-styles also play a role in health. Life-styles are developed by individuals and groups to cope with the requirements and contradictions of their social environment. Life-styles comprise

¹ A model is a set of relationships among key elements in a structure or process that can be generalized to fit a variety of situations in which similar structures or processes occur.

a variety of behaviour patterns that are influenced by shared values, traditions, typical forms of communication and interaction, language, etc. By adopting certain life-styles, individuals and groups establish their identity and give a meaning to their situation in life.

Although it is possible to isolate specific behavioural patterns for epidemiological or etiological studies—for instance, certain behavioural patterns associated with social class differences—this does not imply that one can use these isolated traits as the target for health education efforts, disregarding the general life-style of the people. In fact, a major shift today in health education is from a focus on particular behaviours (smoking, overeating, etc.) to the general life-style of a person, which, in turn, is influenced by the life-style of his or her family, community, and country. This implies that there is a need for new health education models based on a sound knowledge of human ecology, and taking into consideration the interaction between the biological and environmental factors (both physical and social) that influence harmonious development.

With regard to health education, the emphasis on life-styles further demands a change in the selection of target populations. In order to prevent or to encourage the adoption of specific forms of behaviour characteristic of persons with a particular life-style, one has to concentrate on the institution which is mainly involved in this process, namely, the family. One must not forget that it is at the level of the individual and the family that values are formed. It is in the home that the child first learns how to behave. These processes extend later to the school, which has a decisive influence on an individual's future life-style through secondary or formal socialization, and eventually to the workplace.

4.4 New roles for health care providers

Health care providers should appreciate the power they wield through health education. Health education is a very potent approach that can influence people to the extent that unfelt needs become felt needs, and felt needs become demands with political, social and cultural undertones. Health education and primary health care are not merely technical matters: they involve socioeconomic issues that often have political implications. In their new roles, health care providers should ensure that there is a constant flow of information from the people to the decision-makers. They should act in such a way as to make people realize that while they are represen-

tatives of the national health authority, they are also partners of the people in developing a health technology based on community needs and preferences.

Another major function of health care providers should be to help people achieve their own social and health objectives. All must be done to promote self-reliance and to avoid meddling too much with the community's natural processes of growth and development. The desire for change must come from within the community.

Many qualities are needed by health care providers in addition to knowledge and professional skills. These include patience, being a good listener, and a deep desire to understand people's problems: these qualities imply, first and foremost, that love and respect for the people they are to serve and help should permeate the approach of health care providers.

5. IMPLICATIONS FOR HEALTH EDUCATION PRACTICE

The implications of the new concepts for health education practice will be examined with regard to five areas:

- planning and management;
- ethical issues;
- information and communication;
- training;
- evaluation and research.

5.1 Planning and management

The planning and management of health education activities involve a number of stages: formulation of policies, formulation of strategies, planning and programming, implementation, and monitoring of progress.

5.1.1 Formulation of policies

First, health education goals should be an integral component of the overall development goals. They should be conceived within the context of the national health goals, and the former should aim at realistic improvements in the basic quality of life. They should reflect people's aspirations and should be such that individuals and communities can actively contribute to their realization. Health educa-

tion goals conceived in this way should furnish a sound basis for the formulation of policies and strategies and for planning and programming.

Secondly, health education goals should be an integral component of primary health care; these goals should be communicated to all sectors concerned with development and should be integrated in all development programmes. At this stage, policy guidelines should deal with:

(a) the role of the community in identifying its own health problems, including the extent to which it is possible to develop community capabilities in this respect;

(b) ways of finding common ground between the felt needs of the people and the epidemiologically assessed needs, and the role of health education in this process; and

(c) ways of promoting the new concepts in health education that are crucial for the goal of health for all by the year 2000, for example by:

- making mutual respect the basis of the relationship between health care providers and the people;
- promoting acceptance of the fact that for the development of a new health technology both lay persons and professionals are essential and cannot replace each other;
- helping people to become self-reliant and involving people in all activities;
- initiating and/or strengthening intersectoral collaboration; and
- developing new roles for health care providers in which they give support to people's initiatives.

5.1.2 *Formulation of strategies*

At this level, the various approaches that can be used to achieve the proposed health education goals should be assessed, and efforts should be made to develop a number of optional approaches, covering areas of activity and available resources. In formulating health education strategies, attention should be paid to the crucial role of community involvement in achieving health goals. Some essential resources, at least initially and perhaps for many years to come, will not be available in many communities. These gaps must be filled by development agencies until they can be provided locally. In the meantime, communities should try to maximize the utilization of

available resources, explore potential ones (including lay resources), and propose various areas of activity.

Furthermore, strategy-formulation should emphasize the inter-sectoral approach by integrating health education goals with suitable developmental activities in other sectors such as education, agriculture, irrigation, industry, and literacy programmes. Preference should also be given to the development, adaptation, and utilization of appropriate technologies.

5.1.3 *Planning and programming*

Health education goals should be translated at this point into clearly defined objectives and subobjectives to be achieved within a given time and with the resources available. Those responsible for health education should make all possible efforts to identify intersectoral resources that can be coordinated and directed towards the achievement of those objectives. The involvement of the community, as well as of other sectors, is crucial for the development of realistic and socially relevant objectives. Furthermore, it is essential to promote people's involvement at all stages of planning, beginning at the time the objectives are set. People need to learn how to formulate sound objectives. Adequate programmes should then be developed to achieve the objectives decided upon.

5.1.4 *Implementation*

The decentralization of health and health education services seems to be the logical way of implementing the new approaches in primary health care which focus on development and require maximum community participation. In order to involve people and to enable them to formulate their own health care objectives, the health care providers will have to:

(a) provide opportunities for people to learn how to identify and analyse health and health related problems, and how to set their own targets;

(b) make health and health-related information easily accessible to the community, including information on practical, effective, safe, and economical ways of attaining good health and of coping with disease and disability;

(c) indicate to the people alternative solutions for solving the health and health-related problems they have identified;

(d) create awareness of the importance of effective communication in fostering mutual understanding and support between the people and the health care providers;

(e) translate the targets set by the people into simple, understandable, realistic, and acceptable goals which the communities can then monitor; and

(f) help people to learn how to set priorities among the different health problems they have identified and to understand the need to refer to relevant policies in doing so, e.g., that priority should be given to the deprived sections of the community and to certain diseases on the basis of the degree of their contagiousness, susceptibility to treatment, etc.

It is essential that communities have a clear understanding of their role in the implementation of strategies for solving health problems. Here, health education should facilitate the dialogue with the people through culturally and socially acceptable forms of communication.

When introducing new methods and technologies into a community it is usually preferable first to identify local cultural practices that lend themselves to modification, and then to introduce certain modifications to serve the purposes of the strategy, rather than seek commitment to wholly alien practices. Care should also be taken to make the educational material (including its presentation) relevant to the local culture and as practical as possible. The selection of new technologies should be made with the objectives of the overall development policy in mind.

5.1.5 *Monitoring of progress and resources*

At the stage of programme implementation, it is essential to take into account the role of the people in monitoring the progress of health care programmes, at least in terms of the community's criteria for their success. Health education should facilitate community involvement in the monitoring process. The mass media should also be involved by providing information on the state of health care programmes, and by helping to maintain the momentum of activities. Health education could also play a part in achieving intersectoral collaboration in health care programmes by demonstrating to the professionals from different sectors the benefits of working together. Mechanisms of communication are vital to the setting up and maintenance of intersectoral collaboration.

5.1.6 *Training, research, and financing*

At the programming stage, steps should be taken to identify the training needs of the people who are to be recruited from the community for health education activities. This approach will facilitate the designing of training methods and materials and, eventually, the actual training of community members.

In implementing the programme, it is essential to assign these individuals to the right place at the right time. One aspect of training should therefore deal with planning for effective use of human resources including, for example, how to mobilize them, how to improve the quality of their work, and how to prevent wastage. It is also important that people be kept informed of the resource status of their programme.

The development of the new roles and functions for health care providers will require applied research in health education, as will the training the workers in the performance of these roles.

In some countries, the national health and fiscal policies provide that local communities should contribute financially to health expenditures. In such cases, the community may need to raise funds to support their own programmes. In this field, health education should play a role in encouraging community members to participate in fund-raising schemes for health development, and in helping to make the local community organizations more aware of the importance of health in improving the quality of life.

5.1.7 *The role of the health education specialist in planning and management*

The new approaches in the planning and management of health education involve basic changes in the role of the health education specialist. Apart from disseminating health information and providing support to other professionals who, in turn, give technical and administrative backing to the community, the specialist should be capable of developing, using, and adapting educational approaches within the objectives of primary health care.

As a member of a team or of a coordinating body working at the national, state, or district level, the health education specialist has important contributions to make at the different stages of health education planning and management:

(a) *formulation of policies*—defining health education goals as an integral part of the overall goals of primary health care;

(b) *formulation of strategies*—defining the health education approaches needed to realize primary health care goals;

(c) *planning and programming*—defining health education objectives and determining the allocation of human resources in an inter-sectoral perspective;

(d) *implementation*—promoting the involvement of the community and health care providers in planning, implementing, and monitoring health education activities in support of primary health care; ensuring follow-up; and preparing both the community and the health care providers for their role in health education activities;

(e) *monitoring and evaluation of progress*—developing realistic criteria for the monitoring and evaluation of health education activities.

5.2 Ethical issues

In developing policies and strategies and in planning activities for health education, a number of ethical issues should be borne in mind by the health care providers. They should:

- be sensitive to the need to promote the positive aspects of professionalism e.g., respecting the integrity of individuals and communities, increasing their autonomy, and encouraging the people to maintain their own sense of values;
- in strengthening lay resources, give consideration to the strategic role of women in primary health care;
- ensure that there is full and accurate disclosure of information on health issues in order to enable the people to make informed decisions—in doing so, attention should be paid to factors that may bias the issues, the limitations of the information in question, and the fact that current information is being constantly updated by new findings;
- be sensitive to individual/community preferences and priorities with regard to health behaviour and health care that may differ from current professional views;
- ensure that health education activities are based on the people's perception of their health needs, priority being given to goals that reflect both the felt needs of the people and the needs defined by health professionals;
- ensure that health education clarifies the social, environmental, and economic causes of stress and illness, and that it avoids

- blaming the people who are in fact the victims of factors often beyond their control;
- appreciate the risks associated with paternalistic interventions in disease prevention which do not take due account of the individual's rights and of the welfare of the community;
 - identify and control counterproductive biases e.g., sexism, racialism, health fanaticism, and discrimination against certain age groups;
 - prevent ordinary aspects of everyday life (e.g., giving birth, child rearing and infant feeding) being given undue medical emphasis;
 - ensure that both professionals and lay people have respect for each other's experience and knowledge;
 - avoid actions that promote values contrary to those of the community.

5.3 Information and communication

If people are to fulfil their role in primary health care, they have to be well informed, and this is an important function of health care providers and the mass media.¹ Both have a major role in: (a) enlightening the population on the prevailing health problems in their country and community and informing the people about the most appropriate methods of preventing and controlling those health problems; and (b) providing information on alternative types of behaviour and their outcomes so that individuals can make an informed choice and accept the consequences.

The present world economic situation and the poor prospects of increased development resources in the near future, both nationally and internationally, make it imperative to find ways of "doing more with less". One way of doing this is to use the various media, and this has important implications for health education. Since the mass media make it possible to transmit messages inexpensively to large numbers of people, even in the remotest places, their effective use can give high returns for the time and money invested.

However, the speedy development of the various means of communication and their extensive utilization have prompted large-scale advertising of new consumer goods and major changes in human behaviour, some of which have had, and continue to have, adverse

¹ The term "media" is taken here to mean all forms of media, from the traditional folk media to the press, radio and television.

effects on public health and resulted in health impairment. The question to consider therefore is how health education can make better use of the opportunities offered by the very wide coverage of the mass media and their potential impact.

5.3.1 *The role of the mass media*

There are a number of major functions that the media can perform in the field of health. Possibly their most important role is to help create a political will in favour of health by appealing to the policy-makers. While material prepared with this objective in mind is aimed at those in high positions, it can also help in forming public opinion.

Their second role is concerned with raising the consciousness of the people and helping to set norms that have a strong bearing on health. Many illnesses are due to inappropriate life-styles or to changing technological conditions. The media can help foster an objective debate on such issues, and can enable individuals and the society at large to make informed decisions.

The third major role of the media is to inform decision-makers about the latest developments in, and the limitations of, health sciences and health care. This also involves monitoring the impact of development programmes on the health of the people and publicizing successful approaches so that they can be repeated elsewhere.

Finally, the mass media can help in fostering community involvement by reflecting public opinion, by encouraging dialogue between the community and the health care providers, and by facilitating the feed-back to decision-makers.

Innovative approaches are needed, however, to carry out these tasks effectively and to improve methods of communication in health education. For example, messages can be conveyed by all types of television programme, either didactic or purely entertaining. Culture-specific entertainment programmes can in fact become effective vehicles for delivering health education messages in a real-situation context. The media can also often help by giving prominence to particular health messages.

There is little doubt that well-targeted mass media programmes can play a very important role, by both taking the lead in and maintaining the momentum of health education efforts. In order to be really effective, however, the health education programmes trans-

mitted through the mass media must be part of a comprehensive health care package in which health professionals take a leadership role.

5.3.2 *Promoting a continuing dialogue*

A prerequisite for achieving the desired impact is close cooperation between health care providers and the media professionals. There is a severe shortage of good writers on health issues and well-informed media personnel in both developed and developing countries, the shortage being particularly acute in the latter. This calls for training programmes to expose media professionals to valid information on health issues and to ways of securing such information. On the other hand, health professionals need to be trained in communication techniques and the effective use of media resources. A continuing dialogue between the mass media and health professionals is important to ensure a regular flow of accurate information. Health communications emanating from non-governmental organizations and other independent institutions should also be used to encourage such a dialogue.

One challenging task will be to educate media professionals and the proprietors and managers of advertising agencies about the negative impact on health of certain messages, and commodities advertised through the mass media. Thus, in addition to disseminating positive health messages through the mass media, efforts must also be made to eliminate, if necessary through legislation or other appropriate measures, messages that have a negative influence on health behaviour.

5.3.3 *Some important points to be considered*

(a) The information transmitted by the media carries a certain prestige, and interpersonal communication can often enhance the acceptance of certain ideas; when both are combined the chances of influencing people to take appropriate action are greatly increased.

(b) The mass media alone are inadequate for the communication of information leading to behaviour change.

(c) The mass media are only instruments. As such, they are neither good nor bad; what matters is the message they carry, the way that message is delivered, and the policy behind the message.

(d) Sometimes there may be risks involved in transmitting information on treatment and therapy through the mass media. For example, if incorrect information on a new treatment claiming complete cure for an illness is publicized in the media, false hopes may be raised among patients suffering from that illness.

(e) The mass media can relay the voices of health professionals to the people, with the object of encouraging the people to initiate action. First, however, there must be an awareness of the important problems of the individuals or communities concerned, as well as a readiness to become involved in finding an effective solution.

(f) Similarly, the mass media can serve to carry the voice of the people to the decision-makers. Messages that emanate from the people themselves will have considerable impact. Local communities should be encouraged to express their views on health problems through the press, radio, and other media. Community leaders can take an active role in such activities.

(g) The mass media have a special responsibility to transmit to remote underprivileged communities health messages that are adapted to their needs and concerns.

(h) New communication technology may be useful in many instances, but caution should be exercised, especially in the developing countries, in adopting new gadgets promoted by commercial interests.

International discussion of the use of mass communication techniques to support development has promoted in many mass media personnel, and has reinforced in others, a sense of social responsibility in their professional work. Instead of being merely observers and reporters of events, many of those who work in the mass media have come to realize the potential power of communication and the need to participate more actively in the development process. Many of them are ready to be recruited as lay health educators.

5.4 Training

5.4.1 The need

In many countries health personnel are not appropriately trained for the tasks they are expected to perform. For the primary health care policy to be effectively developed and applied, it is necessary, as recommended by the Alma-Ata Conference, that "governments undertake or support reorientation and training for all levels of

health personnel; that health workers, especially physicians and nurses, should be socially and technically trained and motivated to serve the community..." (4).

The WHO Seventh General Programme of Work, covering the period 1984–1989 (7), provides guidelines on the strategies and targets prescribed by WHO for the period 1984–1989 which the Member States are called on to use in deciding on their health activities. It stresses, among other things, that:

"Trained people are the key to the health infrastructure. People can build institutions but institutions cannot function without people. Without the right kind of trained people, the other resources of a health system are underutilized, if not wasted. However, in both the developed and developing countries manpower development in the planning of health services often receives scant attention. In many countries, no manpower policies exist. Where they do, they often have little relevance to the long-term and changing needs of the health system and the communities and individuals within it. Emphasis on cooperation with Member States will therefore have to shift, particularly with a view to promoting political will to change the health manpower development process and make it more relevant to national health development plans aimed at attaining health for all through primary health care."

The Seventh General Programme of Work (7) further states that "health workers will increasingly be required to provide intelligent guidance and encouragement to communities in prevention and health promotion as well as curative care".

The two major areas of primary health care that require changes in training of health care personnel have been stressed earlier in this report. These concern encouraging self-reliance at the individual and community level, and cooperation with other sectors.

As regards encouraging self-reliance, too often in the past preventive health measures have been carried out without involving people in the planning and without informing the people afterwards about the outcomes of these measures. Hence, today, individuals and communities are showing increasing resentment to this approach. Therefore, health care providers must be made aware, through appropriate training, of the fact that people wish to have a say in matters that affect their condition and that they have a right to know about the results of the activities carried out in their community.

With regard to intersectoral cooperation, it is important to promote a real interest in the health aspects of socioeconomic development in all sectors concerned with development. This calls for a wide range of health education activities in all aspects of community life—with schools and workplaces being given priority

—including activities in specific fields such as nutrition, water supply, housing, communication, protection of the environment, and the use of the mass media. This in turn requires new skills on the part of the health educator in developing cooperation with professionals from other disciplines.

5.4.2 *The objectives*

An overall objective of training in health education should be to help trainees perceive clearly their new roles (with regard to the contribution that education can make to primary health care) and to assist them in acquiring the knowledge, attitudes, and skills necessary for their jobs.

To summarize what has been said in other parts of this report, training programmes should develop in the students the capacity to:

- adopt a new outlook and be concerned not only with disease prevention and control but also with development in general and with people-oriented technologies;
- act as “facilitators” of action by the people;
- promote the two-way transfer of technologies between the health system and community;
- assume an advocacy role for the cause of health *vis-à-vis* both the people and the decision-makers; and
- recognize the contribution that professionals in other sectors can make to the promotion of health.

The training should enable future health care providers to realize that one of their main tasks is to concentrate on raising the competence of families in influencing their children to adopt a healthy life-style. This will preclude the need to have to correct adult behaviour, later, after unhealthy habits have set in. Hence, a primary concern must be to teach the families to use appropriate knowledge in bringing-up their children. In this way, health education will become an integral part of the process of socialization.

5.4.3 *The content*

Training models based on human ecology need to be developed. While no definite training curricula can be proposed here, with regard to health education content, training programmes should:

- encourage positive attitudes among trainees in dealing with health problems;
- take into account the relationship between living conditions and

- health and the influence of political, sociological, and cultural factors on individual and community behaviour;
- provide knowledge on health cultures and the social structures of communities;
- include methods of analysing family participation in health care, taking into account the fact that professionals from many sectors, rather than those from the health sector alone, should be involved in promoting such participation;
- reinforce among the trainees an awareness of the need to consider organizational and administrative factors in planning health education activities;
- make it possible for the trainees not only to acquire scientific knowledge, but also to develop skills in transmitting this knowledge;
- include the principles and techniques of communication—health care providers need to know how to transmit health messages effectively, and should be able to train lay persons so that they can become actively involved in health work and in motivating their community;
- develop in the trainees an increased awareness of their social responsibility.

Those concerned with health education should be particularly sensitive to the problem posed by attempting to include additional topics in curricula that are already overloaded. Curriculum planners should be encouraged to give consideration (*a*) to the elimination of subjects that may not be as essential as health education in the perspective of primary health care, and (*b*) to the integration of the educational approach in the teaching of other subjects.

5.4.4 *The approach*

Training should be a continuous process and should not stop after the basic training. Continuous training is essential not only because health technology is changing rapidly, but also because the work experiences of each individual should be shared with others. In this regard, several points need to be emphasized.

Learning by doing. In the context of primary health care, training for health education should be firmly linked to reality, and it is thus preferable to start the training in the field—urban or rural—rather than in a classroom. This approach will give the trainees useful practical experience and will make the classroom teaching

much more relevant; this is particularly valid with regard to social sciences and education. Classroom teaching will be further enhanced by the use of methods such as role playing and simulation games which enable students to grasp the problems better.

Student participation. Some recent programmes aim at making students take on more responsibility for their own training. In such an approach, the experts respond to the students' needs and provide knowledge and guidance "on demand", rather than "teach" in the traditional manner. This kind of relationship between the teacher and trainee enables the latter to understand the approach he or she is expected to use later in dealing with individuals and communities.

Training the teachers. The WHO Seventh General Programme of Work (7) stresses the need to "encourage teachers in the health professions, including those for middle level and primary health care workers, to define the learning objectives of their training programmes on the basis of the health needs of their country and develop competence in the planning, implementation and evaluation of curricula".

Appropriate technology. Teaching and learning materials, including those for self-teaching and audiovisual purposes, adapted to different cultures and languages should be developed by the institutions concerned for all categories of health manpower contributing to health development, particularly for primary health care workers and their teachers and supervisors.

Interdisciplinary training. The new approaches in health education require that training by health professionals be supplemented by multidisciplinary and multisectoral training. In other words, health professionals of different categories and non-health professionals should learn together. In this way they will be able to appreciate each other's responsibilities better, thus avoiding overlapping of responsibilities and gaps in the services rendered.

The aim of interdisciplinary training is to achieve a horizontal type of education that will reduce the isolation in which health care providers are trained. Furthermore, this approach will create an interaction between medical schools, nursing schools, etc., and institutions where disciplines other than health are taught.

5.4.5 *Obstacles and constraints*

Attempts to modify training curricula and programmes encounter a number of obstacles that originate from three sources: (a) the

faculty, which often shows little inclination to try out innovative programmes; (b) the students, who are usually worried about the unpredictable effects of any change; and (c) administrators, whose efforts at reform sometimes conflict with the views of professionals, who regard innovations as contrary to their interests.

It is obviously difficult to overcome the resistance of these groups and obtain their active support in modifying training programmes. Therefore, to begin with, it will be important to identify the teachers and students in key positions who are most open to the proposed change and then form a core group that will help promote the new approaches. This strategy of "change from within" is a long process, but experience shows that it can be effective.

One way of accelerating changes in training programmes is to make the students realize that there is a public demand for information and education for health. As this awareness develops, the students will more willingly accept that their courses should include health education topics, not merely as additional subjects in an already overloaded programme but as an integral part of the curriculum. This popular demand should be encouraged since it provides a realistic basis for training.

Indeed, the users of health care make no mistake about their needs. When people were asked in a recent survey in what ways a general practitioner could do his job more effectively, they suggested several areas for improvement, including: being more available, offering up-to-date medical facilities, working as a member of a team, and, above all, being more communicative with the patients.

With regard to the last point, students should have the opportunity to improve their health education skills in an environment as similar as possible to that of their future professional activity. This will enable them to make themselves better understood by the people.

5.4.6 *Other professions*

Among the many professionals in other sectors whose activities have an impact on health, teachers occupy a position of privilege. Schools indeed deserve considerable attention in any health policy that stresses cooperation with other sectors. Systematic efforts must be made to integrate health education in the curricula of primary and secondary schools, technical colleges, and universities.

Within the field of disease prevention and health promotion, health education aimed at children should make it possible for them to develop their physical and mental potential to the utmost, to appreciate the need to protect and promote the quality of life, and should help to prepare future generations to build a better, healthier world.

Health education thus becomes a major aspect of "development education" the ultimate objective of which is to encourage "critically aware persons who have the motivation and the skills to participate in development efforts" (8). In other words, development education aims at making people become effective workers for a more livable and equitable world. Such an education requires the support of specialists in different fields including, for instance, town-planners, architects, teachers, and social workers.

In fact, people from all sectors, and professionals in particular, should assume responsibility for helping young people develop a "will for health" through educational efforts that are positive and flexible, and avoid a non-moralizing approach.

5.5 Evaluation

With regard to the health education component of primary health care, ways must be found of making health education sufficiently specific so that implementation of educational activities can be monitored and their effectiveness evaluated. This will enable decision-makers to judge whether or not their allocations to health education are yielding adequate health benefits.

Another purpose of evaluation is to determine whether the adopted strategy has been effective, and what have been its positive or negative side-effects. In the past, very little evaluation of health education activities has been either requested or carried out.

Linking health education activities with a specific outcome is something relatively new and not easily or willingly accepted by those who are responsible for these activities. One obstacle to successful evaluation has been the way health education activities have usually been planned and carried out. It has been assumed that health education should meet the needs of a certain target population, and these needs should be defined in terms of the prevention and/or treatment of various diseases. Consequently, health education has so far been problem-oriented, and has used the medical model—which emphasizes the role of natural sciences in the study

of man and his illnesses and isolates the individual from his environment. By using the medical model, a reasonably high level of association may be found between a certain behaviour and a specific disease, justifying the demand for health education to modify that behaviour. But the built-in evaluation mechanisms in such an approach are often too narrowly focused to provide data on the social, economic, and cultural factors underlying the behaviour.

In fact, a major responsibility of those carrying out evaluation is to undertake periodic monitoring of programme activities in order to ensure that health education activities are being carried out as planned and that the results are satisfactory.

In evaluating the contribution of lay persons to health care, criteria defined by the lay persons themselves should be used. While some of the criteria of lay persons may be consistent with professional values, others may not be, and still others may be outside the range of professional interests. It will therefore be necessary to devise new methods of evaluation (beyond those that have been used so far in health education) and to avoid imposing professional standards in determining whether the results achieved are "important" or "adequate".

The difficulties associated with evaluation of health education activities show the need to develop scientifically rigorous models that specify clearly the role of health education in health care.

5.6 Research

While the value of research in health education has been greatly stressed in the last decade, the emphasis has been mostly on developing and testing health education interventions aimed at reducing morbidity and/or mortality associated with specific diseases and at reducing fertility rates. The biomedical orientation of such research led to neglect of many of the social and behavioural aspects of health, which were outside the clinical range of interest, but which were crucial for achieving successful and sustained changes. However, in recent years there has been a move in research towards studying the importance of life-styles in preventing disease.

It is realized today that in conducting research on new approaches, health education has to be regarded as: (a) an intricate network of activities that require consideration of a number of interacting variables; and (b) as a part of a wider intersectoral system of health services which is the primary health care system. In this

framework, research on mass communication systems should be considered as a part of research on health education. Since the community occupies a central position in all these systems, social scientists will need to make critical contributions, as members of interdisciplinary teams, to the development of new approaches to health education. This will require a reorientation of some of the concepts and methods of social sciences, particularly in the context of developing countries.

In conducting research in health education the points given below should be considered.

(a) Research in health education should aim at developing and/or improving appropriate policies, strategies, and methods of planning, management, and evaluation for health education programmes in order to increase their relevance and effectiveness.

(b) Researchers should keep in mind that education for health is culture-specific and that all health education approaches may not be applicable everywhere. Also, one should not make generalizations about health education on the basis of experience gained in one community.

(c) Research should focus on identifying the areas of agreement between the community and the health care providers on priority health issues.

(d) In testing different models of health education, researchers should keep in mind the importance of knowing the views and attitudes of the people concerned.

(e) Researchers should seek to provide data on ways of involving communities in defining problems, developing evaluation criteria, elaborating hypotheses, and interpreting findings. This will make research and evaluation more relevant to the community and facilitate better utilization of findings and recommendations. Community involvement would also guarantee more realistic evaluation criteria; if the people can define the problems they are also likely to be able to find solutions to them.

Some areas where research is needed include:

(a) *With regard to the community:* ways of developing lay resources; data on the beliefs, knowledge, attitudes, and health practices of communities; data on communities' needs and priorities, perceptions of health services, and treatment-seeking behaviours.

(b) *With regard to health care providers:* epidemiological data; data on the availability, accessibility, and utilization of health services; information on how the health care providers perceive the

health problems of the communities they serve, and on their understanding of the local health cultures and attitudes.

In the final analysis, an essential objective of research should be—as a preliminary to planning—to identify priority areas for action. For this, it is necessary to go to the people with a feeling of respect for their values and their felt needs. This requires also a scientific study of the situation. As repeatedly stressed in this report, there are two dimensions to be considered: the needs as perceived by the people and the epidemiologically assessed needs. Priority should be given to the area where the views of the people coincide with those of the professionals. With regard to major health issues this is where the maximum return can be obtained in the initial stages.

6. CONCLUSIONS

Historically, health care providers have concerned themselves with health problems. Individuals were not necessarily involved in the development of health care priorities. More often than not, they were simply the passive receivers of a service when it existed. The emerging concept of primary health care has drastically changed this view. Many policy-makers and governments have gradually come to understand that men and women—every man and every woman—are capable of being actively involved in matters regarding their own health, provided that they are aware of the issues involved, of the resources available, and that their efforts have social and political sanction.

This concept obviously requires a change of attitude, not only among the individuals themselves but among those who provide health care. Experience has shown that paternalistic approaches and the imposition of decisions upon others are seldom effective. The people need to understand the problems and to collaborate fully in finding a solution, together with the health care providers, in order for health care to have an impact on the health situation. The modern concept is that the role of health education in this process is one in which the health care providers and the people both teach each other and learn from each other, changing roles constantly. Far from merely seeking the cooperation of communities in carrying out plans already made, health education should aim at encouraging people to be actively involved in the planning and maintenance of

their health care system and to act in partnership with health care providers.

In this approach to health education in primary health care, the objective is to foster activities that encourage people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health, and to seek help when needed.

This new objective not only emphasizes a basic purpose of health education, i.e., the provision of knowledge, but goes further in seeking political and social backing for health and health care activities.

This concept obviously emphasizes the intersectoral character of health. No longer is health, or its health education component, the prerogative of any single group; it is the concern of all who are involved in cultural and socioeconomic development.

The new approach thus becomes an upward and horizontal movement which meets people's expectations to take full part in the affairs of the community, of the nation, and of the world. Men and women have become gradually aware of their rights and privileges as human beings. They are demanding social equity—fostered by political development and a greater access to the media. It must be realized that the individual is free to think and plan, despite physical, social, economic, ecological, and political constraints. It is by respecting the individual's freedom and dignity that health education can provide the setting that will lead to the goal of health for all by the year 2000.

SUMMARY

(1) The Alma-Ata Declaration designated "education concerning prevailing health problems and the methods of preventing and controlling them" as the first of eight essential activities in primary health care.

(2) Accordingly, the WHO *Global Strategy for Health for All by the Year 2000* and the WHO Seventh General Programme of Work give to information and education for health a role more prominent than ever before.

(3) It is therefore essential to review the current approaches to health education in order to identify those that continue to be

relevant, to abandon those that are no longer valid, and to develop new approaches which could help in achieving the objectives of health for all through primary health care.

(4) Health science and technology have come to a point where their contribution to the further improvement of health standards can make a real impact *only* if the people themselves become full partners in health protection and promotion.

(5) One major objective of the primary health care approach is to help individuals and communities become self-reliant in dealing with health problems and to raise the effectiveness of the lay contribution to health.

(6) This objective calls for a people-oriented health technology that meets people's needs and aspirations. Too often in the past, "modern" health practices have been promoted without giving sufficient thought to their relevance to the social and cultural background of the communities concerned. An effort must be made to enable individuals and communities to play an active role in the planning and delivery of health care.

(7) To assume such a role, people need guidance and encouragement from the health care providers in ways of identifying their health problems and of finding solutions to them. They also should be able to set targets and translate these into simple and realistic goals that can be monitored. Finally, they should realize the need to refer to the policies behind the public health programmes in setting priorities among the targets identified.

(8) Health care providers require adequate training to: (a) assimilate the concepts of a people-oriented technology and broaden their concerns beyond disease prevention or control; (b) act as "facilitators" of action by the people; and (c) assume an advocacy role for the cause of health *vis-à-vis* both the people and the decision-makers.

(9) For this purpose, training programmes should: (a) be realistic, and preferably start in the field rather than in a classroom setting; (b) use teaching methods that call for participation and that would thus prepare trainees for the approach they are expected to use later with individuals and communities; (c) provide opportunities for the trainees to learn together with workers from other professions so as to recognize the contribution other professionals can make to the promotion of health.

(10) In addition to teachers one group of professionals that can make important contributions to health education are the media

personnel. Many media personnel have come to recognize their social responsibilities in the development process and, in particular, the power of the mass media in creating a political will in favour of health, raising the health consciousness of the people, setting norms, delivering technical messages, popularizing health knowledge, and fostering community involvement.

(11) Greater involvement in health matters on the part of individuals and communities, however, in no way absolves health care providers from their responsibilities. On the contrary, this approach demands additional patience on their part to enable people to develop effective action for health. The health care providers should have a thorough understanding of the "health culture" of the communities they serve and of how that culture is influenced by the dynamics of social and cultural change and by the political and economic organization.

(12) The influence of the social environment on health calls for a reorientation of the health education approach from a focus on changing individual behaviour—implying that the individual is solely responsible for his plight—to an approach taking into consideration the social context in which the individual lives, i.e., the political, economic, and environmental factors that have a negative or neutralizing effect on health behaviour.

(13) This comprehensive approach also implies: (a) that health education cannot attempt to influence particular behaviours (smoking, overeating, etc.) without taking into account the general lifestyles of individuals and communities that are influenced by traditional values, forms of communication, etc., and (b) that health education models based on human ecology should be developed which take into account the interaction between the biological and environmental factors influencing harmonious development.

(14) The integration of health education goals in the planning and management of health programmes requires a systematic approach at all stages, i.e., elaboration of policy, formulation of strategies, planning and management, implementation, and monitoring of progress.

(15) Strategy formulation should emphasize the importance of integrating health education goals into relevant development activities in other sectors such as agriculture, education, irrigation, industry, literacy programmes, etc. Health is no longer the prerogative of any single group; it is the concern of all those who are involved in social and economic development.

(16) “Feasibility”, “realistic improvement”, and “efficient use of available resources” should be watchwords in planning and management activities in health education. Furthermore, it is essential that communities have a clear understanding of their role in the development of policies and strategies for solving health problems.

(17) As a member of a team or a coordination body, the specialist in health education has an important contribution to make at the different stages of planning and management, particularly in defining the goals, approaches, objectives, and evaluation criteria for health education, and in promoting community involvement through appropriate technology.

(18) An essential objective of research should be to identify the priority areas for action, in particular those in which the felt needs of the people coincide with the epidemiologically assessed needs. In planning programmes, priority should be given to goals that emerge from such needs since the achievement of these goals will yield maximum benefit.

(19) To assess the educational impact, evaluation mechanisms should be built into programmes, with criteria reflecting a broad ecological approach and a concern for measuring non-professional inputs without imposing professional values.

(20) In conclusion, health education in primary health care aims to foster activities that encourage people to: *want* to be healthy; *know* how to stay healthy; *do* what they can individually and collectively to maintain health; and *seek* help when needed. The new approaches must match the people’s expectations to take a full part in the affairs of the community and the world at large.

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ACKNOWLEDGEMENTS

The Committee acknowledges the special contributions to its deliberations made by the following WHO staff members: Dr I. Kickbusch, Regional Officer for Health Education, WHO Regional Office for Europe, Copenhagen; Dr C.H. Piyaratana, Regional Adviser in Health Education, WHO Regional Office for South-East Asia, New Delhi; Dr B. Tomic, Regional Adviser, Community Health, WHO Regional Office for the Eastern Mediterranean, Alexandria.

The Committee also acknowledges the special contribution made by Dr L. Baric, Director, Unit for Health Education Studies, and Reader, Department of Community Medicine, Medical School, University of Manchester, Manchester, England.