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RESOURCES FOR COMMUNITY HEALTH EDUCATION

The role of resource personnel, health education officers and resource centres in the promotion of effective health education in developing countries

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1. INTRODUCTION

According to the World Health Organisation and UNICEF, three-quarters of the illness in the World could be prevented or cured by health education linked to inputs of better nutrition, clean water supply, sanitation, immunisation and family planning. Effective communication is an essential part of achieving all of these inputs and of implementing the W.H.O. concept of Primary Health Care enshrined in the Alma Ata Declaration of 1978 which called for "Health for All by the Year 2000".

Health education and communication activities in developing countries are carried out by a wide range of persons within health, sanitation, water supply, nutrition, population, education and home economics and community development services. However, government-based primary health care programmes in many countries have found it difficult to replicate on a national scale the enthusiasm and energy of small-scale projects. A major challenge is to find ways of disseminating improvements in health education approaches at the local field level.

Many countries are now seeing the need to train resource persons within these different services whose task is to both increase the quantity and improve the effectiveness of health education and communication support activities. These resource units may be on a small scale as part of hospitals, training centres or voluntary bodies. At the same time a network of health education and communication resource units at both national and district levels are being set up in many countries. These are staffed by specialist health education officers whose functions involve both the planning as well as coordination of health education and communication activities within the different services.

The staffing and function of these specialist support services has not always been carefully thought out and many difficulties have been encountered. This discussion paper will examine the need for specialist health education resource persons and units, the functions that they can perform, the special problems faced in the organisation of health education services and finally consider the factors to be considered in developing a policy for health education within a country or department.

"In its broadest interpretation, health education concerns all those experiences of an individual group or community that influence beliefs, attitudes and behaviour with respect to health as well as the processes and efforts of producing change when this is necessary for optimum health. This all inclusive concept of health education recognises that many experiences, both positive and negative have an impact on what an individual, group or community thinks, feels and does about health; and it does not restrict health education to those situations in which health activities are planned or formal"

"In more limited meaning health education usually means the planned or formal efforts to stimulate and provide experiences at times and in and ways through situations leading to the development of the health knowledge, attitudes and behaviours that are most conducive to the attainment of individual, group or community health."

W.H.O. (1969)

2. THE NEED FOR HEALTH EDUCATION RESOURCE PERSONNEL AND SERVICES

2.1 Who does health education?

Health education is part of the activities of many persons as shown by figure 1. For example the staff at clinics and health centres are all involved. Community health workers in primary health care programmes are key health educators at the village level. Public health inspectors as well as rural health assistants are heavily involved in health education as part of their promotion of water, environmental sanitation and hygiene. And even curative workers in the hospital sector have a health education role as part of the treatment and rehabilitation process.

Outside the health services many are involved in health education such as teachers in schools and education workers in adult education and literacy programmes. Agricultural workers when they advise communities on growing crops are also involved in education and influencing health and nutrition. Community Development officers promoting community organisation and cooperatives such as dairy programmes have a key role in promoting community action on health issues.

in addition to the government agencies are many voluntary bodies actively involved in health education which might include nutrition groups, family planning associations, the Red Cross, Unicef, Missions and other societies. Politicians are often speaking out and promoting policies on issues that affect health.

Many groups are already involved in health education in some way or other. If health education is part of everyone's job, we need to ask an important question: Why do we need health education specialists? In the rest of this paper I will look at some of the reasons why specialist health education services are needed.

****
* If health education is part of everyone's job, we need to *
* ask an important question: *
* *
* WHY DO WE NEED HEALTH EDUCATION SPECIALISTS? *
* *
****

Figure One:

MANY PEOPLE DO HEALTH EDUCATION IN THE COMMUNITY

HEALTH SERVICES

Doctors and nurses in primary health care
midwives
health visitors
family planning
medical assistants
nutrition programmes
immunisation programmes
special disease programmes
village health workers

INFORMAL PROCESSES IN THE COMMUNITY

elders
parents and child rearing
traditional birth attendants
traditional healers
village leaders
religious leaders
initiation cermonies

PUBLIC HEALTH SERVICES

public health inspectors
water supply
sanitation
hygiene inspection
refuse collection

EDUCATION SERVICES

teachers in primary & secondary schools
adult education
literacy programmes
pre-school programmes
vocational training

AGRICULTURE & SOCIO-ECONOMIC DEVELOPMENT

agricultural extension
vetinary programmes
community development
applied nutrition programmes
cooperative
employment generating programmes
Women's programmes

2.2 The need for coordination

The fact that many people are already doing health education is good. But it also can lead to special problems. Different people may advise different things. For example while the health worker may be advising people to drain pools of water to prevent Malaria, the agricultural officer may be doing the opposite and actually be promoting pools for fish ponds.

Sometimes there can be very controversial issues. An example of this is family planning and the safety of the pill and the injectable contraceptive Depo Provera. Another is the controversy over the risk of vaccine damage with Whooping Cough immunisation. The public can get very confused with the conflicting messages they hear from the different 'experts'.

So it's important that the health education activities of different fieldworkers and agencies do not conflict but REINFORCE each other. There is a need for coordination of different groups so that they work in the same direction.

This important coordination role is often carried out through the health education specialist's participation in planning meetings for different topics. This is especially important for large scale national projects. For example, the health education specialist could be part of committees dealing with topics such as water supply, immunisation, primary health care and family planning. The function of the health educator is to make sure that the health education components of these programmes are properly covered and that the educational activities of all agencies are coordinated.

2.3 The need to up-date field staff

Another related problem is that that the advice that we were giving before on a subject may have been wrong. In some cases the advice may have actually been harmful to health. We need to be aware of the latest developments in epidemiological and medical research to make sure that our advice really will improve people's health.

A good example of outdated knowledge is the mistaken belief that the main cause of child malnutrition is protein deficiency. Nutritionists have known for ten years that this is wrong and nutritionists now emphasise adding fats to increase the energy density of weaning diets. But many health workers and schoolteachers still teach this out-dated knowledge and malnutrition continues.

The Ventilated Improved Pit Latrine - or V.I.P. - has been developed from research in Zimbabwe, Botswana and Lesotho as a major improvement on the traditional pit latrine. The vent pipe with a fly screen takes the bad smells away and prevents flies from spreading disease. Many health workers and teachers are still not aware of this improved pit latrine and continue promoting the traditional pit latrine with its problems of smells and flies.

It is thus necessary to continually up-date the knowledge of all the field workers who do health education. The challenge is to get new ideas out to the field as fast as possible.

2.4 Improving communication and teaching skills

It is not only a matter of new knowledge but also new teaching skills. Far too many health and other field workers teach in formal lectures and classes. The teacher is the expert and there is a one-way flow of information with limited opportunities to discuss. Newer approaches to health education emphasise group discussion methods which allow plenty of opportunities to ask questions and develop a critical understanding of health issues. Learning should be made an active process with projects, surveys and role plays.

Health workers, teachers and other field workers may find it difficult acquiring these new teaching approaches for a number of reasons:

> Their own training has emphasised mainly formal teaching methods such as lectures and they are often unfamiliar with participatory learning methods.
>
> They often come from different backgrounds from the community and this can lead to a lack of understanding or 'empathy' with the community
>
> Their education and medical training can lead to them using complex and language which can confuse the community.
>
> They may be unwilling to give up their role as 'expert' and work on an equal basis with workers from other agencies and the community

Training programmes to prepare health workers for community health education programmes must attempt to overcome these problems. There are important implications for the selection of health workers and decisions over where training courses should be held.

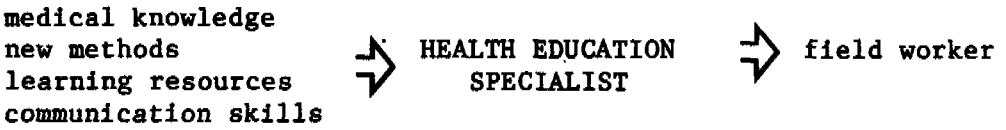
Visual aids have also been used badly in the past just for one-way flows of information. Newer approaches are to use visual aids as a learning aid to promote discussion and understanding of one's environment.

An example of a teaching approach that is still widely used but is now considered wrong is nutrition education using the food groups body-building, protective and energy-giving. The use of food groups is criticised by nutrition educators for a number of reasons. It is irrelevant to the main cause of child malnutrition, nutritionally incorrect by placing important sources of protein such as cereals in the energy group and does not fit in with the dietary concepts of the community.

2.5 **An interface with the outside world**

This need to up-date field workers with knowledge and skills can involve a range of activities. Experience is building up on a world-wide scale from different countries on the ingredients for effective community health education and it is important to find ways of making this international experience widely available. These experiences are reported in journals and newsletters which are often supplied free by international agencies so this is not necessarily an expensive process. The organisation Teaching Aids at Low Cost at the Tropical Child Health Unit of the Institute of Child Health in London has done a valuable service by acting as a distribution centre for relevant books and details of newsletters.

A simple resource library can thus be set up from readily-available material to form a valuable knowledge base on methods for prevention of disease and health education techniques. Books and reports should be properly catalogued so that readers can consult them and get the information that they need. Papers can be stored in filing cabinets under key subject headings. Important information can be extracted from international journals and put into local newsletters for distribution to field workers. In this way, the health education specialist acts as an interface between the outside world, field workers and the community.



2.6 **Building up a local knowledge base of experience**

It is not enough relying on experiences from other countries. They may not be appropriate to local conditions. You may need to have examples of local projects to convince people of the value of community health education. It is useful to set up demonstration field projects e.g. community projects, school health programmes where trainee field workers can visit and work for short periods. It is not a good idea to have too many visitors to community projects as it can upset the relationships between field workers and the community. Another approach is to prepare written case studies or - even better - teaching slide sets or video films where you can see what is happening.

Communication between different voluntary agencies and government departments is not always very good. They may not be aware of what each other is doing. Often interesting and relevant health education work has been done locally but no one knows about it. Work done ten years previously may have been forgotten and many valuable lessons lost. Field workers may be too busy to evaluate or write up what they are doing. People may be reluctant to tell others about their failures although valuable lessons could be learnt. There may be no opportunities for health workers to share experiences either through seminars or newsletters.

An important task in the development of community health education is thus to:

build up a LOCAL body of knowledge

set up small-scale pilot projects which can provide examples for other programmes and training

evaluate health education programmes and disseminate findings though reports, seminars etc.

prepare case studies of local projects either in the form of written reports or teaching slide sets/films

provide opportunities for health workers and the community to share experiences on community health education programmes

provide a resource library and newsletter

Summaries of new ideas can then be circulated to field workers through newsletters. But passing on of new ideas and teaching methods is best done through personal contact. The health education specialist may receive field workers at his health education centre. Or the health education specialist may go out into the field and advise fieldworkers on the spot.

The most common way of passing on new ideas and teaching methods is through training workshops where field workers come together for periods from one day up to as much as one month or even more.

2.7 Production of media and learning resources

There are some activities which it makes sense to centralise at a health education resource centre. For example slide sets and films are too expensive for every school of health centre to keep. These can be kept at a health education unit and loaned out to fieldworkers. Fieldworkers should be encouraged to develop their own educational materials. But at the same time facilities such as artists and printing presses are best centralised as a service to all field workers.

Health education specialists are thus often involved in the design and field testing of audio-visual materials. If effort is put into producing materials, it is important to consider how they should be stored and made available to others. Leaflets should be carefully stored at the health education resource centre and be made available to a wide range of organisations. Posters are also be stored flat and distributed to the field.

Another activity that requires specialised skills and equipment is the production of radio programmes and other mass media. Although fieldworkers are often involved, the health education specialist is a key person in preparing scripts, recording and editing programmes.

2.8 Research and evaluation

Research and evaluation are essential ingredients for planning effective health education programmes. It's a good idea to involve fieldworkers in this process. It is also important to find ways of involving communities directly in participatory research and evaluation activities. But special skills in statistics and research design are needed and this forms an important part of the health education specialist's role.

2.9 Conclusions: The need for resource centres and specialist health educators

The promotion of community health education within existing health programmes will involve a continuing process of training and support. Many countries have found it necessary to set up health education resource centres at a national or district level to coordinate health education effort and deal with problems of conflicting and out-of-date advice from different agencies.

The main functions of a health education resource centre in a developing country can be summarised as:

coordination of activities of health workers and other agencies

training in health and communication skills

providing an information service and up-dating knowledge

stimulating other agencies e.g. schools to become involved in health education

production/distribution of educational materials

planning and implementation of large-scale programmes where appropriate.

producing mass media back-up for community health education

research and evaluation

As typical examples, The job decription adopted in Botswana for a Regional Health Education Officer together with the job description of a Provincial Health Education Officer in Zambia are given in the Appendix.

The most important health education work is that carried out by field workers based in the community. Their effectiveness can be greatly increased by a well-organised health education service. The creation of simple locally-based resource centres and the training of key personnel within health, education and nutrition and other services as health education support staff is thus an important starting point in the development of community-based health education programmes.

3. PROBLEMS IN THE FUNCTIONING OF HEALTH EDUCATION SERVICES

A range of problems are faced by the emerging health education support services in many developing countries. (1)

There may be little government commitment to prevention and health education. Support may be at the level of rhetoric only with the bulk of expenditure remaining firmly with curative urban-oriented health services. Notions of health education, individual responsibility and self-help can be used by governments as a way of avoiding tackling the social and economic determinants of health.

Despite the emphasis on inter-sectoral cooperation and socio-economic measures in the Alma-Ata Declaration on Primary Health Care, there has been a failure to develop the health education potential of different agencies outside the health services e.g. schools, community development, agriculture, adult education, radio and television services. A confused public may thus receive uncoordinated, conflicting and sometimes inaccurate advice on health from different fieldworkers and agencies.

There may be no clear national policy for the development of health education activities and services. A recognition of the need for proper planning of health education effort, coordination between agencies, training of fieldworkers in communication skills and development of support learning materials has led to the establishment in many countries of health education services and the training of health education specialists. However their role has not always been well-understood by government and health planners - especially their relationship to the fieldworkers who carry out the main part of the health education. The health education specialist is usually in a weak position within health services. The overall responsibility for health education and key decisions on content of health education programmes are often in the hands of medical personnel with little training in the behavioural sciences and communication. Health education specialists can be frustrated because of low status, lack of training, low power and poor career and promotion opportunities.
A survey of health education in developing countries by the World Federation of Public Health Associations (1986) provides a valuable review of appropriate methodology for health education but fails to consider the organisation of health education services and mechanisms for the dissemination of innovations in health education practice. Little attention is given in another comprehensive review by Walt and Constantinides (1984).

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(1) This section is derived from a more general review of barriers facing health education in developing countries: Hubley, J.H. (1987) Barriers to Health Education in Developing Countries. Health Education Research 1(4) in press.

Carlaw et al. (1980) reviewed the development of health education services in Indonesia, Papua New Guinea and Nepal and related this to the use by services of personnel with diploma or masters training. The relative competence and authority of these two levels of training in Africa has also been discussed by the health educators based at the WHO Africa Regional Health Education Centre at Ibadan, Nigeria (Adeniyi and Brieger, 1981).

A useful discussion of the roles of regional health education officers in Botswana has been presented by Finlay et al. (1983) who describe a training programme based on the roles defined.

Nichter (1986) has provided an interesting analysis of role conflicts and organizational problems within the various field workers in the health centre and primary health care teams in Sri Lanka. The particular problems of the newly-established health educators are considered and provide a good example of the dilemmas involved in the issue of professionalization of health education support services. Non-graduate health educators with a coordinating role were well received by other workers. However this was unsatisfactory to the health educators because of the ill-defined salary scale and career structure. A decision to use graduate personnel as health educators allowed the creation of specific salary scales but their new supervisory role was resented by the non-graduate PHC staff.

Ochor (1984) has developed a comprehensive check list of 30 criteria for health education service functioning covering four broad areas: guiding philosophy and policy; organisational structure and management; resources; and services and operations. These criteria were applied to Oyo State Health Education Unit in Nigeria and showed short-falls in personnel, funds, facilities, equipment and supplies. Although the survey methodology is poorly described, factors of inadequate status and poor hierarchical status were reported to be linked to the non-attainment of many of the factors. A fruitful topic for future research would be to develop this check-list of Ochor (1984) and apply it to a variety of health education settings. It is also important to consider the problems of health education within the broader context of analyses such as Segall (1983) of appropriate health policy making for primary health care.

A summary of the various reasons for failure due to the organisation of health education is given in Table I below. There has been little research in this important area of organisation of health education services and health education policy in general. This is a valuable area for future study.

Table I Failures Due to the Organisation of Health Education

1. Lack of a clear government commitment and national policy for health education. Low priority for health education in health services compared to curative medicine.

2. Poor understanding of the role and importance of health education and prevention on the part of politicians and the public.

3. Failure to develop the health education potential of different agencies outside the health services e.g. schools, community development, agriculture, adult education, radio and television services.

4. Uncoordinated, conflicting and sometimes inaccurate advice on health from different fieldworkers and agencies.

5. Health education is left to a small group of health education "specialists" only. other health workers, teachers etc. say that it is not their job.

6. The weak position of the health education specialist e.g. low status, lack of training, low power, poor career and promotion opportunities.

7. Frustration of the health educator because of isolation and lack of understanding, encouragement, support and practical help from others including national health education services.

8. The overall responsibility for health education in health services and the key decisions on the content of health health education programmes are in the charge of medical personnel with little training in the behavioural sciences and communication.

4. POLICY MAKING IN HEALTH EDUCATION

4.1 Why is a policy necessary?

Many of the difficulties facing health education services could be anticipated and overcome by careful planning and government action. It is important that health education services have an agreed policy for their work which should be written down in a policy document. The purpose of a policy document is to:

provide a basis for forward planning in the allocation of effort and procurement of material and manpower resources

communicate to others the objectives and priorities for the health education services

create the framework within which health education staff can carry out their work with a minimum of delays and protocol in their communication with other departments and agencies

4.2 Who should make the policy?

The health education specialist staff are the persons who will have to implement the policy and should coordinate the process of preparing the policy. However it is important that all groups who are likely to be involved in future health education activities are consulted and participate in preparing the policy. The policy should be seen to meet the needs of all relevant groups. It should fit in with policies for other issues e.g. primary health care and community development.

Any policy must take into account issues and concerns that the general public feel are important. It is important to build in some element of community participation into the policy-making process.

It is essential that the policy is accepted and formally approved at the highest level by the various departments involved e.g. Health, Education and Social Work. Obtaining approval at a high level may slow down the process of obtaining an agreed policy, but in the long term will ensure that proposed health education activities are actually implemented.

4.3 What should a policy contain?

A policy for a health education department should contain the following:

.1 a brief statement defining health education

.2 a statement about needs for health education

indicating:

state of health and scope for prevention
who does health education
problems with existing health education
scope for improvement of health education

what should a policy contain?/continued

.3 A statement about the relationship of health education with national policies for health, primary health care, community development, education etc.

.4 A statement about the NEED for a specialist health education service:

for: coordination
production of educational materials
training of fieldwork staff
guiding national policy
reference/resource centre

.5 policy statements concerning:

.1 priorities within present resource constraints
for:
specific health problems e.g. tuberculosis, sanitation
interventions e.g. schools, radio, community health

.2 size of health education service, future expansion
manpower
facilities
material production equipment
storage/display

.3 management structure for national health education including nature of committee/subcommitees (diagrammme)

.4 duties/job description of health education coordinator and lines of communication within health service and with external agencies/services

.5 relationship of health education coordinator with other agencies

e.g. Universities
Health training institutions
Community Development services
Dept Education, teacher training colleges, curriculum developmemt centres

what should a policy contain?/continued

4.3.6 specific objectives

The policy document should set targets for short- and long-term development of health education activities which should cover at least a five-year period. A time-scale should be given for the achievement of each objective. This programme should be summarised in a bar chart.

targets could be set for the following:

establishment of health education resource centres

setting up of pilot projects/demonstration programmes

school health education

curriculum development for - teacher training
nurse training
community health worker training

in-service training programmes (who to train, length of training, training needs, trainers)

manpower development for health education specialists
provisions for training

purchase/production/distribution of materials

radio

etc. (depending on priorities)

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APPENDIX

SPECIMEN JOB DESCRIPTIONS OF HEALTH EDUCATION OFFICERS

1. Provincial Health Education Officer (Zambia)

Administrative:

(a) Supervise health education activities in all institutions.
(b) Supply supporting materials to health staff and others.
(c) Report back to headquarters periodically on progress and desired changes in the health education programmes.
(d) Maintain liaison with related ministries and institution.

Development:

(a) Plan and organise health education component of all health programmes in the province for the provincial medical officer.
(b) Plan and conduct health education training programmes.

Technical:

(a) Undertake health education teaching in nurse training schools and other institutions.
(b) Undertake health education teaching in teacher training colleges and other departmental training institutions.
(c) Undertake training of village level leadership in health education.
(d) Conduct in-service training programmes for all categories of village level staff.
(e) Assist health staff in health centres in promoting helath education activities in their institutions and organise community projects in solving health-related problems.
(f) Help and assist in developing health education programmes in hospital and encourage patient education.
(g) Develop public relations programme in all health institutions.
(h) Plan and prepare local health education materials to suit local language, culture and communications systems.
(i) Organise health education acititvies in rural areas for the mobile film unit.
(j) Prepare and distribute technical materials to all health staff.
(k) Assist teachers in developing school health education programmes in schools and supply materials.
(l) Undertake periodical evaluation of health education programmes.
(m) Undertake field studies to determine health education needs.

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1982

2. Region-based Health Education Officers in Botswana

1. Provide technical advice and resource aid to regional, district and local health personnel for their community and patient helath education efforts.

2. In collaboration with local health workers, direct, encourage and participate in the creation and/or activation of Village Health Committees.

3. In collaboration with local health workers, direct, encourage, and participate in the coordination and implementation of Regional and Local Health Seminars,

4. As a member of the regional health Team, identify the principal health problems of the Region, assess their associated human behaviours, and determine the underlyin personal, community, and learning factors contributing to these behaviours.

5. Considering the availability of resources and the magnitutde of health problems and their related human behaviours, deelop realistic priorities and a programme of activities for Health Education in the Region.

6. Be the principal liaison between the Regional Health Team and community extension agents of other government and non-governbment organizations in the region.

7. Maintain liaison and collaborate with District and Sub-District Educational aurothrities to plan and implement sound Family Life, Nutrition and other positive health principals in the education of primary school children.

9. Coordinate the use of Audio-visual materials and equipment for health purposes in the Regions thorugh distribution of health education literature and instruction in the use of available media.

10. In collaboration with the Central Healh Education Unit, coordinate the collection of specific information about knowledge, beliefs, attitudes and behaviours related to helath through household and other types of surveys.

11. As a member of the Regional Health Team, prepare and coordinate in-service for health professionals.

12. Encourage and participate in the establishment of a formal or informal health dialogue with faith healers, traditional healers and with traditional birth attendants.

Finlay et al. (1983)