

INNOVATION IN COMMUNITY HEALTH EDUCATION

173. One of the questions asked in the health education questionnaire was whether individual Commonwealth countries were engaged in any experimental or innovatory health education work. Of the 47 countries who responded to this question 19 said frankly that they were not.

174. In some cases this lack of innovative approach was linked directly to tiny, under-staffed, under-financed health education units, and indeed a few Commonwealth countries were and are in an overall acutely difficult economic and political situation. But other countries with units on limited budgets - Botswana is one of several possible examples - are breaking new ground in community health education despite such limitations. What seems far more relevant than lack of resources is the general ethos of health education in some countries: the failure, as yet, to move away from the notion of health education as having a simple "top down" information-giving role, detached from the social and economic context of the health messages' recipients.

175. This becomes clearer when we look at the answers provided by those countries who did consider that they were doing experimental or innovatory work in the health education field. For many it was clear that merely to link health education to a primary health care model, to train primary health care workers in aspects of health education, to involve lay people at the local community level, and to begin to respond to local feedback was in itself innovatory. In other words, moving away from an information-giving model of health education towards a more participatory model involving education, and even community development, in the broader sense was itself experimental. A few countries seemed to imply that it was an uncertain experiment at that.

176. Evidence to date collected from within the Commonwealth, but also from outside, does suggest, however, that community health education can produce positive, and occasionally startlingly good, results. This seems to happen where:

- (a) health education projects arise in response to the expressed need of communities;
- (b) there is a strong local participatory component;
- (c) there is an integrated approach;
- (d) ministries and governments have the flexibility and imagination to move quickly with back-up support and services.

177. Though the more affluent Commonwealth countries, such as Australia and Canada, have several imaginative community programmes involving high-technology media, the availability of such media is by no means a prerequisite for success. Several smaller and economically poorer countries in Africa, Asia and the Caribbean appear to be achieving good, cost-effective results by utilising culturally appropriate indigenous communication techniques such as song, dance, drama and story-telling.

178. In this section we shall examine a few examples of innovation from within and outside the Commonwealth that are reported in the literature. Unfortunately, not all are carefully evaluated. Some are reported only anecdotally by optimistic participants. Some are rather culture-specific. But all seem to have certain desirable features which other Commonwealth countries might wish to look at more closely to see if they could be applied in their own context. The studies are grouped roughly into categories of current interest to health educators, particularly in the developing world:

- (a) school-centred health education;
- (b) mass media approaches with a participatory element;
- (c) community-involving, integrated approaches.

School-centred health education programmes with wider community outreach

179. A majority of Commonwealth countries, 39 out of the 47 who responded, have health education programmes in their schools. For all 39 health education is built into the primary school curriculum and for 32 it is part of the secondary curriculum as well. Some countries with very limited resources are putting the major thrust of their health education programmes into the schools and the rising generation.

180. We do not propose here to enter into the lively debate among practitioners and theorists of school health education as to which curricula and techniques provide stimulating rather than run-of-the-mill health education, and which are the best criteria for assessing the success of school health education. (For more on these questions see: Gatherer, Parfit, Porter and Vessey, 1979, "Is health education effective?", especially pp. 50-84). Answers to the questionnaire indicate that the curricula of most Commonwealth countries include a pragmatic balance of traditional classroom teaching with talks by outside experts and practical activity and discovery. In developing countries the latter range from cultivating and harvesting school gardens as part of nutrition education to the digging of school latrines to foster the understanding and practice of sanitation and environmental health. In several instances the teacher's work is reinforced by the introduction of local health service personnel or primary health care workers into the classroom, and by the active involvement of the parents-and-teachers associations in the practical work.

181. What we want to look at here are a few examples where innovations in school health education have been carefully evaluated, and at a few where the school has been the starting point for health education of the wider community.

Dwivedi, K.N., Tiwari, I.C., Marwah, S.M., 1973, India: Innovations in health education in rural schools, *International Journal of Health Education*, Vol. 16, 2: 100-108.

This small study's value lies first in its careful design and evaluation and second in its demonstration of the effectiveness of two minimal and low-cost innovations, namely, short (one week) in-service teacher training together with co-ordinated action between school teachers and health personnel.

Two to twelve year olds from five primary schools in rural India were divided randomly into five comparable groups - four experimental and one control group. All groups were tested on their knowledge, attitudes and

practice of health-related behaviour. The children were all then given a course of book lessons on malaria, smallpox and cholera, with classes also in personal hygiene and nutrition. The four teachers of the experimental groups were given one week's training in health education, while two of them also received help and co-operation from local health inspectors. Three months after the course the groups were tested again. All the experimental groups showed a significantly increased score over the control group in all tests, but the two groups who had also experienced co-ordinated action between teachers and health personnel showed the highest improvement of all in knowledge, attitudes, and most importantly, practice.

Another evaluated study from a more affluent part of the world is described from America (Coates, T.J., Jeffrey, R.W., Slinkard, L.A., 1981. **Heart healthy eating and exercise introducing and maintaining changes in health behaviours**, American Journal of Public Health, 71: 15-23). Here healthy eating habits were learnt and maintained by elementary school pupils. This study is also interesting for its attempt to involve the members of the pupils' families and generalise the changes outwards to them, though actual changes in practice were only directly observed, rather than reported, for the pupils themselves at school.

Again, measures of knowledge, attitude and practice were employed before and after the health education programme, which involved a total of seven elementary school classes from two schools and consisted of twelve class lessons for informative instruction, participatory classroom activities, personal goal-setting, plus parent handouts, feedback and reinforcement. Results indicated substantial changes in eating behaviour at school, knowledge about heart health, food preferences and family eating patterns as reported by parents. Moreover, eating habit changes persisted over a four-month follow-up which included the long vacation.

182. A direct attempt to use primary school teachers in improving the health education and health status both of pupils and of the wider community is reported in:

Archung, M. and Finlay, J., 1979, **The improvement in the health knowledge of primary school teachers as a means to the development of integrated primary health care in Central Africa**, 10th International Conference on Health Education Abstracts, p. 2.

An in-service training programme for village school teachers in the use of health curriculum was employed to:

- (a) improve the knowledge of teachers in preventive health care;
- (b) stimulate teachers actively to participate in health affairs of their communities;
- (c) introduce a health curriculum in primary schools;
- (d) improve the preventive health behaviour of primary school students.

Here it was the **teachers'** health knowledge, and the practical application of that knowledge, which was tested. Evaluation showed a 30-50 per cent improvement of teachers' health knowledge, and follow-up testing showed knowledge retention and "teacher health action". The authors conclude that their study demonstrates that "periodic in-service training of primary school teachers enhances the establishment of village-level primary health care efforts".

183. As one example of the attempt to use elementary school pupils as health educators within their community, we have the interesting study reported by:

Rohde, J.E. and Sadjamin, T., 1980, **Elementary school pupils as health educators: the role of school health programmes in primary health care**, *The Lancet*, 1, 1350-2.

This project involving elementary school children and their teachers took place in Indonesia. The authors designed a school health manual, organising their material in a format that was familiar to primary school teachers. A total of 49 lessons covered 14 subjects, such as diarrhoea, nutrition, accident prevention, skin care and dental health. A ten per cent sample of families in two villages served by the schools was surveyed both before and after the students received their lessons, the method of survey being questions regarding attitudes, knowledge and practice regarding one topic, diarrhoea. Results showed that after pupils had received their lessons there was a substantial improvement in the knowledge about prevention, appropriate treatment, and the need for referral among both pupils and their families in the community.

184. An example of a co-operative health education project between local health services and a school in a peri-urban setting is provided in:

Bhalerao, V.R., **Schoolchildren as health leaders in the family**, *World Health Forum* 2 (2): 209-210.

The staff of a local health care centre in a Bombay slum began a free lunch programme at a nearby school in an attempt to improve the health status of the neighbourhood's children. Clinic staff began to use the school setting in an attempt systematically to educate the children in nutrition and personal hygiene in the expectation that the health messages would be relayed home. Initial success in using the children as a route to the home encouraged the clinic to use the children further in arranging immunisation for their siblings, a programme which worked very well and which convinced the clinic that schoolchildren could effectively be used as general monitors of health and hygiene in their families.

185. One final interesting attempt to use school, or school-age, children as a resource in community health education and action deserves mention here, and that is the:

Child-to-Child Programme and Report of the evaluation of the Child-to-Child Programme, Feuerstein, Marie-Therese, Institute of Child Health, 30 Guilford Street, London WC1N 1EH, England.

Developed to coincide with the International Year of the Child in 1979, the Child-to-Child Programme is based on the social reality that, in many countries, especially in the developing world, it is other children who provide a great deal of care for their younger siblings. It was reasoned that if these older children could be taught the benefits of adequate nutrition, hygiene, and imaginative stimulation in play, as well as simple techniques for measuring malnutrition and administering rehydration in cases of diarrhoea, then both they and their young charges would have improved chances of achieving better health status.

A booklet and simple activity sheets were prepared to be distributed and used by and through schools and youth groups of various kinds. Regional workshops to explain and disseminate the ideas have been held in Kenya, India, the Philippines, Jamaica, Lesotho and Indonesia. A preliminary evaluation of the programme was attempted in 1981. Though by no means

conclusive, the report does show that the idea has been taken up in varying degrees in nearly 60 countries within and outside the Commonwealth in a wide variety of locally-adapted Child-to-Child activities.

186. The use of local schools, teachers, and pupils as an important resource in community health education has not been overlooked by many Commonwealth countries. Most which have active community-involving primary health care programmes see the school teacher as a key figure in their workshops/village health committees/sanitation programmes. Zambia is one of the many countries which single out schoolchildren as one of their primary targets and is in the process of training primary school teachers as community health workers, giving them a combined role in the community. Teachers and schoolchildren in several parts of the Commonwealth are involved in a wide variety of "family life" education programmes dealing with such topics as sexuality, family planning, sexually transmitted diseases and so on. St Vincent and the Grenadines, one of several West Indian countries to have such programmes, reports on the training of adolescents in peer-group counselling as part of their "Outreach Family Life Education" programme.

187. One of the useful features of school health education programmes is that it is often possible to evaluate them fairly carefully. In our questionnaire, several of these countries who had carried out evaluation of their health education programmes specifically mentioned the evaluation of schools projects. As we hope to have shown in the few examples provided here, it is also possible to design, apply and evaluate programmes which extend outside the classroom and into the wider community.

Some mass media approaches with a participatory element

188. the effective use of mass media techniques in community health education is a vexed question which is dealt with more fully in the section dealing with media use. The general consensus seems to be that, as they have been used up to now, media approaches in health education have on the whole been less than satisfactory. One of the main problems has been the lack of a participatory element from the receivers of media health education packages. Communication does, after all, derive from the Latin "communicare", to share, and ought to be a two-way process. Radio is less at fault here than television. Response to our questionnaires showed that radio, apart from being far more widespread, was also more flexible in the sense that it was often locally produced and used local language and dialect. A "roving microphone" approach means that local views can be solicited even among an illiterate population unable to write in to the broadcasting station.

189. Quite a lot of success has been achieved with the radio group learning approach, and several Commonwealth countries - notably India, Ghana, Botswana and Tanzania - have experimented, or are experimenting, with this form of community education. Perhaps the most well-known and oft-quoted application of this technique to the specific field of health education is Tanzania's **Man is health** radio group learning project which has been described earlier in this report. Botswana's experimentation with radio learning groups is assessed in:

Byram, M., Kuate, C.B. and Matenge, K., 1980, **Botswana takes a participatory approach to mass media educational campaigns**, Development Communication (AID).

In this case the programme was about "Understanding Government" but the technique suggests itself strongly for health education in scattered rural settlements, and the two-page report provides useful insights into the successes, shortcomings and organisational problems of radio learning groups.

190. A manual is available for those interested in the details of how to design and organise a radio learning group campaign:

Crowley, D., Etherington, A., and Kidd, R., 1978, **Mass media manual; how to run a radio learning group campaign**, Friedrich-Ebert-Stiftung, Germany.

191. Although appropriate use of television presents a much greater problem, there have been, and are currently, several successful television group learning projects handling aspects of community health education. The community education branch of the Open University in Britain runs several imaginative courses designed so that they may be followed by people literate in English but without formal scholastic qualifications. A useful reference for those interested in the design of these courses and the principles involved is:

Wolfson, J., and Bailey, L., 1978, **A community education approach to health; the Open University**, International Journal of Health Education, 21, 4, 249-252.

Current courses are on: the first years of life; the pre-school child; childhood 5-10; health choices; parents and teenagers; caring for older people. All these have some elements of health education in the broadest sense, but "health choices" has been specifically produced in collaboration with the Health Education Council and the Scottish Health Education Group. Based on a combination of radio, television and book guidance, students can study individually but are encouraged to form local study/discussion groups for support. A series of simple tests, returned to the Open University for assessment, determine how far individuals have been able to grasp the points raised for discussion.

192. This type of programme, like the media aspects of the Finnish North Karelia project which will be described later in this section, are of course expensive, reach relatively small audiences, and imply a fairly high degree of economic development.

193. An early and interesting experiment in TV group learning in the developing world is reported from Dakar in:

Fougeyrollas, P., 1967, **Television and the social education of women**, UNESCO, Reports and Papers on Mass Communication No. 50, Paris.

This was part of a wider UNESCO/Senegal pilot project for the production, utilisation and evaluation of audio-visual media and materials including radio and TV, for adult education. Five hundred illiterate urban women were organised into television clubs in working class, peri-urban Dakar. There were two regular weekly programmes, one on hygiene and illness, the other on nutrition. These were broadcast to television receivers in the clubs and each programme was followed by a discussion among club members. The learning groups were assessed by the members themselves and by the project directors to have been very successful.

An overview and assessment of the entire project, including an evaluation of additional rural educational programmes coupled with organised community listening, is provided in:

Cassirer, H. 1974, **Mass media in an African context**, UNESCO, Reports and Papers on Mass Communication No. 69, Paris.

194. A very useful example of a project which did not work well, but from which positive lessons may be drawn for future attempts, is provided by:

Ramadasmurthy, V., Rao, D.H., Clarence, I.D. and Balasubramanian, S.C., 1978, **Nutrition education and SITE telecasts**, International Journal of Health Education, 21, 3: 168-173.

This project was carried out in India under the Indian Satellite Instructional Television Experiment Programme (SITE) and is a fairly timely reminder of the need for thorough local planning stages if high technology media are to be of any use in community health education. Selected nutrition-oriented telecasts were transmitted to rural villages provided with television sets under the scheme. The target group for these particular broadcasts was rural women of child-bearing age. Considerable thought was given to the main dialects/languages of the area and to the decision of the health messages. However, the telecasts failed to reach even a reasonable proportion of the target group for a series of fairly simple social reasons, the main one being that they were broadcast at a time when most women, having returned from the fields, were engaged in their essential cooking and domestic duties. As the authors point out, the very poor results highlighted important gaps at the planning stage. Apart from improved quality in the telecasts themselves, the authors stress the need for greater preliminary research into the felt needs and social/work patterns of the target population, and the development of a supportive/follow-up infrastructure based on face-to-face communication.

Community-involving integrated approaches

195. There are an increasing number of examples in the literature, from within and outside the Commonwealth, where experiments involving whole communities in health education/environmental health/sanitation projects have brought satisfactory results. Successful results have been reinforced where there has been an integrated approach and when political will, financial means and health service back-up and adaptability have matched local efforts.

196. In the Western world, health education efforts have tended in the past to assume the existence of more adequate services and are directed towards individuals and individual responsibility. However, this is slowly changing, and there are several interesting European examples of an integrated, community-orientated approach. One such, which has received a lot of attention, is the North Karelia Project in Finland. This is reported in:

McAlister, A., Puska P., Salonen, J.T., Tuomilehto, J. and Koskela, K., **Theory and action for health promotion: illustrations from the North Karelia project, 1982**, American Journal of Public Health, January, Vol. 72, 1, 43-50.

A complete and comprehensive description of the project and its results are provided in:

Puska, P., Tuomilehto, J., Salonen, J. et al., 1981, **The North Karelia Project: evaluation of a comprehensive community programme for control of cardiovascular diseases in 1972 and 1977 in North Karelia, Finland**, Monograph, WHO/EURO, Copenhagen.

The results of the project "are not conclusive, but they are encouraging", and the authors themselves stress that they would like the project to be viewed as "a promising case study rather than a critical test of the effects of health promotion".

From our point of view, one of the most interesting aspects of this "case study" is that it arose in direct response to a petition by the local population to the government to do something to reduce high cardiovascular disease in the area. From the start then, the project was able to involve fully and work alongside community leaders, volunteers, groups and organisations in this rural farming area in Finland. It also had the backing of government agencies in the reorganising of local preventive services and the control of tobacco and cigarette promotion, and by using local influence managed to persuade local food industries, especially the dairy industry, to develop and promote low fat foodstuffs. In response, then, to the expressed need of the local population, the project set itself the following inter-related goals:

- (a) **Improved preventive services** to identify persons at abnormal risk of disease and provide appropriate medical attention;
- (b) **information** to educate people about their health and how it can be maintained;
- (c) **persuasion** to motivate people to take healthy action;
- (d) **training** to increase skills of self-control, environmental management and social action;
- (e) **community organisation** to create social support and power for social action;
- (f) **environmental change** to create opportunity for healthy actions and improve various unfavourable conditions.

The project used a great deal of health service and media expertise. It collected and collated an enormous amount of data. It was also expensive, though there are indications that the expense may already be more than recouped by reduced application for disability pensions. Many countries would not be in a position to mount such an ambitious project for an, as yet, uncertain outcome. We include it as a good example of a community-initiated, integrated approach to a pressing health problem.

197. Another simpler European study in which villagers interacted and co-operated in promoting environmental health is reported in:

Tomic, B. et al., 1977 Ivanjica; **A community conquers health**, International Journal of Health Education, 20, 2 supp.

A small, rural Yugoslavian village with difficult access to an irregular water supply had nevertheless not carried through some earlier plans to gain easier access to cleaner water. A government programme of health education in the district emphasised the connection between polluted water and the high local incidence of intestinal disease. At the same time the Government offered help to all those villages willing to contribute manpower to secure a clean water supply. The success of schemes in the surrounding villages, plus the increasingly vociferous co-ordinated complaints of the women who actually had to carry the water, led to the setting-up of a village committee which sought government help. Government technical assistants worked together with the villagers and all villagers worked on the digging of a long channel through which water was piped from a more distant but reliable spring. Each household committed itself to digging of a section of the channel. The village set up a health committee to oversee maintenance of the supply and the committee gradually extended its interests to adequate sanitation, the production of a variety of cleaner

and more nutritious foods, and even to gaining an electricity supply for the village.

Though the project was not systematically evaluated, the reported spin-off from people's participation in obtaining their clean and regular water supply was an improvement in overall community development and improved community health.

198. The setting-up of village health committees in Africa is discussed in:

Iseley, R.B., Sanwogou, L.L. and Martin, J.F., 1979, **Community organisation as an approach to health education in rural Africa**, International Journal of Health Education, 22, 3, Supplement, 3-19.

The authors describe the organisation of village health committees in South Central Cameroon, with a useful discussion of the methods used and some of the difficulties encountered, as well as a description of some of the activities and accomplishments of the committees. These range from the digging of latrines, the protection and maintenance of water sources and the digging of garbage pits to the building of animal enclosures. Evaluation is limited by the number of activities undertaken by the health committees, but there is a helpful general discussion of the committees' work and their, often underestimated, potential in bringing about individual and collective change in health and health-related behaviour. Pertinent points are made about the need for substantial, consistent and flexible support from the university and the health services if such committees are to make a real impact on rural health.

199. A more detailed discussion of just how the village health committees were set up and village health priorities were determined, is provided in:

Iseley, R.B., and Martin, J.E., 1977, **The village health committee - starting-point for rural development**, W.H.O. Chronicle, 31, 307-315.

200. Village or suburban health committees are not of course a new concept, and replies to our questionnaire showed that they already exist fairly widely throughout the Commonwealth and that they perform a variety of useful roles, especially in the area of environmental health. An original and interesting example of the setting-up of a village health committee comes again from Africa, and is reported in:

Ade Laoye, J., 1980, **Selling health in the market place: the Araromi approach**, International Journal of Health Education, Vol. 23, 2, 87-93.

The study centres on Araromi, a rural Nigerian village which acts as a centre for surrounding villages and has a market every five days to which all come. The village had a traditional hierarchical structure with a chief and village council. It also had a high percentage of practising traditional healers and inadequate and under-used health service provisions. The project's health educators lived in the village for a period and worked initially through the chief and the village council. Acting as resource persons, they gradually guided community members towards enumerating health problems in the villagers' own order of priority. The knowledge and support of traditional healers was especially solicited.

The project team had set themselves three major objectives:

- (a) to "sell" the concept of "good health";
- (b) to identify major health problems with the help of community members;

(c) to foster their participation solving these problems.

To these they added, after their initial experiences, a further four:

- (d) to identify factors inhibiting positive health attitudes and practices with a view to removing or minimising these factors;
- (e) to foster contact between the community and nearby health and allied services;
- (f) to stimulate individual willingness to contribute in spare time to professional know-how as a major step in self-help projects;
- (g) to enlighten community members about the usefulness of local resources in maximising individual and community health.

One of the prime novel techniques applied in the concept of "selling" health was to set up a "health stall" at the local market. Clean drinking water was provided to market-goers; demonstrations and information were given on disease prevention; a pit latrine constructed from local materials was used as a prime "exhibit"; and a free entertainment took the form of the showing of health education films. Villagers were trained to run the stall themselves, and market-goers were much impressed that local people were able to give health talks. A request from a nearby village to set up a similar scheme gave the project leaders the chance they had been looking for to suggest to Araromi that the villagers should now oversee their own health activities. A village health committee was duly set up with the project leaders staying on as ordinary members and co-ordinators. As well as health service personnel, traditional healers and birth attendants were included in the committee.

From initial indifference to environmental health, broad local involvement in the health committee began to produce an "it's our problem" approach, and positive steps were taken to improve environmental health. These included the protection of water sources, the digging of pit latrines, the burning of rubbish and covering of prepared food in the market. Co-operation with existing health services improved. The local dispensary recorded an increase of 300 per cent attendance and the maternity centre a 100 per cent increase, with traditional birth attendants allowed to be present in the labour room at the patients' request.

201. Our last example of an integrated community development approach with a strong community health education element comes from:

Adamson, P., 1982, *The Gardens*, *New Internationalist*, No. 109,

This is an anecdotal but vivid and moving account of life in "The Gardens", now a section of the slums of Colombo, Sri Lanka. Their apparently inappropriate name derives from the fact that the shanties which make them up are crowded into the walled areas which once demarcated the gardens of the large houses of the area.

The author's account incorporates an interesting critical assessment of the UNICEF-sponsored "Colombo Project", a project designed to promote environmental health and community development in the slums and shanties of Colombo.

The goals of the project were to install and upgrade latrines, to install washrooms, and to provide clean water standpipes in "The Gardens".

Community health education was seen as a vital component of the project, since such poor facilities as already existed were ill-kept and abused, and health behaviour was at a low level generally.

One hundred primary health care workers were trained to act as health wardens in the area, disseminating health education and advice and liaising for the inhabitants with the existing health services and with those government agencies related to environmental health.

The would-be recipients of the "Colombo Project" were encouraged to organise themselves into community development councils with elected representatives. These were to promote their case with officialdom over their health and sanitation problems and also the problems of unemployment and poverty which marked the area.

The report gives some very useful insights into how and where big foreign aid schemes can go wrong. It illuminates some of the difficulties that have to be overcome in applying an integrated approach. The successes and failures of the project also provide an excellent example of the almost overwhelming economic, political and social problems facing community health education in peri-urban slums.

202. Finally, for those interested in the possible use of folk-medicine practitioners as community health educators, we include an interesting example of innovation from Mexico:

Simoni, J.J., Vargas L.A. and Casillas, L., 198, **Medicine showmen and the communication of health information in Mexico**, Occasional paper No. 7, Non-Formal Education Information Centre, College of Education, Michigan State University, East Lansing, Michigan.

The medicine showmen or **Merolicos** frequent market and other meeting places and use a combination of skills, showmanship, patter and entertainment, to attract an audience and sell medicinal products. Rapport with their audience is usually good, and they are able to utilise their understanding of local culture and language to enhance their effectiveness.

Initial research by the project team suggested that "communications on the medicine-show model might not only be favoured by many of the poor, but might be especially effective in combining the persuasive advantages of mass media and interpersonal communication channels".

They set up a pilot project to answer three questions:

- (a) Are medicine showmen actually able to effect changes in health related knowledge, attitudes and behaviour of their audiences?
- (b) Are medicine showmen effective only in rural areas?
- (c) Are medicine showmen only effective with the least educated?

Twelve communities, six rural and six peri-urban, were selected for testing and were divided into six test and six control groups. None of the communities had any previous history of localised interpersonal attempts at nutrition education. Five showmen were selected to work with the project and spent three weeks in workshops and training sessions to design and perfect a child nutrition routine based principally upon the key themes of breast feeding and early supplementary feeding. The medicine showmen were to combine their own particular style with a list of quite precise and unvarying infant nutrition "health messages". The showmen worked for

three months communicating the message in the test sites, and after a pause of two months mothers in 20 per cent of households in the test and control sites were interviewed on three lay themes:

- (a) the first breast secretion, colostrum;
- (b) breastfeeding hygiene;
- (c) the "magic meal", a bean-based supplement.

The results, which are fully discussed and enumerated in the report, showed that the medicine showmen were able significantly to influence knowledge, attitudes and behaviour in the areas where they had worked. They were effective in both the rural and urban areas, and their influence was not limited only to the uneducated.

Heartened by their results, the project team enthusiastically endorse the idea of using medicine shows as part of public health programmes.

203. As the results of our questionnaire have indicated, several Commonwealth countries, and not necessarily the more economically developed ones, are breaking new ground in community health education. Uganda's HEC unit stresses that "community participation is our cardinal principle". Botswana and Swaziland are among some of the smaller countries which advocate an integrated approach, which are trying to involve traditional healers in their health education programmes, which are experimenting with such educational techniques as popular theatre, and whose health education programmes are implanted within wider community development programmes. From among the several islands of the West Indies and the Pacific which stress community involvement and indigenous communication techniques, Western Samoa reports also involving income-generating activities in its health education programmes - such as poultry-raising, vegetable gardening and the manufacture and sale of handicrafts.

204. All this implies the beginnings of the recognition of the importance of community health education and its place in overall development. We can only hope that further experimental and innovatory projects will be carefully designed and evaluated to help point more clearly to appropriate directions for community health education to follow.