

## WHAT IS COMMUNITY HEALTH EDUCATION?

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### Historical background

13. Although the idea of health education has a long history, government involvement in it is relatively recent. Over time, and all over the Commonwealth, individuals have taken it on their shoulders to extol the need for health education and "propaganda", but it is probably fair to say that it is only in the last twenty or thirty years that health education has received financial and institutional support on a national scale.

14. The World Health Organisation gave health education a recognised place in the 1950s by convening an expert committee who reported on "Health education of the public" in 1954 (WHO, 1954). The committee recognised that the progress of health education would depend on the training of personnel; on the interest, understanding and support of official authorities and voluntary organisations; and on the financial resources made available. As more and more countries of the Commonwealth became independent, so gradually were steps taken to support health education programmes.

15. In India, for example, a Central Health Education Bureau was set up in 1956, and by 1980 there were health education bureaux in 20 states and five union territories, as well as some district health education units (Central Health Education Bureau, 1980). In Africa, health education became a focus of interest in the 1960s, culminating in 1975 in the setting-up of the African Regional Health Education Centre in Ibadan, Nigeria (Ademuwagun, 1979). At the 1973 Caribbean Health Ministers Conference in Dominica, it was decided to set up a model programme of health education, which was later established in Antigua (Schweser, 1976). The various countries of the Pacific region have held a number of regional workshops on health education (eg WHO/UNICEF, 1981) which mirror the growth of official interest in health education throughout the 1970s.

16. Thus, although it has long been recognised that many groups have made important contributions to health education in the last decade, health education has increasingly come to be accepted into the mainstream of government services. Likewise, it has long been accepted that the community plays an important role in health education. The first WHO expert committee of 1954 recognised "the prime necessity for enlisting the goodwill and participation of the people, since health education of the public always involves working with people whatever the circumstances may be" (WHO, 1954).

### The evolution of community health education

17. The concept of community health education has evolved from the old notion of "health education of the public", together with a re-focusing on preventive health care and a changing emphasis in community participation.

18. **Health education of the public.** One of the popular models used by professional health educators in the 1950s and 1960s was the KAP model (knowledge, attitude, and practice) which assumed that once people had

knowledge (given by health educators) they would change their attitudes or practice.

19. In other words, once people were told about the dangers of cigarette smoking they would stop smoking or at least cut down, or once they were told how to control their fertility they would have fewer children. As morbidity and mortality in the industrialised world became more associated with life style so the KAP model was boosted, as it was argued that individuals could control their own health by proper diet, taking exercise and not smoking.

20. These assumptions were increasingly challenged in the 1970s. It was first of all clear that KAP was over-simplified. Merely providing information was no guarantee of change in knowledge or attitude, let alone practice. Behaviour is governed by a complex system of values. This was particularly true in relation to family planning.

21. Second, concluding that health status would improve if people took individual action assumed a substantial degree of individual choice which the critics of "victim-blaming" were quick to point out hardly existed. All the evidence suggested that health status was closely linked to occupation, income and social conditions, all factors that health education alone could not affect. Indeed some have argued that ascribing culpability to individuals or groups is totally misplaced, and it is towards the "manufacturers of illness" that attention should be directed. Thus, for example, health educators should be concerned not about individuals' diets but about the food industry and the processed, synthetic "convenience foods" and widely-used additives it promotes (McKinlay, 1975). In the less developed countries, where the so-called "diseases of affluence" were less in evidence (although growing in a number of such countries), it became equally obvious that health education could only partly affect major problems like diarrhoeal diseases. Adequate water supplies and reasonable sanitation were much more likely to make an impact on a community's health status.

22. **Preventive health.** The discussion about victim-blaming came from changes in attitudes to preventive health. The great preventive health moves made in the industrial world last century were directed largely towards improving sanitary conditions but did not involve the public. The community was, on the whole, passive. As medical science developed this century, revolutionary new drugs opening a new era of medical technology and capital investment, focus shifted from preventive to curative medicine, from "the public" to individuals. Again, it was directed towards a passive recipient public.

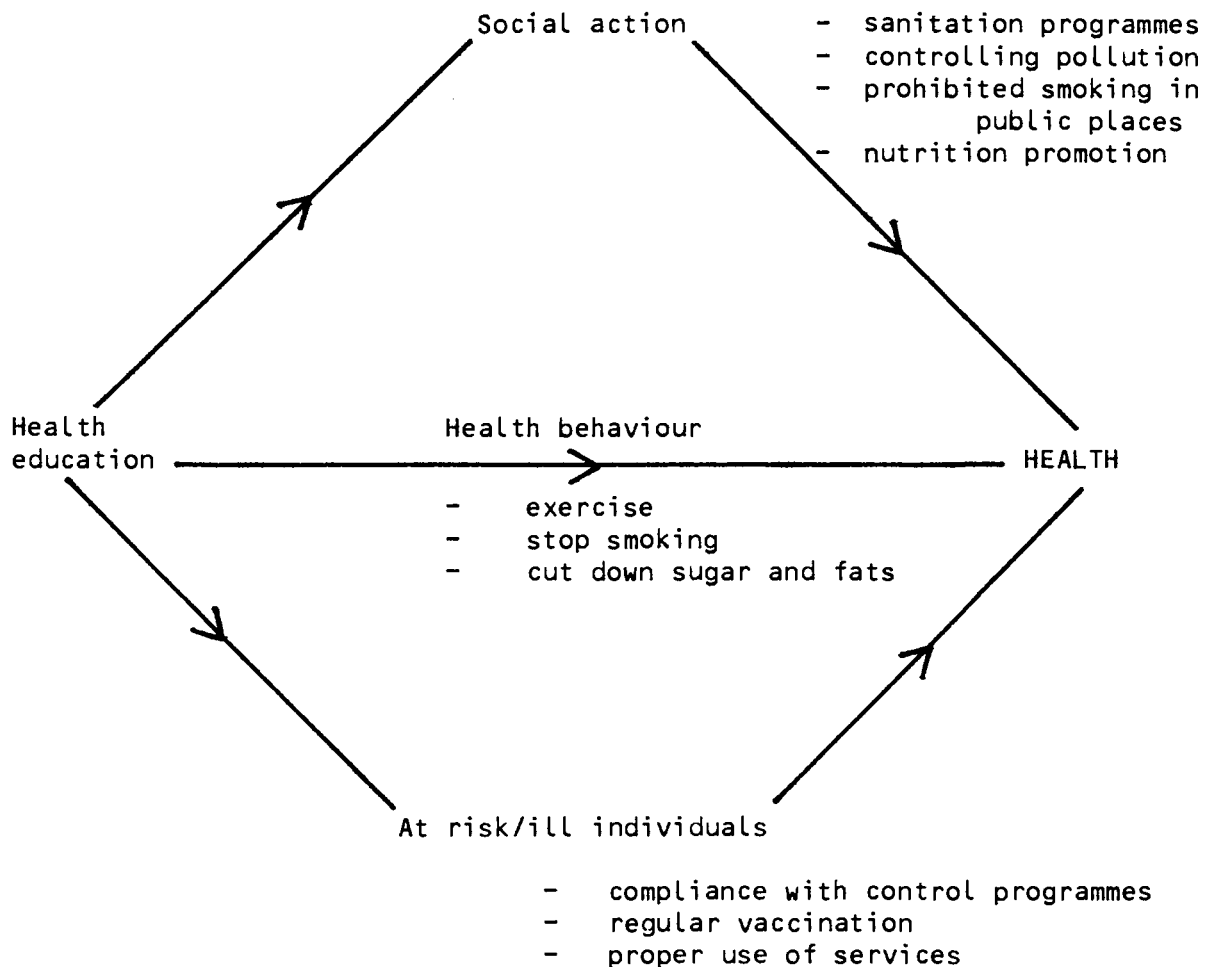
23. Reaction to the limited gains of medical technology (and rising costs) came to the fore in the 1970s, and a number of studies demonstrated the relationship between mortality and life style, arguing that **individuals** had to take responsibility for their own health by eating less and cutting down on certain foods, exercising more, stopping smoking and so on (British Department of Health and Social Security, 1976). Thus, for example, "Prevention and health: everybody's business" demanded action from individuals.

24. This propensity to place all stress on individual behaviour led the revolt against victim-blaming, giving way to a more cautious concept of prevention that increased the ability of people to take maximum power over their own lives, and expanded their capacity to change the social relations and structures in which they live and work. The implications for health educators and health education were far-reaching. Health education moved along a continuum from information and education to promotion. It moved away from its **informational** role - distributing posters and pamphlets, lecturing to passive audiences on radio or at clinics - towards an **educational** role, in which people work towards changing behaviour by intervening in the political and social processes that can bring about changes. Health **promotion** later became the order of the day: the move towards

people campaigning for better health by changing their environment rather than, or as well as, changing individual behaviour.

25. This can be better understood if health education is aimed at three levels:

- (a) healthy individuals, in order to keep them healthy;
- (b) social action for a better environment;
- (c) sick or at-risk individuals, to help them restore health.



26. As road accidents increase in third world countries, as local food is replaced by synthetic, perhaps imported "convenience" food, as death rates from coronary heart disease rise, so many less developed countries need to move towards promotive health education. Indeed, a recent WHO publication has challenged these countries to think about "primordial prevention" aimed at preventing the emergence and entrenchment of social, economic and cultural patterns of living that are known to contribute to elevated risk factor distributions (especially coronary heart disease) in developed countries. Examples of such action would be national government policies on nutrition, or on smoking control, in co-ordination with the agricultural sector, the food and tobacco industries, import and export sectors and education (WHO, 1982).

27. Such action implies a high level of government commitment. Many governments obtain large amounts of tax revenues from the sale of such products as tobacco and alcohol, which raise clear conflicts between health educators who wish to promote environmental change, industry and government.

28. **Community participation and primary health care.** The other move which led to the concept of community health education was related to the push towards primary health care and, in particular, community participation in primary health care.

29. Officially adopted in 1978 by the World Health Organisation, the primary health care approach became the impetus for change in health policy around the world (Walt and Vaughan, 1981). One of the stimuli for this change in health policy came from reported successes in community participation. The primary health care approach accepted that health was conditioned by other factors, such as nutrition, housing, water and sanitation, and that people's participation in the control of their own health could make a vital difference to the health of the community.

30. The assumption underlying community participation is that community organisation or people working together, when combined with professional skill, can overcome problems that would remain unresolved if total reliance were placed on professionals and formal government institutions.

31. In a background paper prepared for a regional WHO meeting held in 1978, the *raison d'être* for health education as part of the primary health care approach was given. "This concept of primary health care must be based on community participation, which is in turn totally dependent on systematic health education." Part of the resolution that resulted from the meeting expressed the conviction that the programmes in primary health care would not be successful without adequate health education based on the needs and wants of communities (WHO, 1978).

32. Community health education is thus a complex concept that has arisen out of a focus on communities rather than individuals, an emphasis on participation and involvement, and a desire to promote preventive health action. It is an approach to health education that has been paralleled in other fields such as adult education, where the emphasis has switched from individual to group learning, to mass literacy campaigns using Freire's ideas about communication as a tool. In its widest sense community health education is not separate from development: in the less developed countries in particular, health educators are more likely to be effective if they campaign with the community for piped water supplies rather than simply give advice on boiling river or well water before drinking it. The recognition of the importance of socio-economic factors in relation to health is understood: without development, improvements in health are limited.

## Community health education in the Commonwealth

33. Most countries of the Commonwealth are involved in some community health education at some or all of the levels described above - keeping individuals healthy, promoting social action, or helping to prevent further illness in those at risk or already ill.

34. Community health education programmes involve many different groups, from large to small, highly organised to very informal. It is a mistake to see the "community" as a homogeneous mass. In the same way, community health education may imply involvement in a collective process or action, or involvement in decision-making or planning. This last sort of community participation is less common, however, since it implies a level of decentralisation unusual in most countries. However, most Commonwealth countries claimed to be involving communities in health education.

35. This fits in with most countries' expressed intention of expanding primary health care. However, just as it has been stated that commitment to the implementation of primary health care depends enormously on political will (WHO/UNICEF, 1978), so does community health education depend on political support. From the responses to the questionnaire it is clear that, although many countries pay lip-service to health education, there is a gap between planning, or intent, and practice. Health education is not generally given high priority in terms of resources, nor on the whole does it have much status or influence in ministries of health. One result of this is the tendency of health educators to fall back on conventional informational roles, where numbers of talks given and publications produced give a comforting impression of productivity. Another result is to rely on technology - to buy hardware to enhance the status of the profession.

36. Green (1981) calls attention to three fallacies that equate the effectiveness of health education with the quality and quantity of advanced educational technology available. The first is the **empty vessel fallacy** - the belief that health educators have simply to pour health information into the empty minds of an eagerly waiting target population. The second fallacy is the belief in the **inherent superiority or inferiority** of some methods - most educational methods being as effective as they are appropriately applied. The final fallacy of **the more, the better** suggests that more television and radio coverage and more media equipment will increase positive outcomes proportionately. The pros and cons of using such technology are explored in the section on using the media.

37. Thus, although there is a stated commitment to community health education, as will be seen in the next chapter when we look at responses to questionnaires there seems to be a discrepancy between policy statements and how much health education units actually do in the community. The intention is there, the belief in community health education, but according to the priority activities of most health education units, less is put into community health education than might be supposed from the stated support it receives.

## Notes

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