38. In this section we discuss the responses to the questionnaires sent to Commonwealth countries. Forty-seven countries (including four dependencies) completed questionnaires.

Health education units

39. Almost all countries of the Commonwealth have a special section in their ministries of health dealing specifically with health education. In five low-income countries health education is not a separate section but is subsumed under the public health division. Two countries are in the process of establishing health education sections. The health education unit is the most typical name give to the section, but there is some variety: health promotion unit, division of health education and information, and bureau of health education are all examples. For convenience we will refer to health education units in this report.

40. Seventeen countries do not have a specific section dealing with community health education. This does not necessarily mean that community health education is not considered important. Indeed it often indicates an unwillingness to separate community health education from other health education. Many countries would agree with the Zimbabwean respondent who declared that **all** health education is community health education.

Staff

41. We asked countries to tell us the qualification of the heads of their health education units. We felt this would be an indication of several things: the status accorded health education, the likely level of influence of the unit within the ministry of health, and the extent to which health education has become professionalised. Of course, the answers also reflect the availability of personnel and opportunities for training.

42. The most typical qualification of the head of the health education unit is a diploma in health education or a masters in public health with a special emphasis on health education. Medical qualifications are common, as are diplomas or degrees in nursing and community health. There is a good deal of diversity in educational background, with education, social science, and communication skills more likely in the high income countries like Canada, Britain and Australia. (See Table One.)

43. Support staff for the health education unit follow the above pattern to some extent: there is a scattering of health educators, doctors, more nurses, several public health inspectors or sanitarians, and a few midwives. Four countries have a dentist (Fiji, Papua New Guinea, Singapore and Sri Lanka), six countries have social scientists (Australia, Britain, Canada, The Gambia, India and Uganda). Many countries have people concerned with producing material: artists, journalists, photographers, audio-visual experts, publicity officers. One country includes a scriptwriter-translator, another a home economist. A concern

about family planning comes through in some countries which have family life educators and family planning motivators.

Table One

Heads of health education units and their qualifications* January 1982

Diplomas in h.e. (or advanced dip. in h.e.)	Dominica, The Gambia, Kiribati, Lesotho (BSc) Malawi (BA), Seychelles,*** Sierra Leone, St Kitts-Nevis, Tanzania, Tonga
Masters in public health	Ghana, Grenada, Jamaica (h.e.), Malaysia (h.e.), Nigeria, Swaziland, Uganda (h.e.), Zambia
Diploma in public health	Fiji, Guyana*** (community health), India,** Mauritius,** Singapore,** Sri Lanka,** St Vincent (community health)
Masters in health education	Bahamas,*** Kenya (ed. and communication), New Zealand (communication), Zimbabwe
SRN or other nursing	St Lucia, Solomon Islands, Vanuatu, Western Samoa
Other	Australia (B Econ), Britain (DM, FRCP), Canada (Ph D educ), Malta (epidemiologist),

* Not all countries answered this question, and some countries - eg Tuvalu, Nauru, Brunei, Cook Islands, Cyprus - do not have a formal head of health education.

** Medically qualified as well.

*** Nursing qualifications as well.

44. It is striking, however, to see how few health education personnel exist within the countries. In only seven countries are there more than 40 health education personnel employed by the health education unit. They are: Jamaica (population 2.1 million), Malaysia (3.1 million), Nigeria (82.6 million), Singapore (2.3 million) and Sri Lanka (14.5 million),* and only in Sri Lanka have all (43) got any formal health education qualification. The large rich countries like Australia (14.3 million) and Canada (23.7 million), with their federal or state systems, have more, but in total not many over 100 personnel. For most Commonwealth countries then, it seems that health education is the responsibility

* All population figures approximate, based on 1979 figures (Commonwealth Secretariat).

of a very small number of people. However, this may be an inaccurate picture. As one respondent put it, "We see all professionals being involved in health education and have scrapped **all** full-time health education posts". In many countries there are people engaged in health education, working through community development projects or education departments at district or local levels, who are not necessarily attached to the health education unit or the ministry of health.

45. Two impressions emerge from the replies to the questionnaire. First, most people in health education in the Commonwealth have a public health or medical background, and only a few high-income countries have broader focuses, using the social sciences and communication skills. Second, although most ministries of health have a health education unit, these units are not usually very large, and do not support large networks of health educators in the field. However, small numbers of health educators in the field may be a strength if health education is seen as an essential part of most health workers' jobs.

Activities

46. What sort of activities are health education units involved in? We asked countries to list their activities in high, medium or low priority. Production of materials is considered to be a high priority in practically every country; only four of the respondents did not place particular emphasis on dissemination of information through pamphlets, books and posters. Radio and sometimes television are also considered to be important, and the emphasis on rural or peri-urban community programmes probably reflects to some extent the infrastructure of each country. (Only seven countries have greater than 50 per cent of people living in urban areas.) The special campaigns accorded high priority tell us about current concerns: anti-smoking, anti-VD, anti-cancer, "Food is life", breast-feeding, functional literacy, school health, teenage programmes, immunisation. Training programmes are also recognised as important.

47. Table Two gives a breakdown of priorities in activities. It is interesting that newspapers and journals are seen as far less useful than radio: this may well reflect the relative ease of communication by radio in countries where the infrastructure makes regular supply and distribution of newspapers difficult.

48. Not surprisingly perhaps, most countries have similar target groups with specific social or health problems towards whom health education is aimed. Mothers and their children aged under five years, parents and schoolchildren are mentioned by most countries. There is clearly a concern with young people and there are many special campaigns ranging around addiction - smoking, alcohol and other drugs and also sexual problems - sexually transmitted diseases, family planning, teenage pregnancies. These are all relatively common to most countries. A number of other targets are interesting, and reflect concern with particular groups: ethnic minorities, immigrant workers, political refugees, school vendors, food handlers, and specific problems such as TB treatment defaulters, diabetics and thalassaemia.

Table Two
High priority activities in health education units

	No. = 47 %
Production of materials	90
Radio (or/and) television programmes	76
Rural community programmes	71
Training courses	69
Peri-urban community programmes	47
Newspaper or journal information	40
Outpatient clinic programmes	40

Community participation

49. We asked how communities were involved in health education. This sort of question can be interpreted in many ways, and it is not easy to glean from the respondents how widespread community participation is. Tentatively, types of community involvement fall into six groups:

(a) there are those countries (usually small) where a whole community may participate in a "clean-up campaign", for example;

(b) there may be extensive use of voluntary groups, women's groups or clubs in health education;

(c) teachers, parent-teachers associations and then schoolchildren themselves may be invoived in health activities;

(d) many countries mentioned village health committees and primary health care workers who work generally on specific health education projects;

(e) there are many types of volunteers, who relate to families, adolescent peer groups and so on, and who are important in involving communities;

(f) there are the media programmes which involve listening groups - sometimes whole communities, sometimes special groups like alcoholics.

50. Community involvement can be traced along a time continuum: from one-off projects that involve large numbers of people, to projects that may take two to three months and involve people quite intensively, to volunteers who interact with the community on a regular basis over long periods.

51. All the Commonwealth countries gave examples of such programmes. For example, Brunei had a health week with the whole community involved in a clean-up campaign. Tanzania experimented with radio-listening groups in a **Man is health** programme* over three months. Jamaica trained teenage volunteers as peer

* See paragraph 85 et seq for description of this project.

group leaders in family life education. Tonga used village volunteers in its diarrhoeal campaign, and St Kitts-Nevis involves volunteers in the production of material for health campaigns.

52. We asked about experimental or innovatory projects, but replies were a little disappointing. There are interesting examples, however. Nigeria has tried selling health in the market place,* Western Samoa has, as part of health education, encouraged income-generating activities like poultry raising and vegetable growing. Botswana, Swaziland and Zambia have used theatre in community development projects. In Sri Lanka young volunteers take health messages into village homes.** Other countries are trying to decentralise, and many are training volunteers or primary health workers in health education activities.

53. We asked whether health education units had tried to evaluate any of their programmes. Many countries have made attempts to assess their activities, but it is probably true to say that evaluation is not built in as an on-going process. It is sometimes undertaken as a one-off exercise and several countries mentioned one or more particular projects that they had tried to evaluate. A general lack of overall evaluation is, however, evident if one looks at the gap between what the health education theorists are saying and what most health education units put as their highest priority. In other words, the theorists suggest that posters and pamphlets by themselves have been shown to be a poor use of resources, a poor way of communicating, a poor way of getting over information and of little effect in changing behaviour. Yet it seems that it is precisely this activity on which most units are spending time and money.

Training

54. In order to get an idea of where people obtain their health education qualifications, and how important health education units consider their training role, we asked several questions about training. Only 11 of the responding countries have institutions which offer basic health education qualifications. They are Australia, Britain, Canada, India, Jamaica, Kenya, Malaysia, Nigeria, Sierra Leone, Sri Lanka and Zimbabwe. However, several countries run short courses for health personnel to become health educators - India (90 days), Nigeria (2 weeks - 1 month), St Lucia (3 - 6 months) and Sri Lanka (3 months), among others.

55. Twenty-six countries run short health education courses for health workers and others, teachers being a main target group but including community leaders, social workers and rural development staff. These take the form of workshops and seminars, often at district or local level, and include things like communication skills. At least six other countries have plans in the pipeline to introduce short courses, and several made the point that health education is an integral part of the curriculum of most health workers, and also in many schools. Only ten countries have not organised short courses in health education. One country said explicitly that courses had been discontinued because of lack of personnel and funds.

56. Those countries that send personnel abroad for further training tend to do so to regional centres. Nine African countries mentioned Ibadan University in

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* See paragraph 200 for description of this project.

** See paragraph 113 et seq for description of this project.

Nigeria as their preferred choice, and institutions in the USA were popular choices, Michigan State University being the most often named. Both the University of Hawaii and the University of the West Indies in Jamaica attract people from their local regions, as also does the University of Papua New Guinea. Other courses mentioned were in India, Australia, Britain, Lebanon, the Philippines and one in Rennes, France. It is interesting that of the 11 countries claiming to have institutions which offer higher health education qualifications (Australia, Britain, Canada, India, Jamaica, Kenya, Malaysia, Nigeria, Papua New Guinea, Sierra Leone and Zimbabwe) only six of these were mentioned by other countries as places to which they send health personnel for further education.

57. Some countries believe in in-service training, and do not send their health personnel abroad; others are planning to set up their own qualifying courses, with objectives appropriate to their own needs. In view of the general debate about professionalisation in health education, this could be a useful area for exchange of ideas; also useful would be a discussion on more regional collaboration and co-operation.

Media

58. The answers to our question on what percentage of people own a radio differ somewhat from official figures. Official statistics are gleaned from ownership of radio licences, and it is obvious that many countries do not have the infrastructure to enforce the purchase of licences or to check on their ownership. It is also clear that one licence may cover many people's listening. Indeed a radio in a community centre could be accessible to a great number of people.

59. However, from the information in the questionnaire and other sources* we can make some fairly accurate generalisations. The rich countries (Australia, Britain, Canada, New Zealand) have a very high radio ownership: it would be fair to say that almost 100 per cent of their populations have fairly immediate access to radio. Many of the Caribbean countries and island communities (Fiji, Cook Islands, Nauru, Seychelles) also claim high coverage by radio, and indeed some of the multi-island countries rely on radio for most communication. Finally, there is a group of countries for whom information is scarce and probable radio ownership and access quite low. These are often poor countries with large rural populations, limited road and electricity networks, perhaps multi-lingual, where structural difficulties are compounded by lack of resources. Some of the African countries fall into this category, as do some of the smaller island communities.

60. It is perhaps not surprising that television is limited to a few countries, and where it exists to very few people within the country.

61. Given that even radios can be scarce items in rural communities, we asked whether countries had had any schemes for group listening to radio or watching television. Only 12 countries mentioned specific projects - in schools, with farmers, or for adult literacy - but a few others have plans for listening groups, and yet others pointed out that informal crowds often gather around radios and televisions in bars or community centres.

62. Alive to the fact that many countries have several languages or dialects and that it is all too easy to produce programmes in the national (which is not necessarily the majority) language, we asked whether there was any production of programmes in local language or dialect. It was reassuring to see that practically all the countries of the Commonwealth have programmes in local languages or dialects, although the extent to which they are produced or used was not asked.

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* Commonwealth Secretariat statistics based on World Development Report and UN Statistical Yearbook.

63. If radio is to be an effective medium for communication it must extend throughout the country, and according to our questionnaires it does. Every response was positive. This was clearly not so for television and newspapers. About 15 countries claimed the television network is available everywhere, but in some cases this was patently not so, although it may have meant it was potentially available. Newspapers are similarly not available everywhere, although 29 countries claimed they were. A number of countries do not have a daily newspaper, but only a weekly paper, and one country has no newspaper at all, only government circulars. For many countries, distributing the newspaper is the difficulty, so it tends to be limited to urban groups. Clearly these are important issues when taking into consideration effective methods of communicating health education messages.

64. We were interested to find out how much control each country might have over its media. This can be important in stemming or countering any commercial messages that are not in the interest of health, or banning them completely. It could also make access to time for health messages easier if ministries of health are not competing on a commercial basis with other interest groups, although this depends very much on government policy in running the media. Given that most governments have at least a controlling share in the media, it was interesting to ask both whether any attempts are made to restrict undesirable advertising on radio, television or in the press and how much promotion of good health behaviour is done through these mechanisms.

65. There is some control of radio advertising in 19 countries, and 21 countries restrict what can be advertised on television, and 16 in the press. They are not all the same countries: some, for example, have legally forbidden cigarette advertising on television but not on radio. The most common restrictions are on advertising cigarettes and baby milks, although two countries mention a ban on alcohol advertising. Not all the restrictions are legally binding; some rest on voluntary agreements.

Table Three
Government ownership of the media

	Government-owned			
	partly	wholly	Independent	Total
Radio	15	28	4	47
Television	8	16		24*
Press	17	10	20	46**

* Twenty-three countries do not have television.

** This includes weekly as well as daily papers. One country has no newspapers.

66. Although 36 countries said they were promoting good health behaviour through the radio, very few countries followed up their claim with the examples we asked for. Those that were given related to the dangers of drinking and driving, not using seat belts, or information on the benefits of proper exercise, nutrition and family planning. Some countries said that these were only occasional campaigns, and such methods of health promotion were not used continuously.

67. We asked whether countries had any television or radio programmes designed specifically for use in schools. Thirty countries said yes, one more saying they are being developed. Radio and television especially are used for regular health education: these programmes most popularly take the form of straight talks or discussions.

Table Four
Countries controlling or promoting health advertising

	Controlling	Promoting	Controlling and Promoting	Neither	Total
Radio	5	22	14	6	47
TV	8	2	13	1	24*
Newspapers	6	15	10	15	46**

* Twenty-four countries have television.

** One country has no newspapers.

68. Other ways of getting the message across are through "flashes" on radio; programmes to appeal to special groups - farmers, women and so on; one country mentioned a family serial, another a radio doctor, and another contests in question and answer form. Several countries mentioned formats used by health educationists other than the conventional media: video tapes for schools, mobile cinema, calypsos, songs, poetry and drama, indigenous story tellers, puppets, poem and poster competitions, exhibitions, bus panels, projection of slides on high rise walls and traditional theatre groups were some of the many interesting ideas being tested. Again this seemed a promising area for the exchange of ideas at regional level, since cultural similarities in regions suggest that many of these schemes could be copied and tried in other countries too.

69. It is interesting to see how favourably countries regard radio, in particular, as a useful medium for health education, and yet how much disillusion about radio exists in the theoretical literature. This is discussed in detail in the later section of this report dealing with the use of mass media.

Co-operation between ministries

70. Health education is clearly not something that should be confined to the ministry of health: all our respondents pointed to schoolchildren as being an extremely important target group. We therefore asked some questions related to co-operation with other government sectors.

71. Not surprisingly perhaps, all countries said that there was collaboration with education sectors, either occasionally or regularly. Some ministries of education have special school health education sectors. However, most of the interaction occurs through curriculum committees or departments, although there is quite wide variation between countries. Clearly, the contacts between ministries of health and education exist, and in many places on a very regular

basis. In those 22 countries which have had a major literacy drive - usually under the aegis of the ministry of education - 18 used health education material. Many schools in fact include health education as part of the primary school curriculum. Thirty-four countries are in this position, with three more planning to introduce health education into the curriculum. Health education is an integral part of secondary schooling in 27 countries.

72. Most countries have extensive ties, running to co-operative programmes, with other sectors too. Those named included adult education and ministries of information, agriculture and labour.

Co-operation with non-government organisations

73. Health education units may collaborate with voluntary organisations in health projects both directly and indirectly. We asked whether there were any voluntary or non-government organisations working specifically in the field of community health education. The response was interesting in its variety and size. All countries named several organisations, both with specific objectives (the Anti-TB League) and general (the Red Cross was most commonly mentioned), as well as international agencies (all the UN organisations were named) and many indigenous groups from women to youth organisations to religious bodies and teaching institutions. The number is large and, remembering the limitations of such questionnaires, probably an underestimate.

74. The sorts of projects that might be collaborative were enumerated by the respondents. Most fall into the category of maternal and child care, nutrition having high priority. Family planning or family life education are also commonly chosen projects, while risk groups in the community are sometimes singled out for joint programmes: heart disease and cancer are no longer only rich country preoccupations. In most cases the health education unit supports voluntary organisations running such programmes with materials or sometimes by providing technical assistance. Only occasionally is financial help given, and this tends to be in the richer countries. It is clear that the financial resources of most health education units are extremely limited.

75. The success of such intersectoral projects between government departments and non-government bodies is no doubt due not only to the dynamism of the health educators but also to the interest and receptivity of other sectors and organisations whose prime concern may not be health. It is one way a poorly resourced health education unit may stretch its resources, and indeed its "message".

Conclusions

76. Although the notion of community health education is well accepted, there does not appear to be a clear conceptual view of what it is. Communities are involved in various ways in health education activities, and the commonest view of community health education is that it is diffused through the health system, and not centralised as a specific activity in itself. This raises one of the conflicts for many health education units: that they are usually small, situated within ministries of health, and have difficulties in decentralising their activities. Many rely on voluntary organisations to involve communities (we noted the large number of indigenous voluntary organisations) or on the training of health workers in community health education methods.

77. It seems as if there are two different approaches to health education, which may affect the methods used as priorities chosen in health education activities. One is an essentially medical approach, taught in community health or

medicine departments and public health schools of universities. It is a fairly technical approach, focusing relatively narrowly on target groups or particular problems, often using fairly authoritarian methods of information giving. This is the common pattern. The second is a model which is more related to communication and the use of social science and education methods and theories in changing behaviour. This approach concentrates more on environmental issues, taking into account culture and belief systems. It is relatively rare, and more usual in the richer countries. The two approaches are not mutually exclusive, and even conventional health education units based on the medical model may be using, or be aware of, the concepts and skills of the social sciences.

78. One of the clear findings is that radio coverage is very widespread in most countries of the Commonwealth, and programmes are often transmitted in local languages. The possibilities for health education using this medium are recognised, although the advantages of radio over television (and even newspapers) for ease of communication and feedback are possibly not being fully exploited. Media experts have emphasised that flexible use of radio can involve communities relatively easily, through phone-ins, tape-recording villagers' opinions and so on. This will be discussed fully in the section on using the mass media. It is also perhaps slightly ironic that financial and other scarce resources are often spent countering anti-health messages with health promotive messages on radio (and television), instead of controlling the anti-health advertisements.

79. The focus of concern differs from country to country. In the West Indies particular emphasis is put on teenage pregnancies and sexually transmitted diseases. This is sometimes euphemistically called family life education. Other countries share a concern about sexually transmitted diseases but also addictive problems - alcohol, cigarettes and other drugs. It seems that many of the less developed countries are learning to poison themselves in the style of their industrialised fellow members of the Commonwealth.

80. It is perhaps surprising, given the known serious ill-health that can result from urban industrial processes and other technological innovations, that so little health education is aimed at workers in the workplace: a few countries have put in a great deal of effort into occupational health education, but it is quite rare. Here is an obvious target group that may be neglected. Of course there may be occupational units within ministries of health which are very much concerned with workers' health, but which would not have appeared on the questionnaires. Otherwise, there seems to be a difference of emphasis between the developed and less developed countries. The latter, given their combination of health problems and limited resources, tend to concentrate on the coming generation: they put special emphasis on schoolchildren. The more developed countries, on the other hand, tend to identify particular target groups.

81. Health education in schools is very widespread but, judging from the answers to questionnaires, it is rather conventional: there seems to be a lack of imagination in this area which should be open to much improvement. It seems that opportunities are being lost to involve communities through their schoolchildren.

82. The picture that emerges, then, is one of broad brushstrokes - the finer details can be gleaned only from visits and experiencing the realities of each country. Health education certainly has its place in the health system; and community health education is recognised as an essential, indeed central, concept. However, judging from what were noted as high priorities and from the activities most health education units were engaged in, there may be a discrepancy between recognised needs and practice.

83. In Appendix A are details of particular aspects of community health education in individual countries.